Special Medicare Plan

Plan Year 2024 and Plan Year 2025 Benefits


PLAN

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Medicare Part D Notice

As a Medicare beneficiary, a Federal law gives you more choices about your prescription drug coverage. *Please see page 66 for details*.

NOTE

Open Enrollment for health coverage for Medicare retirees is held each October, and the Plan Year is from January 1 to December 31.

Open Enrollment for Mountaineer Flexible Benefits (dental, vision and hearing aid coverage) will continue to be held each spring, and the Plan Year remains July 1 to June 30.

Introduction

Welcome to your PEIA Special Medicare Plan Benefit booklet. This booklet describes the benefits provided for PEIA insureds who have Medicare as their primary insurance coverage, but not enrolled in the Humana/PEIA Medicare Advantage and Prescription Drug (MAPD) Plan during either Plan Year 2024 or 2025 (January-December 2024 or 2025). Enrollment in the Special Medicare Plan is generally for no more than one calendar year.

It is important to review this information closely so that you may familiarize yourself with all aspects of the Special Medicare Plan. Please keep this booklet close at hand and refer to it often if you have questions about your health care benefits.

This Benefit booklet provides PEIA Special Medicare Plan participants with an easy-to-read description of benefits available through the Plan and instructions on how to use these benefits. This booklet is a summarized version of a portion of PEIA's Plan Document. The Plan Document describes, in detail, all aspects of the operations of the Agency, and is on file with the Secretary of State.

PEIA contracts with third-party administrators (TPAs) to process health and drug claims for the PEIA Plans. If you have a question about a specific claim or benefit, the fastest way to obtain information is to contact the TPA directly at one of the numbers listed below.

Subject to Change

PEIA may amend any portion of this benefit booklet in order to reflect changes required by court decisions, legislation, actions by the PEIA/RHBT Finance Board, actions by the Director or for any other matters as are appropriate. The benefit booklet will be amended within a reasonable time of any such actions, and notice will be provided no later than 60 days prior to the date on which the modification will become effective. All amendments to the benefit booklet must be in writing, dated and approved by the Director. The Director shall have sole authority to approve amendments. The Summary Plan Description and all approved amendments will be filed with the office of the West Virginia Secretary of State.

Who to Call with Questions

Health Claims and Benefits: UMR at **1-888-440-7342** (toll-free) or on the web at **www.umr.com**

Prescription Drug Claims and Benefits: Express Scripts at **1-855-224-6247** (toll-free) or on the web at **www.express-scripts.com/wvpeia.**

Common Specialty Medications: Accredo, an Express Scripts Specialty Pharmacy, at **1-800-803-2523** (toll-free)

Subrogation and Recovery: Beacon Recovery Group at **1-800-874-0500** (toll-free)

PEIA: Answers to questions about eligibility and third-level claim appeals at **1-304-558-7850** or **1-888-680-7342** (toll-free) or on the web at **peia.wv.gov**

MetLife: Answers to questions about life insurance or to file a life insurance claim. Call MetLife at **1-888-466-8640.**

Mountaineer Flexible Benefits: Dental, vision and hearing coverage. FBMC Benefits Management at **1-844-559-8248** (toll-free) or on the web at **www.myfbmc.com**

Terms You Need To Know

Affordable Care Act (ACA) Out-of-Pocket Maximum: The Affordable Care Act places a limit on how much you must spend for healthcare in any plan year before your plan starts to pay 100% for covered essential health benefits. This limit includes deductibles (medical and prescription), coinsurance, copayments, or similar charges and any other expenditure required of an individual which is a qualified medical expense for the essential health benefits. This limit does not include premiums, balance billing amounts for non-network providers and other out-of-network cost-sharing, or spending for non-essential health benefits.

The maximum out-of-pocket cost for Plan Years 2024 and 2025 can be no more than the rates set by the federal government for individual and family plans. Because PEIA's plans have out-of-pocket maximums that are substantially lower than the ACA required limits, the ACA out-of-pocket maximum should never come into play for Special Medicare Plan members.

Allowed Amounts: For each PEIA-covered service, the allowed amount is the lesser of the actual charge amount or the maximum fee for that service as set by the PEIA.

Alternate Facility: A facility other than an acute care hospital.

Annual Deductible: The amount you must pay each plan year before the plan pays its portion of the cost.

Authorized Individual: A person who has legal authority to make decisions related to health care for an individual. Examples are a spouse or other family member named in a health care power of attorney, a parent or legal guardian of a minor, a person appointed by a court to serve as custodian, guardian or conservator and an executor, administrator, or other person with authority to act on behalf of a deceased individual.

Beacon Recovery Group: The subrogation and recovery vendor for PEIA. Beacon pursues recovery of money paid for claims that were not the responsibility of the PEIA Special Medicare Plan. For more information, read the "Recovery of Incorrect Payments" section.

Beneficiary: The person who receives the proceeds of your PEIA life insurance policy. As of July 1, 2022, PEIA is no longer responsible for the management of beneficiaries of PEIA life insurance policies. The designation of, changes to, and updates of beneficiary information are the responsibility of the PEIA life insurance vendor, Met Life.

Claims Administrator: UMR for medical claims and Express Scripts for prescription drug claims.

Common Specialty Medications: Specialty medications are high-cost injectable, infused, oral or inhaled drugs that generally require close supervision and monitoring of the patient's drug therapy. Under the PEIA Special Medicare Plan, all specialty medications require precertification.

Coordination of Benefits: A practice insurance plans use to avoid double or duplicate payments or coverage of services when a person is covered by more than one plan.

Copayment: This is the set dollar amount that you pay when you use services—like the flat

dollar amount you pay for an office visit. Copayments count toward your annual out-of-pocket maximum in the Special Medicare Plan.

Deductible: The amount of eligible expenses you are required to pay before the plan begins to pay benefits. See Annual Deductible above. This plan has both a medical and a prescription drug deductible.

Dependent: An eligible person, under PEIA guidelines, who the policyholder has properly enrolled for coverage under the Plan.

Durable Medical Equipment: Medical equipment that is prescribed by a physician which can withstand repeated use, is not disposable, is used for a medical purpose, and is generally not useful to a person who is not sick or injured.

Eligible Expense: A necessary, reasonable, and customary item of expense for health care when the item of expense is covered at least in part by one or more plans covering the person for whom the claim is made. Allowable expenses under this plan are calculated according to PEIA fee schedules, rates, and payment policies in effect at the time of service.

Emergency: A condition that manifests itself by acute symptoms of sufficient severity including severe pain such that the absence of immediate medical attention could reasonably be expected to result in serious jeopardy to the individual's health or with respect to a pregnant woman the health of the unborn child, serious impairment to bodily functions or serious dysfunction of a bodily part or organ.

Exclusions: Services, treatments, supplies, conditions, or circumstances that are not covered under the PEIA Special Medicare Plan.

Experimental, Investigational, or Unproven Procedures: Medical, surgical, diagnostic, psychiatric, substance abuse or other health care technologies, supplies, treatments, procedures, drug therapies or devices that are determined by the plan (at the time it makes a determination regarding coverage in a particular case) to be: (1) not approved by the U.S. Food and Drug Administration (FDA) to be lawfully marketed for the proposed use and not identified in the American Medical Association Drug Evaluations as appropriate for the proposed use; or (2) subject to review and approval by any Institutional Review Board for the proposed use; or (3) the subject of an ongoing clinical trial that meets the definition of Phase 1, 2, 3 Clinical Trial set forth in the FDA regulations, regardless of whether the trial is actually subject to FDA oversight; or (4) not demonstrated through prevailing peer-reviewed medical literature to be safe and effective for treating or diagnosing the condition or illness for which its use is proposed. Phase 2 and 3 Clinical Trials for terminal cancer and other life-threatening conditions and which meet certain statutory criteria will be covered despite being experimental.

Explanation of Benefits (EOB): A form sent to the person filing the claim after a claim for payment has been evaluated or processed by the Claims Administrator which explains the action taken on the claim. This explanation might include the amount paid, benefits available, reasons for denying payment, etc.

Express Scripts: PEIA's prescription drug benefit manager (PBM). Express Scripts processes and pays prescription drug claims and helps manage the prescription drug benefit.

Handicap: A medical or physical impairment which substantially limits one or more of a person's major life activities. The term "major life activities" includes functions such as care for oneself, performing manual tasks, walking, seeing, hearing, speaking, breathing, learning or working. "Substantially limits" means interferes with or affects over a substantial period of time. Minor, temporary ailments or injuries shall not be considered physical or mental impairments which substantially limit a person's major life activities. "Physical or mental impairment"

includes such diseases and conditions as orthopedic, visual, speech and hearing impairments; cerebral palsy; epilepsy; muscular dystrophy; autism; multiple sclerosis and diabetes. The term "handicap" does not include excessive use or abuse of alcohol, tobacco or drugs.

Inpatient: Someone admitted to the hospital as a bed patient for medical services.

Insured: Someone who is eligible for and enrolled in a PEIA Plan, a managed care plan or life insurance only. Insured refers to anyone who has coverage under any plan offered by PEIA.

Legal Guardianship: A legal relationship created when a person or institution is named by the Court to take care of minor children. Eligibility for guardianship requires an Order from a Court of Record. Notarized documents signed by parents assigning "guardianship" are not sufficient to establish eligibility. The term "guardian" may also refer to someone who is Court-appointed to care for and/or handle the affairs of a person who is incompetent or incapable of administering his/her affairs. Sometimes a separate person is appointed to handle the financial matters of the child(ren) or the adult and that relationship is called a conservatorship.

Medicare Advantage/Prescription Drug (MAPD) Plan: A type of Medicare benefits that combines Medicare Parts A, B, and D into one comprehensive benefit package. Most Medicare retirees with PEIA benefits are enrolled in the Humana/PEIA MAPD plan.

Medicare: The federal program of health benefits for retirees and other qualified individuals as established by Title XVII of the Social Security Act of 1965, as amended. Medicare Parts A and B provide medical coverage to Medicare Beneficiaries. Retired qualified Medicare Beneficiaries covered by PEIA are REQUIRED to enroll for both Medicare Part A and Part B. Medicare Part D (drug coverage) IS NOT required for members of the PEIA Plan.

Medicare Beneficiary: Individual eligible for Medicare as established by Title XVII of the Social Security Act of 1965, as amended.

Member: A policyholder or dependent enrolled in a managed care plan offered by PEIA.

Outpatient: Someone who receives services in a hospital, alternative care facility, freestanding facility, or physician's office but who is not admitted as a bed patient.

Pharmacy Benefits Manager (PBM): A company with which PEIA has contracted to administer the prescription drug benefit component of the Special Medicare Plan. The PBM processes and pays prescription drug claims and helps manage the prescription drug benefit.

Plan: The plan of benefits offered by the Public Employees Insurance Agency, including the PEIA PPB Plans, the Special Medicare Plan, the managed care plans and life insurance coverages.

Plan Year: A 12-month period beginning January 1 and ending December 31.

Policyholder: The employee, retired employee, surviving dependent or COBR A participant in whose name the PEIA provides any health or life insurance coverage.

Premium: The payment required to keep coverage in force.

Prior Authorization: The required process of obtaining authorization from the Rational Drug Therapy Program for coverage for some non-specialty prescription medications and from Express Scripts for some specialty prescription medications under the PEIA PPB Plans.

Qualifying Event: A qualifying event is a personal change in status which may allow you to change your benefit elections. Examples of qualifying events include, but are not limited to, the following:

1. Change in legal marital status – marriage or divorce of policyholder or dependent

2. Change in number of dependents – birth, death, adoption, placement for adoption, award of legal guardianship
3. Change in employment status of the employee's spouse or employee's dependent – switching from part-time to full-time employment status or from full-time to part-time, termination or commencement of employment, a strike or lockout, commencement of or return from an unpaid leave of absence which results in employee/dependent becoming ineligible for coverage

If you experience a qualifying event, you have the month in which the event occurs and the two following calendar months to act upon the qualifying event and change your coverage. If you do not act within that timeframe, you cannot make the change until the next open enrollment. Qualifying events which end eligibility (such as divorce, termination of Guardianship/parental rights, etc.) must be reported **immediately**. For purposes of eligibility, the term "immediately" shall mean as soon as practically possible and, in no case, greater than thirty (30) days from the date of the event, e.g. divorce. For purposes of this section, "Reporting" means the proper submission of a "Change in Status" form to the member's Employer Agency Benefit Coordinator and/or the proper submission of the Qualifying Event through the PEIA Manage My Benefits Portal with the appropriate supporting documentation, e.g. a copy of the divorce decree, Court Order(s), etc. "Calling" and/or e-mailing and informing your participating employer and/or PEIA of an event does not meet the reporting requirements of this section.

Rational Drug Therapy Program (RDT): The Rational Drug Therapy Program of the WVU School of Pharmacy provides clinical review of requests for drugs that require prior authorization under the PEIA Plans.

Reasonable and Customary: The prevailing range of charges and fees charged by providers of similar training and experience, located in the same area, taking into consideration any unusual circumstances of the patient's condition that might require additional time, skill or experience to treat successfully.

Secondary Payer: The plan or coverage whose benefits are determined after the primary plan has paid. *See Coordination of Benefits on page 56.*

Special Medicare Plan: The plan created by PEIA to provide benefits to retirees unable to access providers in the Medicare Advantage plan and those retirees who become eligible for Medicare benefits during a plan year. Claims under this plan are processed by UMR and Express Scripts, and the medical benefits are generally the same as those provided to members of the PEIA Medicare Advantage plan

Spousal Surcharge: PEIA is required by law to apply a monthly spousal surcharge to active employees of State agencies, colleges, universities, and county boards of education if the active employee's spouse is eligible for employer-sponsored coverage through his/her employer and has PEIA coverage. **If the active employee's spouse is eligible for coverage as an employee of a PEIA-participating agency, has Medicare, Medicaid, TRICARE or is retired, the spousal coverage surcharge does not apply.**

Third Party Administrator (TPA): A company with which PEIA has a contract to provide services such as customer service, utilization management and claims processing to PEIA Special Medicare Plan participants.

UMR: The third-party administrator that handles medical claim processing and customer service for the PEIA Special Medicare Plan.

What PEIA Offers

Health Coverage

PEIA offers the Special Medicare Plan to two groups of Medicare-eligible retirees:

1. Members who are unable to access medical care through the PEIA Medicare Advantage (Humana) Plan due to provider network limitations are permitted, on a case-by-case basis, to move into PEIA's Special Medicare Plan. These members may remain in the Special Medicare Plan until adequate provider access becomes available.
2. Medicare-eligible employees who retire after the beginning of a plan year, and retired employees who become eligible for Medicare during the Plan year will be moved to the Special Medicare Plan. Retired members who are enrolled in an HMO when they become Medicare-eligible will be transferred to PEIA's Special Medicare Plan. These members in the Special Medicare Plan will be moved to PEIA's Medicare Advantage Plan at the beginning of the next plan year (the following January).

Under the Special Medicare plan, the member purchases traditional Medicare Parts A and B, and their secondary medical and prescription claims are paid by UMR and Express Scripts, respectively. Medical benefits under the Special Medicare Plan are generally the same as those provided under PEIA's Medicare Advantage plan. These members can request to be transferred immediately to the Humana/PEIA Plan 1.

There are two main benefit differences between the PEIA Special Medicare Plan and the Humana/PEIA Plan 1:

1. The Special Medicare Plan does not offer the SilverSneakers® fitness benefit that includes a free fitness center membership. This is only available from Humana.
2. The cost of non-preferred brand name medications is different.
    a. Under the Humana/PEIA Plan 1, the copay for a 30-day supply of a non-preferred drug is 50% and maintenance medications in this category are eligible for the maintenance medication discount.
    b. Under the Special Medicare plan, a 30-day supply of a non-preferred drug will cost you 75% of the cost of the drug, and maintenance medications in this category are NOT eligible for the maintenance medication discount.

Life Insurance

As a retired employee, you are eligible for Basic decreasing term life insurance. When you enroll for health benefits, you must choose whether to also enroll for Basic life insurance. If you choose not to enroll for health benefits, you may still enroll for basic life insurance. You must have basic life insurance before you elect any of the optional life insurance coverages. Eligibility and enrollment details for the life insurance plans are included in this booklet. For a complete description of the life insurance benefits, please see the *Life Insurance Certificate provided by MetLife*. The designation of, changes to, and updates of beneficiary information is the responsibility of the PEIA life insurance vendor, MetLife.

Mountaineer Flexible Benefits

Mountaineer Flexible Benefits offers dental, vision and hearing coverage on a post-tax basis to retired employees. Enrollment materials are mailed to all eligible retired employees prior to the

annual Open Enrollment period of April 2-May 15 each year. If you have questions about these benefits, contact Fringe Benefits Management Company at **1-844-559-8248**.

Medicare Open Enrollment for health insurance is held in the fall, but Open Enrollment for Mountaineer Flexible Benefits is held each spring. The current information about these benefits and associated premiums is included in the enrollment materials mailed prior to the annual Open Enrollment.

If you have questions about Mountaineer Flexible Benefits, contact Fringe Benefits Management Company at **1-844-559-8248**.

Benefit	Options
Dental Benefits	Four plans are available with varying levels of coverage for dental care. Deductibles, copayments and benefits vary.
Vision Benefits	Coverage for vision exams and corrective lenses.
Hearing Benefits	Coverage for hearing exams and hearing aids.

All benefits are available to retirees on a post-tax basis.

Eligibility and Enrollment for Retired Employees

Who Is Eligible?

As a retired public employee, you are eligible for health and life benefits through PEIA, provided you meet the minimum eligibility requirements of the applicable State retirement system or a PEIA-approved retirement system, and your last employer immediately prior to retirement is a participating employer in the PEIA Plan and under the State retirement system or a PEIA-approved retirement system. Members who participate in a non-State retirement system must, in the case of education employees (such as TIAA-CREF or similar plans), meet the minimum retirement eligibility requirements of the State Teachers Retirement System, and in other cases, meet the minimum retirement eligibility requirements of the Public Employees Retirement System. If you have questions about your retirement, contact the Consolidated Public Retirement Board (CPRB) toll-free at **1-800-654-4406**.

Participation in the PEIA benefits plan is not automatic. Policyholders must complete the proper enrollment forms. Enrollment in a PEIA benefit plan authorizes a policyholder's employer or retirement system to deduct premiums for coverage from his/her salary or pension. Policyholders are responsible for notifying PEIA of any change in their address, marital status, Medicare eligibility, their eligibility status, or status of their dependent(s).

Return to Active Employment

If you retire, then return to active employment with a participating agency, you will lose your right to use your sick and/or annual leave for extended employer-paid PEIA coverage. When you return to active employment, you have PEIA benefits as an active employee, which makes your new effective date of coverage in the PEIA plan after July 1, 2001, and therefore you are ineligible for the sick/annual leave benefit. The only exception to this rule is provided for those who participated in the plan prior to July 1, 2001, and who become re-employed with an employer participating in the plan within two years following separation from employment (retirement). In this case, the employee would be permitted to apply any sick and/or annual leave earned after

re-employment, toward health premiums at retirement.

Employees hired on and after July 1, 2010, will not receive any plan subsidy of their premiums at retirement. These employees may continue coverage in the plan at retirement, but must pay the unsubsidized premium for the coverage of their choice. Two exceptions will be made to this rule:

1. Active employees hired before July 1, 2010, who separate from public service but return within two years of their separation may be restored to their original (pre-July1, 2010) hire date.

2. Retired employees who had an original hire date prior to July 1, 2010, may return to active employment and retain their pre-July 1, 2010, original hire date for purposes of determining their eligibility for premium subsidy.

Disability Retirement

A member who is granted disability retirement by a state retirement system or who receives Social Security disability benefits is eligible to continue coverage in the PEIA Plan as a retired employee, provided that the member meets the minimum years of service requirement of the applicable state retirement system. Members in this category continuously covered since before July 1, 2010, pay the same premiums as those with 25 or more years of service. Those hired on or after July 1, 2010, may continue coverage, but will pay the full, unsubsidized premium for that coverage.

Medicare

As a retired employee or a dependent of a retired employee, who is an eligible beneficiary of Medicare, you must maintain coverage in Medicare Part A and Medicare Part B. Part A is an entitlement program and is available without payment of a premium to most individuals. Part B is the supplementary medical insurance program that covers physician services, outpatient laboratory and x-ray tests, durable medical equipment and outpatient hospital care. Part B requires payment of a monthly premium.

Most Medicare-eligible retired employees and Medicare-eligible dependents of retired employees have coverage through the Humana/PEIA MAPD Plan. PEIA provides this Special Medicare Plan to cover members who have access issues with the Humana/PEIA MAPD Plan, and members who become eligible for Medicare in the middle of a plan year. Most members are enrolled in the Special Medicare Plan for less than a year. For those who become eligible for Medicare in the middle of a plan year, they stay in the Special Medicare Plan for the balance of that plan year and are transferred to the PEIA Medicare Advantage Plan on the following January 1. Those who become eligible for the Special Medicare plan during a plan year have the right to request immediate enrollment in the Humana plan. *Call PEIA for details.*

PEIA offers only one Special Medicare Plan, and its benefits mirror the benefits of PEIA/Humana Plan 1. When you become a member of the Special Medicare Plan, any non-Medicare dependents on your plan will be enrolled in PEIA PPB Plan A. If you were enrolled in PEIA PPB Plan B as a non-Medicare retiree, your and your dependents' coverage will change when you move to the Special Medicare Plan. Once you move to Humana (the following January 1), as long as you have non-Medicare dependents, you are only eligible for PEIA/Humana Plan 1. When you and all of your dependents have Medicare coverage, you will be offered the opportunity to enroll in PEIA/Humana Plan 2 during the next open enrollment.

If you have not done so already, please send a copy of your Medicare card to PEIA. This notification will make the claims payment process go much more smoothly.

Medicare offers prescription drug coverage through a program called Medicare Part D. **Please be aware that you should NOT purchase Medicare Part D coverage. You DO NOT need to enroll in a separate Medicare Part D plan, since PEIA and Express Scripts will provide prescription drug coverage for Special Medicare Plan members.**

Dependents

If you elect PEIA coverage, you may also enroll the following dependents with proper documentation:

- your legal spouse;
- your biological or adopted children or stepchildren under age 26;
- other children for whom you are the court-appointed guardian to age 18.

From time-to-time PEIA may conduct eligibility audits to verify that policyholders and dependents in the plan qualify for coverage. If you are audited, you will have to produce documentation for the dependent in question, including your most recent Federal tax return showing that you've claimed the dependent(s) on your taxes. If you cannot prove that the dependent qualifies for coverage, coverage will be terminated retroactively to the date the dependent would otherwise have been terminated, and PEIA will pursue reimbursement of any medical or prescription drug claims paid during the time the dependent was ineligible

How to Enroll

You may enroll for or change PEIA health and life benefits by completing enrollment forms available from the PEIA. On these forms, you will select the types of coverage you want and enroll the eligible dependents you wish to cover. When you have completed the forms, return them to the PEIA. Participation in PEIA benefit plans is not automatic upon retirement; you must complete the proper enrollment forms. Enrollment authorizes PEIA to deduct the premiums from your annuity for the coverages you select.

If you cancel your PEIA coverage or you allow your PEIA coverage to lapse as a retiree, you may choose to re-enroll for health coverage during Open Enrollment each year. You may enroll at other times during the plan year ONLY if you have a qualifying event. *See page 23 for a list of the qualifying events.* Coverage will be effective on the first day of the month following enrollment.

There are restrictions on how and when you may enroll and make changes in your coverage. Please read all parts of the "Eligibility" section of this booklet carefully before you enroll, so that you will fully understand your options and responsibilities.

You may also make changes in your benefits and demographic information by going to **peia.wv.gov** and clicking on **"Manage My Benefits"**, or by calling PEIA to request the appropriate forms.

Life Insurance

You may make an election to continue your basic, optional and dependent life insurance at the time of retirement. If you wish to elect new or increased life insurance as a retired employee, you must enroll and submit medical information during the calendar month of retirement or the two following calendar months. Coverage will be effective upon approval of PEIA's life insurance carrier. You may not add or increase life insurance after this period. As of July 1, 2022, MetLife manages life insurance beneficiaries for PEIA. If you need to update, add or change your beneficiary information, please contact MetLife at the number at the front of this book.

Enrolling Your Dependents

You may enroll dependents for health coverage when you enroll as a retiree, and if you do, their coverage begins the same day as yours. You may enroll dependents for health coverage outside your initial enrollment period only if you experience a qualifying event. If you enroll them at a later date, their coverage will become effective the first day of the month following enrollment. In the absence of a qualifying event, you may only enroll dependents for health coverage during Open Enrollment. Coverage will be effective on the first day of the following plan year. To add a dependent to your coverage, you must submit documentation to prove that this is an eligible dependent. As a result of changes in federal regulations, PEIA is now required to collect and maintain the Social Security number of each covered person; therefore, dependents (except newborn children) cannot be added to PEIA coverage without a Social Security number.

If you are adding a dependent to your existing dependent life insurance policy at a date later than the calendar month following an enrollment event, coverage will not become effective until medical information has been submitted to, and approved by, PEIA's life insurance carrier. To add a dependent to your coverage, you must submit documentation to prove that this is an eligible dependent.

Dependents may be removed from coverage during open enrollment or at the time of a qualifying event. The policyholder must provide documentation supporting the qualifying event to remove dependents. Coverage of removed dependents will terminate at the end of the month in which the policyholder removes them from coverage.

Special Medicare Plan

For the Special Medicare Plan, you must enroll new dependents during the calendar month of, or the two calendar months following, the date of the qualifying event that makes them eligible (i.e., date of marriage, date of birth or adoption) even if you already have family coverage. To add a dependent to your coverage, you must submit documentation to prove that this is an eligible dependent. In the absence of a qualifying event, coverage may be added or changed for the employee and/or eligible dependents, only during PEIA's annual Open Enrollment period.

Life Insurance

Add new dependents to your existing dependent life insurance policy during the calendar month of or the two calendar months following the date they become eligible (i.e., date of marriage, date of birth or adoption).

Special Rules for Newborn or Adopted Children

Health Coverage Newborn Child

When you have a child you must:

- enroll your biological newborn child during the calendar month of birth or the two following calendar months.
  - coverage will be made effective retroactive to the date of birth,
  - any premium increase associated with the addition of this child will also be retroactive to the month of birth, and
  - if you do not enroll your newborn within this time frame, you cannot add the newborn child until the next open enrollment period.
- provide documentation
  - PEIA will accept the Certificate of Live Birth from the hospital as documentation to enroll the child initially, but you must provide the Birth Certificate within 90 days or PEIA will terminate the child's coverage;
  - you do not need a Social Security Number to enroll your newborn, but when you get the baby a Social Security Number, please provide it to your benefit coordinator or to PEIA, or PEIA will suspend the child's coverage until we receive it.

Adopted Child

When you adopt a child you must:

- enroll an adopted child during the calendar month the child is placed in your home or the two following calendar months;
  - coverage will be made effective retroactive to the date of placement, and
  - any premium increase associated with the addition of this child will also be retroactive to the date of placement.
  - Coverage for an adopted infant will become effective the day the adoptive parents are legally and financially responsible for the medical expenses if bona fide legal documentation is presented to PEIA.
  - If you do not enroll your child within this timeframe, the adopted child cannot be added to your coverage until the next open enrollment period.
- provide documentation:
  - PEIA requires a copy of the adoption papers to enroll the child.
  - In the case of a foreign adoption, PEIA requires adoption papers in English, and may require entry visa and/or statement from the U. S. consulate in the country of origin recognizing the adoption.

Life Insurance

Newborn Child: If you add a biological newborn child to your existing dependent life insurance policy during the calendar month of or the two calendar months following the date of birth, coverage will be made effective retroactive to the date of birth, and any premium increase associated with the addition of this child will also be retroactive to the month of birth.

Adopted Child: If you add an adopted child to your existing dependent life insurance policy during the calendar month of or the two calendar months following the date of placement in your home, coverage can be made effective retroactive to the date of placement, and any premium increase associated with the addition of this child will also be retroactive to the date of placement.

Eligibility and Enrollment for Surviving Dependents

Who Is Eligible

If you are a surviving spouse or dependent of an active or retired public employee, and you were insured as a spouse or dependent under the policyholder's coverage by PEIA at the time of the policyholder's death, you may elect to continue health coverage as a policyholder in your own right under your health plan. To do so, you will need to complete a Surviving Dependent enrollment form available from PEIA.

If you are a surviving spouse and you choose not to enroll immediately for coverage, you may elect PEIA health coverage during a future Open Enrollment Period, **if you have not remarried. The surviving spouse's eligibility for PEIA coverage terminates upon remarriage.** If a divorce occurs after the remarriage, re-enrollment as a surviving dependent is not allowed.

Dependent Children

Surviving dependent children are eligible to **continue** health coverage, if they were enrolled in the health coverage at the time of the policyholder's death, subject to the same age restrictions as other dependent children in the PEIA plan.

- The deceased policyholder's biological or adopted children or stepchildren may continue coverage to age 26
- Other children for whom the deceased policyholder was the court-appointed guardian to may continue coverage to age 18

Surviving dependent biological children, adopted children, or stepchildren may be covered under the plan to age 26, regardless of their residency, marital status, or the availability of other insurance coverage. The dependent child's marriage is a qualifying event to cancel PEIA coverage. A married surviving dependent child may not enroll his or her spouse for PEIA coverage.

From time-to-time PEIA may conduct eligibility audits to verify that policyholders and dependents in the plan qualify for coverage. If you are audited, you will have to produce documentation for the dependent in question. If you cannot prove that the dependent qualifies for coverage, coverage will be terminated retroactively to the date the dependent would otherwise have been terminated, and PEIA will pursue reimbursement of any medical or prescription drug claims paid during the time the dependent was ineligible.

How to Enroll

To continue health coverage, surviving dependents must complete enrollment forms in the calendar month death occurs or the two following calendar months. In this case, surviving dependents must enroll in the same plan in which they were covered at the time of the policyholder's death. Surviving dependents are not eligible for life insurance.

In the event that the surviving dependent is a retired public employee who is benefit-eligible in his or her own right, the surviving dependent must choose whether to enroll as a surviving dependent of the policyholder, or as a retired employee.

- If enrolled as a surviving dependent, premiums will be based on the Medicare or Non-Medicare retiree premium (depending on the survivor's Medicare entitlement) and the years of service earned by the deceased policyholder, but the surviving dependent is not eligible for life insurance.

- If enrolled as a retired employee, premiums will be based on his/her own years of service and he/she will be eligible for life insurance.

If you need help evaluating which would be better, please contact PEIA's customer service unit at **1-888-680-7342**.

Special Eligibility Situations

Disabled Child

Your dependent child may continue to be covered after reaching the age at which coverage would otherwise have ended if he or she is incapable of self-support because of mental or physical disability. To be eligible:

- the disabling condition must have begun before the child reached the age at which coverage would otherwise have ended;
- the child must have been covered by PEIA upon reaching the age at which coverage would otherwise have ended; and
- the child must be incapable of self-sustaining employment and chiefly dependent on you for support and maintenance.

To continue this coverage, contact PEIA for an application. You will be asked to provide documentation upon application for this benefit and periodically thereafter.

Court-Ordered Dependent (COD)

If a PEIA-insured retired employee and his or her spouse divorce, the retired employee must remove the ex-spouse from coverage, even if the court orders the retired employee to provide medical coverage for the ex-spouse. **Ex-spouses are NOT eligible dependents in the PEIA plan**. To provide the coverage for an ex-spouse as ordered by the court, the retired employee must look to COBRA coverage or for other privately available coverage.

If a PEIA-insured retired employee and his or her spouse divorce, and the retired employee is not the custodial parent for the dependent child(ren), the retired employee may continue to provide medical benefits for the child(ren) through the PEIA plan. If the non-custodial parent is ordered by the court to provide medical benefits for the child(ren), the custodial parent may submit medical claims for the court-ordered dependent(s), and benefits may be paid directly to the custodial parent. Special claim forms are required. The custodial parent will also receive Explanations of Benefits (EOBs) for the CODs as claims are processed. PEIA is required by law to comply with National Medical Support Orders and may be compelled to administratively add coverage(s) for dependents listed in these Orders. *Contact PEIA to discuss this benefit*.

Medicare Retired Policyholder with Non-Medicare Dependents

If you are a Medicare retiree covered by PEIA's Special Medicare Plan and you have non-Medicare dependents, the non-Medicare dependents have coverage through PEIA PPB Plan A.

The non-Medicare dependents' benefits are described in the current Summary Plan Description, which is available on PEIA's website at **peia.wv.gov** or you can request a copy by calling PEIA's customer service unit at **1-888-680-7342**.

Medicare-eligible Members Who Reside and Incur Medical Claims Outside the U.S. and Residents with No Medicare Part A and/or Part B

Medicare-eligible retirees who reside and incur medical claims outside the United States do not have Medicare coverage; therefore, their benefits are provided through UMR and Express Scripts, with PEIA serving as the primary insurer. Those who live in the U.S., but who are not eligible for Medicare Part A and/or Part B, also have PEIA as their primary insurer. Since you do not have Medicare, there is no coordination of benefits and PEIA will pay as it does for active employees and non-Medicare retirees based on PEIA's fee schedules. You will be responsible for any balance. This plan has the same deductible and out-of-pocket maximum as the non-Medicare retiree plans. Medical claims are processed by UMR, and PEIA pays only the PEIA allowed amount. Prescription drug claims are processed by Express Scripts under the active employee and non-Medicare retiree benefit. For members who would normally be entitled to Medicare but for some reason are not eligible, the non-Medicare premium will apply.

Other Eligibility Details

Annual Open Enrollment

Open Enrollment is the time of year when members can make benefit changes without a Qualifying Event. Policyholders can add or drop dependents during this time without having to provide a reason. Humana members can also choose between the available Humana/PEIA Plans with coverage effective on January 1 of the following year.

Also, during Open Enrollment, eligible policyholders who have not taken advantage of any health coverage from PEIA have the opportunity to enroll, subject to the deadlines and rules in force for that enrollment period. Coverage becomes effective on the first day of the next plan year.

Open Enrollment dates are determined by the policyholder's status. Policyholders in the Humana/PEIA MAPD or Special Medicare Plans have Open Enrollment during the month of October, with benefits effective on January 1 of the following year. Active employees and non-Medicare retirees have Open Enrollment during the month of April with changes effective on July 1 of that year.

Medical Identification Cards

UMR issues ID cards upon enrollment in the Special Medicare Plan, and subsequently when there are changes in the plan that warrant it.

Your Special Medicare Plan ID card verifies that you have medical and prescription drug coverage through PEIA. On the back we've listed important phone numbers you may need. One card will be issued for individual coverage, and two cards will be issued for family coverage. The policyholder's name and identification number will be printed on all cards. *If you want additional cards for dependents not residing with you, or if you need to replace a lost card, please contact UMR at* **1-888-440-7342**.

Members enrolled in PEIA's Medicare Advantage plan, will receive an identification card from that plan, not from PEIA. For additional or replacement cards, call your plan.

When Coverage Ends

Voluntary Termination of Benefits

PEIA coverage for a retired policyholder and any covered dependents terminates at the end of the month in which the retired employee voluntarily terminates the coverage as the result of a qualifying event. If coverage is terminated, it cannot be reinstated until the next Open Enrollment period, unless the retired employee has a qualifying event.

Dependents/Surviving Dependents

Coverage for dependents terminates at the end of the calendar month in which one of the following occurs:

- policyholder (active or retired) terminates or loses coverage;
- dependent spouse (includes step-children) is divorced from employee;
- biological or adopted child or stepchild reaches 26th birthday;
- child for whom the policyholder is the court-ordered guardian reaches age 18;
- surviving spouse remarries;
- disabled dependent no longer meets disability guidelines; or
- policyholder voluntarily removes dependent from coverage.

The policyholder is required to report these events online at **peia.wv.gov** using the "**Manage My Benefits**" button, or by completing the appropriate forms to remove ineligible dependents. If a policyholder fails to remove ineligible dependents (divorced spouse, married children, etc.) the Plan may pursue reimbursement of any claims paid for the ineligible dependent from the employee. Stepchildren must be removed from the policy upon finalization of a divorce.

The policyholder may voluntarily terminate coverage for dependents as a result of a qualifying event online at **peia.wv.gov** using the **"Manage My Benefits"** button, or by completing the appropriate forms. If coverage is terminated, it cannot be reinstated until the next Open Enrollment period, unless the policyholder has a qualifying event.

Failure to Pay Premium

Your coverage as a retired policyholder, and coverage of your dependents, will be terminated if you fail to pay your premium contributions when due. Premiums are due by the fifth day of the month following the month for which the premium was invoiced. **Example:** May premium is due June 5. If payment is not received by PEIA within 30 days following the due date, all claims may be suspended. If payment is not received within 45 days following the due date, coverage will be cancelled, and all claims incurred will be your personal responsibility.

For Medicare policyholders who pay premiums directly to PEIA, failure to pay premiums will result in termination from the plan consistent with applicable Medicare rules.

Paying for Benefits

Each year the PEIA Finance Board sets premium rates for the Special Medicare Plan. Your coverage as a retired policyholder, and coverage of your dependents, will be terminated if you fail to pay your premium contributions when due. Premiums for most retired employees are deducted from their annuity on a monthly basis. Some retired employees pay premiums directly to the PEIA each month, and for them, premiums are due by the fifth of the month following the

month for which the premium was invoiced. **Example:** May premium is due June 5.

For retirees participating in one of the Consolidated Public Retirement Board systems, their share of the premium will be deducted from their monthly retirement check and forwarded by the appropriate retirement system to the Agency. If the retiree's pension is not sufficient to cover the cost of the monthly premium, a direct-pay account will be established, and the retiree will be required to remit the balance of the premium due on a monthly basis.

Tobacco-free Discount

PEIA's Special Medicare Plan premiums and optional life insurance premiums are based on the tobacco-use status of insureds. Tobacco-free insureds receive the preferred monthly premium rate. Insureds must have been tobacco-free for 6 months prior to the beginning of the Plan Year to qualify for the discount for the entire plan year. If your doctor certifies on a form provided by the PEIA, that it is unreasonably difficult due to a medical condition for you to become tobacco-free or it is medically inadvisable for you to become tobacco free, PEIA will work with you for an alternative way to qualify for the tobacco-free discount. Send all such doctors' certifications and requests for alternative ways to receive the discount to: **PEIA Discount Alternatives, 601 57th St., SE, Suite 2, Charleston, W V 25304-2345**. From time to time, the tobacco-free waiting period may be adjusted and, members will be notified in writing. For family health coverage, all enrolled family members must be tobacco-free to qualify the family for the reduced rate. PEIA reserves the right to review medical records to check for tobacco use. *See the "What is Covered" section for details*.

Members who become tobacco-free during a plan year may apply for the discount when they have been tobacco-free for at least six months. PEIA has sixty days from receipt of the tobacco affidavit to process the request and implement the discount. The tobacco-free discount will apply only to future premiums and WILL NOT be applied retroactively. **No refunds will be granted based on tobacco status.**

Advance Directives/Living Will Discount

PEIA no longer offers the Advance Directive/Living Will premium discount, although we encourage members to have an Advance Directive/Living Will, and to discuss their wishes with loved ones and health care providers. You may request information from the WV Center for End-of-Life Care at **www.wvendoflife.org** or by calling **1-877-209-8086.**

For Direct Pay Medicare Eligible Retirees

For Medicare policyholders who pay premiums directly to PEIA, failure to pay premiums will result in termination from the plan consistent with applicable Medicare rules.

Retired Employees Who Retired before July 1, 1997

Retired employees who retired prior to July 1, 1997, pay premiums based on the plan they choose, their tobacco-use status and eligibility for Medicare, but NOT their years of service. These retirees are not subject to the "years of service" policy. For premium purposes, employees who retired prior to July 1, 1997, fall into the "25 or more" years of service category on PEIA's premium charts. Generally, retired employees' contributions pay for about 30% of the cost of their claims. The remaining 70% of the cost is paid by employers. Eligible retired employees may use sick and/or annual leave to extend employer-paid health coverage. These premiums may be adjusted annually for medical inflation.

Employees Hired Before July 1, 2010, and Retired on or after July 1, 1997

Employees with a hire date before July 1, 2010, who retire on or after July 1, 1997, pay premiums for their health coverage based on the plan they choose, their eligibility for Medicare, their tobacco-use status, and their credited years of service as reported by the Consolidated Public Retirement Board (CPRB), or for those in the Teachers Defined Contribution Plan or a non-State retirement plan, the years of service reported by the employing agency or the non-State plan.

These premiums may be adjusted annually for medical inflation. Employees with 25 or more years of service will be charged the same premium as those who retired before July 1, 1997.

Those with fewer than 25 years of service will pay higher premiums. If you are using accrued sick and/or annual leave or years of service to extend your employer-paid insurance, all, or a portion of the premium will be covered by your accrued leave. (Accrued sick and/or annual leave can only be used at the time of retirement. It cannot be saved for use later.) The amount of sick and/or annual leave accrued by the retiring employee is reported by the benefit coordinator at the agency from which the employee is retiring. Disability retiree premiums are assessed on twenty-five (25) years of service.

Employees Hired after July 1, 2010, who Retire

Employees who retire with a hire date after July 1, 2010, pay premiums for their health coverage based on the plan they choose, their eligibility for Medicare, their tobacco-use status, and their credited years of service as reported by the Consolidated Public Retirement Board (CPRB), or for those in the Teachers Defined Contribution Plan or a non-State retirement plan, the years of service reported by the employing agency or the non-State plan.

These premiums may be adjusted annually for medical inflation. Employees hired on or after July 1, 2010, are not eligible for extended employer-paid insurance upon retirement.

If a member with a hire date after July 1, 2010, is granted disability retirement, they will pay the full unsubsidized premium. **Regardless of the reason for retirement, if the hire date is on or after July 1, 2010, the policyholder will pay the full, unsubsidized health care premium.**

Surviving Dependents

Surviving dependents of public employees pay premiums for their health coverage based on the plan they choose, their eligibility for Medicare, the years of service earned by the deceased employee, and their tobacco-use status. These premiums may be adjusted annually for medical inflation. Surviving dependents are not eligible for life insurance coverage. Those who were enrolled before July 1, 2015 were grandfathered under the previous benefit and continue to pay premiums based on 25 or more years of service. Premiums for surviving dependents are deducted from their annuity on a monthly basis or are paid directly to PEIA.

For surviving dependents who pay premiums directly to the PEIA each month, premiums are due by the fifth of the month following the month for which the premium was invoiced.
Example: May premium is due June 5.

Using Accrued Sick and Annual Leave to Extend Coverage

If you are a retired employee of a State agency or a county board of education (or an eligible employee of a local agency) with coverage through a PEIA plan and you had accrued sick and/or

annual leave when you retired, you may have extended your employer-paid insurance coverage. This employer-paid coverage will continue until you exhaust your accrued leave. (Accrued sick and/or annual leave can only be used at the time of retirement. It cannot be saved for use later.) You will be notified 90 days in advance, and PEIA will begin deducting the premium from your annuity or will set up an account to allow you to pay your premium directly to PEIA. If the policyholder dies, the accrued leave benefit terminates, even if the surviving dependent continues coverage. The amount of this benefit depends on when you were hired and came into the PEIA plan as follows:

Before July 1, 1988:

If you are a retired employee who has been continuously covered by PEIA since before July 1, 1988, then your additional coverage is calculated as follows:

2 days of accrued leave = 100% of the premium for one month of single coverage
3 days of accrued leave = 100% of the premium for one month of family coverage

Between July 1, 1988 and June 30, 2001:

If you were hired after July 1, 1988 and before July 1, 2001, or if you had a lapse in coverage during this period then your additional coverage is calculated as follows:

2 days of accrued leave = 50% of the premium for one month of single coverage
3 days of accrued leave = 50% of the premium for one month of family coverage

On or after July 1, 2001:

If you were hired on or after July 1, 2001, or if you had a lapse in coverage during this period, you are not eligible for extended employer-paid insurance upon retirement.

Extending Coverage for Higher Education Faculty

If you are a retired full-time faculty member who was employed on an annual contract basis for a period other than 12 months, your benefit is calculated as follows:

3 1/3 years of teaching service = 1 year of single coverage
5 years of teaching service = 1 year of family coverage

Retired Employee Assistance Programs

Retired employees whose total annual income is at or below 250% of the federal poverty level (FPL) may receive assistance in paying a portion of their PEIA monthly health premium based on years of active service, through a grant provided by the PEIA called the Retired Employee Premium Assistance program. Applicants must be enrolled in the PEIA PPB Plan, the Special Medicare Plan or PEIA's Medicare Advantage plan. Managed care plan members are not eligible for this program. Retired employees using accrued sick and/or annual leave to pay their premiums are not eligible for this program until their accrued leave is exhausted. Applications are mailed to all retired employees with health coverage each spring. Medicare-eligible retirees with 15 or more years of service who qualify for Premium Assistance may also qualify for Benefit Assistance. Benefit Assistance reduces the medical and prescription out-of-pocket maximums and most copayments. *It is described in detail beginning on page 59. For a copy of the application, call PEIA's customer service unit*.

The amount of premium assistance for which you are eligible is based on years of active service, and percentage of FPL. For surviving dependents, it will be based on years of service earned by

the deceased policyholder. Disabled retirees with a hire date prior to July 1, 2010, are considered to have twenty-five (25) years of service. Disabled retirees with a hire date on or after July 1, 2010, will pay the full unsubsidized premium.

Following is a chart that shows the premium reductions provided under the Retired Employee Premium Assistance program.

Policyholder Only Monthly Premium Reduction				
This amount will be deducted from your monthly premium for Medicare or non-Medicare coverage. If the amount of the reduction is greater than the premium due, then the premium due will be $0.				
Years of Service	**<100% of FPL**	**100-150% of FPL**	**150-200% of FPL**	**200 – 250% of FPL**
5 to 14 years	$51.00	$34.00	$19.00	$13.00
15 to 24 years	$65.00	$50.00	$31.00	$19.00
25 or more years	$88.00	$74.00	$46.00	$24.00

Policyholder with Dependents Monthly Premium Reduction				
This amount will be deducted from your monthly premium for Medicare or non-Medicare coverage. If the amount of the reduction is greater than the premium due, then the premium due will be $0.				
Years of Service	**<100% of FPL**	**100-150% of FPL**	**150-200% of FPL**	**200 – 250% of FPL**
5 to 14 years	$76.50	$51.00	$28.50	$19.50
15 to 24 years	$97.50	$75.00	$46.50	$28.50
25 or more years	$132.00	$111.00	$69.00	$36.00

Life Insurance Premiums

Life insurance premiums for all participants are set by PEIA's life insurance carrier. Retired employees must pay the basic life insurance premium to keep coverage in force. Optional life insurance premiums are paid by the retired employee and are based on age and amount of coverage. *See your Life Insurance Certificate for further details of the options available to you*.

Plan Changes and Qualifying Events

A qualifying event is a personal change in status which may allow you to change your benefit elections. Examples of qualifying events include, but are not limited to, the following:

1. Change in legal marital status – marriage or divorce of policyholder or dependent
2. Change in number of dependents – birth, death, adoption, placement for adoption, award of legal guardianship
3. Change in employment status of the employee's spouse or employee's dependent – switching from part-time to full-time employment status or from full-time to part-time, termination or commencement of employment, a strike or lockout, commencement of or return from an unpaid leave of absence which results in employee/dependent becoming ineligible for coverage

If you experience a qualifying event, you have the month in which the event occurs and the two following calendar months to act upon the qualifying event and change your coverage. If you do not act within that timeframe, you cannot make the change until the next open enrollment. Qualifying events which end eligibility (such as divorce) must be reported **immediately**. For purposes of eligibility, the term "immediately" shall mean as soon as practically possible and, in no case, greater than thirty (30) days from the date of the event, e.g. divorce. For purposes of this section, "Reporting" means the proper submission of a "Change in Status" form to PEIA and/or the proper submission of the Qualifying Event through the PEIA Manage My Benefits Portal with the appropriate supporting documentation, e.g. a copy of the divorce decree, Court Order, etc. Phone calls and/or e-mails informing PEIA of an event does not meet the reporting requirements of this section.

To make a change in your coverage, use PEIA's online enrollment site, **"Manage My Benefits"** or get a Change-in-Status form from PEIA. *ALL changes require substantiating documentation , which must be provided in English or have a certified English translation, as detailed in the following chart.*

Qualifying Event	Documentation Required
Divorce	Copy of the divorce decree showing that the divorce is final. A "bifurcated" divorce ends the marriage and the eligibility of the now ex-spouse and step-children and therefore must be reported immediately.
Marriage (of policyholder or dependent)	Copy of valid marriage license or certificate — the dependent child's marriage is a qualifying event for the policyholder to remove the dependent child from coverage. The policyholder MAY remove the child, but is not required to do so.
Birth of Child	Copy of child's birth certificate
Adoption	Copy of adoption papers
Adding coverage for a dependent child	Copy of child's birth certificate
Adding coverage for any other child who resides with policyholder	Copy of court-ordered guardianship papers
Open Enrollment under spouse's or dependent's employer's benefit plan	Copy of printed material showing open enrollment dates and the employer's name
Death of spouse or dependent	Copy of death certificate
Beginning of spouse's or dependent's employment	Letter from the spouse's employer stating the hire date, effective date of insurance, what coverage was added, and what dependents are covered

End of spouse's or dependent's employment	Letter from the employer stating the termination or retirement date, what coverage was lost, and dependents that were covered
Significant change in health coverage due to spouse's or dependent's employment	Letter from the insurance carrier indicating the change in insurance coverage, the effective date of that change and dependents covered
Unpaid leave of absence by employee, spouse or dependent	Letter from your or your spouse's or your dependent's personnel office stating the date the covered person went on unpaid leave or returned from unpaid leave
Change from full-time to part-time employment or vice versa for policyholder, spouse or dependent	Letter from the employer stating the previous hours worked and the new hours worked and the effective date of the change

All documents used in support of eligibility transactions: birth certificates, adoption papers, marriage certificates, divorce decrees, and citizenship documents (Visas, permits, residency documents, etc.), must be in English or have a certified English translation.

When submitting documents to PEIA, unless otherwise specified, PEIA requires a "true and correct" copy of the document(s). Partial and/or incomplete submissions are not acceptable.

Pictures and/or photographs of legal documents are not acceptable. "True and Correct" copies would be considered copied or scanned to PDF formats. Legal documents include, but are not necessarily limited to:

- Enrollment forms
- Change In Status Forms
- Retirement Paperwork
- Termination forms
- Life Insurance forms
- Powers of Attorney
- Premium Assistance forms and supporting documents
- Guardianship paperwork
- Divorce decrees – PEIA only requires the first and last page
- Marriage certificates
- Birth certificates
- National Medical Support Notices
- Visas/Immigration documents
- Adoption documents
- Other

PEIA will accept legible, unaltered photos of the following:

- Medicare cards
- Social Security Cards
- Employee Identification cards

Keeping Your Life Insurance Beneficiary Up to Date

Medicare retirees should keep their basic and optional life insurance beneficiaries up to date.

To view and/or change beneficiaries for your plan, please visit **mybenefits.metlife.com/**. All beneficiary changes must be made through this website or submitted on a paper form. For more information, please contact MetLife at **888-466-8640**.

Your Responsibility to Make Changes

It is your responsibility to keep your PEIA enrollment records up to date. You must notify PEIA immediately of any changes in your participation status or in your family situation and make the appropriate change to keep your PEIA coverage up to date. Examples of such changes include a change of address, a change in your marital status, or a dependent child no longer qualifying for coverage.

You should do this whether you belong to the PEIA PPB Plan, the Special Medicare Plan, PEIA's Medicare Advantage plan or if you've elected only life insurance coverage. If you fail to notify PEIA promptly of changes in your family status, your plan may adjust claims paid for ineligible enrollees.

You can update your enrollment records at any time by logging on to the PEIA website at **peia.wv.gov** and clicking on the green "**Manage My Benefits**" button. If you do not have internet access, you may update your records using a Change-in-Status form or a Change of Address form (depending on what information you need to update). The forms are available by calling PEIA. Completed forms should be returned to PEIA.

Health Care Benefits

The PEIA Special Medicare Plan pays for a wide range of health care services for retired employees and their dependents. These benefits include hospital services, medical services, surgery, durable medical equipment and supplies, and prescription drugs.

Under the plan, certain costs are your responsibility. *Please read the health care benefits section carefully so that you will have a clear understanding of your coverage under the plan*.

If you have any questions about coverage or payment for health care services, please call Medicare or:

- Medical claims and benefits UMR at **1-888-440-7342**
- Prescription drug claims and benefits Express Scripts at **1-855-224-6247**
- Common Specialty Medication claims and benefits – Accredo, an Express Scripts Specialty Pharmacy, **1-800-803-2523**

What You Pay with the PEIA Special Medicare Plan

Retired employees in the Special Medicare Plan pay copayments for some services, once the annual deductible is met. These copayments all count toward the Medical Out-of-Pocket Maximum. The deductible and copayments for medical services are shown in the following table:

Service Description	Medicare Retiree Plan Year 2024/2025 Benefit
Annual Deductible	$150
Primary Care Office Visit	$20
Specialty Office Visit	$40
Emergency Room	$50
Hospital Inpatient care	$100 per admission
Outpatient and Office Surgery	$100
Other services (testing, etc.)	$0
Medical Out-Of-Pocket Maximum	$1,200

During any plan year, if you or your eligible dependents incur expenses for covered medical services, you must meet a deductible before the plan begins to pay. The deductible in the Special Medicare Plan is $150 per person.

For inpatient admissions that span two plan years, the facility charges are paid based on the first plan year, but physician charges are paid based on the date of service, which could be in the first plan year, new plan year or both plan years. For example, if you go into the hospital on Dec. 28 and are released on Jan. 6, the hospital bill is paid based on the date of admission, so it would fall under the old plan year's deductible. Physician charges are paid based on the date of service, so if you have surgery on Jan. 2, the surgeon's bill will be processed based on the new plan year, and the deductible for the new plan year will apply to the surgeon's bill. Prescription drug benefits are covered separately. *See the "Prescription Drug Benefit" section for details*.

Lifetime Maximum

The PEIA Special Medicare Plan has no lifetime maximum.

Covered in Full

The following services are covered in full if provided by an in-network provider for the Special Medicare Plan. These are subject to change as USPSTF, CDC, and HRS recommendations are updated.

Type of Service	Frequency
Covered Preventive Services for Adults (AWV = Annual Wellness Visit)	
Abdominal Aortic Aneurysm one-time screening for men aged 65-75 who have ever smoked	Once per lifetime
Alcohol Misuse screening and counseling	Included in AWV
Aspirin use for men and women of certain ages (requires a prescription; covered under prescription drug plan)	As Needed
Blood Pressure screening for all adults	Included in AWV
Cholesterol screening for men age 35 and older and women age 45 and older or others at higher risk	Included in AWV
Colorectal Cancer screening for adults over 45	See Colorectal Cancer Screening, page 30
Depression screening for adults	Included in AWV
Type 2 Diabetes screening for adults aged 40-70 who are overweight or obese	Included in AWV
Diet counseling for adults at higher risk for chronic disease	Included in AWV
Falls prevention for adults 65 years and older	As Needed
Hepatitis B screening for people at high risk	As Needed
Hepatitis C screening for adults aged 18-79	As Specified
HIV screening for all adults at higher risk	Annually
HPV	As Needed
Immunization vaccines for adults—doses, recommended ages, and recommended populations vary: Covid Hepatitis A — Hepatitis B Herpes Zoster — Human Papillomavirus Influenza (Flu Shot) — Measles, Mumps, Rubella Meningococcal — Pneumococcal Tetanus, Diphtheria, Pertussis Respiratory Syncytial Virus (RSV) Varicella Other vaccines recommended by the CDC	As Recommended by the CDC
Lung cancer screening for adults 50-80 at high risk for lung cancer because they are heavy smokers or have quit in the past 15 years	As Specified
Obesity screening and counseling for all adults	Included in AWV
Sexually Transmitted Infection (STI) prevention counseling for adults at higher risk	Included in AWV
Tobacco Use screening for all adults and cessation interventions for tobacco users (tobacco cessation products covered under prescription drug plan; see Tobacco Cessation)	See Tobacco Cessation, page 33
Syphilis screening for all adults at higher risk	Annually
Statin preventive medication for adults 40-75 at high risk	As Needed
Tuberculosis screening for high-risk adults without symptoms	As Needed
Unhealthy drug use screening	Included in AWW
Covered Preventive Services for Women, Including Pregnant Women	
Anemia screening on a routine basis for pregnant women	As Needed
Bacteriuria urinary tract or other infection screening for pregnant women	As Needed

Type of Service	Frequency
Breastfeeding comprehensive support and counseling from trained providers, as well as access to breastfeeding supplies, for pregnant and nursing women	As Needed
Cervical Cancer screening for women aged 21-65	Every 3 Years
Chlamydia Infection screening for younger women and other women at higher risk	Annually
Contraception: Food and Drug Administration-approved contraceptive methods, sterilization procedures, and patient education and counseling (generic oral contraceptives require a prescription; covered under the prescription drug plan)	As Needed
Domestic and interpersonal violence screening and counseling for all women	Included in AWV
Folic Acid supplements for women who may become pregnant (requires a	As Needed
prescription; covered under prescription drug plan)	Once per pregnancy
Gestational diabetes screening for women 24 to 28 weeks pregnant and those at high risk of developing gestational diabetes	Annually
Gonorrhea screening for all women at higher risk	Once per pregnancy
Hepatitis B screening for pregnant women at their first prenatal visit	Annually
Human Immunodeficiency Virus (HIV) screening and counseling for sexually active	Every 3 years
women	Annually
Human Papillomavirus (HPV) DNA Test: high risk HPV DNA testing every three years for women with normal cytology results who are 30 or older	As Needed
Osteoporosis screening for women over age 65 or women younger depending on risk factors	As Needed
Preeclampsia prevention and screening	See Tobacco Cessation, page 33
Rh Incompatibility screening for all pregnant women and follow-up testing for women at higher risk	Included in AWV
Tobacco Use screening and interventions for all women, and expanded counseling for pregnant tobacco users (tobacco cessation products covered under prescription drug plan; see Tobacco Cessation)	Annually
Sexually Transmitted Infections (STI) counseling for sexually active women	Included in AWV
Syphilis screening for all pregnant women or other women at increased risk	Annually
Urinary incontinence screening	Annually
Well-woman visits to obtain recommended preventive services	Included in AWV
Well-woman visits to obtain recommended preventive services	Annually
Covered Preventive Services for Children (WCC = Well Child Care)	
Alcohol and Drug Use assessments for adolescents	Included in WCC
Autism screening for children at 18 and 24 months	Included in WCC
Behavioral assessments for children of all ages Ages: 0 to 11 months, 1 to 4 years, 5 to 10 years, 11 to 14 years, 15 to 17 years	Included in WCC
Bilirubin concentration screening for newborns	As Needed
Blood Pressure screening for children. Ages: 0 to 11 months, 1 to 4 years, 5 to 10 years, 11 to 14 years, 15 to 17 years	Included in WCC
Congenital Hypothyroidism screening for newborns	Once, for newborn
Congenital/inherited metabolic disorders and hemoglobinopathies	Once, for newborn
Depression screening for adolescents	Included in WCC
Developmental screening for children under age 3, and surveillance throughout childhood	Included in WCC
Dyslipidemia screening for children at higher risk of lipid disorders Ages: 1 to 4 years, 5 to 10 years, 11 to 14 years, 15 to 17 years	As specified

Type of Service	Frequency
Fluoride Chemoprevention supplements for children without fluoride in their water source (requires a prescription; covered under the prescription drug plan)	As Needed
Fluoride varnish for all infants and children as soon as teeth are present through age 5	As specified
Gonorrhea preventive medication for the eyes of all newborns	Once, for newborn
Hearing screening for all newborns	Included in WCC
Height, Weight and Body Mass Index measurements for children Ages: 0 to 11 months, 1 to 4 years, 5 to 10 years, 11 to 14 years, 15 to 17 years	Included in WCC
Hematocrit or Hemoglobin screening for children	Once per lifetime
Hepatitis B screening in adolescents at increased risk	Annually
HIV screening for adolescents at higher risk	Annually
Immunization vaccines for children from birth to age 18—doses, recommended ages, and recommended populations vary: Covid vaccine Diphtheria, Tetanus, Pertussis Haemophilus influenzae type b Hepatitis A Hepatitis B Human Papillomavirus Inactivated Poliovirus Influenza (Flu Shot) Measles, Mumps, Rubella Meningococcal Pneumococcal Rotavirus Varicella Other vaccines recommended by the CDC	As Recommended by the CDC
Iron supplements for children ages 6 to 12 months at risk for anemia (requires a prescription; covered under the prescription drug plan)	As Needed
Lead screening for children at risk of exposure	As Needed
Maternal depression screening for mothers of infants at 1,2,4, and 6 month visits	Included in WCC
Medical History for all children throughout development Ages: 0 to 11 months, 1 to 4 years, 5 to 10 years, 11 to 14 years, 15 to 17 years	Included in WCC
Obesity screening and counseling	Included in WCC
Oral Health risk assessment for young children Ages: 0 to 11 months, 1 to 4 years, 5 to 10 years	Included in WCC
Phenylketonuria (PKU) screening for this genetic disorder in newborns	Once, for newborn
Preexposure prophylaxis for HIV in ages 12 or older	As Needed
Sexually Transmitted Infection (STI) prevention counseling and screening for adolescents at higher risk	Included in WCC
Skin Cancer Prevention	Included in WCC
Tuberculin testing for children at higher risk of tuberculosis Ages: 0 to 11 months, 1 to 4 years, 5 to 10 years, 11 to 14 years, 15 to 17 years	As specified
Vision screening for all children	Included in WCC

What Is Covered: Medically-Necessary Services

Covered services must be medically necessary or be one of the specifically listed preventive care benefits. Medically-necessary health care services and supplies are those provided by a hospital, physician or other licensed health care provider to treat an injury, illness or medical condition. A service is considered medically necessary if it is:

- consistent with the diagnosis and treatment of the illness or injury;
- in keeping with generally accepted medical practice standards;
- not solely for the convenience of the patient, family or health care provider;
- not for custodial, comfort or maintenance purposes;
- rendered in the most cost-efficient setting and level appropriate for the condition; and
- not otherwise excluded from coverage under the PEIA Special Medicare Plan.

The fact that a physician has recommended a service as medically necessary does not make the charge a covered expense. PEIA reserves the right to make the final determination of medical necessity based on diagnosis and supporting medical data.

Who May Provide Services

The PEIA Special Medicare Plan will pay for covered services rendered by a health care professional or facility if the provider is:

- licensed or certified under the law of the jurisdiction in which the care is rendered; and
- providing treatment within the scope or limitation of the license or certification; and
- not under sanction by Medicare, Medicaid or both. Services of providers under sanction will be denied for the duration of the sanction; and
- not excluded by PEIA due to adverse audit findings.

Types of Services Covered

PEIA Special Medicare Plan covers a wide range of health care services. Some major categories of coverage are listed below.

Allergy Services. Including testing and related treatment are covered at 100% after the deductible is met.

Ambulance Services. Emergency ground or air ambulance transportation, when medically necessary, to the nearest facility able to provide needed treatment is covered at 100% after the deductible.

Ambulatory Surgery. This benefit is subject to a $100 copayment. The copayment amount applies after the deductible has been met.

Autism Spectrum Disorder. Applied behavior analysis (ABA) services when provided in network are covered with applicable coinsurance after the deductible has been met.

Bariatric Surgery. This benefit is subject to a $500 copayment and applicable coinsurance after the deductible has been met. Must meet plan guidelines.

Cardiac or Pulmonary Rehabilitation. Covered at 100% after the deductible is met.

Chelation Therapy. Benefits for these services are limited. If covered, therapy is paid at 100% after the deductible has been met.

Childhood Immunizations. Immunizations, as recommended by the CDC the American Academy of Pediatrics, for children through age 16 are covered at 100% of allowed charges, including the office visit. This benefit is not subject to deductible, coinsurance, or copayment. See

also Immunizations.

Chiropractic Services. Treatment by a chiropractor for acute neuromuscular-skeletal conditions are covered at 100% after the deductible. Related office visits would have a $40 copayment applied. Maintenance services are not covered.

Christian Science Treatment. Treatment for a demonstrable illness or injury if provided in a facility accredited by the Commission for Accreditation of Christian Science Nursing Facilities/ Organizations, Inc. or by a practitioner accredited by the Mother Church is covered at 100% after the deductible. No benefits will be paid for the purpose of rest or study, for communication costs, or if the person requiring attention is receiving parallel medical care. Coverage is limited to a maximum cost to the plan of $1,000 per plan year. If required, this benefit may be extended for inpatient care for up to 60 days per plan year.

Cochlear Implants. Surgically implanted hearing devices when medically necessary.

Colorectal Cancer Screenings. Routine screening to detect colorectal cancer is covered at 100%. This benefit is covered as follows:

- Fecal-occult blood test—1 in 12 months/age 45 and over
- Flexible sigmoidoscopy—1 in 5 years/age 45 and over
- Colonoscopy for high risk—1 in 24 months/high risk patients*; 1 in 10 years/age 45 and over
- X-ray, barium enema—1 in 5 years/age 45 and over
- X-ray, barium enema—1 in 24 months/high risk patients*
- Cologuard every 3 years/age 45 and older.
- CT colonography age 45 and older

* High risk is defined as a patient who faces high risk for colorectal cancer because of family history; prior experience of cancer or precursor neoplastic polyps; history of chronic digestive disease condition (inflammatory bowel disease, Crohn's disease, ulcerative colitis); and presence of any appropriate recognized gene markers for colorectal cancer or other predisposing factors.

Cosmetic/Reconstructive Surgery. Services provided when required as the result of accidental injury or disease, or when performed to correct birth defects.

Dental Services (accident-related only). Services provided as a result of an accident and required to restore tooth structures damaged due to that accident are covered at 100% after the deductible is met. Biting and chewing accidents are not covered. The Least Expensive Professionally Acceptable Alternative Treatment (LEPAAT) for accident-related dental services will be covered. For example, the dentist may recommend a crown, but the Plan will only provide reimbursement for a large filling. *Contact UMR for more information*.

Dental Services (impacted teeth). Medically necessary extraction of impacted teeth is covered at 100% after the deductible is met. Extractions for the purpose of orthodontia are not covered.

DEXA Scans. Dexa Scans are covered for women under age 65 who are at an increased risk of osteoporosis, as determined by a formal clinical risk assessment tool. Dexa Scans are covered for women aged 65 years or older as a screening for osteoporosis as recommended by the USPSTF.

Diabetes Education. Services of a diabetes education program that meets the standards of the American Diabetes Association are covered with applicable coinsurance after the deductible is met.

Dietitian Services. Services of a licensed, registered dietitian are covered with the appropriate office visit co-payment. Coverage is provided when prescribed by a physician for members with chronic medical conditions. *Diabetic patients see Diabetes Education above*.

Durable Medical Equipment (DME) and Prosthetics. Coverage for the initial purchase and reasonable replacement of standard implant and prosthetic devices, and for the rental or purchase (at the plan's discretion) of standard DME, when prescribed by a physician. DME and prosthetics are covered at 100% after the deductible is met.

Emergency Services (including supplies). Services received in an emergency room when the condition has been certified as an emergency are subject to a $50 copayment. The copayment applies after the annual deductible has been met.

Emergency Room Treatment. Services received in an emergency room when the condition is determined to be a nonemergency are subject to a $50 copayment. The copayment applies after the annual deductible has been met.

Home Health Services. Intermittent health services of a home health agency when prescribed by a physician are covered at 100% after the deductible is met. Services must be provided in the home, by or under the supervision of a registered nurse. The home health services are covered only if they would otherwise have required confinement in a hospital or skilled nursing facility.

Hospice Care. When ordered by a physician; covered at 100% after the deductible is met.

Hyperbaric Oxygen Therapy. Covered at 100% after the deductible is met.

Immunizations. For adults and children over age 16. The plan covers immunizations provided and administered in a physician's office as recommended by the CDC at 100%. The associated office visit is subject to the applicable copayment. Other immunizations covered at 100% after the deductible is met. If purchased at a pharmacy, the member will be reimbursed according to PEIA's fee schedule. Catch up immunizations per CDC guidelines will also be covered at 100%. This list is subject to change as PEIA will follow any recommendations to the pediatric or adult immunization scheduled published by the CDC:

https://www.cdc.gov/vaccines/schedules/hcp/imz/child-adolescent.html
https://www.cdc.gov/vaccines/schedules/hcp/imz/adult.html

Inpatient Hospital and Related Services. Confinement in a hospital including semi-private room, special care units, confinement for detoxification, and related services and supplies during the confinement are covered after the deductible and $100 per admission copayment are met.

Inpatient Medical Rehabilitation Services. When ordered by a physician, these services are covered at 100% after the deductible and $100 per admission copayment are met. Coverage is limited to 150 days per plan year.

Intensive Modulated Radiation Therapy (IMRT). Covered at 100% after the deductible is met.

Mammogram. A routine mammogram every 1 to 2 years for women over 40 to detect breast abnormalities is covered at 100% with no coinsurance or deductible required.

Massage Therapy. Therapeutic services of a licensed massage therapist for treatment of neuromuscular-skeletal conditions are covered when ordered by a physician. Covered at 100% after the deductible is met.

Mastectomy and Follow-Up. If you are receiving benefits in connection with a mastectomy due to cancer and elect breast reconstruction in connection with such benefits, you are entitled to the following procedures:

- Reconstruction of the breast on which the mastectomy was performed;
- Reconstructive surgery of the other breast to present a symmetrical appearance; and
- Prostheses and coverage for physical complications at all stages of the mastectomy procedure including lymphedemas.

Mental Health Services. Inpatient programs and outpatient partial hospitalization day programs for mental health, chemical dependency and substance abuse services are covered at 100% after the deductible and $100 per admission copayment are met. Outpatient mental health, chemical dependency and substance abuse services are covered at 100% after the deductible is met.

MRA. Magnetic Resonance Angiography services when performed on an outpatient basis are covered at 100% after the deductible is met.

MRI. Magnetic Resonance Imaging services when performed on an outpatient basis, are covered at 100% after the deductible is met.

Neuromuscular stimulators and bone growth stimulators are covered at 100% after the deductible is met.

Oral Surgery. Only covered for extraction of impacted teeth, orthognathism and medically necessary ridge reconstruction at 100% after the deductible is met. Dental implants are not covered.

Organ Transplants. Services are covered at 100% after the deductible and $100 per-admission copayment are met.

Outpatient Diagnostic and Therapeutic Services. Laboratory, diagnostic tests, and therapeutic treatments, when ordered by a physician, are covered at 100% after the deductible is met.

Outpatient or Office Surgery. This benefit is subject to a $100 copayment when performed in a physician's office, hospital or alternative facility.

Pain Management Services. Covered at 100% after the deductible is met.

Pap Smear. An annual Pap smear and the associated office visit to screen for cervical abnormalities are covered every three years.The Pap smear is covered at 100% with no deductible, and the office visit is subject to the applicable office visit copayment.

Periodic Physicals (for Adults). A routine physical exam once each year is covered in full. Diagnostic testing, lab and x-rays, provided in conjunction with a periodic physical are covered, if medically-necessary and billed with a medical diagnosis. The deductible will apply.

Primary Care Physician's Office Visits. These visits are subject to a copayment of $20

Prostate Cancer Screening. For men age 55 and over. TThe screening is covered in full if conducted as a part of the Routine Physical and Screening Exam. The PSA blood test associated with this screening, when ordered by a physician, is covered at 100% with no deductible or coinsurance in-network.

SPECT. Single Photon Emission Computed Tomography is covered at 100% after the deductible is met.

Skilled Nursing Facility Services. CConfinement in a skilled nursing facility including semi-private room, related services and supplies is covered at 100% after the deductible is met. Confinement must be prescribed by a physician in lieu of hospitalization. Coverage is limited to 100 days per plan year.

Face-to-Face (F2F) Diabetes Program

Members who are in the Face-to-Face Diabetes program and age into the Special Medicare Plan will be permitted to remain in the program for the rest of that plan year but will be disenrolled from F2F on the following January 1. This program is not approved by Medicare. Members of the Humana/PEIA MAPD plans are not eligible for F2F.

For more information call PEIA Customer Service at **1-888-680-7342**.

Weight Management Program

PEIA offers a facility-based weight management program for plan members who have a Body Mass Index (BMI) of 25 or greater or a waist circumference of 35 inches or greater for women or 40 inches or greater for men. The program includes comprehensive services from registered and licensed dietitians, degreed exercise physiologists and personal trainers at approved fitness centers. The current list of participating facilities is on PEIA's website at **peia.wv.gov** under Wellness Tools. This is a once per lifetime benefit that may last up to two years.

Members who are in the Weight Management Program and age into the Special Medicare Plan will be permitted to remain in the program for the rest of that plan year, but will be disenrolled from the program on the following January 1, due to enrollment in Humana MAPD Plan. This program is not approved by Medicare. Members of the Humana/ PEIA MAPD plans are not eligible for the Weight Management Program. *For more information call PEIA Customer Service at* **1-888-680-7342**.

Tobacco Cessation

The PEIA Special Medicare Plan provides benefits for participants who wish to quit smoking or using smokeless tobacco products. Only those members who have been paying the Standard (tobacco-user) premium are eligible for the Tobacco Cessation benefit. If you signed an affidavit claiming to be tobacco-free, you will be declined the Tobacco Cessation benefit.

To access the benefits, simply visit your primary care provider. PEIA will cover an initial and follow-up visit to your physician or nurse practitioner. PEIA covers both prescription and non-prescription tobacco cessation medications if they are dispensed with a prescription. PEIA will cover a total of 12 weeks of drug therapy, even if more than one type of therapy is used. If extended therapy is required, the provider must submit a written appeal to the Director of PEIA with proof of medical necessity.

You can use the benefit (office visits and prescriptions) twice per year (rolling 12-month period).

Payment Level

PEIA will cover an initial and follow-up visit to your physician or nurse practitioner at no cost to the member. Tobacco cessation products are available at no cost to the member; both the deductible and the copayment are waived when prescribed by a physician and purchased at a network pharmacy.

What Is Not Covered

Some services are not covered by the PEIA Special Medicare Plan regardless of medical necessity. Some specific exclusions are listed below. *If you have questions, please contact UMR at* **1-888-440-7342**. The following services are not covered:

1. Acupuncture
2. Autopsy and other services performed after death, including transportation of the body or repatriation of remains
3. Biofeedback
4. Coma stimulation
5. Cosmetic or reconstructive surgery when not required as the result of accidental injury or disease, or not performed to correct birth defects. Services resulting from or related to these excluded services also are not covered.
6. Custodial care, intermediate care, domiciliary care, respite care, rest cures, or other services primarily to assist in the activities of daily living, or for behavioral modification, including applied behavior analysis (ABA), except to the extent ABA is mandated to be covered for treatment of autism spectrum disorder by federal law.
7. Dental implants, whether medically indicated or not
8. Dental services including dental implants, routine dental care, x-rays, treatment of cysts or abscesses associated with the teeth, dentures, bridges, or any other dentistry and dental procedures.
9. Daily living skills training
10. Duplicate testing, interpretation or handling fees
11. Education, training and/or cognitive services, unless specifically listed as covered services
12. Elective abortions
13. Electronically controlled thermal therapy
14. Emergency evacuation from a foreign country, even if medically necessary
15. Expenses for which the patient is not responsible, such as patient discounts and contractual discounts
16. Experimental, investigational or unproven services, unless pre-approved by UMR
17. Family or Group therapy when the patient is not present
18. Fertility drugs and services
19. Foot care. Routine foot care including:
    - Removal in whole or in part of: corns, calluses (thickening of the skin due to friction, pressure, or other irritation), hyperplasia (overgrowth of the skin), or hypertrophy (growth of tissue under the skin);
    - Cutting, trimming, or partial removal of toenails;
    - Treatment of flat feet, fallen arches, or weak feet; and
    - Strapping or taping of the feet.
20. Gender reassignment surgery
21. Genetic testing for screening purposes is generally not covered, unless needed to diagnose or treat a condition and precertified
22. Glucose monitoring devices or test strips, except OneTouch Verio Reflect,OneTouch Verio Flex, FreeStyle Lite, FreeStyle Freedom Lite, and Precision Xtra monitors and OneTouch Ultra, OneTouch Verio, FreeStyle Lite, FreeStyle Freedom Lite, and Precision Xtratest strips covered under the prescription drug benefit
23. Homeopathic medicine
24. Hospital days associated with non-emergency weekend admissions or other unauthorized hospital days prior to scheduled surgery
25. Hypnosis
26. Incidental surgery performed during medically-necessary surgery
27. Infertility Treatment

- Fertility tests
- Surgical reversal of a sterilized state that was a result of a previous surgery
- Direct attempts to cause pregnancy by any means, including, but not limited to, hormone therapy or drugs
- Artificial insemination, in vitro fertilization, gamete intrafallopian transfer (GIFT), or zygote intrafallopian transfer (ZIFT)
- Embryo transfer
- Freezing or storage of embryo, eggs or semen
- Donor services
- Genetic testing

28. Maintenance outpatient therapy services, including, but not limited to:
    - Chiropractic
    - Massage Therapy
    - Occupational Therapy
    - Osteopathic Manipulations
    - Outpatient Physical Therapy
    - Outpatient Speech Therapy
    - Vision Therapy
29. Marriage counseling
30. Medical and pharmaceutical claims for persons while in the custody of a civil or criminal state or federal authority. The state or federal authority having custody of the person shall be responsible for payment of all healthcare costs.
31. Medical equipment, appliances or supplies of the following types:
    - augmentative communication devices
    - bathroom scales
    - educational equipment
    - environmental control equipment such as air conditioners, humidifiers or dehumidifiers, air cleaners or filters and portable heaters
    - dust extractors
    - equipment or supplies which are primarily for patient comfort or convenience, such as bathtub lifts or seats; massage devices; elevators; stair lifts; escalators; hydraulic van or car lifts; orthopedic mattresses; walking canes with seats; trapeze bars; child strollers; lift chairs (including Hoyer lifts); recliners; contour chairs; adjustable beds; or tilt stands
    - equipment which is widely available over the counter such as wrist stabilizers and knee supports
    - exercise equipment such as exercycles; parallel bars; walking, climbing or skiing machines
    - hearing aids except anchored
    - hygienic equipment such as bed baths, commodes, and toilet seats
    - motorized scooters
    - nutritional supplements (with the exception of amino acid-based formula for the treatment of severe protein allergic conditions or absorption disorders or infant formula administered through a feeding tube), over-the-counter (OTC) formula, food liquidizers or food processors
    - Out-of-Network services unless an emergency or medically necessary
    - orthopedic shoes, unless attached to a brace
    - professional medical equipment such as blood pressure kits or stethoscopes
    - replacement of lost or stolen items
    - supplies such as tape, alcohol, Q-tips/swabs, gauze, bandages, thermometers, aspirin, diapers (adult or infant), heating pads or ice bags
    - standing/tilt wheel chairs
    - traction devices
    - vibrators

- whirlpool pumps or equipment
- wigs or wig styling

32. Medical examinations, vaccinations, inoculations, and/or other procedures required prior to immigration and/or re-entry into the United States.
33. Medical rehabilitation and any other services that are primarily educational or cognitive in nature
34. Mental health or chemical dependency services to treat mental illnesses which will not substantially improve beyond the patient's current level of functioning
35. Optical services:
    - Routine eye examinations, refractions, eye glasses, contact lenses and fittings
    - Glasses and/or contact lenses following cataract surgery
    - Low-vision devices, including magnifiers, telescopic lenses and closed circuit television systems
36. Orientation therapy
37. Orthodontia services
38. Orthotripsy
39. Out of network services except in an emergency or if approved in advance by UMR.
40. Physical examinations and routine office visits except those covered under the Periodic Physicals benefit
41. Personal comfort and convenience items or services (whether on an inpatient or outpatient basis) such as television, telephone, barber or beauty service, guest services, and similar incidental services and supplies, even when prescribed by a physician
42. Physical conditioning and work hardening. Expenses related to physical conditioning programs and work hardening such as athletic training, body building, exercise, fitness, flexibility, diversion, or general motivation
43. Physical, psychiatric, or psychological examinations, testing, or treatments not otherwise covered under the plan, when such services are:
    - conducted for purposes of medical research;
    - for participation in athletics;
    - needed for marriage or adoption proceedings;
    - related to employment;
    - related to judicial or administrative proceedings or orders;
    - to obtain or maintain a license or official document of any type; or
    - to obtain or maintain insurance.
44. Provider charges for phone calls or prescription refills (Telemedicine visits are payable as any other visit)
45. Radial keratotomy, Lasik procedure and other surgery to correct vision. Surgery to prevent legal blindness or restore vision from legal blindness is covered, if not correctable by lenses or other more conservative means
46. Reversal of sterilization and associated services and expenses
47. Safety devices. Devices used specifically for safety or to affect performance primarily in sports-related activities.
48. Screenings, except those specifically listed as covered benefits.
49. Service/therapy animals and the associated services and expenses, including training.
50. Services rendered by a provider with the same legal residence as a participant, or who is a member of the policyholder's family. This includes spouse, brother, sister, parent, or child
51. Services rendered outside the scope of a provider's license or certification.
52. Sensory stimulation therapy
53. Skilled nursing services provided in the home, except intermittent visits covered under the Home Health Care benefit
54. Take-home drugs provided at discharge from a hospital or any facility
55. TMJ. Treatment of temporomandibular joint (TMJ) disorders. Including intraoral

prosthetic devices or any other method of treatment to alter vertical dimension or for temporomandibular joint dysfunction not caused by documented organic disease or acute physical trauma.

56. The difference between private and semi-private room charges
57. Therapy and related services for a patient showing no progress
58. Therapies rendered outside the United States that are not medically recognized within the United States
59. Transportation other than medically-necessary emergency ambulance services
60. War-related injuries or illnesses. Treatment in a State or Federal hospital for military or service-related injuries or disabilities
61. Weight loss. Health services and associated expenses intended primarily for the treatment of obesity and morbid obesity, including wiring of the jaw, weight-control programs, weight-control drugs, screening for weight-control programs, and services of a similar nature, except those services provided through the Weight Management Program offered by PEIA
62. Work-related injury or illness

How to File a Claim

Filing a Medical Claim

Medical claims are processed first by Medicare, then by UMR. Claims for UMR should be submitted to:

UMR, P.O. Box 30541, Salt Lake City, UT 84130-0541

This post office box should be used only for PEIA claims. Please do not submit PEIA claims to other UMR post office boxes. This will only delay their processing.

To process a medical claim, UMR requires a complete itemization of charges including:

- the patient's name;
- the nature of the illness or injury;
- date(s) of service;
- type of service(s);
- charge for each service;
- diagnosis and procedure codes;
- identification number of the provider; and
- Medical ID number of the policyholder.

If the necessary information is printed on your itemized bill, you do not need to use a PEIA claim form to submit your charges. Cash register receipts and canceled checks are not acceptable proof of your claim.

If you have other insurance (including Medicare) which is primary, you need to submit an Explanation of Benefits (EOB) from the other insurance with each claim, or ask your provider to do so if the claim is being submitted for you.

You have six (6) months from the date of service to file a medical claim. If PEIA is your secondary insurer (even if you have Medicare), you have six (6) months from the date of your primary insurer's Explanation of Benefits processing date to file your claim with PEIA. If you do not submit claims within this period, they will not be paid, and you will be responsible for payment to the provider.

If your claim is for an illness or injury wrongfully or negligently caused by someone else, and you expect to be reimbursed by another party or insurance plan, you must file a claim with PEIA

within six (6) months of the date of service to ensure that the covered services will be paid. Later, if you receive payment for the expenses, you will have to repay the amount you received from PEIA. *See "Subrogation" on page 70 for details*.

Medicare Crossover Claims

UMR has a program that allows providers to bill PEIA electronically as your secondary insurance after Medicare has adjudicated the claim. This program, called Medicare Crossover, saves you the time and trouble of filing the claim yourself.

Claims Incurred Outside of the U.S.A.

If you or a covered dependent incur medical expenses while outside the United States, you may be required to pay the provider yourself. Request an itemized bill containing all the information listed on the previous page from your provider and submit the bill along with a claim form to UMR or the prescription drug administrator.

PEIA is a Covered Entity under 45 CFR 160.103 and is required to be compliant with any and all applicable provisions of the Health Insurance Portability and Accountability Act of 1996 (HIPAA), as well as other Privacy and Security laws, rules, and regulations enacted by the State of West Virginia or the United States, and not rules of the European Union. The European Union's GDPR (General Data Protection Regulation) does not apply to PEIA or its operations.

UMR or the prescription drug administrator will determine, through a local banking institution, the currency exchange rate and you will be reimbursed according to the terms of the plan you're enrolled in.

Appealing an Adverse Benefit Decision (Denied Claims)

Adverse Benefit Determination means a denial, reduction, or termination of a benefit, or a failure to provide or make payment, in whole or in part, for a benefit. It also includes any such denial, reduction, termination, rescission of coverage (whether or not, in connection with the rescission, there is an adverse effect on any particular benefit at that time), or failure to provide or make payment that is based on a determination that the Participant is no longer eligible to participate in the Plan. If a claim is being denied, in whole or in part, and the Participant will owe any amount to the provider, the Participant will receive an initial claim denial notice, usually referred to as an Explanation of Benefits (EOB) form, within the timelines described above.

The EOB form will:

- Explain the specific reasons for the denial.
- Provide a specific reference to pertinent Plan provisions on which the denial was based.
- Provide a description of any material or information that is necessary for the Participant to perfect the claim, along with an explanation of why such material or information is necessary, if applicable.
- Provide appropriate information as to the steps the Participant may take to submit the claim for appeal (review).

If an internal rule or guideline was relied upon, or if the denial was based on Medical Necessity or Experimental, Investigational, or Unproven treatment, the Plan will notify the Participant of that fact. The Participant has the right to request a copy of the rule/guideline or clinical criteria that were relied upon, and such information will be provided free of charge.

Special Medicare Plans
If you are a PEIA Special Medicare Plan participant or provider and think that an error has been made in processing your claim or reviewing a service, the first step is to call the Third-Party Administrator to verify that a mistake has been made. (For information about prescription drug appeals, see page 61) all appeals must be initiated within one hundred and eighty (180) days of claim payment or denial.

Type of Error	Who to Call	Where to Write
Pre-Service Medical claim or COMPLEX Condition CARE denial	UMR Appeals **1-888-440-7342**	UHC Appeals – UMR P.O. Box 400046 San Antonio, TX 78229 Fax: **1-888-615-6584** Attn: UMR Appeals
Post-Service Medical claim	UMR **1-888-440-7342**	UMR P.O. Box 30541 Salt Lake City, UT 84130-0541
Out-of-state care denial or denial of precertification	UMR **1-888-440-7342**	UMR P.O. Box 30541 Salt Lake City, UT 84130-0541
Prescription drug claim	Express Scripts **1-877-852-4070**	Express Scripts Attn: Clinical Appeals Department P.O. Box 66588 St. Louis, MO 63166-6588
Common Specialty Medications Claim	Express Scripts **1-877-852-4070**	Express Scripts Attn: Clinical Appeals Department P.O. Box 66588 St. Louis, MO 63166-6588
Specialty Injectable Drugs	UMR **1-888-440-7342**	UMR P.O. Box 30541 Salt Lake City, UT 84130-0541

How to appeal an adverse benefit decision (denied claims): This is a **mandatory** appeal level. The Covered Person must exhaust internal procedures before taking any outside legal action.

- If your medical claims or service has been denied, or if you disagree with the determination made by one of the Third-Party Administrators, the second step is for you or your authorized individual to appeal in writing to the Third-Party Administrator at the address listed above. The Participant must file the appeal within 180 days of the date they received the EOB form from the Plan showing that the claim was denied. The Plan will assume the Participant received the EOB form seven days after the Plan mailed the EOB form. Explain what you think the problem is, and why you disagree with the decision. Please have your physician provide any additional relevant clinical information to support your request.
- If the benefit denial was based, in whole or in part, on a medical judgment, the Plan will consult with a health care professional with training and experience in the relevant medical field. This health care professional may not have been involved in the original denial decision and may not have been supervised by the health care professional who was involved. If the Plan has consulted with medical or vocational experts in connection with the claim, these experts will be identified upon the Participant's request, regardless of whether the Plan relies on their advice in making any benefit determinations.
- After the claim has been reviewed, the Participant will receive written notification letting them know if the claim is being approved or denied. In the event of new or additional

evidence, or any new rationale relied upon during the appeal process in connection with a claim that is being appealed, the Plan will automatically provide the relevant information to the Participant. The notification will provide the Participant with the information outlined under the "Adverse Benefit Determination" section above.

Filing a Second Appeal: This is a mandatory appeal level. The Participant must exhaust internal procedures before taking any outside legal action.

Your Plan offers two internal levels of appeal. If you are not satisfied with the first level appeal decision, you have the right to request a second level appeal from PEIA. The Participant or their authorized individual must file the appeal within 60 days of the date they received the EOB form from the Plan showing that the claim was denied. The Plan will assume the covered person received the EOB form seven days after the Plan mailed the EOB form. Appeals should be directed to the Director of the PEIA. Facts, issues, comments, letters, Explanation of Benefits (EOBs), and all pertinent information about the case should be included and mailed to: **Director, Public Employees Insurance Agency, 601 57th Street, SE, Suite 2, Charleston, WV 25304-2345.**

When your request for review arrives, PEIA will reconsider the entire case, considering any additional materials which have been provided. If the benefit denial was based, in whole or in part, on a medical judgment, the Plan will consult with the medical director. This health care professional may not have been involved in the original denial decision or first appeal and may not have been supervised by the health care professional who was involved. If the Plan has consulted with medical or vocational experts in connection with the claim, these experts will be identified upon the Participant's request, regardless of whether the Plan relies on their advice in making any benefit determinations.

A decision, in writing, explaining the reason for modifying or upholding the original disposition of the claim will be sent to the Participant or his or her Authorized Individual. If additional information is required to make a decision, this information will be requested in writing. The additional information must be received within sixty (60) days of the date of the letter. If the additional information is not received, the case will be closed.

TIME PERIODS FOR MAKING DECISIONS ON APPEALS

After reviewing a claim that has been appealed, the Plan will notify the Participant of its decision within the following timeframes, although Participants may voluntarily extend these timelines. In addition, if any new or additional evidence is relied upon or generated during the determination of the appeal, the Plan will provide such evidence to You free of charge and sufficiently in advance of the due date of the response to the Adverse Benefit Determination. If such evidence is received at a point in the process where the Plan is unable to provide You with a reasonable opportunity to respond prior to the end of the period stated below, the time period will be tolled to allow You a reasonable opportunity to respond to the new or additional evidence.

URGENT CLAIM APPEALS THAT REQUIRE IMMEDIATE ACTION

A request by a Participant or their Authorized Individual for the review and reconsideration of coverage that requires notification or approval prior to receiving medical care may be considered an urgent claim appeal. Urgent claim appeals must meet one or both of the following criteria to be considered urgent in nature:

- A delay in treatment could seriously jeopardize life or health or the ability to regain maximum functionality.
- In the opinion of a Physician with knowledge of the medical condition, a delay in

treatment could cause severe pain that cannot be adequately managed without the care or treatment that is the subject of the claim. UMR must respond to the urgent claim appeal request as soon as possible, taking into account the medical exigencies, but no later than 72 hours after receiving the request for review.

- Pre-Service Claims: Within a reasonable period of time appropriate to the medical circumstances, but no later than 10 business days after the Plan receives the request for review for the first appeal, and another 10 business days for the second appeal, or a maximum of 20 business days for the two appeal levels.
- Post-Service Claims: Within a reasonable period of time, but no later than 30 calendar days after the Plan receives the request for review for the first appeal, and another 30 calendar days for the second appeal, or a maximum of 60 calendar days for the two appeal levels.
- Concurrent Care Claims: Before treatment ends or is reduced.

RIGHT TO EXTERNAL REVIEW

If, after exhausting Your internal appeals, You are not satisfied with the final determination, You may choose to participate in the external review program.

This program applies only if the Adverse Benefit Determination involves:

- Clinical reasons;
- The exclusions for Experimental, Investigational, or Unproven services;
- Determinations related to Your entitlement to a reasonable alternative standard for a reward under a wellness program;
- Determinations related to whether the Plan has complied with non-quantitative treatment limitation provisions of Code 9812 or 54.9812 (Parity in Mental Health and Substance Use Disorder Benefits);
- Determinations related to the Plan's compliance with the following surprise billing and cost-sharing protections set forth in the No Surprises Act:

  ► Whether a claim is for Emergency treatment that involves medical judgment or consideration of compliance with the cost-sharing and surprise billing protections;

  ► Whether a claim for items and services was furnished by a non-network provider at a network facility;

  ► Whether an individual gave informed consent to waive the protections under the No Surprises Act;

  ► Whether a claim for items and services is coded correctly and is consistent with the treatment actually received;

  ► Whether cost-sharing was appropriately calculated for claims for Ancillary Services provided by a non-network provider at a network facility; or

- Other requirements of applicable law.

This external review program offers an independent review process to review the denial of a requested service or procedure (other than a pre-determination of benefits) or the denial of payment for a service or procedure. The process is available at no charge to You after You have exhausted the appeals process identified above and You receive a decision that is unfavorable, or if UMR or PEIA fails to respond to Your appeal within the timelines stated above. You may request an independent review of the Adverse Benefit Determination. Neither You nor UMR nor PEIA will have an opportunity to meet with the reviewer or otherwise participate in the reviewer's decision. If You wish to pursue an external review, please send a written request as indicated below.

Notice of the right to external review for Pre-Service appeals should be sent to:

UHC APPEALS - UMR
PO BOX 400046
SAN ANTONIO TX 78229

Alternatively, You may fax Your request to 888-615-6584, ATTN: UMR Appeals

Notice of the right to external review for Post-Service appeals should be sent to:

UMR
EXTERNAL REVIEW APPEAL UNIT
PO BOX 8048
WAUSAU WI 54402-8048

Your written request should include: (1) Your specific request for an external review; (2) the Participant's name, address, and member ID number; (3) Your Authorized Individual's name and address, if applicable; (4) a description of the service that was denied; and (5) any new, relevant information that was not provided during the internal appeal. You will be provided more information about the external review process at the time we receive Your request.

Any requests for an independent review must be made within four months of the date You receive the Adverse Benefit Determination. You or an Authorized Individual may request an independent review by contacting the toll-free number on Your ID card or by sending a written request to the address on Your ID card. The independent review will be performed by an independent Physician, or by a Physician who is qualified to decide whether the requested service or procedure is a qualified medical care expense under the Plan.

The Independent Review Organization (IRO) has been contracted by UMR and has no material affiliation or interest with UMR or PEIA. UMR will choose the IRO based on a rotating list of approved IROs.

In certain cases, the independent review may be performed by a panel of Physicians, as deemed appropriate by the IRO. Within applicable timeframes of UMR's receipt of a request for independent review, the request will be forwarded to the IRO, together with:

- All relevant medical records;
- All other documents relied upon by UMR and/or PEIA in making a decision on the case; and
- All other information or evidence that You or Your Physician has already submitted to UMR or PEIA.

If there is any information or evidence that was not previously provided and that You or Your Physician wishes to submit in support of the request, You may include this information with the request for an independent review, and UMR will include it with the documents forwarded to the IRO. A decision will be made within applicable timeframes. If the reviewer needs additional information in order to make a decision, this time period may be extended. The independent review process will be expedited if You meet the criteria for an expedited external review as defined by applicable law.

The reviewer's decision will be in writing and will include the clinical basis for the determination. The IRO will provide You and UMR and/or PEIA with the reviewer's decision, a description of the qualifications of the reviewer, and any other information deemed appropriate by the organization and/or required by applicable law.

If the final independent decision is to approve payment or referral, the Plan will accept the

decision and provide benefits for such service or procedure in accordance with the terms and conditions of the Plan. If the final independent review decision is that payment or referral will not be made, the Plan will not be obligated to provide benefits for the service or procedure.

You may contact the claims administrator at the toll-free number on Your ID card for more information regarding Your external appeal rights and the independent review process.

Managed Care Plan Members

If you are a managed care plan member, and you think that an error has been made in processing your claim, the first step is to call your managed care plan to discuss the matter. If your claim has been denied, or if you disagree with the determination made by your managed care plan refer to the Evidence of Coverage (EOC) provided by your plan for details of your plan's appeals process.

Prescription Drug Benefits

Along with your PEIA Special Medicare Plan medical coverage, you also have prescription drug coverage. The prescription drug program is administered by Express Scripts. There are three parts to the program:

1. The Retail Pharmacy Program gives you access to local participating pharmacies to get your prescriptions filled;
2. The Express Scripts Mail Service Pharmacy Program lets you order your prescriptions through the mail, saving you time and money by having your maintenance medications delivered to your door;
3. Accredo, an Express Scripts Specialty Pharmacy (mail order), or local Specialty Precision Network pharmacies (retail or mail order), provide access to your common specialty medciations.

Your prescription drug benefits pay for a wide range of medications, with differing copayments depending on where you purchase those drugs, and whether you purchase generic or brand-name drugs.

What You Pay

Deductible

During any plan year, if you or your eligible dependents incur expenses for covered prescription drugs, you must meet a deductible before the plan begins to pay. The deductibles are:

Prescription Drug Deductibles	
Policyholder Only	$75
Family	$150

The family deductible is divided up among the family members. No one member of the family will pay more than the individual deductible. Once that person has met the individual deductible, the plan will begin paying on that person. When another member of the family meets the individual deductible, then the plan will begin paying on the entire family. Alternatively, all members of the family may contribute to the family deductible with no one person meeting the individual deductible; once the family deductible is met, the plan pays on all members of the family. After you meet your deductible, you will pay copayments or coinsurance based on the amount and type of drug you're taking. The following chart shows the copayments and coinsurance.

Copayments and Coinsurance

Once you meet your deductible, you pay a copayment or coinsurance to obtain drugs. Copayments and coinsurance are the portion of the cost that you are required to pay per new or refill prescription. The rest of the cost is paid by PEIA. Several factors determine your copayment or coinsurance.

Prescription Drug Copayments and Coinsurance	Up to a 30-day supply	90-day supply*
Generic Drug	$10	$20
Brand-name drug listed on the WV Preferred Drug List	$25	$50
Brand-name drug not listed on the WV Preferred Drug List#	75% Coinsurance	75% Coinsurance
Common Specialty Medications on WV Preferred Drug List	$100	Not available
Common Specialty Medications NOT on WV Preferred Drug List†	$150	Not available

*For maintenance medications only. See the Maintenance Medications section for the list of qualifying medications. You must purchase all medications on the Maintenance Drug List in 90-day supplies through a Retail Maintenance Network pharmacy or through Mail Service. Read on for details.

† Should your doctor prescribe, or you request the brand-name Specialty Medication when a generic drug is available, you must pay 75% coinsurance.

Should your doctor prescribe, or you request the brand-name drug when a generic drug is available, you must pay 75% coinsurance.

Generic Drugs

The brand name of a drug is the product name under which the drug is advertised and sold. Generic medications have the same active ingredients and are subject to the same rigid U.S. Food and Drug Administration (FDA) standards for quality, strength and purity as their brand-name counterparts. Generic drugs usually cost less than brand-name drugs. Please ask your doctor to prescribe generic drugs whenever possible.

West Virginia Preferred Drug List (WVPDL)

The West Virginia Preferred Drug List (WVPDL) is a list of carefully selected medications that can assist in maintaining quality care while providing opportunities for cost savings to the member and the plan. Under this program, your plan requires you to pay a lower copayment for medications on the WVPDL and a higher copayment for medications not on the WVPDL. By asking your doctor to prescribe WVPDL medications, you can maintain high quality care while you help to control rising health-care costs.

Here's how the copayment structure works:

- **Highest Cost:** You will pay a 75% coinsurance for brand-name drugs that are not listed on the WVPDL.
- **Middle Cost:** You will pay a mid-level copayment for brand-name drugs that are listed on the WVPDL.
- **Lowest Cost:** You will pay the lowest copayment for generic drugs. Generic drugs are subject to the same rigid U.S. Food and Drug Administration standards for quality, strength and purity as their brand-name counterparts. Generic drugs usually cost less than brand-name drugs. Please ask your doctor to prescribe generic drugs for you whenever possible.

Sometimes your doctor may prescribe a medication to be "dispensed as written" when a WVPDL

brand name or generic alternative drug is available. As part of your plan, an Express Scripts pharmacist or your retail pharmacist may discuss with your doctor whether an alternative formulary or generic drug might be appropriate for you. Your doctor always makes the final decision on your medication, and you can always choose to keep the original prescription at the higher copayment.

Drugs on the WVPDL are determined by the Express Scripts Pharmacy and Therapeutics Committee. The committee, made up of physicians, meets quarterly to review the medications currently on the Formulary, and to evaluate new drugs for addition to the Formulary. The Formulary may change periodically, based on the recommendations adopted by the committee.

If you have any questions, please call Express Scripts Customer Care at **1-855-224-6247**.

Prescription Out-of-Pocket Maximum

PEIA has an out-of-pocket maximum on drugs of $1,750 for an individual and $3,500 for a family. Once you have met the out-of-pocket maximum, PEIA will cover the entire cost of your prescriptions for the balance of the plan year. The out-of-pocket maximum only includes actual copays, not deductibles or other charges, and is separate from your medical out-of-pocket maximum.

Getting Your Prescriptions Filled

Using a Retail Network Pharmacy

Express Scripts has a nationwide network of pharmacies. To get a prescription filled, simply present your medical/ prescription drug ID card at a participating Express Scripts network pharmacy. You can purchase both acute and maintenance medications at an Express Scripts network pharmacy. Maintenance medications must be purchased from a Retail Maintenance Network pharmacy or using the Express Scripts Mail Service Pharmacy Program (see below for details). You may refill your prescription when 75% of the medication is used up or 80% of a controlled substance is used up.

Your ID card contains personalized information that identifies you as a PEIA Special Medicare Plan member, and ensures that you receive the correct coverage for your prescription drugs.

If you use a network pharmacy, you do not have to file a claim form. The pharmacist will file the claim for you online, and will let you know your portion of the cost.

If you use a network pharmacy and choose not to have the pharmacist file the claim for you online, you will pay 100% of the prescription price at the time of purchase. All applicable management, such as prior authorization, step therapy, and quantity limits still apply. You may submit the receipt with a completed claim form to Express Scripts for reimbursement. The prescription receipt must be attached to the form. You will usually be reimbursed within 30 days from receipt of your claim form. You will be reimbursed the amount PEIA would have paid, less your required copayment, and your deductible (if applicable). This reimbursement is usually less than you paid for the prescription.

If you need claim forms, call Express Scripts Customer Care at **1-855-224-6247.** or visit their website at **www.express-scripts.com/wvpeia**.

To find the participating pharmacies nearest you, call Express Scripts Customer Care at **1-855-224-6247**. If you have Internet access, you can find a pharmacy online at **www.express-scripts.com/wvpeia**.

Using the Retail Maintenance Network

If you take a drug on a long-term basis, you **MUST** purchase a 90-day supply of that drug if it is on the maintenance list (see the Maintenance Drug List later in this section) from a Retail Maintenance Network pharmacy or through the Express Scripts Mail Service Program. Check with your local pharmacist to verify participation.

Maintenance Drug Copayments	Up to 30-day supply	90-day supply*
Generic medication	$10	$20
Brand-name medication listed on the WV Preferred Drug List	$25	$50
Brand-name medication not listed on the WV Preferred Drug List#	75% coinsurance	75% coinsurance

*For maintenance medications only. See the Maintenance Medications section for the list of qualifying medications. You may be able to get a discount on your generic or preferred brand maintenance medications through a Retail Maintenance Network pharmacy or through Mail Service. Read on for details.

Should your doctor prescribe, or you request the brand-name drug when a generic drug is available, you must pay 75% coinsurance.

Using Non-Network Pharmacies

If you use a non-participating pharmacy, you will pay 100% of the prescription price at the time of purchase, and submit a completed claim form to Express Scripts.. The prescription receipt must be attached to the form. You will usually be reimbursed within 21 days from receipt of your claim form. You will be reimbursed the amount PEIA would have paid at a participating pharmacy, less your required copayment and your deductible (if applicable). This reimbursement is usually less than you paid for the prescription.

If you purchase a Maintenance Medication at a non-network pharmacy, you will not be reimbursed for your purchase. Maintenance Medications must be purchased from Retail Maintenance Network pharmacies or using the Express Scripts Mail Service Pharmacy Program.

If you need claims forms, call Express Scripts Customer Care at **1-855-224-6247** or visit their website at **www.express-scripts.com/wvpeia.**

Using the Express Scripts Mail Service Pharmacy Program

Express Scripts provides a convenient mail service pharmacy program for PEIA Special Medicare Plan insureds. You may use the mail service pharmacy if you're taking medication to treat an ongoing health condition, such as high blood pressure, asthma, or diabetes. When you use the mail service pharmacy, you must order a 90-day supply of a medication on the maintenance list, as prescribed by your doctor, and pay the member cost share indicated above. You may refill your prescription when 75% of the medication is used up. Express Scripts' licensed professionals fill every prescription following strict quality and safety controls. If you have questions about your prescription, registered pharmacists are available around the clock to consult with you.

New Prescriptions and the Mail Service Pharmacy

If you want to use the mail service pharmacy, the first time you are prescribed a medication that you will need on an ongoing basis, ask your doctor for two prescriptions: the first for a 14-day supply to be filled at a participating retail pharmacy; the second, for a 90-day supply, to be filled through the mail service pharmacy. There are several ways to submit your mail service prescriptions. Just follow the steps below. Some restrictions apply.

1. Ordering new prescriptions. Ask your doctor to prescribe a 90-day supply of your maintenance medications, plus refills if appropriate. Mail your prescription and required copayment along with an order form in the envelope provided. Or ask your doctor to fax your order to **1-888-327-9791**. You will need to give your doctor your member ID number located on your ID card.
2. Refilling your medication. A few simple precautions will help ensure you don't run out of your prescription. Remember to reorder on or after the refill date indicated on the refill slip. Or reorder when you have less than 14 days of medication left.
    a) Refills online: Log on or register at Express Scripts' website at **www.express-scripts.com/wvpeia**. Have your member ID number, the prescription number (it's the 9-digit number on your refill slip), and your credit card ready when you log on.
    b) Refills by phone: Call **1-855-224-6247** and use the automated refill system. Have your member ID number, refill slip with the prescription number, and your credit card ready.
    c) Refills by mail: Use the refill and order forms provided with your medication. Mail them with your copayment.
3. Delivery of your medication. Prescription orders receive prompt attention and, after processing, are usually sent to you by U.S. mail or UPS within two weeks. Your enclosed medication will include instructions for refills, if applicable. Your package may also include information about the purpose of the medication, correct dosages, and other important details.
4. Paying for your medication. You may pay by check, money order, VISA, MasterCard, Discover, American Express, electronic check, or PayPal. Please note: The pharmacist's judgment and dispensing restrictions, such as quantities allowable, govern certain controlled substances and other prescribed drugs. Federal law prohibits the return of any dispensed prescription medicines.

Prior Authorization

Your prescription drug program provides coverage for some drugs only if they are prescribed for certain uses and amounts, so those drugs require prior authorization for coverage. Prior Authorization is handled by the Rational Drug Therapy Program (RDT) and Express Scripts, depending on the medication. If your medication must be authorized, your pharmacist or physician can initiate the review process for you. The prior authorization process is typically resolved over the phone; if done by letter it can take up to two business days. If your medication is not approved for plan coverage, you will have to pay the full cost of the drug.

PEIA will cover, and your pharmacist can dispense, up to a five-day supply of a medication requiring prior authorization for the applicable copayment. This policy applies when your doctor is either unavailable or temporarily unable to complete the prior authorization process promptly. Your pharmacist or doctor should contact the Rational Drug Therapy Program for an emergency supply. Prior authorizations may be approved retroactively for up to 30 days to allow time for the physician to work with and provide documentation to RDT. If the prior authorization is ultimately approved, your pharmacist will be able to dispense the remainder of the approved amount with no further copayment for that month's supply if you have already paid the full copayment. All prior authorization requests must be reviewed annually.

If a medication requires prior authorization and was approved by a previous insurer within the last 90 days, PEIA will honor that prior authorization for the first 90 days of your coverage. Your provider must still request prior authorization review for continued therapy. If you have just been discharged from a hospital (within 24 hours), then PEIA will cover a 5-day supply of the medication even if it requires prior authorization. Your provider must still request prior authorization review for continued therapy. Your provider or pharmacist must let either RDT or

Express Scripts know when either of the above situations apply.

For the most up-to-date clinical management, please refer to the Full Formulary listing found on our website at peia.wv.gov. Once on the website, simply click the Partners tab, select Express Scripts and click on the Prescription Drug Lists link. Your medication can also be reviewed on the Express Scripts website using the Find My Drug tool. The medications listed below require prior authorization

1. Adrenal Hormones (Acthar*, Cortrophin*, Tarpeyo*)
2. Alkylating Agents (Temodar*, Temozolomide*)
3. Antiasthmatics (Advair, Airduo, Breo ellipta, Daliresp, Dulera, Roflumilast, Symbicort, Wixela)
4. Antifungals - Oral (Cresemba, Noxafil, Vfend, Voriconazole)
5. Colony Stimulating factors (Aranesp*, Epogen*, Neupogen*, Procrit*, Retacrit*)
6. Compounded medications
7. Continuity of Care (requested drug dispensed within the last 90 days approved for coverage previously by a prior plan)
8. Diuretics (Jynarque*, Samsca*, Tolvaptan*,)
9. Dupixent*
10. Eye Preparations - Tears (Cequa, Cyclosporine, Restasis, Verkazia)
11. Fentanyl drugs (Abstral, Actiq, Duragesic, Fentora, Lazanda, Subsys)
12. Forteo*
13. Gastrointestinal (Bylvay*, Livmarli*, Ocaliva*, Xermelo*)
14. GLP-1 Agonists/Incretin Mimetics Combination (Adlyxin, Byetta, Bydureon, Mounjaro, Ozempic, Rybelsus, Trulicity, Victoza)
15. Growth Hormones (Genotropin*, Humatrope*, Norditropin* Flexpro*, Omnitrope*, Skytrofa*)
16. Hepatitis C medications (Harvoni*, Epclusa*)
17. Increlex*
18. Immunosuppressants (Dupixent*, Kevzara*, Skyrizi*, Stelara*)
19. Lidocaine Patches
20. Lupron*
21. Medications to treat Cancer*
22. Medications to treat Inflammatory Conditions*
23. Medications to treat Prostate Cancer*
24. Omnipod
25. Ophthalmic Prostaglandin (Latanoprost, Lumigan, Xalatan, Travatan Z, Zioptan)
26. Opioids – Short and Long-acting, MEQD, and day limit rules
27. Pulmonary Arterial Hypertension (Bosentan*, Tracleer*, Tyvaso*)
28. Revlimid*
29. Sedative/Hypnotics (Ambien, Edluar, Lunesta, Zolpimist, Intermezzo, Dayvigo, Rozerem, Zaleplon)
30. Sickle Cell Anemia (Endari*, Oxbryta*)
31. Specialty medications*
32. Testosterone products (Androderm, AndroGel, Depo-Testosterone, Fortesta, Natesto, Striant, Testim, Vogelxo, Xyosted)
33. Vacation supplies of medication for foreign travel (allow 7 days for processing)
34. V-Go
35. Vitamin A derivatives – Topical Tretinoins (Altreno, Atralin, Avita, Retin-A, Retin-A Micro, Tazorac, Tretin-X)
36. Xyrem*, Xywav*

*These drugs must be purchased through the Common Specialty Medications Program. See information later in this section.

This list is subject to change during the plan year if circumstances arise which require adjustment, and notice will be provided no later than 60 days prior to the date on which the modification will become effective. The changes will be included in PEIA's Plan Document, which is filed with the Secretary of State's office, and will be incorporated into the next edition of the Summary Plan Description.

Drugs with Special Limitations

Step Therapy

Step Therapy promotes appropriate utilization of first-line drugs and/or therapeutic categories. Step Therapy requires that participants receive one or more first-line drug(s), as defined by program criteria before prescriptions are covered for second-line drugs in defined cases where a step approach to drug therapy is clinically justified. To promote use of cost-effective, first-line therapy, PEIA uses step therapy in the following therapeutic classes:

1. Acne agents - Topical (Aczone, Avar, Cleocin, Duac, Epiduo, Plexion, Rosula)
2. ADHD (Adhansia XR, Concerta, Daytrana, Focalin XR, Methylphenidate, Quillichew, Ritalin)
3. Amphetamines (Adderall XR, Adzenys, Dexedrine, Dyanavel, Mydayis, Vyvanse)
4. Antibiotics - Topical (Altabax, Mupirocin, Xepi)
5. Antifungals - Topical (Ciclodan, Penlac)
6. Angiotensin II Receptor Blockers & Renin Inhibitors (Atacand, Avapro, Benicar, Cozaar, Diovan, Edarbi, Edarbyclor, Hyzaar, Micardis)
7. Anticonvulsants (Depakene, Depakote, Keppra, Lamictal, Namenda, Neurontin, Spritam, Topamax, Vimpat)
8. Antidepressants (Cymbalta, Drizalma, Effexor, Fetzima, Pristiq)
9. Antihistamines (Carbinoxamine Maleate, Karbinal, Ryvent)
10. Antihypertensive Combinations (Azor, Exforge, Twynsta, Tribenzor)
11. Antiparkinson drugs (Azilect, Xadago,)
12. Antipsoriatic / Antiseborrheic (Dovonex, Pramosone, Sorilux, Taclonex, Wynzora)
13. Benign Prostatic Hyperplasia (Flomax, Rapaflo, Uroxatral)
14. Corlanor
15. Corticosteroids – Topical (Apexicon, Cordran, Halog, Nucort, Topicort, Triderm, Tridesilon)
16. Diabetes - Oral (Actos, Avandia, Farxiga, Fortamet, Glucophage XR, Glumetza ER, Invokana, Jardiance, Metformin ER, Riomet, Steglujan, Synjardy, Trijardy)
17. Eye Anti-inflammatory agents (Acular, Alrex, Durezol, Flarex, Lotemax, Maxidex, Pred mild)
18. Gout therapy (Colcrys, Colchicine, Febuxostat, Uloric)
19. Immunosuppressants (Astagraf, Envarsus)
20. Intranasal Steroids (Beconase, Dymista, Mometasone Furoate, Nasonex, Qnasl, Zetonna)
21. Lipid/Cholesterol Lowering agents (Crestor, Lescol, Lipitor, Livalo, Pravachol, Vytorin, Zocor)
22. Narcolepsy and sleep disorder (Armodafinil, Nuvigil, Provigil, Sunosi)
23. Neurological therapy (Aricept, Exelon, Namenda, Razadyne)
24. NSAIDS (Arthrotec, Cambia, Celebrex, Celecoxib, Daypro, Feldene, Flector, Meloxicam, Mobic, Naproxen, Relafen, Sprix, Tivorbex, Vivlodex, Voltaren, Zorvolex)
25. Osteoporosis (Actonel, Binosto, Boniva, Fosamax)

26. Overactive Bladder (Detrol, Ditropan, Enablex, Oxytrol, Toviaz, Vesicare)
27. Proton Pump Inhibitors (Aciphex, Dexilant, Dexlansoprazole, Esomeprazole, lansoprazole ODT, Nexium, Prevacid, Prilosec, Protonix, Zegerid)
28. Rheumatological agents (Otrexup, Rasuvo, Reditrex, Savella)
29. Selective Serotonin Reuptake Inhibitors (Celexa, Lexapro, Paroxetine, Paxil, Prozac, Zoloft)

This list is subject to change during the plan year if circumstances arise which require adjustment, and notice will be provided no later than 60 days prior to the date on which the modification will become effective. The changes will be included in PEIA's Plan Document, which is filed with the Secretary of State's office, and will be incorporated into the next edition of the Summary Plan Description.

For the most up-to-date clinical management, please refer to the Full Formulary listing found on our website at peia.wv.gov. Once on the website, simply click the Partners tab, select Express Scripts and click on the Prescription Drug Lists link.

Quantity Limits (QL)

Under the PEIA Special Medicare Plan Prescription Drug Program, certain drugs have preset coverage limitations (quantity limits). Quantity limits ensure that the quantity of units supplied in each prescription remains consistent with clinical dosing guidelines and PEIA's benefit design. Quantity limits encourage safe, effective and economic use of drugs and ensure that members receive quality care. If you are taking one of the medications listed below and you need to get more of the medication than the plan allows, ask your pharmacist or doctor to call RDT or Express Scripts discuss your refill options. For the most up-to-date clinical management, please refer to the Full Formulary listing found on our website at **peia.wv.gov**. Once on the website, simply click the Partners tab, select Express Scripts, and click on the Prescription Drug Lists link. Examples of medications with quantity limits are listed below. This list is not all-inclusive.

THERAPEUTIC CATEGORY	QUANTITY LIMIT
ANDROGENIC AGENTS	ANDRODERM IS LIMITED TO 30 PATCH PER FILL
ANDROGENIC AGENTS	NATESTO IS LIMITED TO 22 GRAM PER FILL
ANDROGENIC AGENTS	TESTOSTERONE IS LIMITED TO 75 GRAM PER FILL
ANTIEMETIC/ANTIVERTIGO AGENTS	APREPITANT IS LIMITED TO 1 UNIT PER FILL
ANTIEMETIC/ANTIVERTIGO AGENTS	GRANISETRON HCL IS LIMITED TO 6 UNIT PER FILL
ANTIEMETIC/ANTIVERTIGO AGENTS	ONDANSETRON ODT IS LIMITED TO 9 UNIT PER FILL
ANTIEMETIC/ANTIVERTIGO AGENTS	ONDANSETRON HCL IS LIMITED TO 100 UNIT PER FILL
ANTIEMETIC/ANTIVERTIGO AGENTS	VARUBI IS LIMITED TO 2 TABLET PER FILL
ANTIHYPERGLYCEMIC	TRULICITY IS LIMITED TO 2 MILLILITER PER FILL
ANTIHYPERGLYCEMIC	BYETTA IS LIMITED TO 3 MILLILITER PER FILL
ANTIHYPERGLYCEMIC	OZEMPIC IS LIMITED TO 1 UNIT PER FILL
ANTIHYPERGLYCEMIC	RYBELSUS IS LIMITED TO 30 TABLET PER FILL
ANTIHYPERLIPIDEMIC	EZETIMIBE-SIMVASTATIN IS LIMITED TO 30 UNIT PER FILL
ANTIHYPERLIPIDEMIC	AMLODIPINE-ATORVASTATIN IS LIMITED TO 30 UNIT PER FILL
ANTIHYPERLIPIDEMIC	ATORVASTATIN CALCIUM IS LIMITED TO 30 UNIT PER FILL
ANTIHYPERLIPIDEMIC	FLUVASTATIN SODIUM IS LIMITED TO 30 UNIT PER FILL
ANTIHYPERLIPIDEMIC	LOVASTATIN IS LIMITED TO 30 UNIT PER FILL
ANTIHYPERLIPIDEMIC	LIVALO IS LIMITED TO 30 UNIT PER FILL
ANTIHYPERLIPIDEMIC	PRAVASTATIN SODIUM IS LIMITED TO 30 UNIT PER FILL
ANTIHYPERLIPIDEMIC	ROSUVASTATIN CALCIUM IS LIMITED TO 30 UNIT PER FILL
ANTIHYPERLIPIDEMIC	SIMVASTATIN IS LIMITED TO 30 UNIT PER FILL
ANTIMIGRAINE PREPARATIONS	ALMOTRIPTAN MALATE IS LIMITED TO 12 UNIT PER FILL
ANTIMIGRAINE PREPARATIONS	DIHYDROERGOTAMINE MESYLATE IS LIMITED TO 8 UNIT PER FILL
ANTIMIGRAINE PREPARATIONS	ELETRIPTAN HBR IS LIMITED TO 6 UNIT PER FILL
ANTIMIGRAINE PREPARATIONS	AIMOVIG AUTOINJECTOR IS LIMITED TO 1 UNIT IN 23 DAYS
ANTIMIGRAINE PREPARATIONS	AJOVY AUTOINJECTOR IS LIMITED TO 3 UNIT IN 68 DAYS
ANTIMIGRAINE PREPARATIONS	FROVATRIPTAN SUCCINATE IS LIMITED TO 9 UNIT PER FILL
ANTIMIGRAINE PREPARATIONS	EMGALITY IS LIMITED TO 1 UNIT IN 23 DAYS
ANTIMIGRAINE PREPARATIONS	NARATRIPTAN HCL IS LIMITED TO 9 UNIT PER FILL
ANTIMIGRAINE PREPARATIONS	RIZATRIPTAN IS LIMITED TO 18 UNIT PER FILL
ANTIMIGRAINE PREPARATIONS	SUMATRIPTAN IS LIMITED TO 6 UNIT PER FILL
ANTIMIGRAINE PREPARATIONS	SUMATRIPTAN SUCC-NAPROXEN SOD IS LIMITED TO 9 UNIT PER FILL
ANTIMIGRAINE PREPARATIONS	SUMATRIPTAN SUCCINATE IS LIMITED TO 1 UNIT PER FILL

ANTIMIGRAINE PREPARATIONS	ZOLMITRIPTAN IS LIMITED TO 6 UNIT PER FILL
ANTIMIGRAINE PREPARATIONS	ZOMIG IS LIMITED TO 6 UNIT PER FILL
ANTIPSYCHOTIC,ATYPICAL	ASENAPINE MALEATE IS LIMITED TO 60 TABLET PER FILL
ANTIPSYCHOTIC,ATYPICAL	LATUDA IS LIMITED TO 30 TABLET PER FILL
ANTIPSYCHOTIC,ATYPICAL	OLANZAPINE IS LIMITED TO 30 TABLET PER FILL
ANTIPSYCHOTIC,ATYPICAL	PALIPERIDONE ER IS LIMITED TO 30 TABLET PER FILL
ANTIPSYCHOTIC,ATYPICAL	QUETIAPINE FUMARATE ER IS LIMITED TO 30 TABLET PER FILL
ANTIPSYCHOTIC,ATYPICAL	RISPERIDONE IS LIMITED TO 60 TABLET PER FILL
ANTIPSYCHOTIC,ATYPICAL	ZIPRASIDONE HCL IS LIMITED TO 60 CAPSULE PER FILL
ANTIPSYCHOTICS, ATYPICAL	ARIPIPRAZOLE IS LIMITED TO 30 TABLET PER FILL
INHALERS	SYMBICORT IS LIMITED TO 11 UNIT PER FILL
INHALERS	ADVAIR HFA IS LIMITED TO 12 UNIT PER FILL
INHALERS	FLUTICASONE-SALMETEROL IS LIMITED TO 1 UNIT PER FILL
INHALERS	WIXELA INHUB IS LIMITED TO 1 UNIT PER FILL
INHALERS	BREO ELLIPTA IS LIMITED TO 60 UNIT PER FILL
INHALERS	DULERA IS LIMITED TO 1 UNIT PER FILL
INHALERS	BREZTRI AEROSPHERE IS LIMITED TO 10.7 GRAM PER FILL
INHALERS	TRELEGY ELLIPTA IS LIMITED TO 60 UNIT PER FILL
ESTROGENS	DOTTI IS LIMITED TO 8 PATCH IN 21 DAYS
ESTROGENICS	ESTRADIOL IS LIMITED TO 4 PATCH IN 21 DAYS
ESTROGENICS	LYLLANA IS LIMITED TO 8 PATCH IN 21 DAYS
ORAL INHALERS	QVAR REDIHALER IS LIMITED TO 11 GRAM PER FILL
ORAL INHALRS	BUDESONIDE IS LIMITED TO 120 UNIT PER FILL
ORAL INHALERS	ARNUITY ELLIPTA IS LIMITED TO 1 INHALER PER FILL
ORAL INHALERS	ARMONAIR RESPICLICK IS LIMITED TO 1 INHALER PER FILL
ORAL INHALERS	FLOVENT DISKUS IS LIMITED TO 1 UNIT PER FILL
ORAL INHALERS	FLOVENT HFA IS LIMITED TO 12 UNIT PER FILL
ORAL INHALERS	ASMANEX IS LIMITED TO 1 UNIT PER FILL
ORAL INHALERS	ASMANEX HFA IS LIMITED TO 13 GRAM PER FILL
LOCAL ANESTHETICS	GLYDO IS LIMITED TO 60 MILLILITER IN 23 DAYS
LOCAL ANESTHETICS	LIDOCAINE HCL IS LIMITED TO 60 MILLILITER IN 23 DAYS
NOREPINEPHRINE AND DOPAMINE REUPTAKE INHIB (NDRIS)	BUPROPION XL IS LIMITED TO 30 TABLET PER FILL
OPHTHALMIC ANTI-INFLAMMATORY	RESTASIS IS LIMITED TO 60 UNIT PER FILL
OPHTHALMIC ANTI-INFLAMMATORY	RESTASIS MULTIDOSE IS LIMITED TO 6 MILLILITER PER FILL
SELECTIVE SEROTONIN REUPTAKE INHIBITOR (SSRIS)	CITALOPRAM HBR IS LIMITED TO 30 TABLET PER FILL
SELECTIVE SEROTONIN REUPTAKE INHIBITOR (SSRIS)	ESCITALOPRAM OXALATE IS LIMITED TO 30 TABLET PER FILL
SELECTIVE SEROTONIN REUPTAKE INHIBITOR (SSRIS)	FLUVOXAMINE MALEATE IS LIMITED TO 60 CAPSULE PER FILL

SELECTIVE SEROTONIN REUPTAKE INHIBITOR (SSRIS)	PAROXETINE HCL IS LIMITED TO 30 TABLET PER FILL
SELECTIVE SEROTONIN REUPTAKE INHIBITOR (SSRIS)	SERTRALINE HCL IS LIMITED TO 60 TABLET PER FILL
SEROTONIN-NOREPINEPHRINE REUPTAKE-INHIB (SNRIS)	DESVENLAFAXINE SUCCINATE ER IS LIMITED TO 30 TABLET PER FILL
SEROTONIN-NOREPINEPHRINE REUPTAKE-INHIB (SNRIS)	DULOXETINE HCL IS LIMITED TO 60 CAPSULE PER FILL
SEROTONIN-NOREPINEPHRINE REUPTAKE-INHIB (SNRIS)	FETZIMA IS LIMITED TO 28 CAPSULE PER FILL
SEROTONIN-NOREPINEPHRINE REUPTAKE-INHIB (SNRIS)	VENLAFAXINE HCL ER IS LIMITED TO 30 CAPSULE PER FILL
TOPICAL ANTIFUNGAL/ANTI-INFLAMMATORY,STEROID AGENT	CLOTRIMAZOLE/BETAMETHASONE IS LIMITED TO 45 GRAM IN 21 DAYS
TOPICAL ANTIFUNGALS	NYSTATIN IS LIMITED TO 30 GRAM IN 21 DAYS
TOPICAL ANTIFUNGALS	NYSTATIN W/TRIAMCINOLONE IS LIMITED TO 60 GRAM IN 21 DAYS
TOPICAL LOCAL ANESTHETICS	LIDOCAINE IS LIMITED TO 50 GRAM IN 21 DAYS
TOPICAL LOCAL ANESTHETICS	LIDOCAINE-PRILOCAINE IS LIMITED TO 30 GRAM IN 23 DAYS
TOPICAL LOCAL ANESTHETICS	LIDOCAINE IS LIMITED TO 50 GRAM IN 21 DAYS
TOPICAL LOCAL ANESTHETICS	LIDOCAINE-PRILOCAINE IS LIMITED TO 30 GRAM IN 23 DAYS

Maintenance Medications

Maintenance medications dispensed in quantities less than 90 days are not covered by the plan. If you are starting on a new maintenance medication, you may receive up to two 30-day fills to be sure you tolerate the medication and that your dosage is correct. After the second 30-day fill, the maintenance medication will be covered only in a 90-day supply, and only when filled at a Retail Maintenance Network pharmacy or using the Express Scripts Mail Service Pharmacy Program.

To view a list of current maintenance medications, please visit our website at **https://peia.wv.gov/Forms-Downloads/prescription-drug-benefits/Documents/Maintenance_Drug_List.pdf**

Specialty Drug Program

PEIA's Specialty Drug Program has two components:

1. Specialty Injectable Drugs are administered by injection or infusion and are managed by UMR through the medical benefit.
2. Common Specialty Medications are self-administered and are managed by Accredo, an Express Scripts Specialty Pharmacy.

Specialty Injectable Drugs are prescription drugs used to treat complex, chronic, or rare medical conditions (e.g., cancer, rheumatoid arthritis, hemophilia, HIV, multiple sclerosis, inflammatory bowel disease, psoriasis, and hepatitis). Drugs in this category are typically administered by injection or infusion. Specialty Injectables often require special handling (e.g., refrigeration) and ongoing clinical monitoring. The PEIA PPB Plans cover specialty injectable drugs through a program managed by UMR. The program provides comprehensive direction to policyholders and their dependents for treatments utilizing specialty drugs. If your physician prescribes a specialty drug, that physician, you, or the pharmacist must call UMR at **1-888-440-7342**. The Specialty Injectable Drug list is located at **https://www.umrwebapps.com/SpecialtyInjectable/77700000**. To obtain a paper copy, call **1-888-680-7342**. UMR will

review the drug for medical necessity If denied, UMR will contact your physician for additional information which may allow approval of the requested medication.

Common Specialty Medications are self-administered specialty injectable drugs through Accredo, an Express Scripts Specialty Pharmacy, or a local retail Specialty Precision Network pharmacy. Through the Specialty Pharmacy, specialists will check in to see what you need and how they can help moving forward. They'll also make arrangements for injection training, as needed. If your physician prescribes a specialty drug, they can call **1-800-803-2523**, fax **1-888-302-1021**, or e-prescribe the specialty drug to Accredo or to a local retail Specialty Precision Network pharmacy. The Accredo Specialty Pharmacy will then work with your doctor to obtain prior authorization for the specialty medication. Once approved, you can have your specialty medications delivered directly to you.

PEIA participates in the SaveOnSP program which includes many specialty medications. SaveOnSP accesses many manufacturer programs which will assist patients and PEIA financially in the purchase of these specialty medications. If your medication is included in the SaveOnSP list, PEIA requires you to participate in the program. Only your actual out-of-pocket payments will count toward your drug deductible and annual out-of-pocket maximum; not amounts discounted off the price by the manufacturer or seller of the specialty medication. Specialty drugs have the following key characteristics:

- Need frequent dosage adjustments
- Cause more severe side effects than traditional drugs
- Need special storage, handling and/or administration
- Have a narrow therapeutic range
- Require periodic laboratory or diagnostic testing.

After you have met your prescription drug deductible, the copayment on these medications will generally be $100 for any Common Specialty Medications on the WV Preferred Drug List and $150 for any Common Specialty Medications not on the WV Preferred Drug List if the specialty medication is not on the SavOnSP list; however, certain specialty medications are subject to variable copayments, depending on the availability of programs. Only your actual out-of-pocket payments will count toward your drug deductible and annual out-of-pocket maximum, not amounts discounted off the price by the manufacturer or seller of the specialty medications. Contact Express Scripts to verify copayments. These drugs are not available in 90-day supplies. If you are prescribed one of these common specialty medications, call Express Scripts at **1-855-224-6247**.

SaveOnSP Copay Assistance Benefit

PEIA offers members access to a copay assistance benefit, administered by SaveOnSP, which helps members save money on certain specialty medications. SaveOn reaches out when it identifies eligible members taking the drugs that are included. Enrollment in the SaveOnSP manufacturer assistance program is now required for specialty prescriptions. Members can get their specialty medications filled for $0 cost if the specialty medication is on the SaveOnSP list. **If a member does not enroll in the program, the member cost of the drug will be 30% coinsurance.**

Common Specialty Medications

Examples of specialty medications are listed below. This list is not all-inclusive.

Drug Name	Category
ACTEMRA (QLL)	RHEUMATOLOGICAL AGENTS
ACTIMMUNE	INTERFERONS
ALECENSA (QLL)	ANTINEOPLASTIC DRUGS
AUBAGIO (QLL)	NEUROLOGICAL THERAPY
BALVERSA	ANTINEOPLASTIC DRUGS
CINRYZE	PULMONARY AGENTS
DARAPRIM	ANTIMALARIALS
DUPIXENT (QLL)	DERMATOLOGICALS
EGRIFTA	GROWTH HORMONES
ENBREL (QLL)	RHEUMATOLOGICAL AGENTS
FORTEO (QLL)	OSTEOPOROSIS THERAPY
GENOTROPIN	GROWTH HORMONES
LUPRON DEPOT-PED	ANTINEOPLASTIC DRUGS
NUPLAZID (QLL)	ANTIDEPRESSANTS
OFEV (QLL)	PULMONARY AGENTS
OTEZLA (QLL)	RHEUMATOLOGICAL AGENTS
PROCRIT	ERYTHROID STIMULANTS
SKYRIZI (QLL)	ANTIPSORIATIC / ANTISEBORRHEIC
STELARA (QLL)	ANTIPSORIATIC / ANTISEBORRHEIC
TYMLOS (QLL)	OSTEOPOROSIS THERAPY
XYREM (QLL)	PSYCHOTHERAPEUTIC AGENTS
ZEPOSIA (QLL)	NEUROLOGICAL THERAPY
TYMLOS (QLL)	OSTEOPOROSIS THERAPY
XYREM (QLL)	PSYCHOTHERAPEUTIC AGENTS
ZEPOSIA (QLL)	NEUROLOGICAL THERAPY

All Common Specialty Medications require Precertification from Express Scripts. [QLL] This drug is subject to Quantity Level Limits (QLL). This list is not all-inclusive. This list is subject to change during the plan year if circumstances arise which require adjustment, and notice will be provided no later than 60 days prior to the date on which the modification will become effective. The changes will be included in PEIA's Plan Document, which is filed with the Secretary of State's office, and will be incorporated into the next edition of the Summary Plan Description.

Diabetes Management

PEIA covers diabetes management items under its Maintenance Medication benefit, which means that needles, syringes, lancets and test strips must be purchased in 90-day supplies from a Retail Maintenance Network Pharmacy or through Express Scripts mail service. For patients just starting use of needles, syringes, lancets or test strips, PEIA will permit two 30-day fills of the new prescription at a network pharmacy, but after that, all items must be purchased in 90-day supplies from a Retail Maintenance Network Pharmacy or through Express Scripts mail service.

Cost-sharing Limits: There are limits on the amount of cost-sharing a member with diabetes must pay for a 30-day supply of some medications and devices for treating diabetes.

Diabetes devices include blood glucose test strips, glucometers, continuous glucose monitors (CGM), lancets, lancing devices, or insulin syringes, but not insulin pumps. Cost sharing for a 30-day supply of covered devices may not exceed $100 in aggregate, even if the member is prescribed more than one device per 30-day supply.

Prescription insulin drugs' cost-sharing cannot exceed $35 in aggregate for a 30-day supply, even if the member is prescribed more than one insulin drug, per 30-day supply, regardless of the amount or type of insulin needed to fill the member's prescription.

Omnipod insulin delivery systems are covered under the Prescription Drug Program at the preferred drug copay of $25 per 30-day supply or $50 per 90-day supply in Plans A and D, or $30 per 30-day supply or $60 per 90-day supply in Plan B. The standard Express Scripts quantity limit (QL) for Omnipod is 15 pods per thirty-day supply or 45 pods per ninety-day supply. Quantities greater than this will require prior authorization from the Rational Drug Therapy Program (RDTP).

UMR will no longer precertify Omnipod, but all other Insulin pumps will still require pre-certification through UMR and be covered under the medical benefit.

UMR will no longer precertify continuous glucose monitors and all continuous glucose monitors, CGM supplies, blood glucose monitors, test strips, and lancets must be billed through Express Scripts. Traditional insulin pumps and their supplies will remain precertified and covered by UMR only.

Blood Glucose Monitors: Covered diabetic insureds can receive a free OneTouch Verio, OneTouch Reflect, FreeStyle Lite, FreeStyle Freedom Lite, or Precision Xtra blood glucose monitor with a current prescription. All major chain pharmacies and some doctor's offices have vouchers for the OneTouch meters. Take your prescription to them or call the Express Scripts Diabetic Meter Program at 1-855-224-6247 to request a meter.

Glucose Test Strips: The plan covers only OneTouch Ultra, OneTouch Verio, FreeStyle Lite, Freestyle Freedom Lite, and Precision Xtra test strips at the preferred copayment of $50 per 90-day supply for PPB Plans A and D, and $60 per 90-day supply for PPB Plan B. Other brands require a 100% copayment.

Needles/Syringes and Lancets: You can obtain a supply of disposable needles/syringes and lancets for the copayments listed below:

Diabetes Management Copayments	Up to 30-day supply	90-day supply*
OneTouch and FreeStyle and Precision Xtra test strips, as noted above	Not covered	$50
BD needles/syringes	Not Covered	$20
Lancets	Not Covered	$20

* You must purchase all Diabetes Management items in 90-day supplies through a Retail Maintenance Network pharmacy or through Mail Service.

Tobacco Cessation Program

PEIA has a tobacco cessation program that includes coverage for both prescription and over-the-counter (OTC) tobacco cessation products. For a full description of the benefits, please see "Tobacco Cessation" on *page 33*. The drugs are covered under your prescription drug program.

What is Covered?

PEIA will cover prescription and over-the-counter (OTC) tobacco cessation products if they are dispensed with a prescription. Toll-free numbers are provided by the manufacturers of most of these products for phone coaching and support.

Coverage is limited to two twelve-week cycles per rolling twelve-month period. Tobacco-cessation products are available at no cost to the member; both the deductible and the copayment are waived when prescribed by a physician and purchased at a network pharmacy.

Who is Eligible for Tobacco Cessation?

Only those members who have been paying the Standard (tobacco-user) premium are eligible for this benefit. If you have signed an affidavit claiming to be tobacco-free, and then you attempt to use the tobacco cessation benefit, you will be declined services. Pregnant women will be offered 100% coverage during any pregnancy.

Drugs or Services That Are Not Covered

Your plan does not cover the following medications or services:

1. Abortifacient (i.e., Mifeprex)
2. Anorexiants (any drug used for the purpose of weight loss)
3. Anti-wrinkle agents (e.g., Renova®)
4. Arestin
5. Bleaching agents (e.g., Eldopaque®, Eldoquin Forte®, Melanex®, Nuquin®, Solaquin®)
6. Bulk ingredients (i.e. bulk chemicals, bulk powders, bulk compounding ingredients, hormone replacement bulk ingredients, high cost bases, compound kids, etc.)
7. Cequr, Finesse® and all other disposable insulin delivery systems, except Omnipod and VGo
8. Charges for the administration or injection of any drug
9. Compounds containing one or more ingredients which are commercially available in alternate medications, are an over-the-counter (OTC) product or lack clinical evidence in compounded dosage forms. This list is subject to change throughout the Plan Year.
10. Contraceptive devices and implants
11. Diagnostic agents
12. Drugs dispensed by a hospital, clinic or physician's office
13. Drugs excluded from the formulary by Express Scripts. You can find a list of these medications at **https://peia.wv.gov/prescription_drug_lists/Documents/Formulary_Exclusions.pdf**
14. Drugs labeled "Caution-limited by federal law to investigational use," or experimental drugs not approved by the FDA, even though a charge is made to the individual.
15. Drugs requiring prior authorization when prescribed for uses and quantities not approved by the FDA
16. Drugs requiring a prescription by State law, but not by federal law (State controlled) are not covered
17. Erectile dysfunction medications
18. Fertility drugs
19. Fioricet® with Codeine (butalbital/acetaminophen caffeine with codeine)
20. Fiorinal® with Codeine (butalbital/aspirin/caffeine with codeine)

21. Hair growth stimulants
22. Homeopathic medications
23. Hypoactive Sexual Desire Disorder (HSDD) Agents
24. Immunizations, biological sera, blood or blood products, Hyalgan®, Synvisc®, Remicade®, Synagis®, Xolair®, Amevive®, Raptiva®, Vivitrol® (these are covered under the medical plan)
25. Latisse™
26. Medical or therapeutic foods
27. Medication which is to be taken by or administered to an individual, in whole or in part, while he or she is a patient in a hospital, sanitarium, or extended care facility.
28. Medication for which the cost is recoverable under any Workers' Compensation or occupational disease law, or any State or governmental agency, or medication furnished by any other Drug or Medical Service for which no charge is made to the member.
29. Newly released prescription medications that have been on the market less than 4 months
30. Non-legend drugs
31. Nutritional Supplements (that require a prescription, i.e., Metanx, Limbrel, Deplen)
32. Pentazocine/Acetaminophen (Talacen®)
33. Prescription drug charges not filed within 6 months of the purchase date, if PEIA is the primary insurer, or within 6 months of the processing date on the Explanation of Benefits (EOB) from the other plan, if PEIA is secondary.
34. Products unapproved by the FDA.
35. Replacement medications for lost, damaged or stolen drugs
36. Requests for less than a 90-day supply of maintenance medications, or requests for more than a 30-day supply of short-term medications.
37. Respiratory Therapy Supplies: Nebulizers
38. Respiratory Therapy Supplies: Peak Flow Meters
39. Stadol® Nasal Spray (butorphanol)
40. Select medical devices and artificial saliva products (e.g., Avenova, Beau Rx, Eletone, Epiceram, HPR Plus, PromiseB, NetraSal, SalivaMAX)
41. Select medications with clinically appropriate, cost-effective alternatives (e.g., Aplenzin, Duexis, Jublia, Kerydin, Nascobal, Sitavig, Vimovo, Xerese, Zipsor, Zyflo, Absorica, Absorica LD)
42. Specialty Mental Health Category (e.g., Spravato, Zulresso)
43. Therapeutic devices or appliances, including support garments and other non-medicinal substances, regardless of intended use, except those listed above.
44. Unit dose medications
45. Vacation supplies, unless leaving the country. If you are leaving the country, and want PEIA to cover a vacation supply, you must submit documentation (copy of an airline ticket, travel agency itinerary, etc.) to substantiate your international travel arrangements. Please allow seven (7) days for processing.

Other Important Features of Your Prescription Drug Program

Your prescription drug program is designed to provide the care and service you expect, whether it's keeping a record of your medication history, providing toll-free access to a registered pharmacist, or keeping you in touch with any changes to your program.

Express Scripts uses the health and prescription information about you and your dependents to administer your benefits. They also use information and prescription data from claims submitted nationwide for reporting and analysis without identifying individual patients.

When your prescriptions are filled at one of Express Scripts' mail service pharmacies or at a participating retail pharmacy, pharmacists use the health and prescription information on file

for you to consider many important clinical factors including drug selection, dosing, interactions, duration of therapy and allergies. Express Scripts' pharmacists may also use information received from your network retail pharmacy.

Drug Utilization Review

Under the drug utilization review program, prescriptions filled through the mail service pharmacy and participating retail pharmacies are examined by Express Scripts for potential drug interactions based on your personal medication profile. The drug utilization review is especially important if you or your covered dependents take many different medications or see more than one doctor. If there is a question about your prescription, your pharmacist may notify your doctor before dispensing the medication.

Education and Safety

You will receive information about critical topics like drug interactions and possible side effects with every new prescription Express Scripts mails. Your retail pharmacy may also provide you with drug information. By visiting **www.express-scripts.com/wvpeia**, you also can access other health-related information. To view health information personalized to fit your interests, register with **www.express-scripts.com/wvpeia**. Any written health information cannot replace the expertise and advice of health care practitioners who have direct contact with a patient. All Express Scripts health information is designed to help you communicate more effectively with your doctor and, as a result, understand more completely your situation and choices.

Health Management

Based on your prescription and health information, Express Scripts may provide information to you on one or more of Express Scripts' Care Management programs, provided as a service to you by PEIA. Program participants generally receive educational mailings and may receive a follow-up call from an Express Scripts pharmacist or nurse. Express Scripts develops these programs to support your doctor's care, and they may contact your doctor regarding your participation in these programs.

Coordination of Benefits

If another insurance carrier is the primary insurer for a policyholder or a dependent, or if you are Medicare-eligible, PEIA will pursue coordination of benefits.

Commercial Insurance: As a secondary payor, PEIA will pay only if the other insurance plan's benefit is less than what PEIA would have provided as the primary insurer. If PEIA is the secondary insurer, you must submit the following documentation to Express Scripts to have the secondary claim processed:

- a completed Express Scripts claim form;
- the receipt from the pharmacy; and
- an Explanation of Benefits from the primary plan or a pharmacy printout that shows the amount paid by the primary plan.

You will usually be reimbursed within 30 days from receipt of your claim form.

If you need claims forms, call Express Scripts Member Services at **1-855-224-6247** or visit their website at **www.express-scripts.com/wvpeia**.

Medicare Part B: If Medicare is the primary insurer, Medicare must be billed first for any drugs covered by Medicare Part B. Your pharmacist should bill Medicare Part B as the primary insurer. UMR will receive the crossover claims from Medicare Part B and pay the pharmacy directly. This will save you money since PEIA will pay the member responsibility for prescription

drugs covered by Medicare Part B. You should not pay any deductible or co-insurance for Medicare Part B-covered drugs. You can find a listing of pharmacies willing to bill Medicare and accept assignment on our web page at **peia.wv.gov** or by calling our customer service unit at **1-888-680-7342**. These classes of drugs are usually covered by Medicare Part B:

a. Immunosuppressants
b. Oral Chemotherapeutic medications
c. Drugs for nausea associated with chemo meds
d. Diabetic testing supplies
e. Limited Inhalation therapies

How to File a Claim

Filing a Prescription Drug Claim

Prescription drug claims are processed by Express Scripts and should be submitted to:

Express Scripts Attn: Commercial Claims P.O. Box 14711 Lexington, KY 40512-4711

To process a prescription drug claim, Express Scripts requires a prescription receipt/label which includes:

- Pharmacy Name/Address
- Date Filled
- Drug Name, Strength and NDC
- Rx Number
- Quantity
- Days Supply
- Price
- Patient's Name

Claims received missing any of the above information may be returned or payment may be denied or delayed.

Cash register receipts and canceled checks are not acceptable proof of your claim.

If you have other insurance which is primary, you need to submit an Explanation of Benefits (EOB) from the other insurance which shows the amount the primary insurance paid with each claim, or ask your provider to do so if the claim is being submitted for you. You have six (6) months from the date of service to file a prescription claim. If PEIA is your secondary insurer, you have six (6) months from the date of your primary insurer's Explanation of Benefits processing date to file your claim with PEIA. If you do not submit claims within this period, they will not be paid.

If your claim is for an illness or injury wrongfully or negligently caused by someone else, and you expect to be reimbursed by another party or insurance plan, you must file a claim with PEIA within six (6) months of the date of service to ensure that the covered services will be paid. Later, if you receive payment for the expenses, you will have to repay the amount you received from PEIA. See "Subrogation" on page 70 for details.

Filing Claims for Court-ordered Dependents (COD)

If you are the custodial parent of a child who is covered under the other parent's PEIA plan as a result of a court order, you must use your I.D. card at a participating pharmacy to receive prescription benefits.

Claims Incurred Outside of the U.S.A.

If you or a covered dependent incur prescription drug expenses while outside the United States, you will be required to pay the provider yourself. Request an itemized bill containing all the information listed above from your provider and submit the bill along with a claim form to Express Scripts.

Express Scripts will determine, through a local banking institution, the currency exchange rate and you will be reimbursed according to the terms of PEIA Special Medicare Plan.

Appealing a Drug Claim

Appealing an Adverse Benefit Decision (Denied Claims)

Adverse Benefit Determination means a denial, reduction, or termination of a benefit, or a failure to provide or make payment, in whole or in part, for a benefit. It also includes any such denial, reduction, termination, rescission of coverage (whether or not, in connection with the rescission, there is an adverse effect on any particular benefit at that time), or failure to provide or make payment that is based on a determination that the Participant is no longer eligible to participate in the Plan. If a claim is being denied, in whole or in part, and the Participant will owe any amount to the provider, the Participant will receive an initial claim denial notice, usually referred to as an Explanation of Benefits (EOB) form, within the timelines described above.

The EOB form will:

- Explain the specific reasons for the denial.
- Provide a specific reference to pertinent Plan provisions on which the denial was based.
- Provide a description of any material or information that is necessary for the Participant to perfect the claim, along with an explanation of why such material or information is necessary, if applicable.
- Provide appropriate information as to the steps the Participant may take to submit the claim for appeal (review).

If an internal rule or guideline was relied upon, or if the denial was based on Medical Necessity or Experimental, Investigational, or Unproven treatment, the Plan will notify the Participant of that fact. The Participant has the right to request a copy of the rule/guideline or clinical criteria that were relied upon, and such information will be provided free of charge.

PEIA Special Medicare Plan

If you are a PEIA Special Medicare Plan participant or provider and think that an error has been made in processing your prescription drug claim or in a prescription benefit determination or denial, the first step is to reach out to Express Scripts or RDT to verify that a mistake has been made. All appeals must be initiated within one hundred and eighty (180) days of claim payment or denial.

Type of Error	Who to Call	Where to Write
Prior Authorization error or denial	RDT **1-800-847-3859** For urgent appeals or appeals generated by the physician or pharmacist.	Rational Drug Therapy Program WVU School of Pharmacy P.O. Box 9511 HSCN Morgantown, WV 26506

Type of Error	Who to Call	Where to Write
Prescription drug claim payment error or denial	Express Scripts **1-855-224-6247**	Express Scripts Attn: Clinical Appeals Department P.O. Box 66588 St. Louis, MO 63166-6588
Appealing a Specialty Drug Claim	Express Scripts **1-855-224-6247**	Express Scripts Attn: Clinical Appeals Department P.O. Box 66588 St. Louis, MO 63166-6588

How to appeal an adverse benefit decision (denied claims): This is a **mandatory** appeal level. The Covered Person must exhaust internal procedures before taking any outside legal action.

If your pharmacy claim has been denied, or if you disagree with the determination made by RDT or Express Scripts, the second step is for you or your Authorized Individual to appeal in writing to RDT or Express Scripts at the address listed above. The Participant must file the appeal within 180 days of the date they received the EOB form from the Plan showing that the claim was denied. The Plan will assume the Participant received the EOB form seven days after the Plan mailed the EOB form. Explain what you think the problem is, and why you disagree with the decision. Please have your physician provide any additional relevant clinical information to support your request.

If the benefit denial was based, in whole or in part, on a medical judgment, the Plan will consult with a health care professional with training and experience in the relevant medical field. This health care professional may not have been involved in the original denial decision and may not have been supervised by the health care professional who was involved. If the Plan has consulted with medical or vocational experts in connection with the claim, these experts will be identified upon the Participant's request, regardless of whether the Plan relies on their advice in making any benefit determinations.

After the claim has been reviewed, the Participant will receive written notification letting them know if the claim is being approved or denied. In the event of new or additional evidence, or any new rationale relied upon during the appeal process in connection with a claim that is being appealed, the Plan will automatically provide the relevant information to the Participant. The notification will provide the Participant with the information outlined under the "Adverse Benefit Determination" section above.

Filing a Second Appeal: This is a **mandatory** appeal level. The Participant must exhaust internal procedures before taking any outside legal action.

Your Plan offers two internal levels of appeal. If you are not satisfied with the first level appeal decision, you have the right to request a second level appeal from PEIA. The Participant or their Authorized Individual must file the appeal within 60 days of the date they received the EOB form from the Plan showing that the claim was denied. The Plan will assume the covered person received the EOB form seven days after the Plan mailed the EOB form. Appeals should be directed to the Director of the PEIA. Facts, issues, comments, letters, Explanation of Benefits (EOBs), and all pertinent information about the case should be included and mailed to:

Director, Public Employees Insurance Agency,
601 57th Street, SE, Suite 2, Charleston, WV 25304-2345

When your request for review arrives, PEIA will reconsider the entire case, considering any

additional materials which have been provided. If the benefit denial was based, in whole or in part, on a medical judgment, the Plan will consult with the medical director. This health care professional may not have been involved in the original denial decision or first appeal and may not have been supervised by the health care professional who was involved. If the Plan has consulted with medical or vocational experts in connection with the claim, these experts will be identified upon the Participant's request, regardless of whether the Plan relies on their advice in making any benefit determinations.

A decision, in writing, explaining the reason for modifying or upholding the original disposition of the claim will be sent to the Participant or his or her Authorized Representative. If additional information is required to make a decision, this information will be requested in writing. The additional information must be received within sixty (60) days of the date of the letter. If the additional information is not received, the case will be closed.

TIME PERIODS FOR MAKING DECISIONS ON APPEALS

After reviewing a claim that has been appealed, the Plan will notify the Participant of its decision within the following timeframes, although Participants may voluntarily extend these timelines. In addition, if any new or additional evidence is relied upon or generated during the determination of the appeal, the Plan will provide such evidence to You free of charge and sufficiently in advance of the due date of the response to the Adverse Benefit Determination. If such evidence is received at a point in the process where the Plan is unable to provide You with a reasonable opportunity to respond prior to the end of the period stated below, the time period will be tolled to allow You a reasonable opportunity to respond to the new or additional evidence.

URGENT CLAIM APPEALS THAT REQUIRE IMMEDIATE ACTION

A request by a Participant or their Authorized Individual for the review and reconsideration of coverage that requires notification or approval prior to receiving medical care may be considered an urgent claim appeal.

Urgent claim appeals must meet one or both of the following criteria in order to be considered urgent in nature:

- A delay in treatment could seriously jeopardize life or health or the ability to regain maximum functionality.
- In the opinion of a Physician with knowledge of the medical condition, a delay in treatment could cause severe pain that cannot be adequately managed without the care or treatment that is the subject of the claim.

The Plan must respond to the urgent claim appeal request as soon as possible, taking into account the medical exigencies, but no later than 72 hours after receiving the request for review.

- Pre-Service Claims: Within a reasonable period of time appropriate to the medical circumstances, but no later than 10 business days after the Plan receives the request for review for the first appeal, and another 10 business days for the second appeal, or a maximum of 20 business days days for the two appeal levels.
- Post-Service Claims: Within a reasonable period of time, but no later than 30 calendar days after the Plan receives the request for review for the first appeal, and another 30 calendar days for the second appeal, or a maximum of 60 calendar days for the two appeal levels.
- Concurrent Care Claims: Before treatment ends or is reduced.

RIGHT TO EXTERNAL REVIEW

If, after exhausting Your internal appeals, You are not satisfied with the final determination, You may choose to participate in the external review program. This program applies only if the Adverse Benefit Determination involves:

- Clinical reasons;
- The exclusions for Experimental, Investigational, or Unproven services;
- Determinations related to Your entitlement to a reasonable alternative standard for a reward under a wellness program;
- Determinations related to whether the Plan has complied with non-quantitative treatment limitation provisions of Code 9812 or 54.9812 (Parity in Mental Health and Substance Use Disorder Benefits);
- Determinations related to the Plan's compliance with the following surprise billing and cost-sharing protections set forth in the No Surprises Act:
  - ► Whether a claim is for Emergency treatment that involves medical judgment or consideration of compliance with the cost-sharing and surprise billing protections;
  - ► Whether a claim for items and services was furnished by a non-network provider at a network facility;
  - ► Whether an individual gave informed consent to waive the protections under the No Surprises Act;
  - ► Whether a claim for items and services is coded correctly and is consistent with the treatment actually received;
  - ► Whether cost-sharing was appropriately calculated for claims for Ancillary Services provided by a non-network provider at a network facility; or
- Other requirements of applicable law.

This external review program offers an independent review process to review the denial of a requested service or procedure (other than a pre-determination of benefits) or the denial of payment for a service or procedure. The process is available at no charge to You after You have exhausted the appeals process identified above and You receive a decision that is unfavorable, or if Express Scripts, RDT, or PEIA fails to respond to Your appeal within the timelines stated above.

You may request an independent review of the Adverse Benefit Determination. Neither You nor RDT, Express Scripts nor PEIA will have an opportunity to meet with the reviewer or otherwise participate in the reviewer's decision. If You wish to pursue an external review, please send a written request as indicated below.

Notice of the right to external review for appeals should be sent to:

Director, Public Employees Insurance Agency
601 57th Street, SE, Suite 2 Charleston, WV 25304-2345

Alternatively, You may fax Your request to 877-233-4295, ATTN: PEIA External Appeal

Your written request should include: (1) Your specific request for an external review; (2) the Participant's name, address, and member ID number; (3) Your Authorized Individual's name and address, if applicable; (4) a description of the service that was denied; and (5) any new, relevant information that was not provided during the internal appeal. You will be provided more information about the external review process at the time we receive Your request.

Any requests for an independent review must be made within four months of the date You

receive the Adverse Benefit Determination. You or an Authorized Individual may request an independent review.

The independent review will be performed by an independent Physician, or by a Physician who is qualified to decide whether the requested service or procedure is a qualified medical care expense under the Plan. The Independent Review Organization (IRO) has been contracted by PEIA's Third Party Administrator (UMR) and has no material affiliation or interest with UMR or PEIA. UMR will choose the IRO based on a rotating list of approved IROs.

In certain cases, the independent review may be performed by a panel of Physicians, as deemed appropriate by the IRO.

Within applicable timeframes of UMR's receipt of a request for independent review, the request will be forwarded to the IRO, together with:

- All relevant medical records;
- All other documents relied upon by RDT, Express Scripts, and/or PEIA in making a decision on the case; and
- All other information or evidence that You or Your Physician has already submitted to RDT, Express Scripts, or PEIA.

If there is any information or evidence that was not previously provided and that You or Your Physician wishes to submit in support of the request, You may include this information with the request for an independent review, and UMR will include it with the documents forwarded to the IRO. A decision will be made within applicable timeframes. If the reviewer needs additional information to make a decision, this time period may be extended. The independent review process will be expedited if You meet the criteria for an expedited external review as defined by applicable law.

The reviewer's decision will be in writing and will include the clinical basis for the determination. The IRO will provide You and UMR and/or PEIA with the reviewer's decision, a description of the qualifications of the reviewer, and any other information deemed appropriate by the organization and/or required by applicable law.

If the final independent decision is to approve payment or referral, the Plan will accept the decision and provide benefits for such service or procedure in accordance with the terms and conditions of the Plan. If the final independent review decision is that payment or referral will not be made, the Plan will not be obligated to provide benefits for the service or procedure

How to Reach Express Scripts

On the Internet: Reach Express Scripts at **www.express-scripts.com/wvpeia**. Visit Express Scripts' website anytime to learn about patient care, refill your mail service prescriptions, check the status of your mail service pharmacy order, request claim forms and mail service order forms or find a participating retail pharmacy near you.

By Telephone: For those insureds who do not have access to Express Scripts via the Internet, you can learn more about your program by calling Express Scripts Customer Care at **1-855-224-6247**, 24 hours a day, 7 days a week.

Special Services: Express Scripts continually strives to meet the special needs of PEIA's insureds: You may call a registered pharmacist at any time for consultations at **1-855-224-6247**.

PEIA's hearing-impaired insureds may use Express Scripts' TDD number at **1-800-759-1089**.

Visually impaired insureds may request that their mail service prescriptions include labels in Braille by calling **1-855-224-6247**.

Medicare Part D

Medicare offers prescription drug coverage through Medicare Part D. **Please be aware that you *SHOULD NOT* purchase a separate Medicare Part D plan.** PEIA will provide prescription drug coverage to its Medicare members.

If you are a Medicare Advantage plan member and enroll in a separate Medicare Part D plan, you will be disenrolled from all medical and prescription benefits from PEIA. You will have only original Medicare A & B for medical coverage and your Medicare Part D plan with no secondary coverage.

Medicare Part D Creditable Coverage Notice

This is information about prescription drug coverage for all PEIA Special Medicare Plan members. It does not apply to Medicare-eligible retired employees or dependents of Medicare-eligible retirees who are enrolled in PEIA's Medicare Advantage plan. It explains the options you have under Medicare prescription drug coverage and can help you decide whether or not you want to enroll. At the end of this notice is information about where you can get help to make decisions about your prescription drug coverage.

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 (MAPD plans). 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. PEIA has determined that the prescription drug coverage offered by the PEIA Special Medicare Plan is, on average for all plan participants, expected to pay out as much as the standard Medicare prescription drug coverage will pay and is considered Creditable Coverage. Because your existing coverage is on average at least as good as standard
3. 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 15 through December 31. Beneficiaries leaving employer/union coverage may be eligible for a Special Enrollment Period to sign up for a Medicare prescription drug plan.

You should compare your current coverage, including which drugs are covered, with the coverage and cost of the plans offering Medicare prescription drug coverage in your area.

If you do decide to enroll in a Medicare prescription drug plan and drop your PEIA Special Medicare Plan prescription drug coverage, be aware that you and your dependents may not be able to get this coverage back. Please contact us for more information about what happens to your coverage if you enroll in a Medicare prescription drug plan.

You should also know that if you drop or lose your coverage with PEIA and don't enroll in Medicare prescription drug coverage after your current coverage ends, you may pay more (a penalty) to enroll in Medicare prescription drug coverage later. If you go 63 days or longer without prescription drug coverage that's at least as good as Medicare's prescription drug coverage, your monthly premium will go up at least 1% per month 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.

Contact our office for further information at **1-888-680-7342**. **NOTE:** You will receive this notice annually and at other times in the future such as before the next period you can enroll in Medicare prescription drug coverage, and if this coverage through PEIA changes. You also may request a copy.

More detailed information about Medicare plans that offer prescription drug coverage is in the *Medicare & You* handbook. You'll 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**
- Call your State Health Insurance Assistance Program (see your copy of the *Medicare & You* handbook for their telephone number) for personalized help
- Call **1-800-MEDICARE** (**1-800-633-4227**). TTY users should call **1-877-486-2048**.

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 call them at **1-800-772-1213** (TTY **1-800-325-0778**).

Benefit Assistance Program

PEIA offers a program to assist Medicare-eligible retired employees with increasing health care costs. To qualify for benefit assistance you must meet all of the following criteria:

- Medicare must be your primary insurance,
- you must have 15 or more years of service,
- you must be enrolled in the Medicare Advantage Prescription Drug (MAPD) Plan or the Special Medicare Plan, and
- your household income must have been at or below 250% of the Federal Poverty Level (FPL).

Retired employees who are using sick or annual leave or years of service to extend their employer-paid insurance qualify for this program once their leave is exhausted if their annual income meets the guidelines.

Benefit Assistance

Benefit assistance is only provided if the policyholder is a Medicare beneficiary. Out-of-pocket

costs for members with benefit assistance are shown in the following chart:

	Standard Benefit (without assistance)	New Benefit (with assistance)
Medical Benefits		
Medical Deductible	$150	$50
Medical out of pocket maximum	$1,200	$600
Office visit copayment	$20	$2
Specialist office visit copayment	$40	$5
Prescription Drug Benefits		
Generic (30-day supply)	$10	$5
Generic (90-day supply) mail order or retail maintenance network	$20	$10
Preferred Brand (30-day supply)	$25	$15
Preferred Brand (90-day supply) mail order or retail maintenance network	$50	$30
Non-preferred Brand (30-day supply)	75% coinsurance	75% coinsurance
Non-preferred Brand (90-day supply) mail order or retail maintenance network	75% coinsurance	75% coinsurance
Prescription Out-of-Pocket Maximum	$1,750	$250
Prescription Deductible	$75 individual/$150 family	$75 individual/$150 family

If you believe you qualify, contact PEIA's customer service unit for an application, or you can print a copy at **peia.wv.gov**.

Remember, if you are a Medicare retiree with non-Medicare dependents, then the non-Medicare dependents covered by the Medicare policyholder will have benefits through the PEIA PPB Plan. Non-Medicare dependents are not eligible to be covered by Humana or the Special Medicare Plan.

Controlling Costs

Prohibition of Balance Billing

All PEIA health plans are governed in part by the Omnibus Health Care Act which was enacted by the West Virginia Legislature in April 1989. This Law requires that any West Virginia health care provider who treats a PEIA insured must accept assignment of benefits and cannot balance bill the insured for any portion of charges over and above the PEIA fee allowance or for any discount amount applied to a provider's charge or payment. This is known as the "prohibition of balance billing."

A PEIA insured who has Medicare as the primary payor has protection against balance billing when the provider accepts Medicare assignment. If the provider accepts Medicare assignment, you are not responsible for amounts which exceed the Medicare allowances.

New Technologies

Upon FDA approval of new technology, PEIA determines whether or not to cover the item, service or procedure. These new technologies may or may not be covered. PEIA often waits until the new technology proves effective before approving coverage. *If you have concerns about coverage of a new technology, contact UMR for details*.

Healthcare Fraud and Abuse

By law, PEIA must report suspected fraud to the WV Insurance Commission. In addition, PEIA works with the U.S. Attorney's office in the investigation of potential fraud and/or abuse.

Examples of Provider Fraud:

- Waiving member copays
- Balance billing members for services
- Billing for services not provided
- Billing for a non-covered service as a covered service (e.g. billing a "tummy tuck" (non-covered) as a hernia repair (covered)
- Billing that appears to be a deliberate claim for duplicate payments for the same services
- Misrepresenting dates, services or identities of members or providers
- Intentional incorrect reporting of diagnoses or procedures to maximize payment (up-coding)
- Billing for separate parts of a procedure rather than the whole (unbundling)
- Accepting or giving kickbacks for member referrals
- Prescribing additional and unnecessary treatments (over-utilization)

Examples of Member Fraud:

- Providing false information when applying for PEIA coverage
- Forging or selling prescription drugs
- "Loaning" or using another's insurance card

How to Report Healthcare Fraud and Abuse:

If you suspect healthcare fraud, please call the PEIA toll-free number (**1-888-680-7342**) and ask to speak with a member of the Special Investigations Team or complete the Health Care Fraud and Abuse Form on PEIA's website. You will be asked to provide as much information as possible. PEIA will investigate your concern(s) and if appropriate, refer the information to the appropriate legal authorities.

Coordination of Benefits

In its effort to control health care costs, the PEIA Special Medicare Plan has a coordination of benefits (COB) provision. Under this provision, when a person covered by PEIA also has coverage under another policy (or policies), there are certain rules determining which policy is required to pay benefits first. The policy paying first is called the primary plan, and any other applicable policy is called the secondary plan.

UMR, on PEIA's behalf, will request information about other coverage using a questionnaire mailed to the policyholder periodically. If the policyholder fails to respond to the questionnaire, claims will be denied until the information is received.

If you have health insurance coverage in addition to the PEIA Special Medicare Plan, it is important to understand how the coordination of benefits provision works. In many instances, if the PEIA Special Medicare Plan is secondary, PEIA will pay little or nothing of the balance of your medical bill. In some cases, it may be financially advisable to elect only one insurance coverage. *If, after reviewing this section, you have questions concerning how PEIA's coordination of benefits provision may affect you, contact a PEIA customer service representative at* **1-304-558-7850** *or toll-free at* **1-888-680-7342**.

Coordinating PEIA Benefits with Medicare

The PEIA Special Medicare Plan will reimburse the difference between the amount allowed by

Medicare and the amount paid by Medicare, less the copayment and/or deductible if the balance is not more than the PEIA Special Medicare Plan would have paid as the primary plan.

When Medicare is your primary insurer, all services are considered in-network and are processed at the higher benefit level.

If you have met your PEIA Special Medicare Plan annual medical deductible, you will pay your copayment, if applicable, and PEIA will usually pay the balance.

Medicare Order of Determination

For retirees covered by PEIA and Medicare, regardless of age (see exception below), Medicare is the primary insurer and PEIA is the secondary insurer. All claims must be submitted to Medicare and then to PEIA along with an Explanation of Medicare Benefits (EOMB). Generally, claims are submitted to Medicare and then to PEIA by your provider or by Medicare through the Medicare Crossover program.

When you become an eligible beneficiary of Medicare, you must enroll in Medicare Part A and Medicare Part B. If you do not enroll in Medicare Parts A & B, your coverage may be terminated. Part A is an entitlement program and is available without payment of a premium to most individuals. Part B is the supplementary medical insurance program that covers physician services, outpatient laboratory and x-ray tests, durable medical equipment and outpatient hospital care. Part B is a voluntary program that requires payment of a monthly premium. If you do not enroll in Medicare Part B, PEIA will process your claims as if you did have the Part B coverage. In other words, PEIA will pay only the amount we would have paid if Medicare had processed your claim and made a payment.

If you or your dependents have other coverage in addition to PEIA and Medicare, contact UMR or PEIA to determine what coverage will be primary, secondary or tertiary (third) and whether you need to enroll in Medicare Part B.

Exception: If you are entitled to Medicare as an End Stage Renal Disease (ESRD) beneficiary, call UMR or PEIA to determine who the primary insurer will be.

You MUST NOT enroll in a separate Medicare Part D plan, since PEIA will provide prescription drug coverage for retirees with Medicare.

Recovery of Incorrect Payments

If PEIA discovers that a claim has been paid incorrectly, or that the charges were excessive or for non-covered services, PEIA has the right to recover its payments from any person or any entity.

You must cooperate fully with the PEIA to help it recover any such payment. The PEIA may request refunds or deduct overpayments from a provider's check in order to recover incorrect payments. This provision shall not limit any other remedy provided by law.

Subrogation and Reimbursement

PEIA may pay medical expenses on an insured's behalf in those situations where an injury, sickness, disease or disability, is caused in whole or in part by, or results from, the acts or omissions of a third party, or from the acts or omissions of a PEIA insured where other insurance (such as auto or homeowners) is available. As a condition of receiving such expenses, the PEIA and its agents have the right to recover the cost of such medical expenses from the responsible party directly (whether an unrelated third party or another covered insured) or from their insured, if they have already been reimbursed by another. This right is known as subrogation.

The PEIA is legally subrogated to its insured as against the legally responsible party, but only to the extent of the medical expenses paid on the insured's behalf by the PEIA attributable to such sickness, injury, disease, or disability. PEIA has the right to seek repayment of expenses from, among others, the party that caused the illness or injury, his or her liability carrier or the PEIA insured's own auto insurance carrier in cases of uninsured, underinsured motorist coverage, or medical pay provisions. Subrogation applies, but it is not limited to, the following circumstances:

A) payments made directly by the person who is liable for a PEIA insured's sickness, injury, disease or disability, or any insurance company which pays on behalf of that person, or any other payments on his or her behalf;
B) any payments, settlements, judgments, or arbitration awards paid by any insurance company under an uninsured, underinsured motorist policy or medical pay provisions on the insured's behalf; and
C) any payments from any source designed or intended to compensate a PEIA insured for sickness, injury, disease, or disability sustained as the result of the negligence or wrongful action or alleged negligence or wrongful action of another person.

Your Responsibilities:

It is the obligation of the PEIA insured to:

A) notify the PEIA in writing of any injury, sickness, disease or disability for which the PEIA has paid medical expenses on behalf of a PEIA insured that may be attributable to the wrongful or negligent acts of another person;
B) notify the PEIA in writing if the insured retains services of an attorney, and of any demand made or lawsuit filed on behalf of a PEIA insured, and of any offer, proposed settlement, accepted settlement, judgment, or arbitration award;
C) provide the PEIA or its agents with information it requests concerning circumstances that may involve subrogation, provide any reasonable assistance requested in assimilating such information and cooperate with the PEIA or its agents in defining, verifying or protecting its rights of subrogation and reimbursement; and
D) promptly reimburse the PEIA for benefits paid on behalf of a PEIA insured attributable to the sickness, injury, disease, or disability, once they have obtained money through settlement, judgment, award, or other payment.

Non-Compliance

Failure to comply with any of these requirements may result in:

A) the PEIA's withholding payment of further benefits; and
B) an obligation by the PEIA insured to pay costs, attorneys' fees and other expenses incurred by the PEIA in obtaining the required information or reimbursement.

By acceptance of benefits paid under the plan, the PEIA insured agrees that PEIA's rights of subrogation and reimbursement shall have a priority lien and the right of first recovery against any settlement or judgment obtained by or on behalf of an insured. This right shall exist without regard to allocation or designation of the recovery.

These provisions shall not limit any other remedy provided by law. This right of subrogation shall apply without regard to the location of the event that led to or caused the applicable sickness, injury, disease or disability.

Please note: As with any claim, the claims resulting from an accident or other incident which may involve subrogation should be submitted within the PEIA's timely filing requirement of six (6) months. It is not necessary that any settlement, judgment, award, or other payment from a third party have been reached or received before filing a claim with the PEIA or with one of the managed care plans associated with the PEIA.

Amending the Benefit Plan

The West Virginia Public Employees Insurance Agency reserves the right to amend all or any portion of this Benefit booklet in order to reflect changes required by court decisions, legislation, actions by the Finance Board, actions by the Director or for any other matters as are appropriate. The Benefit booklet will be amended within a reasonable time of any such actions and notice will be provided no later than 60 days prior to the date on which the modification will become effective. All amendments to this Benefit booklet must be in writing, dated and approved by the Director. The Director shall have sole authority to approve amendments. The Summary Plan Description and all approved amendments will be filed with the office of the West Virginia Secretary of State.

West Virginia Public Employees Insurance Agency (PEIA) HIPAA Notice of Privacy Practices

Effective date of this notice: November 1, 2016

If you have questions about this notice, please contact the person listed under "Who to Contact". THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

Summary

In order to provide you with benefits, PEIA will receive personal information about your health, from you, your physicians, hospitals, pharmacies, and others who provide you with health care services. We are required to keep this information confidential. This notice of our privacy practices is intended to inform you of the ways we may use your information and the occasions on which we may disclose this information to others.

We use members' health information to provide benefits, including making claims payments and providing customer service. We disclose members' information to health care providers to assist them in providing you with treatment or to help them receive payment. We may disclose information to other insurance companies as necessary to receive payment or coordinate benefits. We may use the information within our organization to evaluate quality and improve health care operations, and we may make other uses and disclosures of members' information as required or allowed by law or as permitted by PEIA policies.

Kinds Of Information That This Notice Applies To

This notice applies to any information that is created, received, used, or maintained by PEIA or its Business Associates that relates to the past, present, or future physical or mental health, healthcare, or payment for the healthcare of an individual.

Who Must Abide by This Notice

- PEIA
- All employees, staff, students, volunteers, contractors, and other personnel who work for and/or under the direct control of PEIA.

The people and organizations to which this notice applies (referred to as "we," "our," and "us") have agreed to abide by its terms and have been trained in their roles and responsibilities. We may share your information with each other for the purpose(s) of treatment, and as necessary for payment and healthcare operations activities as described below.

Our Legal Duties

- We are required by law to ensure the confidentiality, integrity, and availability of all PHI we create, use, receive, maintain or transmit;
- We are required to provide this notice of our privacy practices and legal duties regarding health information to anyone who asks for it.
- We are required to respond to your requests or concerns within a timely manner.
  Implement administrative, physical and technical safeguards to ensure compliance with this notice
- We are required to abide by the terms of this notice until we officially adopt a new notice.

How We May Use or Disclose Your Health Information.

This notice describes how we may use your personal, protected health information, or disclose it to others, for a number of different reasons. For each reason, we have written a brief explanation. We also provide some examples. These examples do not include all of the specific ways we may use or disclose your information. But any time we use your information, or disclose it to someone else, it will fit one of the reasons listed here.

1. **Treatment.** We may use your health information to provide you with medical care and services. This means

that our employees, staff, students, volunteers and others whose work is under our direct control, may read your health information to learn about your medical condition and use it to help you make decisions about your care. For instance, a health plan nurse may take your blood pressure at a health fair and use the results to discuss with your health issues. We will also disclose your information to others to provide you with options for medical treatment or services. For instance, we may use health information to identify members with certain chronic illnesses, and send information to them or to their doctors regarding treatment alternatives.

2. **Payment.** We will use your health information, and disclose it to others, as necessary to make payment for the health care services you receive. For instance, an employee in our customer service department or at our claims processing administrators may use your health information to help pay your claims. And we may send information about you and your claim payments to the doctor or hospital that provided you with the health care services. We will also send you information about claims we pay and claims we do not pay (called an "explanation of benefits"). The explanation of benefits will include information about claims we receive for the subscriber and each dependent that are enrolled together under a single contract or identification number. Under certain circumstances, you may receive this information confidentially: see the "Confidential Communication" section in this notice. We may also disclose some of your health information to companies with whom we contract for payment-related services. For instance, if you owe us money, we may give information about you to a collection company that we contract with to collect bills for us. We will not use or disclose more information for payment purposes than is necessary.
3. **Health Care Operations.** We may use your health information for activities that are necessary to operate this organization. This includes reading your health information to review the performance of our staff. We may also use your information and the information of other members to plan what services we need to provide, expand, or reduce. We may also provide health information to students who are authorized to receive training here. We may disclose your health information as necessary to others who we contract with to provide administrative services or health care coverage. This includes our third-party administrators, available managed care plans, lawyers, auditors, accreditation services, and consultants, for instance. These third-parties are called "Business Associates" and are held to the same standards as PEIA with regard to ensuring the privacy, security, integrity, and confidentiality of your personal information. If, in the course of healthcare operations, your confidential information is transmitted electronically, PEIA requires that information to be sent in a secure and encrypted format that renders it unreadable and unusable to unauthorized users.
4. **Legal Requirement to Disclose Information.** We will disclose your information when we are required by law to do so. This includes reporting information to government agencies that have the legal responsibility to monitor the state health care system. For instance, we may be required to disclose your health information, and the information of others, if we are audited by state auditors. We will also disclose your health information when we are required to do so by a court order or other judicial or administrative process. We will only disclose the minimum amount of health information necessary to fulfill the legal requirement.
5. **Public Health Activities.** We will disclose your health information when required to do so for public health purposes. This includes reporting certain diseases, births, deaths, and reactions to certain medications. It may also include notifying people who have been exposed to a disease.
6. **To Report Abuse.** We may disclose your health information when the information relates to a victim of abuse, neglect or domestic violence. We will make this report only in accordance with laws that require or allow such reporting, or with your permission.
7. **Law Enforcement.** We may disclose your health information for law enforcement purposes. This includes providing information to help locate a suspect, fugitive, material witness or missing person, or in connection with suspected criminal activity. We must also disclose your health information to a federal agency investigating our compliance with federal privacy regulations. We will only disclose the minimum amount of health information necessary to fulfill the investigation request.
8. **Specialized Purposes.** We may disclose the health information of members of the armed forces as authorized by military command authorities. We may disclose your health information for a number of other specialized purposes. We will only disclose as much information as is necessary for the purpose. For instance, we may disclose your information to coroners, medical examiners and funeral directors; to organ procurement organizations (for organ, eye, or tissue donation); or for national security, intelligence, and protection of the president. We also may disclose health information about an inmate to a correctional institution or to law enforcement officials, to provide the inmate with health care, to protect the health and safety of the inmate and others, and for the safety, administration, and maintenance of the correctional institution.
9. **To Avert a Serious Threat.** We may disclose your health information if we decide that the disclosure is necessary to prevent serious harm to the public or to an individual. The disclosure will only be made to someone who is able to prevent or reduce the threat.
10. **Family and Friends.** Under specific circumstances covered by policy, we may disclose your health information to a member of your family or to someone else who is involved in your medical care or payment for care. This may include telling a family member about the status of a claim, or what benefits you are eligible to receive. In the event of a disaster, we may provide information about you to a disaster relief organization so they can notify your family of your condition and location. We will not disclose your

information to family or friends if you object.

11. **Research.** We may disclose your health information in an appropriately de-identified format in connection with approved medical research projects. Federal rules govern any disclosure of your health information for research purposes without your authorization.
12. **Information to Members.** We may use your health information to provide you with additional information. This may include sending newsletters or other information to your address. This may also include giving you information about treatment options, alternative settings for care, or other health-related options that we cover
13. **Health Benefits Information.** If your enrollment in PEIA's health plan is offered through your employer, your employer may receive limited information, as necessary, for the administration of their health benefit program. The employers will not receive any additional information unless it has been de-identified or you have authorized its release.
14. PEIA will not release, disclose, exchange, and/or sell your health information for use in marketing or for-profit ventures by third parties.

Your Rights

1. **Authorization.** We may not use or disclose your health information for any purpose that is listed in this notice without your written authorization. We will not use or disclose your health information for any other reason without your authorization. We will only disclose the minimum amount of health information necessary to fulfill the authorization request. If you authorize us to use or disclose your health information in additional circumstances, you have the right to revoke the authorization at any time. For information about how to authorize us to use or disclose your health information, or about how to revoke an authorization, contact the person listed under "Who to Contact" at the end of this notice. You may not revoke an authorization for us to use and disclose your information to the extent that we have taken action in reliance on the authorization. If the authorization is to permit disclosure of your information to an insurance company as a condition of obtaining coverage, other law may allow the insurer to continue to use your information to contest claims or your coverage, even after you have revoked the authorization.
2. **Request Restrictions.** You have the right to ask us to restrict how we use or disclose your health information. We will consider your request. But we are not required to agree. If we do agree, we will comply with the request unless the information is needed to provide you with emergency treatment. We cannot agree to restrict disclosures that are required by law.
3. **Confidential Communication.** If you believe that the disclosure of certain information could endanger you, you have the right to ask us to communicate with you at a special address or by a special means. For example, you may ask us to send explanations of benefits that contain your health information to a different address rather than to home. Or you may ask us to speak to you personally on the telephone rather than sending your health information by mail. We will agree to any reasonable request.
4. **Inspect And Receive a Copy of Health Information.** You have a right to inspect the health information about you that we have in our records, and to receive a copy of it. This right is limited to information about you that is kept in records that are used to make decisions about you and certain specific exclusions do apply. For instance, this includes claim and enrollment records. If you want to review or receive a copy of these records, you must make the request in writing. We will accept electronic request for releases of information in the form of e-mails or other electronic means. If you choose, you may receive your records in an electronic format but PEIA has the right to make sure that electronic information is delivered in s safe, secure, and confidential format. We may charge a fee for the cost of copying, mailing and/or e-mailing the records. To ask to inspect your records, or to receive a copy, contact the person listed under "Who to Contact" at the end of this notice. We will respond to your request within 30 days. We may deny you access to certain information. If we do, we will give you the reason, in writing. We will also explain how you may appeal the decision.
5. **Amend Health Information.** You have the right to ask us to amend health information about you which you believe is not correct, or not complete. You must make this request in writing, and give us the reason you believe the information is not correct or complete. We will respond to your request in writing within 30 days. We may deny your request if we did not create the information, if it is not part of the records we use to make decisions about you, if the information is something you would not be permitted to inspect or copy, or if it is complete and accurate.
6. **Accounting of Disclosures.** . You have a right to receive an accounting of certain disclosures of your information to others. This accounting will list the times we have given your health information to others. The list will include dates of the disclosures, the names of the people or organizations to whom the information was disclosed, a description of the information, and the reason. We will provide the first list of disclosures you request at no charge. We may charge you for any additional lists you request during the following 12 months. You must tell us the time period you want the list to cover. You may not request a time period longer than six years. We cannot include disclosures made before April 14, 2003. Disclosures for the following reasons will not be included on the list: disclosures for treatment, payment, or health care operations; disclosures for national security purposes; disclosures to correctional or law enforcement personnel; disclosures that you have authorized; and disclosures made directly to you.
7. **Paper Copy of this Privacy Notice.** You have a right to receive a paper copy of this notice. If you have received this notice electronically, you may receive a paper copy by contacting the person listed under "Who

to Contact" at the end of this notice.

8. **Complaints.** You have a right to complain about our privacy practices, if you think your privacy has been violated. You may file your complaint with the person listed under "Who to Contact" at the end of this notice. You may also file a complaint directly with the: Region III, Office for Civil Rights, U.S. Department of Health and Human Services, 150 South Independence Mall West, Suite 372, Public Ledger Building, Philadelphia, PA 19106-9111. All complaints must be in writing. We will not take any retaliation against you if you file a complaint.

Our Right to Change This Notice

We reserve the right to change our privacy practices, as described in this notice, at any time. We reserve the right to apply these changes to any health information which we already have, as well as to health information we receive in the future. Before we make any change in the privacy practices described in this notice, we will write a new notice including the change. The new notice will include an effective date. We will make the new notice available to all subscribers within 60 days of the effective date.

Who to Contact

Contact the person listed below:

- For more information about this notice, or
- For more information about our privacy policies, or
- If you have any questions about the privacy and security of your records, or
- If you want to exercise any of your rights, as listed on this notice, or
- If you want to request a copy of our current notice of privacy practices.

Privacy Officer, West Virginia Public Employees Insurance Agency,
601 57th St. SE, Charleston, WV 25304-2345, **304-558-7850** or **1-888-680-7342**

Copies of this notice are also available at the reception desk of the PEIA office at the address above. This notice is also available by e-mail.

Send an e-mail to: **PEIA.Help@wv.gov**

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Public Employees Insurance Agency

601 57th Street, SE / Suite 2
Charleston, WV 25304-2345

Who to call with Questions			
Who	**Why**	**Phone**	**Website**
PEIA	Answers to questions about the PEIA Special Medicare Plans	**888-680-7342** (toll-free)	**peia.wv.gov**
MetLife	Answers to questions about life insurance or to file a life insurance claim	**1-888-466-8640** (toll-free)	**http://www.metlife.com/WV-PEIA/**
Mountaineer Flexible Benefits	Dental, vision, disability insurance, flexible spending accounts, etc.	**844-559-8248** (toll-free)	**www.myfbmc.com**

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