WEST VIRGINIA DEPARTMENT OF TRANSPORTATION
ADMINISTRATIVE PROCEDURES
VOLUME III, CHAPTER 7

SUBJECT:	PAYROLL/PERSONNEL
CHAPTER TITLE:	INSURANCE: HEALTH, LIFE, DISMEMBERMENT (DISABILITY), LEGAL

I. INTRODUCTION

Effective: September 1, 1999

West Virginia Department of Transportation employees have the benefit of choosing group health care insurance that best serves their individual lifestyles. Additionally, each employee has a basic term life insurance policy of $10,000. The employee may elect to buy

additional Optional Life and Accidental Death and Dismemberment, and other kinds of insurance for themselves or their dependents.

This chapter is offered as general guidance, to expand employees' understanding of insurance administration and to aid in their decision making process. Along with this information, employee's may consult with their organization's designated Benefits Coordinator who is responsible for processing enrollments and changes and for relaying questions between DOT Human Resources Division's Insurance Specialist and employees. Also, employees may consult with representatives of the Public Employee's Insurance Agency (PEIA).

Other publications offering information on insurance options and benefits are the *Summary Plan Description* and the current year's *Health Care Plan Shopper's Guide.* The *Summary Plan Description* serves as the employee's "owners manual" for insurance coverage while the *Health Care Plan Shopper's Guide* provides details of the different plans and options and is issued for the annual "open enrollment period." These Public Employee's Insurance Agency publications are available from the PEIA or through your organization's Benefits Coordinator.

In the event that the information contained herein differs from that supplied by PEIA, employees should yield to the interpretation from PEIA. Topics of special interest and specific inquiries should be confirmed by actual service providers. For telephone numbers and addresses of specific service providers see Appendix A.

II. **HEALTH CARE INSURANCE**

A. HEALTH CARE PLANS

Health care plans offered by the West Virginia Public Employees Insurance Agency (PEIA) to the active employees of the West Virginia Department of Transportation are the PEIA PPB Plan, Managed Care Plans (which include Health Maintenance Organizations and Point of Service Plans), and Mountaineer Flexible Benefits.

1. PPB Plan (PEIA Preferred Provider Benefit Health Plan)

This is a fee-for-service plan that pays a fee for every individual medical service each time a health care provider treats a PEIA-insured patient. There is a network of providers called the PEIA PPO. This network is made up of West Virginia healthcare providers who accept PEIA's reimbursements and providers in the BlueCross And BlueShield (BCBS) PPO for out-of-state care. The plan has an annual deductible, based upon the employee's salary, and a coinsurance feature. The copayment is, generally, 20% if in-network providers are used, and 40% if out-of-network providers are used.

2. Health Maintenance Organization (HMO)

These plans contract with select hospitals, physicians, pharmacies

and other health care providers in a community who agree to be part of the plan's "network". Each member must select a network doctor to be their primary care physician (PCP). Usually, each family member may select a different PCP. However, all family members must belong to the same plan. The cost for network services is typically only a small copayment ($5 or $10) for each visit. The PCP coordinates all the member's health care needs providing routine care and making any necessary referrals to other providers for specialty care, lab work, x-rays, or hospital services and pursues the mandatory approval from the HMO. It is the member's responsibility to confirm that the appropriate referrals and approvals have been issued. If a member seeks care from a provider without correct referral and authorization from the HMO, the plan will pay nothing and the member will be responsible for the full cost of the service. If HMO members require emergency medical care outside the network, treatment may be sought at the nearest available facility. The HMO will cover emergency services as if they were network care.

3. Point of Service Plans (POS)

   These plans are a cross between an HMO and a traditional insurance plan. As with an HMO, members have low copayments if they obtain their medical care from network providers. Like traditional insurance, members have the freedom to see any health care provider they choose, and still receive some benefits. In the POS plans offered to PEIA insured, the plans will generally pay 60% and the member will pay 40% if the member elects to be treated by a non-network provider and it is not an emergency.

4. Mountaineer Flexible Benefits

   This benefit plan, also known as a cafeteria plan or IRS Section 125 plan, is administered by a privately owned company that is responsible for complying with all IRS regulations for PEIA. Along with the opportunity of establishing flexible spending accounts (FSA)for medical out-of-pocket expenses and dependent day care, service providing insurance companies have other options on the "menu".

   a. ***Dental Care***

      Coverage is available from either CompDent or Delta Dental. CompDent's prepaid dental care plan provides services through participating dental offices located throughout West Virginia. Coverage is provided on a guaranteed member-cost basis for all covered general dentist services plus oral surgery and orthodontics where specialists are available. Panel dentists must be engaged for this benefit. The dental care plan with Delta Dental allows visits to the dentists of the

participants' choice, or to Participating Provider Network dentists. Network dentists will file claims for patients and have agreed to a predetermined Usual & Customary charge. Delta Dental offers two plans that cover the usual, customary, and reasonable cost of the service received--subject to applicable deductibles and coinsurance. The basic plan covers preventive and basic services only. Carefully study the plan descriptions before making a choice.

b. ***Eye Care***

Routine services including eye exams, eyeglass lenses and frames, and contact lenses are covered. There is a copayment for materials, and the frames are available once every eighteen months under the plan. To obtain vision care benefits, call Vision Service Plan (VSP). VSP will mail you a personalized benefit form and the current list of VSP member doctors in your area even though nonmember doctors may be selected by the participant. If a nonmember physician is selected there are caps on reimbursement.

c. ***Disability Income Protection***

Two plans are available: long term and short term disability. Consult the Fringe Benefit Management Company (FBMC) or their current benefits booklet for details.

d. ***Flexible Spending Accounts (FSA)***

These are IRS-approved accounts. Deposits to an FSA are made from one's salary before taxes. Then tax-free withdrawals are requested from the account to reimburse eligible expenses.

There are two categories of FSAs, a Medical Expense FSA and Dependent Day Care FSA. Employees may contribute up to $5000, depending upon the kind of FSA chosen and the employee's tax filing status, of their pre-tax salary in each type of account per year.

Caution is advised that the allocation for these accounts be realistic amounts. IRS regulations state that any amount left after all reimbursements have been processed for the period of coverage cannot be returned or forwarded to the next plan year.

Special rules apply to employees who make less than

$5000 annually, whose spouses are full time students, and who are married and file separate federal tax returns.

Allowable expenses for the medical FSA include expenses not reimbursed by PEIA such as deductibles and co-payments.

Allowable expenses for the dependent day care FSA are limited to expenditures for the care of dependents under the age of 13 or for the care of dependent adults or children mentally or physically incapable of self-care. These expenses are reimbursable when neither the participant, nor any other dependent can provide day care services.

e. **Life Events**
This plan combines several kinds of insurance into one plan, based upon the premise that an employee's insurance needs will change throughout his or her life. Benefits include critical illness (cancer, blindness, organ transplant, etc.), total and permanent disability, long-term care, terminal illness, and death. If a participant experiences one or more qualifying "life events" and the maximum living benefits have been paid, the named beneficiary will still receive the remaining death benefit - totaling at least 25% of the plan's face amount upon the participant's death. Additionally, the plan may be continued even if the participant leaves State employment.

f. **Legal**
The Group Legal Plan, offered through Hyatt Legal Plans, offers benefits for certain legal services through both in-network and out-of-network attorneys. If in-network attorneys are used, covered services are paid in full

B. ELIGIBLE PERSONS

Effective: September 1, 1999

1. Active Employees

Full-time employees are automatically eligible to participant in offered health-care insurance plans along with:

- their legal spouse,
- their biological or adopted children under age 19,
- step children under age 19 who live with the covered employee,
- children or step children of a covered employee who are

incapacitated and cannot support themselves due to a physical or mental disability which began before age 19 (age 25 if a full time student),

- economically dependent children of a covered employee who are enrolled as a full-time students (as determined by the institution) in a graduate or undergraduate college or university - other than a U.S. military academy - or attending a trade or professional school as the child's full-time occupation to age 25.

MARRIED CHILDREN ARE NOT ELIGIBLE DEPENDENTS.

2. Special Eligibility Situations

Employee and Spouse are Both State Employees - may either enroll in one family plan or under two single plans. They may not, however, both enroll in the same single plan (i.e. both cannot have single plans with the PEIA PPB plan, but one could have single coverage under PEIA PPB with the other having single coverage under one of the HMO's).

Court Ordered Dependents (COD) - are eligible, but require verification and special claim forms. Information about this benefit is available through the Benefit Coordinator.

Employees on Non-Workers' Compensation Medical Leave of Absence - are eligible to continue coverage subject to - the medical leave being approved by the employer - both the employee and employer continuing to pay their respective proportionate share of the premium - the employer being obligated to pay its share only for a period of one year after which the employee may be required to pay the full cost of coverage - the employee submitting a monthly physicians's statement certifying that the employee is unable to return to work.

Employees on Workers' Compensation Medical Leave of Absence - receiving temporary total disability benefits from Workers' Compensation are entitled to continue PEIA coverage until they return to work. The employer and employee must continue to pay their proportionate share of the premium cost as long as the employee receives temporary total disability benefits.

Employees on Family Leave - may continue insurance coverage during family leave. Contact the Benefit Coordinator for more information concerning the federal Family and Medical Leave.

Employees on approved Military leave Without Pay - are liable for paying 100% of the premium costs during their leave.

Employees on Personal Leave - may continue their insurance coverage. The Benefit Coordinator should be contacted for current policy concerning the payment of premiums.

Employees' Surviving Dependents - have the option of continuing their health care plan. The employee's last organization is responsible for enrolling the surviving dependents if the employee was a DOT employee at the time of death. The WVDOT will not make any monetary contributions toward the price of premiums. However, the necessary paperwork will be taken care of through Transportation Human Resources Division.

C. CHOOSING A HEALTH CARE PLAN

Effective: September 1, 1999

1. Factors to be Contemplated

   a. ***Verify plans that are available in the policyholder's area***. Policyholders and dependents are not required to live in the managed care plan's network. However, all non-emergency care must be received in the plan's network. Therefore, employees must carefully choose their plan based on their proximity to and access convenience of the plan's network service.

   b. ***Identify doctors and hospitals that are members in the plans*** NOTE: If your doctor drops out of your managed care plan in mid-year, you cannot change health plans. You will have to choose another network physician.

   c. ***Consider special services required*** by the policyholder and dependents. Will they be covered and are the specialists that are needed or preferred in the plan's provider network?

   d. ***Review the total costs of each plan***. Not only should premium prices be considered, but also the cost of both medical and *prescription drug benefits* should be evaluated. One should also compare *deductibles* (the amount that the participant must invest in medical services before the insurance begins issuing monetary benefits), *copayments* (the participant's share of each medical service), and *out-of-pocket maximums* (the total amount that the participant will have to pay for all combined medical services per year). The simplest way to review all of these costs simultaneously is to use the "Medical Benefits At a Glance" tables in the current year's *Health Care Plan Shopper's Guide*.

2. Enrollment Periods

a. ***The initial enrollment period*** into the PEIA Indemnity Plan or any of the managed care plans for new employees is during the month they are hired and the following month of employment [EXCLUDING MOUNTAINEER FLEXIBLE BENEFITS]. Coverage becomes effective the first day of the month following enrollment.

   Employees who enroll before actually starting to work will not be covered until the first day of the month following the first day actively employed.

   Employees who do not enlist in any health insurance during their initial enrollment period and later decide to enroll in a health care plan have only one option available--The PEIA PPB Plan--until the yearly open enrollment period.

b. ***Open enrollment*** will be conducted annually (in the Spring) for a period of approximately 30 days. At this point in time, policyholders may change plans. All changes will become effective on July 1 of the following fiscal year and will be in effect for one calendar year or until such time as an event occurs having an impact on the selected option such as a change in address that is so far away that the selected plan's network cannot be accessed.

   Enrollment for the flexible benefits plan is held once a year during the open enrollment period. This is the only time enrollments or withdrawals from the flexible benefits plan for anyone are allowed - unless the covered employee experiences a change in family or employment status. The enrollment is binding for one year from July 1 through June 30.

D. ENSURING PAYMENT FOR SERVICES

Effective: September 1, 1999

1. Responsibility for Data Exchange

   a. ***The employee as the policyholder*** has the responsibilities of arriving at a decision concerning which health care insurance is most suitable for him/her; of reviewing and understanding the chosen plan's stipulations and how to contact appropriate sources of information in order to make informed choices; of informing the employer Benefit Coordinator immediately as changes of status in the family occur such as a birth/death, a marriage/divorce, a variation in employment, an address change, or a change of primary care physicians.

b. ***The Benefit Coordinator for each DOT organization*** will be designated by each Division Director/District Engineer for Highways and by the Executive Officer of all other DOT agencies. The Benefits Coordinator's responsibilities are to be familiar with the different types of insurance coverage and able to direct employees to appropriate sources of information. Also, the Benefits Coordinator must communicate new/changing eligibility and enrollment information to the Department of Transportation Insurance Specialist in Transportation Human Resources Division.

c. ***Transportation Human Resources Division*** must remit all premiums in the billed month to ensure that employees do not lose benefits due to failure of paying premiums.

d. ***The PEIA*** is responsible for disseminating information regarding insurance options, restrictions and limitations so eligible employees may make informed choices. The PEIA will process all new enrollments, changes of enrollment, and terminations of enrollment. As part of this process, the PEIA will certify eligibility to enroll in specific plans. The PEIA will compute and bill (state) agencies for the employer and employee share of the premium cost from salaries, wages, or pensions. Therefore, the PEIA will maintain records of all enrollees and issue payment for captivated plan enrollees on a monthly basis.

2. <u>The Importance of Precertification</u>

a. ***Precertification*** is the process of obtaining prior approval of an inpatient stay or outpatient procedure for the PEIA PPB Plan. By using the practice of precertification, the PEIA is able to review and make recommendations regarding the medical necessity of planned services, and the most appropriate and cost-effective ways to obtain such services. If a service requires pre-admission review or medical case management, the **health care provider** must call the PEIA at least seven days in advance to have the service approved. See Appendix B for a description of covered medical services. If designated services are not pre-certified, the plan benefits will be reduced by 30% of the allowable charges. This additional 30% will be the obligation of the **health care provider**.

b. ***Referral by the PCP and approval by the managed care plan*** must be obtained by policyholders for all subsequent treatment received, other than from the PCP, when employees choose a managed care option -- an HMO or POS. Routinely, all medical services will be coordinated by a PCP, who will be responsible for providing and authorizing all health care services. Payment for medical

services obtained without referral of the PCP or prior approval of the managed care plan's administration will be the excluded from payable benefits.

c. ***Emergency Care*** means bona fide emergency services provided after the sudden onset of a medical condition (or as soon as the care is available but not later than 24 hours after the onset) exhibiting acute symptoms of sufficient severity, including sever pain, that the absence of immediate medical attention could reasonably be expected to result in: (1) placing the patient's health in serious jeopardy; (2) serious impairment to bodily functions; or (3) serious dysfunction of any bodily organ or part. (For Example: Heart attacks, severe chest pain, cardiovascular accidents, hemorrhaging, poisonings, major burns, loss of consciousness, serious breathing difficulties, spinal injuries, shock and other Acute Conditions as the HMO shall determine are emergencies.)

   All PCPs must have someone who can be reached 24 hours a day, 7 days a week. It is recommended that managed care plan participants contact their PCP before going to the emergency room or urgent care center. If the emergency risks the life of the participant or a dependent's life, go directly to the emergency room.

   Emergency medical services must be reported to PEIA within 48 hours of the provided service for PEIA PPB policyholders. Managed care plan participants must report emergency care to their plan's administration within 48 hours of the service also.

3. Processing Claims

This important task can be made uncomplicated if the participant remembers to always ask for an itemized bill for services, submits all forms in a timely fashion, and calls the pertinent service representative (See Appendix A) when problems or confusion occur.

Managed Care policyholders will have no paperwork to submit while all their medical care is received within their network. However, they should memorize the advice for making claims processing simple in case an emergency occurs outside of their network.

a. ***A complete itemization of charges*** are required to process PEIA PPB Plan medical claims, including:

   * the patients'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

* federal tax identification number of the provider

* the employee's Social Security number.

PEIA claim forms are not necessary if this information is printed on the itemized bill.

Cash register receipts and canceled checks are not acceptable proof of any type of claims.

If there is other insurance, including Medicare, an Explanation of Benefits (EOB) from the other insurance must be presented for each claim.

b. ***The time limit for claim submission for payment*** of medical expenses is one year from the date of service. For prescription drugs the limitation is one year from the date the prescription is filled. If Medicare is the primary insurer, there is an eighteen month window to file the claim with PEIA. If claims are not submitted within this period the participant will be responsible for payment to the provider.
c. ***Prescription drug claims*** will be submitted for policyholders electronically by participating Network pharmacies. Policyholders are responsible for paying any deductible and copayment amounts to the Network pharmacy. PEIA PPB participants may use a non-Network pharmacy with the use of a PEIA Prescription Drug Claim Form. This form must be completed by the pharmacist and mailed to PEIA.
d. ***Court ordered dependency*** does not have to cause difficulties for the custodial parent of a child who is covered under the other parent's PEIA plan. Claims may be submitted directly to EHAS or PRN, using special claim forms. Benefit information published by PEIA and reimbursements can be sent directly to the custodial parent. Contact PEIA for more information.
e. ***Treatment outside West Virginia*** must be ratified with an out-of-state waiver. To assist policyholders who receive medical treatment in other states, the following guidelines have been established to review these requests.

PEIA is the primary payor for the services provided; and

The participant is billed for provider discounts and/or amounts which PEIA disallows; and

The out-of-state services are rendered because;

* an emergency arises; or

* the insured lives or is traveling out-of-state; or

* the medically necessary service is not available in West Virginia (or within a reasonable travel time); or

* due to geographic location, PEIA has determined that services are only available out-of-state; and

No other insurance will pay toward the balance.

f. ***Treatment outside the United States*** may have to be paid for initially by the policyholder incurring the medical expense. The policyholder should request an itemized bill and submit it to PEIA along with a claim form. Determination of the currency exchange rate will be made and reimbursement will be issued according to the terms of the PEIA plan.

g. ***The Patient Audit Program*** offers rewards to policyholders--PEIA PPB members only--when they help detect and correct overcharges or other mistakes on their health care bills. To participate, examine medical bills for these two types of mistakes; Charges for service not received, and overcharges or overpayment resulting from clerical errors.

   Submit the Patient Audit Report Form (supplied by the PEIA) along with an itemized bill from the provider, the corrected bill (or explanation of disagreement), and a copy of the Explanation of Benefits to PEIA.

   Reported errors must be at least $50.00 to qualify for the Patient Audit Program and must be submitted within 60 days of the date on the Explanation of Benefits statement.

   PEIA will investigate and request a refund, if justified, from the provider of services. When a refund is received, the reporting patient will be paid 50% of the recovered amount, up to $1,000 annually.

h. ***Prohibition of balance billing*** refers to the fact that any health care provider who treats a person whose primary

insurance is PEIA must accept assignment of benefits and cannot balance bill the covered person 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 according to the Omnibus Health Care Act passed by the West Virginia Legislature in April 1989.

4. Coordination of Benefits (Secondary Payment)

This term is used when two or more health insurance policies are purchased and are expected to pay any balance of medical claims after the main plan (primary) has paid its share. When a claim is made, the primary plan pays its benefits without regard to any other plans. Then the secondary plan pays its benefits, adjusting for the benefit paid by the primary plan.

If additional health insurance coverage besides PEIA is held, it is important to understand how the coordination of benefits works. All managed care plans will use the "full" or "traditional" method of coordinating benefits when an insured has coverage under two policies. The PEIA PPB Plan uses the less-generous "carve out" or "maintenance of benefits" method, and generally pays little or nothing when PEIA is the secondary plan. In many instances, if PEIA is determined to be secondary and the primary plan is other than Medicare, PEIA will pay little or nothing of the balance of the medical bill. It may be financially advisable to carry only one health insurance.

Both managed care plans and the PEIA PPB Plan will follow the same rules in determining which plan is primary and which is secondary in any given situation. The policy paying first is called the primary plan, and any other policy is called the secondary plan. For active employees, PEIA is the primary health plan for most circumstances. If the spouse is covered through his or her employer, that plan is usually their primary plan.

The primary plan is determined by the first of the following rules that apply

* Plans lacking coordination of benefits provisions are always primary;

* Plans which cover active or retired employees, members or subscribers (other than dependents) are always primary.

* When two public employees, both eligible to enroll for PEIA coverage in their own names, are married and covered under one PEIA family plan, then the spouse, covered as a dependent, will be treated as an employee under these rules;

* For a dependent child of parents not separated or divorced, if two or more plans cover the child as a dependent; the plan of the parent whose birthday falls earlier in the year will be primary; or if both parents have the same birthday; the plan which has been in effect the longest will be primary; or if the other plan uses the parent's gender to determine benefits, and the plans do not agree on the order of benefits, then the rule of the other plan will determine the order of benefits.

* For a dependent child of parents who are separated or divorced, if two or more plans cover the child as a dependent, benefits are determined in this order;

- the plan of the parent who has custody will pay first;

- the plan of the custodial parent’s spouse will pay next;

- the plan of the parent without custody will pay next;

Exception: If a court decree states that one of the parents is responsible for the health care expense of that child, and the plan of that parent has knowledge of these terms, then that plan is primary. The plan of the other parent will then be secondary and the plan of the spouse of the parent with custody of the child will pay third.

* For a dependent child of divorced parents with joint custody, if the court decree does not specify which parent is liable for health care coverage, the previous rule will apply;

* For a dependent child of separated parents with joint custody, if the court decree does not specify which parent is subject for health care coverage, then the previous rule will apply.

* Plans which cover employees and their dependents as active employees, rather than as a laid-off or retired employees, will pay before a plan which covers laid-off or retired employees. If the other plan does not have his rule, and the plans differ about the order of benefits, this paragraph is disregarded. A person covered by a right of continuation policy required by the Consolidated Omnibus Reconciliation Act (COBRA) and covered under another plan, will apply the following rules;

- First, the benefits of a plan covering the person as an employee, member or subscriber (or that person's dependent);

- Second, the benefits under the continuation coverage.

If none of the above rules apply, the plan which has been in effect the longest will be primary.

To calculate the amount PEIA will pay as a secondary plan, subtract the amount the primary plan pays from the amount PEIA would have paid if there were no other insurance. If the other plan paid as much or more than PEIA would have paid as the primary plan, then PEIA will pay nothing as the secondary plan. If the other plan paid less than PEIA would have paid as the primary plan then PEIA will pay the difference up to that amount.

5. Medicare

For PEIA active employees who are also eligible for Medicare, PEIA will use the traditional method of coordinating benefits. That is, Medicare is always the primary payor and PEIA will reimburse the difference of the amount allowed by Medicare and the amount paid by Medicare if the balance is not more than the PEIA would have paid as the primary plan.

An example:	
Total charge	$120
Medicare allowed amount	$100
Medicare pays	$ 80
PEIA pays	$ 20
You owe	$ 0

If Medicare is the primary health coverage (or will be during the next calendar year) membership in a managed care plan is not allowed, because the federal government restricts managed care plans from providing coverage for Medicare clients.

E. OTHER BENEFIT CONSIDERATIONS

Effective: September 1, 1999

1. Appealing Decisions

All participants have the right of appeal whenever they disagree with any determination made by plan administrators or physicians. The first step is to contact the plan's customer service. The second step is to appeal in writing within 60 days of the origination of the issue. The participant should clearly explain the problem. The administrator of the plan in question will respond in writing by either reprocessing the claim or by sending the distressed participant a letter. If this does not resolve the issue, the third step

is to appeal in writing to the director of PEIA. This request for a review of the issue must be submitted within sixty (60) days of receiving the decision of the administrator of the plan. Third step appeals should include facts, issues, comments, letters, explanation of benefit statements, and all pertinent information and original reviews about the claim. PEIA will reconsider the entire case taking into account any additional materials which have been provided. A decision, in writing, explaining the reason for modifying or upholding the original disposition of the claim will be sent to the covered person or their authorized representative.

2. Subrogation

   This term is used to describe the following scenario. If a claim is for an illness or injury wrongfully or negligently caused by someone else, and there are expectations of reimbursement by another person or insurance plan, the claim should be filed with PEIA within 12 months of the date of service to ensure that the claim will be paid. Later, if/when the payment for the expenses is rendered from the responsible parties, repayment must be made to PEIA.

3. COBRA

   The federal Consolidated Omnibus Budget Reconciliation Act permits enrolled employee members the possibility of continuing to maintain health insurance after standard eligibility to be enrolled has ceased. An election to continue coverage under COBRA must be made within 60 days of the end of the original coverage. Individuals electing COBRA coverage are responsible for paying the full premium plus a 2% administration fee.

4. Retired Employee Options

   If you have PEIA coverage as an active employee, you may continue coverage into retirement without interruption. To do so, you must complete Retired Employee Enrollment Forms during the month of retirement or the following month. Continuous coverage is required if you wish to use your accrued sick and/or annual leave for extended PEIA coverage.

   Retired employees pay premiums based on the plan they choose and their eligibility for Medicare.

   Retired-employees may use sick or annual leave to extend employer-paid health coverage. Coverage can only be extended for full (not partial) months.

   If membership in PEIA has existed continuously since before July 1, 1988, additional coverage is calculated as follows:

2 days of accrued leave = 100% premium for 1 month of single coverage.

3 days of accrued leave = 100% premium for 1 month of family coverage.

If membership in PEIA began or if there was a lapse in coverage after July 1, 1988, additional coverage is calculated as follows:

2 days of accrued leave = 50% premium for 1 month of single coverage.

3 days of accrued leave = 50% premium for 1 month of family coverage.

There is also an option of using accrued leave to increase retirement benefits. A choice must be made between additional retirement benefits and extended employer-paid insurance coverage. Augmenting both benefits is not an alternative.

5. Premium Conversion

   Premiums are deducted from pay checks before federal, state, and Social Security taxes are calculated. This results in additional take-home pay for covered employees. Members wishing not to participate must submit a premium conversion plan waiver to the Benefits Coordinator.

6. Pre-existing Medical Conditions

   This is defined as any medical condition which has been diagnosed, treated or paid for within the three months immediately before the effective date of PEIA coverage.

   If a policyholder does not join during the initial enrollment period or during open enrollment, expenses for a pre-existing condition will not be covered by the PEIA Indemnity Plan for the first 12 months coverage. This limitation is waived if there had been coverage under another health plan which terminated no more than 30 days prior to the effective date of PEIA coverage.

   Pregnancy and any condition meeting the definition of handicap are not considered pre-existing conditions.

7. The Lifetime Benefit Maximum

   For PEIA health plans the maximum is $1,000,000 per person.

8. Continuing Benefits During Medical Leave of Absence

When an employee is not drawing from the WVDOT Payroll due to an approved medical leave of absence, the employer's share of the health care premiums will continue to be paid as long as the employee pays their share of the premium and submits an official doctor's excuse on monthly basis. This arrangement is limited to one year for regular sick leave and to four years for Worker's Compensation leave.

III. LIFE AND DISMEMBERMENT (DISABILITY)

Effective: September 1, 1999

Life insurance is available to eligible employees and dependents through a group life insurance policy provided by The Prudential Life Insurance Company of America. Your benefit choices include basic life insurance, optional life insurance, and optional dependent life insurance. If optional life insurance is not selected by an employee during their initial enrollment period [*the first partial and full calendar month of employment*] then a Statement of Health for the person being insured will be required.

A. BASIC LIFE AND ACCIDENTAL DEATH AND DISMEMBERMENT (AD&D) INSURANCE

Effective: September 1, 1999

The State of West Virginia, as an employer, provides active employees with basic life insurance coverage including accidental death and dismemberment (AD&D) in the same amount. The amount of benefits depends on the member's age and employment status.

Basic coverage for active employees under the age of 65 is $10,000; between the ages of 65 and 70 it is $6,500; and over the age of 70 it is $5,000. Retired employees' basic coverage is $5,000, but drops to $2,500 at age 67. Retired employee coverage does not include accidental death and dismemberment.

B. OPTIONAL LIFE AND AD&D INSURANCE

Additional, optional life insurance with an equal amount of AD&D coverage may be purchased by active employees. Additional, optional life insurance with no AD&D benefit is also available to retired employees. Optional life insurance, like basic life insurance is decreasing term coverage.

C. OPTIONAL DEPENDENT LIFE AND AD&D INSURANCE

Dependent Life and AD&D insurance allows employees to insure their family members. The coverage is as follows:

- For Spouse $5,000 in life insurance and $5,000 in AD&D coverage.

- Each Child $2,000 in life insurance and $2,000 in AD&D coverage.

This benefit is available only to active employees and will end when the employee retires. The employee will be the beneficiary.

D. LIFE INSURANCE FOR DISABLED EMPLOYEES(WAIVER OF PREMIUM)

"Total Disability" exists when a person is completely unable, due to sickness or injury or both, to engage in any gainful occupation for which the person has been properly fitted for with training, education and/or experience. Consideration as totally disabled will not occur while any gainful occupation is occurring.

Active employees with basic life insurance who become totally disabled before the age of 60 may continue to be covered by basic life insurance at no cost while totally disabled. To qualify for this waiver of premium, proof of total disability must be presented within one year after the date of disability.

E. RETIREE CONSIDERATIONS

If participants wish to elect new or increased optional life insurance as a retired employee, they must enroll and submit a statement of health during the month of retirement or the following month. Coverage will be effective pending the approval of PEIA's life insurance carrier. Optional life insurance may not be elected or increased after this period.

Dependent life insurance is available to retired employees.

F. BENEFICIARIES

Effective: September 1, 1999

A beneficiary--the person who receives the proceeds of the basic and optional life insurance and AD&D coverage--may be anyone the policyholder wishes to designate.

More than one person can be named as beneficiary, and proceeds foreach beneficiary can be in a different portion. To do this, each of the beneficiaries must be listed on the enrollment form with the amount of the proceeds that person is to receive beside their name. Otherwise, proceeds will be divided equally among all beneficiaries. If a beneficiary has died, the remaining beneficiaries will share the portion that would have been paid to the deceased beneficiary.

Designated beneficiaries may be changed at any time by submitting a completed Change of Beneficiary form. The Change of Beneficiary form is available from the Benefits Coordinator.

If there is failure to name a beneficiary, or if the beneficiary does not survive the policyholder, the benefits will be paid as follows:

widow/widower

surviving children

surviving parents

surviving bothers and sisters

the employee's estate

If the beneficiary is a minor, proceeds will be paid to the guardian.

G. FILING A LIFE INSURANCE CLAIM

Effective: September 1, 1999

1. Beneficiary Claimant

This occurs when an insured person dies and the designated beneficiary is to be paid the amount of coverage. The employee's Benefits Coordinator should be notified. At that time the Benefits Coordinator will initiate a Notice of Death and complete the Employer's Statement of the claim form. The Notice of Death is sent to PEIA. The claim form is sent to the beneficiary for completion. After completing the form the beneficiary should send the form and an authentic court certificate of death (raised seal) to:

PEIA
Attn: Life Insurance Clerk
1900 Kanawha Boulevard, East
Building 5, Room 1001
Charleston, WV 25305-0710

If enrolled in dependent life insurance, the process for filing a claim is the same with proceeds being paid to the employee.

2. Living Benefit Option

This option is available to the terminally ill who have proof that their life expectancy is six months or less. Half of the face value of the basic and optional group life insurance policy--to a maximum of $50,000--may be withdrawn while the participant is still alive. Payment can be in one lump sum or in six monthly payments to be used as the policyholder desires.

Benefits not paid in advance will remain with the plan and will be payable to the beneficiary upon death of the policyholder. This incudes any monthly amounts not paid out.

H. PAYROLL DEDUCTION CONVENIENCE FOR PRIVATELY PURCHASED LIFE INSURANCE

Effective: September 1, 1999

Life insurance purchased privately, not through the State of West Virginia's Employee Insurance Program, may be paid through payroll deduction if the company has been authorized by the State Auditor's office. See your private insurance company's agent if this service is of interest to you.

I. PAYING PREMIUMS DURING A MEDICAL LEAVE OF ABSENCE

When an employee is not drawing from the WVDOT Payroll due to an approved medical leave of absence, any optional life insurance premiums will be paid by the employee through their benefit coordinator. The employee's basic life insurance coverage of $10,000 will still be paid for by the employer as long as an official doctor's excuse is submitted on a monthly basis and all of their personal share of premiums are paid in full.

APPENDIX A - Service Providers' Telephone Numbers and Addresses

Effective: September 1, 1999

TYPE OF SERVICE	**PROVIDER**	**ADDRESS**	**TELEPHONE**
Answers Medical Questions	PEIA	See Public Employees Insurance Agency	1-800-688-6568
Claim Processing for PEIA PPB	PEIA	1900 Kanawha Boulevard Building 5, Room 1001 Charleston, WV 25305	1-800-688-6568
Dental Coverage	COMPDENT	1930 Bishop Lane Louisville, KY 40218	1-800-456-5500
Dental Coverage	DELTA DENTAL	Delta Dental of West Virginia One Delta Drive Mechanicsburg, PA 17055-6999	1-800-932-0783 TTY/TDD: 1-888-373-3582
Drug Administration for PEIA Indemnity	PEIA	See Public Employees Insurance Agency	1-877-779-7342
Eye Care Coverage	VISION SERVICE PLAN	3400 Morse Crossing Columbus, OH 43219	1-800-877-7195

Mountaineer Flexible Benefits Administrator	FRINGE BENEFITS MANAGEMENT CO.	P.O. Box 1878 Tallahassee, FL 32302	1-800-342-8017 FAX 1-904-425-6220
Life Events	FRINGE BENEFITS MANAGEMENT CO.	See Mountaineer Flexible Benefits Administrator	1-800-847-8211
Long-Term Disability Income Plans	FRINGE BENEFITS MANAGEMENT CO.	See Mountaineer Flexible Benefits Administrator	1-800-865-3262
Short-Term Disability Income Plans	FRINGE BENEFITS MANAGEMENT CO.	See Mountaineer Flexible Benefits Administrator	1-800-865-3262
Flexible Spending Accounts	FRINGE BENEFITS MANAGEMENT CO.	See Mountaineer Flexible Benefits Administrator	1-800-342-8017
Group Legal Plan	HYATT LEGAL PLAN	See Mountaineer Flexible Benefits Administrator	1-800-821-6400
Public Employees Insurance Agency	PEIA	1900 Kanawha Blvd. Building 5, Room 1001 Charleston, WV 25305	1-304-558-7850 Claims 1-800-688-6568 Prescriptions 1-877-779-7342
HMO - Managed Care	ADVANTAGE HEALTH	173 Waddles Run Road Wheeling, WV 26003	1-800-405-1616
HMO and POS - Managed Care	OPTIMUM CHOICE	4 Taft Court Rockville, MD 20850	1-800-331-2102 1-301-360-8040
HMO	PRIMEONE	P.O. Box 1109 Charleston, WV 25324	1-800-607-7461
HMO - Managed Care	CARELINK	P.O. Box 1711 Charleston, WV 25326	1-800-348-2922
HMO - Managed	THE HEALTH	52160 National Road E.	1-800-624-6961

Care	PLAN	St. Clairsville, OH 43950	1-614-695-3585

APPENDIX B - Covered Medical Services Definitions and Conditions

Effective: September 1, 1999

MEDICAL SERVICES DESCRIPTION

Managed care plans are required to offer the same basic medical and drug coverage as offered by the indemnity plan and in some cases will offer additional services coverage. Total assessment division between plan policyholder can be found in the most recent publication of the *Health Care Plan Shopper's Guide* or though the individual plan summaries.

To be covered, services must be medically necessary or be one of the specifically listed preventive benefits. Medically necessary health care services and supplies are those provided by a hospital, physician or other licensed health care provider.

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

Physician diagnosis and treatment of illness or injury in keeping with usually accepted medical practice standards including surgery, anesthesia, radiology, and office visits: not solely for the convenience of the patient, family or care provider; not for custodial, comfort or maintenance purposes; rendered in the most cost-efficient setting and level appropriate for the conditions.

Preventive and early detection medical services have been recognized as an important economic factor in most realms. These services include (but are not limited to) immunizations and vaccinations, hypertension screening, mammograms, pap smears, and prostate cancer screening.

Maternity Benefits of the PEIA Indemnity Plan provides coverage for maternity-related professional and facility services, including an obstetrical profile, an ultrasound, pre-natal care, midwife services and birthing center. Maternity related services are covered only for the employee or the employee's enrolled spouse. Healthmarc should be contacted as soon as a covered pregnancy is confirmed.

Maternity Pre-payment Benefits will make an advance payment of up to $500 for deposits on maternity before delivery. This will be deducted from the global fee paid after delivery. To receive this benefit, please contact Healthmarc and request a maternity pre-payment form.

Inpatient Hospital and Related Services include confinement in a hospital including semi-private room, special care units, confinement for detoxification, and related services and supplies during the confinement.

Inpatient, Partial Hospitalization and Day Programs for Mental Health and Chemical Dependency is limited to a maximum cost to the plan of $10,000 per calendar year. The $10,000 maximum may be extended when further treatment is recommended by PEIA.

Inpatient Rehabilitation Services, when ordered by a physician, coverage is limited to 150 days per calendar year.

Hospice Care is covered when ordered by a physician.

Skilled Nursing Facility Services, confinement in a skilled nursing facility including semi-private room, related services and supplies, must be prescribed by a physician in lieu of hospitalization an is limited to 180 days per calendar year.

Home Health Services, intermittent health services of a home health agency when prescribed by a physician, must be provided in the home, by or under the supervision of a registered nurse, and be care and treatment which would other wise require confinement in a hospital or skilled nursing facility.

Outpatient Mental Health and Chemical Dependency Services is limited to a maximum of 26 visits per calendar year, for short-term individual or group outpatient mental health and chemical dependency evaluation and referral, diagnostic, therapeutic, and crisis intervention services. Additional visits may be covered if approved in advance and case managed by PEIA.

Outpatient Physical Therapy, when ordered by a physician, is limited to twenty visits in a calendar year, unless further therapy is approved in advance and case managed by PEIA.

Outpatient Speech Therapy and Occupational Therapy, when ordered by a physician is limited to $1,000 each year for each therapy unless further therapy is approved in advance and case managed by PEIA.

Outpatient Diagnostic and Therapeutic Services for pre-scheduled laboratory and diagnostic tests and therapeutic treatments, when ordered by a physician.

Outpatient Surgery, must be performed in a hospital, alternate licensed facility or physician's office. The following outpatient procedures require pre-certification by PEIA: arthroscopy of the knee, cataract extraction, colonoscopy, laparoscopy (exempt for sterilization), septoplasty or submucous resection, tonsillectomy with or with out adenoidectomy.

MRI and MRA, magnetic resonance imaging and magnet resonance angiography tests, must be precertified by PEIA when performed on an outpatient.

Chelation Therapy, Message Therapy and Vision Therapy, benefits are limited to $750 per calendar year and must be precertified as necessary by PEIA.

Durable Medical Equipment and Prosthetics, for the initial purchase of an reasonable replacement of standard implant and prosthetic devices, and for the rental of more than three months or purchase of more than $500 (at the Plan's discretion) of standard durable medical equipment, when prescribed by a physician, must be pre-certified by PEIA.

Allergy Services includes testing and related treatment.

Ambulance Services to the nearest facility able to provide needed treatment by ground or air transportation.

Cardiac Rehabilitation benefits are limited to three sessions per week for twelve weeks or thirty-six session per year for the following conditions: heart attack in the twelve months preceding treatment,

coronary by-pass surgery or stabilized angina pectoris.

Chiropractic Services of the chiropractor, including office visits and x-rays, for treatment of neuromuscular-skeletal conditions is limited to a maximum cost to the plan of $1,000 per person per year.

Dental Services (accident-related only) must be provided within six months of an accident and required to restore tooth structures damaged due to that accident. Contact PEIA for more information.

Oral Surgery is covered for the extraction of impacted teeth, orthognathism and medically necessary ridge reconstruction.

Christian Science Treatment (NOTE: WILL NOT BE COVERED BY THE MANAGED CARE PLANS DUE TO LACK OF LOCAL CHRISTIAN SCIENCE PRACTITIONERS AND FACILITIES) for the PEIA Indemnity Plan will be covered if there is treatment for a demonstrable illness or injury if provided in a facility or by a practitioner accredited by the Mother Church. 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 maximum cost to the plan of $1,000 per calendar year. If required, this benefit may be extended for inpatient care for up to sixty days per year.

Prescription Drug benefits are offered in all the plans with the main difference being if the participant must choose network pharmacies or may choose out-of-network pharmacies to fill their physician prescriptions. For specific dollar coverage see the "Prescription Drug Benefits At a Glance" table in the current year's *Health Care Plan Shopper's Guide.*