



**WEST VIRGINIA
DEPARTMENT OF TRANSPORTATION**

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Jimmy Wriston, P.E.
Secretary of Transportation
Commissioner of Highways

May 27, 2022

MEMORANDUM

TO: ALL DOT Employees

FROM: Jimmy D. Wriston, P.E. *JW*
Secretary of Transportation/
Commissioner of Highways

THRU: Rita Pauley *RP*
Assistant Commissioner

Alanna J. Keller, P.E. *ajk*
Chief Transportation Engineer

SUBJECT: DOT 3.7 Insurance: Available Plans and Reference Information Policy

The Insurance: Available Plans and Reference Information Policy has been revised. The policy has been reissued to clarify that PEIA administers, and controls offered insurance benefits. The revisions are summarized in Section 7.0 Change Log.

Please carefully review this information; all DOT employees are affected by the new policy.

A copy of the policy can be found at -
<https://sites.google.com/wv.gov/dot/policies>

If you have any questions, please contact Human Resources at 304-558-3111 and you will be directed accordingly.



West Virginia Department of Transportation Policy: Insurance: Available Plans and Reference Information

Issued by the Secretary of Transportation

Policy No: DOT 3.7

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1.0 PURPOSE

The purpose of this policy is to provide an overview of the insurance and benefits offered by the State of West Virginia and guidance of how West Virginia Department of Transportation (WVDOT) administers the various programs.

2.0 SCOPE

This policy applies to all WVDOT employees, of all classifications excluding the Parkways Authority. This is intended to be a helpful guide; it is not the official state benefits law. If there is any discrepancy between this policy and the statutes, rules, and insurance policies that govern these benefits the Public Employees Insurance Agency statutes, rules, and insurance policies control.

3.0 DEFINITIONS

- 3.1 **Agency:** Any authority, bureau, commission, or Division, or similar cabinet subpart of the Department of Transportation.
- 3.2 **Employee:** A person who lawfully occupies a position in a WVDOT agency and who is paid a wage or salary and who has not severed the employee-employer relationship.
- 3.3 **Public Employees Insurance Agency:** The state agency charged with the responsibility of providing various types of insurance to public employees, hereinafter, PEIA.

4.0 INTRODUCTION

- 4.1 The WVDOT employees have the benefit of choosing group health care insurance that best serves their individual lifestyles. Additionally, each employee has the option to enroll in a Basic Life Insurance policy for which the Agency pays, as long as you remain in active employment status. This is a Decreasing Term policy. Detailed information regarding the Basic Life Insurance can be viewed in the most current version of the PEIA Shopper's Guide.
- 4.2 The employee may also elect enrollment in additional Optional Life and Accidental Death and Dismemberment Insurance, as well as Dependent Optional Life for their dependents.
- 4.3 This policy is offered as general guidance, to expand employees' understanding of insurance administration and to aid in their decision-making process. Along with this information, employees may consult with their organization's designated

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Benefits Coordinator who is responsible for submitting enrollments, enrollment changes, and relaying inquiries and information between the Field Office employees and the Human Resources (HR) Division's team of Benefits Specialists.

- 4.4 Other publications offering information regarding insurance enrollment options are the most current version of the PEIA Shopper's Guide and the Summary Plan Description. These documents serve as the employee's primary reference guides for premium and plan information. These documents are available through your Agency Benefit Coordinator, HR Division Benefits Specialists, or an electronic version can be obtained through the PEIA website at <https://peia.wv.gov/Pages/default.aspx>. A hard copy of each document is mailed to employees prior to the beginning of each new Plan Year. New hires and transferring employees are also provided with these documents, as well as an overview and discussion of all benefits offered by the Agency, during the orientation which is mandatory for all of the Agency's new hires to attend.
- 4.5 In the event that the information contained herein differs from that supplied by PEIA, the interpretation from PEIA is controlling. 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.

5.0 HEALTH CARE INSURANCE

5.1 Health Care Plans

Health care plans offered by the West Virginia Public Employees Insurance Agency (PEIA) to the active state 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.

A. PPB Plan (PEIA Preferred Provider Benefit Plans)

1. This network is made up of healthcare providers who accept PEIA's adjustments and payments. Each Plan has an Annual Deductible, based upon the employee's salary tier, and Coinsurance percentage rates. Four plans are currently available. For more detailed and plan-specific information regarding any premium, deductible, or coinsurance rates; please refer to the most current version of the PEIA Shopper's Guide and Summary Plan Description documents or contact your assigned Benefit Coordinator or HR Division Benefits Specialist.

B. Health Maintenance Organization (HMO)

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1. These plans contract with select hospitals, physicians, pharmacies, and other health care providers in a community to be part of the Plan's network. Three plans are currently available. The copayment for in-network and out-of-network services varies according to the type of service. For detailed information regarding premiums, deductibles, coinsurance, copayment, and service coverage details; please refer to the most current version of the PEIA Shopper's Guide and Summary Plan Description or contact your assigned Benefit Coordinator or HR Division Benefits Specialist.
- C. Point of Service Plans (POS)
1. These plans are a cross between an HMO and a traditional insurance plan. As with any health coverage plan, HMO members have copayments and coinsurances which vary according to the specific service and whether the services are provided by in- or out-of-network physicians. For more detailed information, please consult the most current version of the PEIA Shopper's Guide and Summary Plan Description documents or contact your designated Benefit Coordinator or HR Division Benefits Specialist.
- D. Mountaineer Flexible Benefits Plans
1. These plans are administered by Fringe Benefits Management Company (FBMC). FBMC is a privately-owned company that is responsible for complying with all Internal Revenue Service (IRS) regulations for PEIA.

The optional plans offered under the Mountaineer Flexible Benefits Plan administered by FMBC are as follows:

a. Dental Plans

Coverage is provided by Delta Dental of West Virginia. The optimum coverage for services is provided through in-network and participating dental offices located throughout West Virginia.

For complete and detailed information regarding the available dental plans, premiums, copayments, coinsurances, and links to In-Network Provider Directories; please refer to the most current version of the FBMC Reference Guide or contact your designated Benefit Coordinator or HR Division Benefits Specialist.

b. Vision Care Plans

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Coverage is provided by MetLife Vision. **Effective July 1, 2022**, coverage will be provided by Humana/EyeMed. Routine services including eye exams, corrective lenses and frames, and contact lenses, are covered according to plan specifications for each Vision plan that is available for enrollment.

For complete and detailed information regarding the available vision plans, premiums, copayments, coinsurances, and links to In-Network Provider Directories; please refer to the most current version of the FBMC Reference Guide or contact your designated Benefit Coordinator or HR Division Benefits Specialist.

c. Disability Income Protection

Long- and Short-Term Disability coverage plans are provided by The Standard. For complete and detailed information regarding the available Long- and Short-Term Disability coverage options; please refer to the most current version of the FBMC Reference Guide or contact your designated Benefit Coordinator or HR Division Benefits Specialist.

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 various types of FSAs available for enrollment:

- Healthcare Flexible Spending
- Dependent Care Flexible Spending
- Health Savings Account/Limited Use FSA

For complete and detailed information regarding the available FSA options; please refer to the most current version of the FBMC/Mountaineer Flexible Benefits Reference Guide or contact your designated Benefit Coordinator or HR Division Benefits Specialist.

e. Legal

The Group Legal Plan, provided by ARAG Legal, offers benefits for certain legal services through both in-network and out-of-network attorneys.

For complete and detailed information regarding the available options provided by ARAG Legal; please refer to the most current

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version of the FBMC Reference Guide or contact your designated Benefit Coordinator or HR Division Benefits Specialist.

5.2 Eligible Persons

A. Active Employees

Full-Time Permanent employees are eligible to participate in offered health care insurance plans and the additional supplemental coverages. Employees who are enrolling in the plans may also enroll eligible dependents, as follows:

- their legal spouse,
- their biological and adopted children under age 26,
- and stepchildren under age 26
- children or stepchildren of a covered employee who are incapacitated and cannot support themselves due to a physical or mental disability which began before age 26.

Please note that appropriate documentation must be provided to ensure completion of the enrollment of dependents.

For more detailed information, please consult the most current version of the PEIA Shopper's Guide and Summary Plan Description documents or contact your designated Benefit Coordinator or HR Division Benefits Specialist.

B. Special Eligibility Situations

1. Employee and Spouse are Both State Employees - may either enroll in one family plan at a discounted rate based on the average of employee and employee spouse's combined salaries or under two single plans.
2. Employees on Non-Workers' Compensation Medical Leave of Absence - are eligible to continue coverage subject to the medical leave being approved by the employer, with both the employee and employer continuing to pay their respective proportionate share of the premium. The employer is obligated to pay its share only for a period of one (1) year after which the employee may be required to pay the full cost of coverage. The employee is responsible for submitting a monthly physician's statement certifying that the employee is unable to return to work.
3. 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

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their proportionate share of the premium cost as long as the employee receives temporary total disability benefits.

4. Employees on Family Leave - may continue insurance coverage during family leave. The agency would continue to pay the employer portion while the employee would continue to pay the employee portion on or off payroll.
5. Employees on approved Military Leave Without Pay – must continue to pay the employee portion of their insurance premiums until they return to active pay status. The exception would be if the policyholder opted to drop any active employee insurance benefits while on Military Leave.
6. Employees on Personal Leave - may continue their insurance coverage, providing that the employee continues to pay the employee portion of their insurance premiums.
7. Employees' Surviving Dependents - have the option of continuing their health care plan. Surviving Dependents should receive notification from PEIA regarding their eligibility to continue health coverage. Forms, payment responsibilities, and other details would be provided to the Surviving Dependent by PEIA.
8. Court Ordered Dependents (COD) – may be eligible for coverage. For more detailed information regarding this, or any of the aforementioned Special Eligibility situations, please consult the most current version of the PEIA Shopper's Guide and Summary Plan Description documents or contact your designated Benefit Coordinator or Human Resources Division Benefits Specialist.

5.3 Choosing a Health Care Plan

A. Factors to be Contemplated:

1. Verify plans are available in the policyholder's area.
2. Identify doctors and hospitals that are members in the plan's network. 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. Selecting a Primary Care Physician is no longer mandatory at the time of this Policy update.
3. 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?

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4. Review the total costs of each plan. Not only should the cost of premiums be considered, but also the out-of-pocket costs for both medical and prescription drug benefits. One should also compare annual deductibles (the amount that the participant must invest each Plan Year in medical services before the insurance begins to cover costs of services or prescription drug benefits,) copayments (the participant's share of costs for each medical service or prescription drug coverage), and out-of-pocket maximums (the total amount that the participant will have to pay for all combined medical services per Plan Year). The most efficient way to review all of these costs simultaneously is to use the "Benefits at a Glance" charts that are provided in the most current version of the PEIA Shopper's Guide.

For more detailed information regarding this, please consult the most current version of the PEIA Shopper's Guide and Summary Plan Description documents or contact your designated Benefit Coordinator or Human Resources Division Benefits Specialist.

B. Enrollment Periods

1. The initial enrollment period for new hires into any of the Health, Life Insurance, or Mountaineer Flexible Benefits Plans consists of the month of hire and the two (2) consecutively following calendar months. Coverage becomes effective the first day of the month following enrollment. Effective Date of coverage can be affected by the timeframe in which forms are submitted for processing. It is important to submit the enrollment forms promptly.

Employees may not enroll prior to beginning work.

Employees who decline enrollment, or who neglect to submit their forms during the initial enrollment period must wait for the Annual Open Enrollment, unless they experience a documentable Qualifying Event prior to the Annual Open Enrollment period.

2. Open enrollment will be conducted annually. The current timeframe that is in place for each Annual Open Enrollment period is April 2 through May 15 of each year. During Open Enrollment, policyholders may make changes to their Health Insurance or Mountaineer Flexible Benefits Plans. Policyholders may change Plans, remove dependents, or add dependents. During the Open Enrollment, employees who are not enrolled in Health Insurance or Mountaineer Flexible Benefits Plans may opt to enroll. All changes

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made during the Annual Open Enrollment period will become effective on July 1 of the new Plan Year, and all enrollments or enrollment changes will be in effect for one Plan Year, unless the policyholder experiences a documentable Qualifying Event which would permit changes to be requested outside of the next Annual Open Enrollment period. *The insurance Plan Year runs concurrent with the Fiscal Year, encompassing the period of July 1 – June 30.*

For more detailed information regarding the Annual Open Enrollment period, be alert to correspondence which you will receive from PEIA and FBMC/Mountaineer Flexible Benefits, as well as Benefit Fairs conducted by PEIA and Open Enrollment Trainings that are conducted by the HR Division Benefits Specialists, each Plan Year, the Plan Documents are updated, inclusive of: PEIA Shopper's Guide, Summary Plan Description, and FBMC/Mountaineer Flexible Benefits Reference Guide.

5.4 Ensuring Payment for Services

A. Responsibility for Data Exchange

1. The employee as the policyholder has the responsibilities of arriving at a decision concerning which health care insurance is most suitable for them; 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 and HR Division Benefits Specialist immediately as life events occur which would necessitate a Change in Status related to the Qualifying Event, such as: a birth or death; a marriage or divorce; a change in employment status for spouse, dependent child under age 26, or the policyholder; a change in employment or insurance coverage for dependents; or an address change.
2. The Benefit Coordinator for each WVDOT organization will be designated by each Division Director or District Manager for Highways and by the Executive Officer of all other WVDOT agencies. The Benefits Coordinator's responsibilities are to be familiar with the different types of insurance coverage, be able to direct employees to appropriate sources to obtain information, ensure that Benefits forms are completed accurately and submitted to the HR Division Benefits Specialists in a timely manner, as well as communicating effectively with the Benefits Specialists as necessary regarding new and changing eligibility and enrollment information and situations.

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3. The HR Division must remit payment within the mandated timeframe per the billing and payment requirements, policies, and rules set forth by PEIA, in order to ensure that employees do not lose benefits due to the Agency's failure to remit employer portions of payments.
4. The PEIA is responsible for disseminating information regarding insurance options, restrictions and limitations so eligible employees may make informed choices. The PEIA will have final review, approval, and processing authority regarding all New Hire enrollments, Changes in Status, and Terminations of Coverage. 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 plan enrollees on a monthly basis.
5. The FBMC is responsible for disseminating information regarding supplemental insurance enrollment options under the Mountaineer Flexible Benefits Plan. FBMC will have final review, approval, and processing authority in regard to all New Hire enrollments, Changes in Status, and Terminations of Coverage. Premiums for this supplemental coverage are solely employee-funded (i.e. the employer pays no portion of the supplemental benefits plans). FBMC will compute and report in reference to each pay period via Discrepancy Reporting which is submitted to the HR Division Benefits Specialists for review, reconciliation, and resolution.

B. The Importance of Precertification

1. 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 (7) 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 a percentage of the allowable charges. This additional percentage will be the obligation of the health care provider. For the most current and up-to-date information regarding the pre-certification process, it is suggested practice to consult the most current version of the Summary Plan Description document,

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or to contact PEIA or the Third-Party Administrator currently contracted with to handle claims processing.

2. Referral by the Primary Care Physician (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 excluded from payable benefits.
3. 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 severe 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. (i.e. heart attacks, severe chest pain, cardiovascular incidents, 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, seven (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.

C. 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

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memorize the advice for making claims processing simple in case an emergency occurs outside of their network.

1. A complete itemization of charges are required to process PEIA PPB Plan medical claims, including:
 - the patients' 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.

2. The time limit for claim submission for payment of medical expenses and prescription drugs is determined by the third-party administrator for the employee's plan. If Medicare is the primary insurer, refer to the most current Summary Plan Description document for the 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.
3. 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.
4. 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, using special claim forms. Benefit information published by PEIA and

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reimbursements can be sent directly to the custodial parent. Contact PEIA for more information.

5. 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.
 - a. PEIA is the primary payor for the services provided; and
 - b. The participant is billed for provider discounts and/or amounts which PEIA disallows; and

The out-of-state services are rendered because:

- a. an emergency arises; or
 - b. the insured lives or is traveling out-of-state; or
 - c. the medically necessary service is not available in West Virginia (or within a reasonable travel time); or
 - d. due to geographic location, PEIA has determined that services are only available out-of-state; and no other insurance will pay toward the balance.
6. 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.
7. 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 (2) types of mistakes:
 - a. Charges for service not received, and
 - b. 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 EOB 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 EOB statement.

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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.

8. 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.

D. Coordination of Benefits (Secondary Payment)

This term is used when two (2) 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 (2) 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 (1) 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 their 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.

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- When two (2) public employees, both eligible to enroll for PEIA coverage in their own names, are married and covered under one (1) 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 (2) 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 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 this 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);

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- 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.

E. Medicare

For PEIA active employees who are also eligible for Medicare, PEIA will use the traditional method of coordinating benefits. That is, Medicare is secondary payor for active employees, and primary payor for retirees. Reimbursement would be 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.

<u>An example:</u>	
Total charge	\$120
Medicare allowed	\$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.

5.5 Other Benefit Considerations

A. Appealing Decisions

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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 sixty (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, EOB statements, and all pertinent information and original reviews about the claim. PEIA will reconsider the entire case, taking into consideration 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.

The Appeal process for appealing FBMC claims requires the same steps and guidelines as subpart 5.5A.

B. 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 twelve (12) months of the date of service to ensure that the claim will be paid. Later, if or when the payment for the expenses is rendered from the responsible parties, repayment must be made to PEIA.

C. 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 an administration fee.

D. 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 Retiree Insurance Enrollment Forms during the month of retirement or the two (2) consecutively following calendar months.

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Retired employees pay premiums based on the plan they choose, their years of service, and their Medicare eligibility.

In some cases, 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 **between** July 1, 1988 and June 30, 2001, 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.

If membership in PEIA began on or after July 1, 2001, you are **not** eligible for extended employer-paid insurance upon retirement.

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.

Please consult the Summary Plan document, your Benefit Coordinator, or a HR Division Benefits Specialist to obtain information regarding your options for use of accrued sick or annual leave (i.e., eligibility to use leave toward insurance or tenure, or payout information).

E. Premium Conversion/IRS Section 125/Tax Shelter

Premiums are deducted from pay checks before federal, state, and Social Security taxes are calculated.

At the time of initial enrollment, employees select the option to Opt In or Opt Out of the Premium Conversion/IRS Section 125 Tax Shelter. The option is explained during New Employee Orientation, and information is included in the Shopper's Guide, which is updated annually.

If a member wishes to change their option that was initially selected, they can do so only during the Annual Open Enrollment. The Opt In/Opt Out form is in the Shopper's Guide, which is updated each Plan Year.

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F. Pre-existing Medical Conditions

PEIA has no pre-existing condition limitation. PEIA will provide coverage for all eligible medical conditions from the effective date of coverage. Managed care plans do not apply pre-existing condition limitations on their members.

G. The Lifetime Benefit Maximum

The PEIA PPB Plans have no lifetime maximum, however, there are Annual Benefit Maximums on some types of service. Please refer to the most current version of the Summary Plan Description to learn more about specific Benefits Maximums.

For Benefits Maximum Allowance information specific to the FBMC/Mountaineer Flexible Benefits supplemental coverage plans, please refer to the most current version of the FBMC Reference Guide.

5.6 **Life and Dismemberment (Disability)**

Decreasing Term Life Insurance is available to eligible employees and dependents through a group life insurance policy provided by Securian. **Effective July 1, 2022**, MetLife will be the provider. Your benefit choices include Basic Life Insurance, Optional Life Insurance, and Optional Dependent Life Insurance.

A. Basic Life/AD&D Insurance

The State of West Virginia, as an employer, provides active employees with Basic Life Insurance coverage which includes provision for Accidental Death & Dismemberment (AD&D).

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 may also choose to enroll in Retiree Basic Life coverage, an amount of \$5,000, but decreases to \$2,500 at age 67. Retiree Basic Life coverage does not include a provision for Accidental Death & Dismemberment.

B. Optional Life/AD&D Insurance

During the period of initial enrollment eligibility (the month of hire and the two (2) consecutively following calendar months) insurance-eligible employees are offered the one-time opportunity to enroll in Guaranteed Issue amounts of Optional Life or Optional Dependent Life Insurance, which means the employee has Life Insurance enrollment options that do not require a Statement of Health (aka Evidence of Insurability). If the Optional Life Insurance is not selected during the initial

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enrollment eligibility period, then the employee may still apply for coverage at a later date, but the request would be subject to a Statement of Health/Evidence of Insurability review process. The Optional Life Insurance policies offered through Securian do have AD&D provisions.

Optional Life enrollment is also available to retirees, but there is no AD&D provision with regard to retiree coverage. For detailed and current information regarding the AD&D provisions, please refer to the Life Insurance Guide and Information that is distributed by Securian.

C. Optional Dependent Life/AD&D Insurance

During the period of initial enrollment eligibility (the month of hire and the two (2) consecutively following calendar months) insurance-eligible employees are offered the one-time opportunity to enroll in Guaranteed Issue amounts of Optional Life and/or Optional Dependent Life Insurance, which means the employee has Life Insurance enrollment options that do not require a Statement of Health (aka Evidence of Insurability). If the Optional Life Insurance is not selected during the initial enrollment eligibility period, then the employee may still apply for coverage at a later date, but the request would be subject to a Statement of Health/Evidence of Insurability review process. The Optional Life Insurance policies offered through Securian do have AD&D provisions. Optional Dependent Life enrollment is also available to retirees; however, the retiree policies do not have a provision for AD&D. For detailed and current information regarding the AD&D provisions, please refer to the Life Insurance Guide and Information that is distributed by Securian.

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 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 (1) year after the date of disability.

E. Retiree Considerations

Insurance benefits are not automatic for the retiring employee. The proper forms must be completed and submitted to the Agency from which the employee is retiring for the retiring employee to maintain coverage effective upon their retirement date. The Retirement Insurance Enrollment packet consists of the

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Health and Basic Life Enrollment form, the Optional and Dependent Optional Life Enrollment form, the FBMC Retiree form, and the Termination of Coverage Form.

Retiring employees have the month in which they separate from active employment and the two (2) consecutively following calendar months in which to select or revise their enrollment selections.

F. Beneficiaries

A beneficiary is the named person whom a policyholder chooses to receive the proceeds of the Basic or Optional Life Insurance. The beneficiary or beneficiaries whom one designates should be one who has an insurable interest in the policyholder's life. Charities or the Estate can also be named as beneficiaries.

More than one (1) person can be named as beneficiary and proceeds for each 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 your designated Benefit Coordinator, a HR Division Benefits Specialist, or from the PEIA website.

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 brothers 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

1. Beneficiary Claimant

This occurs when an insured person passes away and the designated beneficiary is to be paid the amount of coverage. When active employees, or covered dependents, pass away; the employee's, the designated Benefits Coordinator and a HR Division Benefits Specialist should be notified. At that time, the Benefits Coordinator or HR Division Benefits

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Specialist will initiate a Notice of Death and complete the Employer's Statement of the claim form or submit the claim directly to Securian using the online process. 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, using the address on the form. The most current version of the form can be obtained from the PEIA website.

If enrolled in Dependent Life Insurance, the process for filing a claim is the same with proceeds being paid to the employee.

2. Accelerated Death Benefits

This option is available to the terminally ill whose documentation from their physician indicating the policyholder has a terminal condition. A terminal condition is one caused by sickness or accident which results in the member being diagnosed with a life expectancy of 12 months or less. For specific and detailed information regarding the minimum and maximum accelerated benefit, and other pertinent information, it is advised to reference the Group Term Life Certificate of Insurance: This document is available through the PEIA website, or by contacting PEIA and/or Securian by calling 304-558-7850 and selecting the option to be connected with Securian. **Effective July 1, 2022**, MetLife will be the provider for life insurance.

Benefits not paid in advance will remain with the plan and will be payable to the beneficiary upon death of the policyholder, inclusive of any monthly amounts not paid out under the Accelerated Death Benefit.

H. Payroll Deduction Convenience for Privately Purchased Life Insurance

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 Secretary of State and the State Auditor's office to conduct business as a registered vendor with the State of West Virginia. Contact the private insurance company's agent or representative if this option is of interest to you.

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6.0 APPENDICES

Appendix A Service Providers' Contact Information

	Address	Phone Number	Website
<u>PEIA</u> <u>PPB Plans</u> Customer Service, PPB Plan Inquiries	601 57 th Street, SE, Suite 2 Charleston, WV 25304	1-888-680- 7342	www.wvpeia.gov
<u>UMR</u> Claims	P.O. Box 30546 Salt Lake City, UT 84130	1-888-440- 7342	www.UMR.com
<u>The Health Plan</u> HMO Plans	1110 Main Street Wheeling, WV 26003	1-740-695- 7631	www.healthplan.org
<u>Securian Financial</u> Life Insurance <i>Effective July 1, 2022:</i> <u>MetLife</u> Life Insurance	One Bridge Place 10 Hale Street, 5 th Floor Charleston, WV 25301 200 Park Avenue New York, NY 10166	1-800-203- 9515 1-888-466- 8640	www.securian.com https://www.metlife.com/WV-PEIA/
<u>Fringe Benefits</u> <u>Management</u> <u>Company/FBMC</u> Mountaineer Flexible Benefits	P.O. Box 1878 Tallahassee, FL 32302	1-844-559- 8248	www.myfbmc.com
<u>CVS Caremark</u> Prescription Drug Benefit <i>Effective July 1, 2022:</i> <u>Express Scripts</u> Prescription Drug Benefit	P.O. Box 6590 Lee's Summit, MO 64064 P.O. Box 390873 Bloomington, MN 55439-0873	1-844-260- 5894 1-800-282- 2881	 http://express-scripts.com/
MetLife Vision Vision Service Plans <i>Effective July 1, 2022:</i>	P.O. Box 385018 Birmingham, AL 35238	1-855-638- 7339	Mybenefits- metlife.com/westvirginia www.humana.com

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<u>Humana/EyeMed</u> Vision Service Plans		1-877-398-2980	
Delta Dental of WV Dental Plans	One Delta Drive Mechanicsburg, PA 17055	1-844-260-5894	www.deltadentalins.com
<u>EPIC</u> Hearing Service Hearing Service Plans		1-866-956-5400	www.EPICHearing.com
<u>PayFlex</u> Flexible Spending Accounts	PayFlex Systems USA, Inc. P.O. Box 8396 Omaha, NE 68103	1-844-729-3539	www.payflex.com
<u>The Standard Insurance</u> <u>Co.</u> Long- and/or Short-Term Disability Plans		1-800-368-2859	www.standard.com
<u>ARAG Legal</u> Legal Plans		1-800-247-4184	www.ARAGlegal.com

Appendix B Covered Medical Services Definition and Conditions Effective: February 1, 2022

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 PEIA Shopper's Guide and/or the Summary Plan Description document.

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.

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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 PPB Plan provides coverage for maternity-related professional and facility services. For more information and further detail regarding Maternity Benefits, please consult the current version of the PEIA Shopper's Guide and/or the Summary Plan Description document.

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 details can be located in the current version of the PEIA Shopper's Guide, or the Summary Plan Description document.

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 and does have limitation on the number of covered days that is allowable. See current Plan documents for specific details.

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 otherwise require confinement in a hospital or skilled nursing facility.

Outpatient Mental Health and Chemical Dependency Services is limited to a maximum number of days per year, as outlined in the current versions of Plan documents.

Outpatient Physical Therapy, when ordered by a physician, must be approved in advance and case managed by PEIA. Limitations and specifications are outlined in the current version of Plan documents.

Outpatient Speech Therapy and Occupational Therapy, when ordered by a physician and must be approved in advance and case managed by PEIA. Limitations and specifications are outlined in the current version of Plan documents.

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Outpatient Diagnostic and Therapeutic Services for pre-scheduled laboratory and diagnostic tests and therapeutic treatments, when ordered by a physician. See Plan documents for further detail and guidance.

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 without adenoidectomy. It is recommended that members refer to current versions of Plan documents for further detail and guidance.

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

Chelation Therapy, Message Therapy and Vision Therapy, benefits may have limitations and preauthorization guidelines. Please see the current version of Plan documents for further detail and guidance.

Durable Medical Equipment and Prosthetics, for the initial purchase of a reasonable replacement of standard implant and prosthetic devices, and for the rental of standard durable medical equipment, when prescribed by a physician, must be preauthorized by PEIA. See current versions of Plan documents for further details and guidance.

Allergy Services includes testing and related treatment. Refer to Plan documents for details and guidance.

Ambulance Services to the nearest facility able to provide needed treatment by ground or air transportation. Refer to Plan documents for details and guidance.

Cardiac Rehabilitation benefits have preauthorization requirements and limitations. Please refer to the current version of Plan documents for details and guidance.

Chiropractic Services of the chiropractor, including office visits and x-rays, for treatment of neuromuscular-skeletal conditions. Limitations apply. Please refer to current version of Plan documents for details and guidance.

Dental Services (accident-related only) must be provided within six (6) months of an accident and required to restore tooth structures damaged due to that accident. Contact PEIA for more information. Further details are also included in the Plan documents.

Oral Surgery is covered for the extraction of impacted teeth, orthognathic, and medically necessary ridge reconstruction. Contact PEIA for more information. Further details and guidance are also included in the Plan documents.

Christian Science Treatment is a covered benefit for treatment for a demonstrable illness or injury, as specified by the Plans. There are limitations and preauthorization requirements with this

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treatment option. Please contact PEIA and/or refer to Plan documents for further details and guidance.

Prescription Drug benefits are offered in all the plans, with the primary difference being impacted by the use of in-network pharmacies. For specific copayment information, see the "Prescription Drug Benefits at a Glance" table in the most current version of the Shopper's Guide, or by referring to the Drug Formularies that are available on the PEIA website.

7.0 CHANGE LOG

May 18, 2022 –

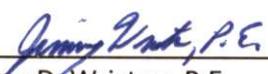
- Significantly updated information to align with current options, practices, etc.
- Added Third Party Administrator Changes effective July 1, 2022, in Appendix A.

May 27, 2022 –

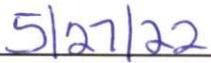
- Clarified areas of responsibility.
- Added stronger statements that PEIA statutes, rules and insurance policies govern all benefits; this policy is a handy reference guide not a statement of coverage.

Effective Date of Policy: 05/27/2022

Approved by:



Jimmy D. Wriston, P.E.
Secretary of
Transportation
Commissioner of
Highways



Date