



# **POLICY**

**Revision Date: July 1, 2007**

**AccessWV  
P.O. Box 50540  
Charleston, WV 25305-0540**



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## Welcome to AccessWV

This Policy is your contract as a member of AccessWV. It describes the benefits available to you and provides instructions on how to use these benefits. It also tells you where to write or call when you have questions or concerns. Please keep it close at hand and refer to it often as you have questions about your AccessWV benefits.

AccessWV contracts with the Public Employees Insurance Agency (PEIA) to be the Plan Administrator and provide various services to AccessWV members. The Plan Administrator contracts with other organizations for certain functions. If you have a question about your benefits or a specific claim, the fastest way to obtain information is to contact the appropriate organization directly at one of the phone numbers on the following page.

AccessWV's coverage plans include benefits for hospital, surgical, prescription drug, and other medical expenses. Monthly premiums for AccessWV are based on the age and gender of the applicant, the geographic area where the applicant resides, the kind of coverage (individual or family coverage), and the deductible amounts and out-of-pocket maximums for medical and prescription drug benefits.

To determine the deductible amounts and out-of-pocket maximums for your coverage plan, see the **Summary of Benefits** insert to this Policy.

### FREE LOOK

You have the right to return this Policy. Examine it carefully. If you are not satisfied with this Policy, you may return it and ask us to cancel it. Your request must be in writing and must be made within 10 days from the date you receive this Policy. We will then refund to you any amount you paid for this Policy. If you return it in this manner, you will receive no benefits under this Policy.

### SUBJECT TO CHANGE

The benefit information in this Policy is subject to change, if circumstances arise which require adjustment. Changes will be communicated to members through the mail at least 30 days before the changes are effective. These changes will be incorporated into the next edition of the Policy.

## WHERE TO CALL WITH QUESTIONS

### **Eligibility and General Customer Service**

WV Public Employees Insurance Agency

1-304-558-7850 ext. 207 (local) or 1-888-680-7342 ext. 207 (toll-free)

[www.wvpeia.com](http://www.wvpeia.com)

### **Medical Benefits and Claims**

Wells Fargo TPA

1-866-864-6142 (toll-free)

[www.wellsfargo.com/tpa](http://www.wellsfargo.com/tpa)

### **Pre-Service Review: Precertification, Prior Authorization for Out-of-State Services, Notification of Inpatient Stays and Preauthorization**

Wells Fargo TPA

1-866-864-6142 (toll-free)

[www.wellsfargo.com/tpa](http://www.wellsfargo.com/tpa)

### **Prescription Drug Benefits and Claims**

Express Scripts: 1-877-256-4680 (toll-free)

[www.express-scripts.com](http://www.express-scripts.com)

### **Subrogation and Recovery**

Beacon Recovery Group

1-800-874-0500 (toll-free)

## HOW TO USE THIS DOCUMENT

Being familiar with this Policy will help you get the most from your Plan – in the quickest, easiest way possible. It can also help you avoid a bill for a service that was not covered or was required to be precertified or authorized in advance. For these reasons we suggest you:

- Read this Policy as soon as you get it.
- Keep it handy or where you can find it right away. It has many important phone numbers you may need later.
- Refer to it whenever needed, especially if you are going to use health services that are not routine check-ups.

## ACCESSWV'S PLAN ADMINISTRATOR AND ITS CONTRACTORS

The Plan Administrator for AccessWV is the WV Public Employees Insurance Agency (PEIA). AccessWV contracts with PEIA for eligibility determination, premium billing, customer service, claims administration and related functions. The Plan Administrator, in turn, contracts with other organizations to provide you with some of these services. These organizations are called Third Party Administrators or TPA's. Their toll-free customer service telephone numbers are listed below.

### **Who They Are and What They Do**

#### **Plan Administrator**

The Public Employees Insurance Agency (PEIA) is the Plan Administrator for AccessWV. PEIA processes applications, bills for premiums, coordinates communications with health care providers and payers, contracts with TPA's for medical claims administration, utilization management and pharmacy benefit management, and works with the AccessWV Program Office to assure all operations are effective and efficient.

*Call AccessWV Customer Service at 1-888-680-7342 ext. 207.*

#### **Medical Claims Administrator and Utilization Manager**

Wells Fargo Third Party Administrators ("Wells Fargo TPA") is the claims processor for all hospital and medical services for AccessWV. They also review services that must be precertified or that must receive prior authorization.

*Call AccessWV Customer Service at 1-866-864-6142.*

#### **Pharmacy Benefits Manager**

Express Scripts, Inc. ("Express Scripts") processes the claims for all prescribed drugs, maintains the preferred drug list, and can give you information you may need about issues concerning your prescription drugs, such as drug interactions. In addition, Express Scripts sends your AccessWV insurance card.

*Call AccessWV Member Services at 1-877-256-4680.*

## IMPORTANT TERMS

The following terms are used throughout this Policy and are defined below as they pertain to AccessWV:

**Allowed Amount:** This refers to the basis for payment by AccessWV. For example, for each service covered by AccessWV, the allowed amount is the lesser of the actual charge amount or the maximum fee for the service as set in the Plan Administrator's (PEIA) reimbursement schedule, when the service is received from a WV network provider.

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

**Annual Deductible:** The amount you must pay each plan year before the plan pays its portion of the cost. Only the Allowed Amounts for covered expenses will be applied to your deductible. In the case of family coverage, the family deductible is divided among the family members. No one person insured on the family policy will pay more than the individual deductible.

**Beacon Recovery Group (Beacon):** The subrogation and recovery vendor for AccessWV. The Plan Administrator (PEIA) contracts with the Beacon Recovery Group for subrogation and recovery services. Beacon pursues recovery of money paid for claims that were not the responsibility of AccessWV. For more information, see the "Recovery of Incorrect Payments" section.

**Board of Directors:** AccessWV is governed by a seven-person Board. The Board includes the Insurance Commissioner and six members appointed by the Governor. The Board has representation from the insurance and hospital industries and includes persons or relatives of persons who are or could be members of the Plan.

**Claims Administrator:** An organization that processes claims on behalf of AccessWV. Wells Fargo TPA and Express Scripts, Inc. are AccessWV's claims administrators. These organizations are contracted by AccessWV's Plan Administrator. See "Medical Claims Administrator" and "Pharmacy Benefit Manager" below.

**Coinsurance:** The percentage of eligible medical expenses that you are required to pay after the annual medical deductible has been met. The amount you pay in coinsurance is applied to your medical out-of-pocket maximum. You are responsible for paying the coinsurance and deductible amounts directly to the provider of services.

**Common Specialty Medication:** Specialty medications are high-cost injectable, infused, oral or inhaled drugs that generally require close supervision and monitoring of the patient's drug therapy. Under AccessWV, Common Specialty Medications are available only via mail order through CuraScript. They are subject to a \$50 copay for up to a 34-day supply and may not be purchased in larger quantities.

**Copay or Copayment:** This is the set dollar amount that you pay when you use services. For example, the flat dollar amount you pay for an office visit or the amount you pay for prescription drugs is a copay. Your copays for office visits and other medical services do not count toward your annual medical deductible or annual medical out-of-pocket maximum. Once you reach your pharmacy deductible, your copays for drugs are counted toward your drug out-of-pocket maximum.

**Coverage Plan:** A health insurance product offered by AccessWV. Plan A, Plan B and Plan C are coverage plans.

**CuraScript:** AccessWV's exclusive pharmacy vendor for specialty medications. This means specialty medications must be obtained through CuraScript. The Plan Administrator contracts with CuraScript to provide specialty medications to AccessWV members. CuraScript provides mail order delivery of the Common Specialty Medications detailed in the "Prescription Drug Benefits" section of this Policy.

**Deductible:** The amount of eligible expenses you are required to pay each plan year before the Plan begins to pay benefits. AccessWV has two deductibles: one for medical services and the other for drugs. Copays for office visits do not count toward the medical deductible. See "Annual Deductible" above.

**Dependent:** An eligible person, as determined by AccessWV guidelines, whom the policyholder has properly enrolled for coverage in AccessWV.

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

**Eligible Expense:** A medically necessary, reasonable and customary item of expense for health care when the item of expense is covered at least in part by AccessWV. For services from West Virginia network providers, allowable expenses under this Plan are calculated according to the Plan Administrator's fee schedules, rates and payment policies in effect at the time of service.

**Emergency:** An acute medical condition resulting from injury, sickness, pregnancy, or mental illness which arises suddenly and which a reasonably prudent layperson would believe requires immediate care and treatment to prevent the death, severe disability or impairment of bodily function of the insured.

**Exclusions:** Services, treatments, supplies, conditions, or circumstances that are not covered under AccessWV.

**Experimental, Investigational, or Unproven Procedures:** Medical, surgical, diagnostic, psychiatric, substance abuse or other health care technologies, supplies, treatments, procedures, drug therapies or devices for a particular case that are determined by AccessWV (at the time it makes a determination regarding coverage in a particular case) to be any of the following:

1. Not approved by the U.S. Food and Drug Administration (FDA) to be lawfully marketed for the proposed use and not identified in the American Medical Association Drug Evaluations as appropriate for the proposed use.
2. Subject to review and approval by any Institutional Review Board for the proposed use.
3. Subject of an ongoing clinical trial that meets the definition of Phase 1, 2, 3 Clinical Trial set forth in the FDA regulations, regardless of whether the trial is actually subject to FDA oversight.
4. Not demonstrated through prevailing peer-reviewed medical literature to be safe and effective for treating or diagnosing the condition or illness for which its use is proposed.

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

**Express Scripts, Inc. ("Express Scripts"):** The pharmacy benefits manager that processes and pays claims for prescription drugs, provides drug information, and carries out drug utilization management functions for AccessWV. Express Scripts is contracted by the Plan Administrator (PEIA) to serve as AccessWV's pharmacy benefits manager.

**Federally Defined Eligible Individuals.** Persons who have guaranteed access to coverage through the federal **Health Insurance Portability and Accountability Act (HIPAA)**, because they have lost coverage in a group health plan offered by an employer. Additional requirements apply.

**Health Coverage Tax Credit (HCTC) Eligibles:** Those who are eligible to enroll in AccessWV because they are eligible for the federal HCTC program. HCTC will pay part of their monthly premiums. They include workers or pensioners displaced by foreign trade, who are certified by the Department of Labor as being HCTC eligible.

**Inpatient:** Someone admitted to a hospital or other facility as a bed patient for medical services.

**Insured:** Someone who is eligible for and enrolled in AccessWV.

**Medical Case Management:** A process by which AccessWV through Wells Fargo TPA assures appropriate available resources for the care of serious long-term illness or injury. Wells Fargo TPA's case management program can assist in providing alternative care plans.

**Medical Claims Administrator:** The third party administrator that handles medical claims processing, customer service, precertification/notification, case management, prior authorization for out-of-state services and preauthorization for AccessWV.

**Medically Eligibles:** Those who are eligible to enroll in AccessWV because they have a pre-existing medical condition that either:

- precludes their enrollment in any other individual health insurance plan within West Virginia; or

- allows enrollment for an insurance product similar to AccessWV but at a higher premium.

**Member:** A policyholder or dependent who is in a coverage plan offered by AccessWV.

**Notification:** The required process of reporting an inpatient stay in a West Virginia facility to Wells Fargo TPA, AccessWV's utilization management vendor. This process is performed to screen for care planning, discharge planning, follow-up care and ancillary service requirements. Failure to notify results in a penalty that is imposed on the provider. Notification is required only for WV facilities. All out-of-state facilities require prior authorization for full benefits to apply.

**Out-of-Network Provider:** A provider outside of the AccessWV networks. AccessWV does not have contracts with these providers. Using these providers requires higher member participation in costs.

**Out-of-State Network Provider:** A provider who participates in a network, with which AccessWV, through its Plan Administrator, has a contractual arrangement. Such contracts help hold down costs, if AccessWV members need to obtain services out-of-state. For full out-of-state benefits to apply, services outside WV must receive prior authorization from Wells Fargo TPA. Contact Wells Fargo TPA with questions about out-of-state network providers. Also see "West Virginia Network Provider" below.

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

**Pharmacy Benefits Manager:** The organization that processes and pays claims for prescription drugs, provides drug information, and carries out drug utilization management functions for AccessWV.

**Plan:** AccessWV.

**Plan Administrator.** The Plan Administrator for AccessWV is the WV Public Employees Insurance Agency (PEIA). AccessWV contracts with PEIA for eligibility determination, premium billing, member services, claims administration, utilization management and other functions. The Plan Administrator contracts with other organizations for some of these functions.

**Plan Year:** The 12-month period beginning July 1 and ending June 30. Member cost-sharing requirements, benefits and limitations are administered on a plan year basis.

**Policyholder:** The person who meets the eligibility requirements of AccessWV, enrolls in the plan, and in whose name the policy is issued.

**Preauthorization:** A voluntary program that allows you to obtain an advance review of a service to assure that it will be covered by the Plan. Preauthorization is handled by Wells Fargo TPA.

**Precertification:** The required process of reporting certain inpatient stays, inpatient and outpatient procedures, and other specified services in advance to obtain approval for the admission, procedure or service. Wells Fargo TPA handles precertification.

Failure to obtain precertification results in a penalty that is imposed either on the provider (in the case of West Virginia network providers) or on the member (in the case of an out-of-state service).

**Pre-existing Condition:** Any physical or mental condition for which medical advice, care or treatment was recommended or received during the six-month period immediately preceding the effective date of coverage in AccessWV.

**Premium:** The payment required to keep coverage in force.

**Prior Authorization for Out-of-State Care:** The required process of obtaining authorization from Wells Fargo TPA when services are received from an out-of-state provider. A penalty applies if covered services are obtained without prior authorization.

**Prior Authorization for Prescription Drugs:** The required process of obtaining authorization from the Rational Drug Therapy Program for coverage for some prescription medications under AccessWV.

**Provider Discount:** A previously determined percentage that is deducted from a provider's charge or payment amount. This amount is not billable to the member when AccessWV is the primary payer and the service is provided within West Virginia or by an out-of-state provider with whom AccessWV, through its Plan Administrator, has a contract.

**Public Employees Insurance Agency (PEIA):** The Plan Administrator for AccessWV. See "Plan Administrator" above.

**Rational Drug Therapy Program (RDT):** The Rational Drug Therapy Program of the WVU School of Pharmacy provides clinical review of requests for drugs that require prior authorization under AccessWV. The Plan Administrator contracts for this service on behalf of AccessWV.

**Reasonable and Customary:** The prevailing range of charges and fees charged by providers of similar training and experience, located in the same area, taking into consideration any unusual circumstances of the patient's condition that might require additional time, skill or experience to treat successfully. AccessWV pays out-of-network providers based on what is "reasonable and customary", when the out-of-network service had prior authorization from Wells Fargo TPA or was provided as emergency care.

**Secondary Payer:** The plan or coverage whose benefits are determined after the primary plan has paid. See "Coordination of Benefits" later in this Policy.

**Third Party Administrator (TPA):** An organization with which the Plan Administrator contracts to carry out such functions as member services, claims processing and utilization

management for AccessWV members. The TPA's for AccessWV are Wells Fargo TPA and Express Scripts.

**Utilization Management:** The general process by which AccessWV controls health care costs. Components of utilization management include precertification of certain inpatient and outpatient surgeries and services, prior authorization of services received outside of West Virginia, notification of inpatient stays in West Virginia facilities and medical case management. Wells Fargo TPA performs utilization management for AccessWV through a contract with the Plan Administrator.

**Wells Fargo TPA (formerly Acordia National).** The third party administrator that handles medical claim processing, customer service, precertification/notification, case management, prior authorization for out-of-state services and preauthorization for AccessWV.

**West Virginia Network Provider:** Any West Virginia provider who accepts the PEIA reimbursement schedule is considered an AccessWV network provider.

## Eligibility & Membership

### WHEN COVERAGE STARTS

Coverage begins on the first day of the month following acceptance of your completed application. This is known as your effective date of coverage. Services received on or after the effective date of coverage are eligible for consideration for payment by AccessWV. Services received prior to your effective date of coverage are ineligible.

You should have received a letter notifying you of your member number and effective date of coverage a few days prior to the first day you became enrolled in AccessWV. You should receive your official identification card by the middle of the first month of your enrollment. Your identification card is for use with both medical providers and also pharmacies. Along with your identification card, you will also receive a copy of the West Virginia Preferred Drug List. You have also been sent this Policy as you begin coverage in AccessWV. It describes the benefits available to you as an AccessWV member.

### Annual Residency Survey

Policyholders will receive an annual Residency Survey, which will ask you to provide proof of your continued residency in West Virginia. You can renew enrollment by completing and returning the mandatory survey in the allotted time frame. If the completed survey is not returned by the specified due date, AccessWV will take steps to cancel your enrollment.

### **Annual Open Enrollment**

Policyholders are offered an Open Enrollment period each May. At this time, you are provided information about any changes that will be effective at the start of the new plan year on July 1. You may change among AccessWV coverage plans at this time. You may also add dependents to your coverage. These changes will be effective on July 1<sup>st</sup>. Members who transfer among plans during open enrollment are not subject to pre-existing condition limitations, if they have already met the requirement in AccessWV.

### **Changing Coverage Plans**

Policyholders and enrolled dependents may transfer among AccessWV coverage plans if:

- Policyholder requests a change during AccessWV's Open Enrollment period, which is held in May. Policyholders will receive information regarding any changes to the coverage plans at that time. All open enrollment transfers will be effective July 1. All enrolled dependents will also be transferred to the new coverage plan on that date.
- There is a substantial change in life situation which may include, but is not limited to, a marriage or dissolution of marriage, the birth or adoption of a child, court-ordered guardianship of a child or dependent adult child, or loss of employer-sponsored health insurance by an eligible dependent.

All requests for transfers submitted in writing on a "Change of Status" form by the 15<sup>th</sup> of the month will be made effective on the first day of the subsequent month. Changes received after the 15<sup>th</sup> will be effective the first of the second subsequent month. For example, if your "Change of Status" form is received on August 10, the change in your coverage will be effective on September 1, but if your Change Form is received on August 21, the change in your coverage will not be effective until October 1.

**To request a copy of the "Change of Status" form, call the Plan Administrator at 1-888-680-7342 ext. 207.**

## **DEPENDENTS**

Coverage for a policyholder's legal spouse and/or children or others for whom the policyholder has court-appointed guardianship is available through AccessWV. Examples include biological or adopted children or step children. Dependents are eligible for coverage provided they are residents of West Virginia and they meet one of the following requirements:

- The dependent is unmarried and under age 19;
- The dependent is unmarried, enrolled full-time at an accredited educational institution and under age 23;
- The adult dependent child is incapable of self-sustaining employment by reason of mental or physical disability and is chiefly dependent upon the policyholder for support or maintenance.

AccessWV may require proof of the incapacity in order for the policyholder to elect to continue the policy in force with respect to the mentally or physically disabled dependent.

Premium rates for those applying for family coverage (i.e. applicant and applicant's spouse and/or dependents) are listed on the "Monthly Premiums" chart included in the AccessWV application packet. Family premium rates are determined by the age, gender and county of residence of the policyholder.

### **Changes for Dependents**

If you wish to add new dependents, such as a new spouse, your biological newborn or adopted child, you must call the Plan Administrator to request a "Change of Status" Form to add them to your coverage. You do not need a Social Security Number to enroll your newborn, but when you obtain a Social Security Number for the child, please provide it to the Plan Administrator. If you wish to add or change coverage for any other dependents, you must submit a "Change of Status" Form to change enrollment.

To request a copy of the "Change of Status" Form, call PEIA at 1-888-680-7342 ext. 207.

## **PRE-EXISTING MEDICAL CONDITIONS**

A pre-existing medical condition is any condition for which medical advice, care or treatment was recommended or received during the six-month period immediately preceding your effective date of coverage in AccessWV. In general, persons who enroll in AccessWV will be subject to a six-month waiting period for pre-existing conditions. The waiting period will also apply to their dependents.

AccessWV will not pay for any services (either medical or pharmacy) related to the pre-existing condition for the first six months of the enrollment. It will pay for services related to a newly experienced injury or illness and for covered preventive care.

If a medical or pharmacy claim is submitted to AccessWV for health services that appear to be related to a pre-existing illness or condition, information will be requested from your provider regarding the diagnosis to determine if the service relates to a condition that you had within the six months prior to your enrollment date.

Persons who qualify for AccessWV in the "medically eligible" category must meet the six-month waiting period for pre-existing conditions.

The pre-existing condition limitation does not apply to persons who qualify for AccessWV as "federally defined eligible individuals" or to HCTC eligible persons who have at least 3 months of prior creditable coverage and who have not had a break in coverage of more than 63 day when they apply to AccessWV. For these members, all eligible claims will be paid as of the effective date of coverage.

## WHEN COVERAGE ENDS

Certain events will cause AccessWV membership to end for you and/or your covered dependents. Generally, coverage will end if you or a dependent become ineligible for AccessWV coverage.

AccessWV coverage for a policyholder and dependents may be terminated by the policyholder as a voluntary termination or by the plan as an involuntary termination, if the plan determines certain events have taken place.

Once enrolled, a policyholder will continue to be a member of AccessWV, as long as the policyholder continues to pay the required premiums and answers the annual Residency Survey unless any of the following occurs:

- Policyholder becomes eligible for other individual coverage because his/her condition has improved.
- Policyholder becomes eligible for group coverage through an employer or union.
- Policyholder is no longer a legal resident of West Virginia.
- Policyholder becomes eligible for Medicare, Medicaid or WVCHIP.
- AccessWV pays \$1,000,000 in lifetime benefits on behalf of the policyholder.
- Policyholder requests disenrollment in writing.
- Policyholder has committed an act of fraud to circumvent the statutes or regulations of AccessWV.
- Policyholder becomes an inmate or resident of a public institution, which means a Federal or State prison or correctional institution or a Veterans' Home.

If a policyholder holder is no longer eligible for coverage, coverage of dependents also ends, unless the dependent independently qualifies for membership as a policyholder.

### **Voluntary Termination**

For voluntary terminations, policyholders must provide AccessWV written notice of their intent to disenroll by the 15th of the month for enrollment to cease at the end of that month. Alternatively, coverage will cease at the end of the month in which the policyholder voluntarily ceases to pay premiums.

### **Involuntary Termination**

AccessWV may cancel coverage for the policyholder and dependents if any of the following occurs:

- Policyholder fails to pay premium when due.
- Policyholder is no longer a resident of West Virginia.
- Policyholder becomes eligible for Medicare, Medicaid, or the WVCHIP.
- Policyholder becomes eligible for similar or more comprehensive policy from another source.
- AccessWV pays a \$1,000,000 in lifetime benefits for the policyholder.
- Policyholder dies.

- Annual Residency Survey is not returned by the requested date.
- Policyholder or dependent has committed an act of fraud to circumvent the statutes or regulations of AccessWV.
- Policyholder becomes an inmate or resident of a public institution, which means a federal or state Prison or correctional institution or a Veterans' Home. (Does not apply if the policyholder is a "federally defined eligible individual".)
- State law requires cancellation of the policy.

### **Termination of Dependent Coverage**

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

- Policyholder is no longer eligible for coverage.
- Dependent spouse is divorced from policyholder.
- Dependent child reaches 19<sup>th</sup> birthday.
- Dependent child who has extended coverage beyond the age of 19 as a full-time student reaches his/her 23<sup>rd</sup> birthday or ceases full-time student status. See section on "Special Eligibility Situations" for information relating to full-time students.
- Dependent child marries.
- Dependent becomes eligible for Medicare, Medicaid, or WVCHIP.
- Disabled dependent no longer meets disability guidelines.
- AccessWV pays the \$1,000,000 in lifetime benefits for the dependent.
- Dependent is no longer a resident of West Virginia.
- Dependent becomes an inmate or resident of a public institution, which means a federal or state prison or correctional facility or a Veterans' home. (Does not apply if the dependent is a "federally defined eligible individual").
- Policyholder voluntarily removes dependent from coverage.

The policyholder is required to report these events and complete the appropriate form to remove ineligible dependents. If the policyholder fails to remove an ineligible dependent, AccessWV may pursue reimbursement of any claims paid for the ineligible dependent from the policyholder. The policyholder may voluntarily terminate coverage for dependents at any time upon written request or by completing a "Change of Status" form.

Upon determination that a member is no longer eligible for AccessWV coverage, the policyholder will receive notification of the termination in the mail at least 30 days before the termination date, except in the case of nonpayment. This notification will include the reason for the termination, date of termination and notice of appeal rights.

In no case will coverage extend beyond the period for which premiums have been paid. If coverage for the policyholder is terminated, coverage for the dependents is also terminated. Members who have terminated coverage for any reason are not eligible to re-apply for AccessWV coverage for 12 months after the cancellation effective date. This restriction does not apply to applicants who are "federally defined eligible individuals" or applicants who have exhausted the annual benefit under the West Virginia Children's Health Insurance Program.

## **YOUR RESPONSIBILITY TO MAKE CHANGES**

It is your responsibility to keep your AccessWV enrollment records up to date. You must notify AccessWV immediately of any changes in your family situation and take the necessary steps to keep your AccessWV coverage up to date. Examples of such changes include a change of address, a change in your marital status, or a dependent child no longer qualifying for coverage. Premiums will be based on the age, gender, geographic location of the policyholder and kind of coverage (individual or family). The policyholder's county of residence will determine which regional premiums are charged.

## **SPECIAL ELIGIBILITY SITUATIONS**

### **Full-Time Students Age 19 and Over**

Coverage for a dependent child ceases at the end of the month in which the child reaches age 19. However, coverage may be extended (on a year-to-year basis) to age 23 if the child is unmarried, enrolled as a full-time student, and dependent on you for support and maintenance. "Enrolled as a full-time student" means the child attends courses full-time (as determined by the institution) in a graduate or undergraduate college or university (other than a U.S. military academy when the academy considers the student to be on active duty) or attends a trade or professional school as the child's full-time occupation.

Student verification is a two-step process:

1. Verification of full-time student status will be requested by AccessWV when your child turns age 19.
2. Once a year thereafter, you must verify your child's full-time student status by providing a letter from the school's registrar. AccessWV coverage for a dependent who is a full-time student during the spring semester will continue through August 31 of that same year, provided the dependent is unmarried and has not reached age 23.

If your child loses eligibility because he or she is no longer a full-time student, you should notify AccessWV promptly.

If your child (age 19 through 22) voluntarily withdraws from school, has a lapse in coverage, and later re-enrolls as a full-time student, he or she may be reinstated for AccessWV coverage. Call the Plan Administrator to request a "Change of Status" Form to add this child to your coverage as a dependent. This child may be subject to pre-existing condition limitations.

### **Disabled Dependent Children**

Your dependent child may be covered after reaching age 19, if he or she is incapable of self-support because of a mental or physical disability. To be eligible in this category:

- The disabling condition must have begun before age 19, or before age 23 if a full-time student; and
- The child must be incapable of self-sustaining employment and chiefly dependent on you for support and maintenance.

To continue this coverage, you must submit a letter detailing the child's information and disability to AccessWV. AccessWV may contact you if more information is needed. You will be asked to provide documentation when the child reaches age 19 and periodically thereafter.

## MEMBER IDENTIFICATION CARDS

You will receive a member identification card within 15 days of your effective date of coverage in AccessWV. Your AccessWV ID card verifies that you have medical and prescription drug coverage under AccessWV. On the back we have listed important phone numbers you may need. One card will be issued for individual coverage, and two cards will be issued for family coverage. The policyholder's name and identification number will be printed on all cards. ***If you want additional cards or if you need to replace a lost card, please contact Express Scripts at 1-877-256-4680.***

## PREMIUMS

By law, AccessWV premiums are based on the price charged by other insurers offering health insurance coverage to individuals in West Virginia. Premiums are generally updated on July 1<sup>st</sup> of each year but may be changed at other times. You will receive a notice by mail of any changes at least 30 days prior to the effective date.

Premiums are based on age, gender, geographic location of the policyholder and individual or family coverage. The policyholder's county of residence determines which regional premium is charged. The policyholder is solely responsible for notifying the plan of changes in residence while a member of the plan. If there is a move which changes the policyholder's premium region, the premium will be adjusted to the new regional rate. If the Plan Administrator becomes aware of the change by the 15th of the month, the premium will change on the first day of the subsequent month. If the Plan Administrator becomes aware after the 15th of the month, the premium will change as of the first day of the second subsequent month.

Since the premiums are structured in five-year age bands, when the policyholder ages into the next age band, the Plan Administrator will change the premium to reflect the new rate as of the first of the month after the policyholder's birth date.

### **Premium Billing**

Members will be given the option of payment by check, money order or automatic withdrawal from their bank account. For members not on automatic withdrawal, billing statements will be mailed by the 10<sup>th</sup> of each month for next month's premium. The premium is due by the 1st of the month for coverage in that month. For example, you will receive a statement on or about October 10th, for the premium that is due on November 1st. The premium due on November 1st pays for coverage for the month of November.

### **Failure to Pay Premium**

Your coverage as a policyholder, and coverage of your dependents, will terminate if you fail to pay your premium contributions when due. Premiums are due by the 1st day of the month for coverage in that month. For example: May premium is due May 1. If payment is not received within 15 days following the due date, coverage will be cancelled as of the last day of the month for which you paid a premium. In this example, coverage would be cancelled as of April 30, and all claims incurred during May will be your personal responsibility.

The policyholder has the right to appeal the termination within 60 days of the termination letter by doing the following:

- Paying the past due premiums and bringing the account up to date, and
- Applying to pay future premiums through direct draft from a bank account.

If this is done, AccessWV will reinstate the policy that has been cancelled for non-payment with no interruption in coverage.

### **Prohibition against Third Party Checks**

AccessWV does not accept third party checks for the payment of premiums. All premiums must be paid by the member or the member's spouse, parent or adult child. WV State law prohibits employers from paying premiums for AccessWV coverage in lieu of providing group coverage. It also prohibits providers from paying AccessWV premiums on behalf of patients.

## **CERTIFICATE OF CREDITABLE COVERAGE**

A Certificate of Creditable Coverage will be sent to you upon termination of your coverage in AccessWV. The Certificate provides evidence that you were covered by AccessWV. If you can establish prior coverage, you may be entitled to certain rights if you enroll in another health plan. If you have questions about this Certificate, please call Customer Service at 1-888-680-7342 ext. 207.

## Health Care Benefits

### AccessWV Coverage Plans

AccessWV pays for a wide range of health care services for members and their dependents. These benefits include hospital services, medical services, surgery, durable medical equipment and supplies, and prescription drugs.

Under AccessWV, certain costs are your responsibility. In addition, to receive maximum benefits for some services, special rules apply. Please read this "Health Care Benefits" section carefully. It will help you understand your AccessWV coverage. If you have any questions about coverage or payment for health care services, please call:

Where to Call with Questions		
Medical claims and benefits	Wells Fargo TPA	1-866-864-6142
Pre-service review including precertification, prior authorization for out-of-state services, notification for inpatient care in WV facilities and voluntary preauthorization.	Wells Fargo TPA	1-866-864-6142
Prescription drug claims and benefits	Express Scripts	1-877-256-4680
Common Specialty Medication claims and benefits	CuraScript	1-866-413-4135

### AccessWV Network Providers

AccessWV is a program of the State of West Virginia for West Virginians. AccessWV benefits are designed to encourage the use of health care services within the State. The AccessWV network is made up of West Virginia providers who provide health care services or supplies to AccessWV members. The member's share of costs is lowest when services are received from these West Virginia providers.

AccessWV, through the Plan Administrator, contracts with several out-of-state provider networks. When it is necessary for members to go out-of-state for services, these contracts enable AccessWV to enjoy more favorable payment rates, which are, in turn, passed on to the members. AccessWV requires prior authorization for out-of-state services for the full out-of-state benefit to apply.

## WHAT YOU PAY

### MEDICAL DEDUCTIBLE

During any plan year, if you or your eligible dependents incur expenses for covered medical services (other than office visits), you must meet a deductible before the AccessWV begins to pay. Medical deductibles are based on whether you get your services within an AccessWV network ("in-network") or outside of the network ("out-of-network"). Your in-network and out-of-network deductibles are shown on your **Summary of Benefits**.

The family deductibles are twice the individual deductibles. The family deductible is divided among the family members. No one member of the family will pay more than the individual deductible. Once the family deductible is met, your coverage plan pays on all members of the family.

For inpatient admissions that span two plan years, the facility charges are paid based on the first plan year, but physician charges are paid based on the date of service, which could be in the first plan year, the new plan year or both plan years. This will affect how the deductible is charged.

For example, if you go into the hospital on June 28 and are released on July 6, the hospital bill is paid based on the date of admission, so it would fall under the previous plan year's deductible. Physician charges are paid based on the date of service, so if you have surgery on July 2, the surgeon's bill will be processed based on the new plan year, which starts July 1. The deductible for the new plan year will apply to the surgeon's bill.

The out-of-network deductible satisfies the in-network deductible, but the in-network deductible does not meet the out-of-network deductible. This means that even if you have met the in-network deductible, you will be responsible for the full out-of-network deductible. The out-of-network deductible is twice the amount of the in-network deductible.

The annual medical deductible will be pro-rated if you first enroll in AccessWV after the first quarter of the plan year, which runs from July through September. For example, if you first enroll in January, which is in the third quarter of the plan year, your medical deductible will be half of what the full year deductible would be. Pro-rating will not apply in the case of a change between coverage types (individual and family).

Prescription drug benefits are subject to a separate deductible. This deductible is not pro-rated, and you will be required to meet the annual drug deductible even if you are not covered for the full plan year. See the "Prescription Drug Benefits" section of this Policy.

### COINSURANCE

AccessWV is designed to provide as much care as possible within the State of West Virginia. For many of the services covered by AccessWV, you will pay a coinsurance after you have met the deductible. For services with a coinsurance requirement, your coinsurance percentage is

lowest for care received from West Virginia network providers. If you receive the service from a WV network provider, you will pay a 20 percent coinsurance.

If you receive prior authorization to receive services out-of-state from a network provider, you will pay 30 percent coinsurance. If you receive prior authorization to receive services from an out-of-network provider, you will pay 40 percent coinsurance. If you do not receive prior authorization for out-of-state services, your share of costs will increase as your benefit will be subject to a penalty. See "Benefits for Services Received Outside of West Virginia" on page 43.

Source of Care	Your Coinsurance
West Virginia Network Provider	20%
Out-of-State Network Provider (with prior authorization)	30%
Out-of-Network Provider (with prior authorization)	40%

Your coinsurance payments count toward your annual out-of-pocket maximum. Once you reach the out-of-pocket maximum, you no longer pay coinsurance.

**COPAYMENTS**

Office visits with WV network providers require a copayment only. In these cases, you do not have to meet the deductible for AccessWV to pay for the service. The amounts you pay for copays do not count toward your deductible or your out-of-pocket maximum.

Some services (for example, ambulatory surgery and emergency services) require a copay and coinsurance. In these cases, you will have to meet the deductible and pay the copayment before AccessWV begins to pay its share of the coinsurance.

**MEDICAL OUT-OF-POCKET MAXIMUM**

The medical out-of-pocket maximum is the most you pay in coinsurance in a plan year. This out-of-pocket maximum refers only to medical services; prescription drugs are subject to a separate out-of-pocket maximum. See the "Prescription Drug Benefits" section of this Policy for details.

Once you have met your out-of-pocket maximum, the plan will pay 100 percent of your covered charges (less applicable copayments and special deductibles) for the remainder of the plan year, until you reach your annual medical benefit maximum or your lifetime combined benefit maximum. See below.

Your out-of-pocket maximum amount depends on whether you are enrolled in an individual or family plan and whether you receive services in-network or out-of-network. The out-of-pocket maximums for your plan are shown in the **Summary of Benefits**.

The family out-of-pocket maximum is twice the individual out-of-pocket maximum. The family out-of-pocket maximum is divided among the family members. No one member of the family will pay more than the individual out-of-pocket maximum. Once the family out-of-pocket maximum is met, AccessWV will pay 100 percent (less applicable copayments and special deductibles) for all family members.

The out-of-pocket maximum for out-of-network services is twice the out-of-pocket maximum for in-network services. Amounts paid toward the out-of-network out-of-pocket maximum count toward the in-network out-of-pocket maximum, but in-network amounts do not count toward the out-of-network maximum.

Amounts you pay toward your annual deductible, your copayments, any precertification or prior authorization penalties, your payments for prescription drugs, any amounts billed in excess of what AccessWV pays to out-of-network providers, and payments for services not covered by AccessWV do not apply toward your annual medical out-of-pocket maximum.

## **BENEFIT LIMITS**

### **Annual Medical Benefit Maximum**

AccessWV has an annual limit of \$200,000 for medical benefits per member for each plan year. This limit includes only the actual dollars paid by the plan on behalf of the member (not the member's share of costs). Once the annual medical benefit limit is reached, AccessWV will no longer pay medical benefits for that member for that plan year.

Once the annual benefit maximum is reached, the member must continue to pay premiums to maintain membership with AccessWV. If the member chooses to cancel coverage, he or she must wait 12 months after termination of coverage to re-apply to AccessWV and will be subject to a waiting period for pre-existing conditions.

Benefits paid under the Prescription Drug Plan have a separate \$25,000 per member limit for each plan year. See the "Prescription Drug Benefits" Section of this Policy.

### **Lifetime Combined Benefit Maximum**

AccessWV will pay a maximum of \$1,000,000 in total benefits per person during each member's lifetime. This maximum includes benefits paid for medical services and prescription drugs. Once this maximum is reached, the member's coverage will be terminated by the Plan. If the member is the policyholder, coverage will be terminated for the policyholder and dependents. If the dependent reaches the maximum, the dependent will be removed from coverage.

### **Six-Month Waiting Period for Pre-Existing Conditions**

If you have a pre-existing condition that requires a six-month waiting period before claims will be paid, medical claims may be denied. If coverage is denied due to the waiting period, you will be required to pay the full amount of the claim. This applies only to care received related to your pre-existing condition. Care for new illness or injuries will be paid as outlined.

## **PROVIDER NETWORKS**

AccessWV is a program of the State of West Virginia for West Virginians. AccessWV benefits are designed to encourage the use of health care services within the State. The AccessWV

network is made up of West Virginia providers who provide health care services or supplies to AccessWV members. The member's share of costs is lowest when services are received from West Virginia network providers.

AccessWV requires prior authorization for out-of-state services for the full out-of-state benefit to apply. Even with prior authorization, the member's share of costs is higher with out-of-state providers. If out-of-state services are received without prior authorization, AccessWV's payments are further reduced.

Prior authorization for out-of-state services may be granted in the following circumstances:

- The service needed by the member is not available in West Virginia.
- Travel to a WV provider would present an undue hardship.
- Member has an established relationship with an out-of-state provider that should not be disrupted.

### **West Virginia Network Providers**

AccessWV reimburses providers using the PEIA reimbursement schedule. Any West Virginia provider that accepts PEIA reimbursement is considered an AccessWV network provider. In West Virginia, any health care provider who provides health care services or supplies to an AccessWV member is automatically considered a member of our network. Members are not responsible for any balance billing when services are received from West Virginia providers.

### **AccessWV Fee Schedules and Rates**

AccessWV pays health care providers according to a maximum fee schedule and rates established by the Plan Administrator, PEIA. If a provider's charge is higher than the PEIA maximum fee for a particular service, then AccessWV will allow only the maximum fee. The "allowed amount" for a particular service will be the lower of the provider's charge or the PEIA maximum fee.

Physicians and other health care professionals are paid according to a Resource Based Relative Value Scale (RBRVS) fee schedule. This type of payment system sets fees for professional medical services based on the relative amount of work, practice expense and malpractice insurance expense involved. These rates are adjusted annually. West Virginia physicians who treat AccessWV members must accept PEIA's allowed amount as payment in full. They may not bill additional amounts to AccessWV members.

AccessWV pays hospitals following the PEIA methodology. Most inpatient hospital services are paid on a "prospective" basis. PEIA's reimbursement to hospitals is based on Diagnosis-Related Groups (DRGs), which is the system used by Medicare. It is a Prospective Payment System (PPS) that classifies medical cases and surgical procedures on the basis of diagnoses. Under this system, West Virginia hospitals know in advance what PEIA (and AccessWV) will pay per day or per admission. West Virginia hospitals have been provided specific information about their reimbursement rates from PEIA. These rates are adjusted annually. West Virginia hospitals that treat AccessWV members must accept PEIA's allowed amount as payment in full.

Many outpatient services are also paid on a prospective basis. PEIA has adopted a modified version of Medicare's Outpatient Prospective Payment System (OPPS). OPPS reimbursement is based on Ambulatory Payment Classification (APC) Groups. APC's include groups of services that are similar clinically and require similar resources. These rates are adjusted annually.

### **Out-of-State Network Providers**

AccessWV, through the Plan Administrator, has contracts with several out-of-state provider networks. When it is necessary for members to receive services out-of-state, these contracts enable AccessWV to enjoy more favorable rates, which are, in turn, passed on to the members.

In general, a member pays a 30 percent coinsurance when AccessWV grants prior authorization for services from these providers. Members are responsible for any copays or deductibles associated with the service. Please see your **Summary of Benefits** for details.

If a member elects to receive services out-of-state from one of the network providers without prior authorization, the member's coinsurance increases to 50 percent and there is an additional \$1,000 penalty for inpatient care. The prior authorization requirement does not apply to Emergency Care.

If you receive medical attention from a provider in an out-of-state network, your claim will be sent to Wells Fargo TPA. AccessWV pays all out-of-state network providers directly for its share of costs. You will pay your share of costs directly to the providers. This includes deductibles, copayments, coinsurance amounts and amounts for non-covered services. When your claim is paid, Wells Fargo TPA will send you an Explanation of Benefits (EOB).

In general, the following networks are available to AccessWV members:

- **Medical Mutual of Ohio's SuperMed Plus Network (in Ohio only).** Information on this network may be obtained by calling 1-866-864-6142 or by visiting the web-site [www.supermednetwork.com](http://www.supermednetwork.com)
- **OneNet PPO Network** (in Maryland, Washington, DC, and North Carolina only). (*Note: For physicians associated with Duke University, AccessWV uses the Beech Street Network*). Information on this network may be obtained by calling 1-866-864-6142 or by visiting the web-site [www.onenetppo.com](http://www.onenetppo.com).
- **Beech Street Network** (All other states). Information on this network may be obtained by calling 1-866-864-6142 or by visiting the web-site [www.beechstreet.com](http://www.beechstreet.com). (*Note: Kings Daughters Medical Center and Our Lady of Bellefont Hospital in Ashland, Kentucky and hospitals in the UPMC Health System do not participate with AccessWV.*)

Not all hospitals in these networks may participate with AccessWV. AccessWV reserves the right to remove providers from the networks, so not all providers in these networks may be available to you.

In addition, the medical claims administrator contracts with some additional out-of-state providers to serve AccessWV members. For further information on out-of-state network providers, call Wells Fargo TPA at 1-866-864-6142.

**Out-of-Network Providers**

AccessWV does not have contracts with out-of-network providers. When AccessWV grants prior authorization for services from these providers, the member pays 40 percent coinsurance after the out-of-network deductible and is responsible for any copays or additional deductibles associated with the services. See your **Summary of Benefits** for details. In this situation, AccessWV pays based on the "reasonable and customary" allowance, which may be less than the provider's charges.

If a member elects to receive services from an out-of-network provider without prior authorization, AccessWV's basis for payment changes from the "reasonable and customary" amount to the PEIA fee schedule. Member is liable for the difference between billed charges and the PEIA schedule ("balance billing".)

**BENEFIT DESIGN**

**Services Covered in Full**

The following services are covered in full, when received from a West Virginia network provider.

Service	Your Cost with WV Network Providers
Routine prenatal care (physician services) <sup>1</sup>	\$0, Covered in full
Well child exams and immunizations	\$0, Covered in full
High risk birth score program	\$0, Covered in full
Annual screening mammogram	\$0, Covered in full
Annual Pap Smear <sup>2</sup>	\$0, Covered in full
Colorectal cancer screening age 50 + above <sup>2</sup>	\$0, Covered in full
Prostate cancer screening age 50 + above <sup>2</sup>	\$0, Covered in full

<sup>1</sup> Deductible applies only if not met with charges for hospital or other services.

<sup>2</sup> Testing covered in full. Preventive care office visit copay applies.

**Services with Copayments Only**

When received from a WV network provider, the following services require only a copayment and are not subject to the deductible.

Service	Your Cost with WV Network Providers
Physician office visit – preventive care	\$10 copay per visit
Physician office visit – for illness or injury	\$15 copay per visit
Adult routine physical exams	\$10 copay per visit
Second surgical opinion	\$15 copay per visit*

\* No copay if required by Wells Fargo TPA

**Services Requiring a Copayment, Deductible and Coinsurance**

When received from a WV network provider, the following services require that the deductible be met before the Plan begins to pay. Once the deductible is met, a copayment applies and the balance is subject to coinsurance.

<b>Service</b>	<b>Your Cost with WV Network Providers</b>
Emergency services including supplies (certified as emergency)	\$25 copay + 20% coinsurance after the in-network deductible
Emergency room treatment (non-emergency)	\$50 copay + 20% coinsurance after the in-network deductible
Ambulatory/outpatient surgery	\$50 copay + 20% coinsurance after the in-network deductible

**Services Requiring Deductible and Coinsurance**

Generally, services not listed in the above three charts are covered at 80 percent after you have met the in-network deductible, when they are received from WV network providers. Your share is 20 percent coinsurance.

**Limits on Specific Benefits**

Benefit limits apply to certain services covered by AccessWV. See below.

<b>Service</b>	<b>Benefit Limit (Per Member Per Plan Year)</b>
Outpatient mental health/chemical dependency*	20 visits
Christian Science treatment	\$1,000
Outpatient therapies (includes all benefits listed under "Outpatient Therapies" in the "What is Covered/Alphabetical List")*	20 visits (total for all therapies combined)
Inpatient rehabilitation	150 days
Skilled nursing facility	100 days
Inpatient mental health/chemical dependency*	30 days
Cardiac or pulmonary rehabilitation	36 sessions

\* May be extended if approved by Wells Fargo TPA.

Members experiencing a severe medical episode and members with complicated medical conditions are assigned a nurse case manager. For these catastrophic cases, the case manager may, based on medical documentation, recommend additional treatment for services marked with an asterisk. For details of these benefits, see "What is Covered (Alphabetical List)" on page 31.

**REQUIREMENT FOR PRE-SERVICE DECISIONS**

AccessWV requires that certain services and/or items be reviewed in advance to determine whether they are medically necessary and being provided in the appropriate setting by a network provider, if possible. These involve contacting Wells Fargo TPA before the service is received. They are listed in the table below and explained in more detailed in the section that follows.

<b>Pre-Service Decision</b>	<b>Affected Services</b>
<b>Precertification</b>	Specified inpatient and outpatient services
<b>Prior Authorization for Out-of-State Services</b>	Any service received outside of West Virginia except emergency care
<b>Notification</b>	All inpatient stays in West Virginia hospitals

Important things to remember about pre-service decisions:

- Requests for pre-service decisions should be submitted to Wells Fargo TPA as early as possible in advance of the service/item.
- Services or items may be approved or denied in whole or part.
- One or more pre-service decision may be required depending on the type of service or item. For example, both the hospital admission and the procedure to be performed may require a pre-service decision, if the plan is to obtain the service outside of West Virginia.

If you have questions about these requirements, please call Wells Fargo TPA's Customer Service at 1-866-864-6142.

**Precertification for Specified Services (Mandatory)**

AccessWV requires that certain services and/or types of services be reviewed to determine whether they are medically necessary and appropriate based on the patient's medical documentation. This is called "Precertification".

**Precertification** is required for the following:

- Surgical procedures (whether performed on an inpatient or outpatient basis):
  - hysterectomy
  - laminectomy

- insertion of implantable devices including, but not limited to, vascular access, implantable defibrillators, implantable pumps, spinal cord stimulators, neuromuscular stimulators, and bone growth stimulators
  - uvulopalatopharyngoplasty
  - Leforte osteotomy
  - elective and cosmetic surgeries including, but not limited to, breast reduction, blepharoplasty, abdominoplasty, breast reconstruction, and surgery for varicose veins
  - bariatric surgery (gastric bypass, etc.)
  - transplants
- Inpatient admissions for mental health or substance abuse treatment
  - Inpatient medical rehabilitation services
  - Partial/day mental health or substance abuse programs
  - Multidisciplinary pain management programs
  - Durable medical equipment purchases and/or rentals of \$1,000 or more
  - Allergy testing for more than 70 skin pricks and/or intradermal sticks
  - Home health services (more than three visits)
  - Hospice care
  - Skilled nursing facility care

Failure to precertify a service with Wells Fargo TPA within the timeframes specified in the chart below will result in a reduction of benefits under AccessWV of 30 percent. When the service is received from WV network providers, the penalty will be imposed on the provider.

For all out-of-state providers, this penalty will be the responsibility of the member in addition to any applicable copayment, coinsurance, deductible, and amounts that exceed AccessWV's maximum allowance. **Note: Prior authorization from Wells Fargo TPA is required for services received from out-of-state providers. Failure to obtain this authorization results in an additional penalty.** See "Prior Authorization for Out-of-State Services (Mandatory)" below.

<b>Timely Precertification Requirements</b>	
All Services Requiring Precertification	5 business days in advance

If the member or provider feels that Wells Fargo TPA inappropriately denied a service or that extenuating circumstances existed that prevented requesting precertification from Wells Fargo TPA within this timeframes, the member or provider may file an appeal. See "Your Right to Appeal Decisions Made by AccessWV" on page 66.

**Prior Authorization for Out-of-State Services (Mandatory)**

For full benefits to apply, all services received outside of West Virginia must receive prior authorization by AccessWV. Without prior authorization, members will still be covered for out-of-state services, but a penalty will apply. Emergency care is not subject to this requirement.

Prior authorization to receive services out-of-state may be requested by calling AccessWV's claims administrator toll free on 1-866-864-6142. Prior authorization will be granted if the service cannot be received within West Virginia, if travel to the WV service would present an undue hardship or if AccessWV determines that there is an established patient-provider relationship that should not be disrupted.

The "prior authorization" review process considers the justification for receiving the service outside West Virginia. A request for prior authorization will also trigger a precertification review for those services requiring precertification. This component of the review will determine the medical necessity of the proposed service.

The AccessWV member who wishes to receive services out-of-state is responsible for requesting prior authorization. If a member fails to request prior authorization and receives a service out-of-state that requires precertification; for example, inpatient mental health services, a penalty will apply for the failure to obtain prior authorization as well as a 30 percent penalty for failure to precertify. In this situation, a service may not be covered at all, if AccessWV determines that it was not medically necessary.

**Timing of Request for Prior Authorization for Out-of-State Services**

Members are encouraged to request prior authorization for out-of-state services as soon as they know they wish to seek services out-of-state. Prior authorization should be requested no later than 5 business days before the expected date of service.

**Penalties for Failure to Obtain Prior Authorization**

Benefits for services received outside of West Virginia without prior authorization, if otherwise eligible for coverage, will be subject to the penalties shown below.

<b>Out-of-State Network Providers</b>	<b>Penalty without Prior Authorization</b>
All Services (except Emergency Care)	Plan's share of coinsurance drops from 70% to 50%.
Inpatient Hospital Care	Reduction in Plan's share of coinsurance as noted above + \$1,000 penalty payable by member.
<b>Out-of-Network Providers</b>	<b>Penalty without Prior Authorization</b>
All Services	Plan's basis for payment changes from "reasonable and customary" to the fee schedule used by AccessWV, which is the PEIA fee schedule. Member is liable for the difference between billed charges and this schedule ("balance billing.")

If the insured or provider feels that Wells Fargo TPA inappropriately refused to grant authorization for services to be received out-of-state, the AccessWV or member may file an appeal. See "Your Right to Appeal Decisions Made by AccessWV" on page 66.

**Notification of Inpatient Admissions in WV Facilities (Mandatory)**

"Notification" provides the opportunity for AccessWV to evaluate the admission to determine if the patient's medical condition will require case management, such as discharge planning for home health services. Notification to Wells Fargo TPA is required for the following inpatient admissions to West Virginia facilities:

- medical (non-surgical)
- surgical admissions (except those specifically listed as requiring precertification since the precertification triggers the "notification")
- emergency (including chest pain and congestive heart failure, and other cardiac events)
- maternity and newborn

Failure to notify Wells Fargo TPA of an inpatient admission within the time frames specified in the chart below will result in a reduction of benefits under AccessWV of 30 percent. This penalty will be the responsibility of WV network providers.

<b>Timely Notification Requirements</b>	
<b>Type of Admission</b>	<b>Advance Notice Required</b>
<b><i>Scheduled:</i></b>	
Planned Admission	5 business days in advance
Inpatient elective surgery or procedure	5 business days in advance
<b><i>Maternity (notify Wells Fargo TPA during your first trimester)</i></b>	
Term pregnancy	Within 48 hours of admission
Caesarean section (planned)	5 business days in advance
Caesarean section (emergency)	Within 48 hours of admission
<b><i>Urgent/Emergency</i></b>	Within 48 hours of admission
<b><i>Extended stay</i></b>	Additional days may be recommended based on medical necessity

If the member or provider feels that extenuating circumstances existed that prevented notification to Wells Fargo TPA within these time frames, the member or provider may file an appeal. See "Your Rights to Appeal Decisions Made by AccessWV" on page 66.

**Medical Case Management**

If you are experiencing a serious or long-term illness or injury, Wells Fargo TPA's medical case

management program can help you learn about available resources, provide early support for your family, and find ways to contain medical costs, including your out-of-pocket expenses. Through case management, Wells Fargo TPA can:

- arrange home care to prevent hospitalization
- arrange services in the home to facilitate early hospital discharge
- obtain discounts for special medical equipment
- locate appropriate services to meet the patient's health care needs
- allow additional visits for outpatient mental health or outpatient therapy services in catastrophic cases, when medically indicated as part of a comprehensive plan of care
- under very limited circumstances, allow additional visits for short-term outpatient physical therapy services for treatment of a separate condition which is also a new incident or illness—not a worsening of a chronic illness. For example, a member who receives physical therapy following a stroke and later in the plan year has a new condition; such as a broken leg, may receive coverage for additional physical therapy visits.

Wells Fargo TPA must be notified for medical case management for the following services:

- home health care, including but not limited to:
  - skilled nursing of more than three (3) visits
  - I.V. therapy in the home
  - physical therapy, occupational therapy or speech therapy done in the home
  - hospice care; and
  - medication provided or administered by a home health agency.
- skilled nursing facility services; and
- rehabilitation services.

### Other Pre-Service Review

#### **Preauthorization (Voluntary)**

Preauthorization is a voluntary program which allows you to contact Wells Fargo TPA in advance of a procedure to verify that the service is covered and that it will be paid so that you can make an informed decision about the procedure. Obtaining preauthorization from Wells Fargo TPA assures that your claim will be paid when it is submitted. To obtain preauthorization, ask your provider to send your request to:

Wells Fargo TPA  
P. O. Box 2451  
Charleston, WV 25329-2451

Your provider should include your name, address, telephone number, your member identification number, and all information about the recommended procedure. Wells Fargo TPA may contact your physician for more information. Remember, if your request for preauthorization is denied, you will be responsible for paying for the procedure, if you choose to have it. Due to specific benefit criteria, preauthorization is recommended for the following procedures:

- Accident-related Dental Services
- Chelation Therapy
- Chiropractic Services under age 16
- Massage Therapy
- Oral Surgery
- Orthotics
- Vision Therapy

## WHAT IS COVERED

### Medically Necessary Services

Covered services must be medically necessary or be one of the specifically listed preventive care services covered by AccessWV.

Medically necessary health care services and supplies are those provided by a hospital, physician or other licensed health care provider to treat an injury, illness or medical condition. A service is considered medically necessary, if it is:

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

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

### Who May Provide Services

AccessWV will pay for covered services rendered by a health care professional or facility if the provider is:

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

### Types of Medical Services Covered

AccessWV covers a wide range of health care services. Some major categories are listed below. The description of each service includes the level of coinsurance and any applicable copayments you must pay when the service is received from a West Virginia network provider.

Services you receive outside of West Virginia from network providers ("out-of-state network providers") or from out-of-network providers are subject to higher levels of coinsurance, may require higher copays or additional deductibles, and require prior authorization from Wells Fargo

TPA, except in the case of an emergency. See "Benefits for Services Received Outside of West Virginia" on page 43 for details.

If you have questions about coverage of services, call Wells Fargo TPA at 1-866-864-6142.

### What is Covered (Alphabetical List)

- **Acupuncture.** Services of a licensed acupuncturist for treatment of medical conditions are included in the "Outpatient Therapies" benefit (see below) and are covered at 80 percent from WV network providers after the in-network deductible. Contact Wells Fargo TPA for specific benefit limitations. Combined coverage for "Outpatient Therapies" is limited to a maximum of 20 visits per member per plan year. Office visits are covered with a \$15 copay, and treatments are covered at 80 percent after the in-network deductible is met.
- ◆ **Allergy Services.** Including testing and related treatment. Covered at 80 percent from WV network providers after the in-network deductible is met. **Allergy testing (for more than 70 tests) requires precertification by Wells Fargo TPA.**
- **Ambulance Services.** Emergency ground or air ambulance transportation, when medically necessary, to the nearest facility able to provide needed treatment. Services from WV network providers covered at 80 percent after the in-network deductible is met. Non-emergency transportation is not covered.
- ◆ **Ambulatory Surgery ("Outpatient Surgery").** When performed in a WV network hospital or alternative facility, this service is covered at 80 percent after the in-network deductible and a \$50 copay are met. When performed in a WV network physician's office, the \$50 copay does not apply. **Certain ambulatory surgical procedures require precertification by Wells Fargo TPA.**
- **Cardiac or Pulmonary Rehabilitation.** Benefits are limited to 3 sessions per week for 12 weeks or 36 sessions per member per plan year for the following conditions: heart attack in the 12 months preceding treatment, heart failure, coronary by-pass surgery or stabilized angina pectoris. Covered at 80 percent from WV network providers after the in-network deductible is met.
- **Chelation Therapy.** Benefits for these services are limited. Contact Wells Fargo TPA to see if coverage will be provided. If covered, therapy from a WV network provider is paid at 80 percent after the in-network deductible is met.
- **Childhood Immunizations.** Immunizations, as recommended by the American Academy of Pediatrics, for children through age 16 are covered at 100 percent of allowed charges,
  - ◆ **Services marked with a ◆ require precertification by Wells Fargo.**

including the office visit. This benefit does not require a deductible, coinsurance, or a copayment. See also "Immunizations".

- **Chiropractic Services.** Services of a chiropractor for acute treatment of neuromuscular-skeletal conditions are included in the "Outpatient Therapies" benefit (see below). Combined coverage for these therapies is limited to a maximum of 20 visits per member per plan year. Office visits with WV network providers are covered with a \$15 copay. X-rays with WV network providers are covered at 80 percent after the in-network deductible. Maintenance services are not covered. Voluntary preauthorization is recommended for services for children under age 16.
- **Christian Science Treatment.** Treatment for a demonstrable illness or injury if provided in a facility accredited by the Commission for Accreditation of Christian Science Nursing Facilities/Organizations, Inc. or by a practitioner accredited by the Mother Church is covered at 80 percent after the in-network deductible. No benefits will be paid for the purpose of rest or study, for communication costs, or if the person requiring attention is receiving parallel medical care. Coverage is limited to a maximum cost to the plan of \$1,000 per plan year. If required, this benefit may be extended for inpatient care for up to 60 days per plan year. **Inpatient care must be precertified by Wells Fargo TPA.**
- **Colorectal Cancer Screenings.** Routine screening to detect colorectal cancer is covered at 100 percent with a WV network provider with no deductible or coinsurance required. The related office visit expenses are subject to the applicable "Preventive Care" office visit copay. This benefit is covered as follows:
  - Fecal-occult blood test—1 in 12 months/age 50 and over
  - Flexible sigmoidoscopy—1 in 48 months/age 50 and over
  - Colonoscopy —1 in 24 months/high risk patients\*; 1 in 10 years/age 50 and over
  - X-ray, barium enema—1 in 24 months/high risk patients\*, 1 in 48 months/age 50 & over

*\*High risk is defined as a patient who faces high risk for colorectal cancer because of family history, prior experience of cancer or precursor neoplastic polyps, history of chronic digestive disease condition (inflammatory bowel disease, Crohn's disease, ulcerative colitis), or presence of any appropriate recognized gene markers for colorectal cancer or other predisposing factors.*
- **Cosmetic/Reconstructive Surgery.** Services provided when required as a result of accidental injury or disease or when performed to correct birth defects are covered at 80 percent from WV network providers after the in-network deductible is met. Other cosmetic or reconstructive surgery is not covered.
- **Dental Services (Accident-Related Only).** Services provided within six (6) months of an accident and required to restore tooth structures damaged due to that accident are covered at 80 percent with WV network providers after the in-network deductible is met. The initial treatment must be provided within 72 hours of the accident. Biting and chewing accidents are not covered. Services provided more than six (6) months after the accident are not covered

◆ Services marked with a ◆ require precertification by Wells Fargo

The Least Expensive Professionally Acceptable Alternative Treatment (LEPATT) for accident-related dental services will be covered. For example, the dentist may recommend a crown, but AccessWV will only provide reimbursement for a large filling. Contact Wells Fargo TPA for more information. For children under the age of 16, the six-month limitation may be extended if an approved treatment plan is provided to Wells Fargo TPA within the initial six months.

- **Dental Services (Impacted Teeth).** Medically necessary extraction of impacted teeth is covered at 80 percent from WV network providers after the in-network deductible is met. Extractions for the purpose of orthodontia are not covered.
- **DEXA Scans.** Bone mass measurement by DEXA is limited to one scan every 24 months for members who meet at least one of the following criteria:
  - Member has received results from a peripheral osteoporosis screen indicating moderate or high risk for osteoporosis.
  - Member has documented clinical risk for osteoporosis.

Diagnostic testing is covered at 80 percent with WV network providers after the in-network deductible is met. Routine screening scans are not covered. For additional information contact Wells Fargo TPA at 1-866-864-6142.

- **Diabetes Education.** Services of a diabetes education program that meets the standards of the American Diabetes Association are covered at 80 percent with WV network providers after the in-network deductible is met. Coverage is limited to six (6) visits per member, which include three visits with the dietitian and three visits with a registered nurse. Contact Wells Fargo TPA for specific benefit limitations.
- ◆ **Durable Medical Equipment (DME) and Prosthetics.** Includes coverage for the initial purchase and reasonable replacement of standard implant and prosthetic devices, and for the rental or purchase (at AccessWV's discretion) of standard DME, when prescribed by a physician. DME and prosthetics are covered at 80 percent from WV network providers after the in-network deductible is met. **Prosthetics and DME purchases of \$1,000 or more, or rental for more than 3 months must be precertified by Wells Fargo TPA.**
- **Emergency Services (Including Supplies).** Services received in an emergency room when the condition has been certified as an emergency are subject to a \$25 copay and are covered at 80 percent after the in-network deductible is met.
- **Emergency Room Treatment.** Services received in an WV network emergency room when the condition is determined to be a non-emergency are covered at 80 percent after the in-network deductible and a \$50 copay are met.

◆ **Services marked with a ◆ require precertification by Wells Fargo.**

- ◆ **Home Health Services.** Intermittent health services of a home health agency when prescribed by a physician are covered at 80 percent from WV network providers after the in-network deductible is met. Services must be provided in the home, by or under the supervision of a registered nurse. The home health services are covered only if they would otherwise have required confinement in a hospital or skilled nursing facility. **If more than 3 visits are necessary, precertification by Wells Fargo TPA is required.**
  
- ◆ **Hospice Care.** When ordered by a physician, covered at 80 percent from WV network providers after the in-network deductible is met. **Precertification by Wells Fargo TPA is required.**
  
- **Hypertension Screening.** AccessWV pays for diagnostic screening to determine if you are at risk for high blood pressure, heart disease or stroke. Benefits include coverage for an office visit, blood pressure check, and a blood chemistry profile. With a WV network provider, the office visit is subject to a \$10 "Preventive Care" copay. The blood chemistry is covered at 80 percent after the in-network deductible is met. The blood pressure check is included as part of the office visit. AccessWV will pay for this screening according to the following schedule:
  - One time between the ages of 20 and 30
  - Once every three years between ages 31 and 39
  - Once every two years after age 40.
  
- **Immunizations.**

**Children through Age 16.** The plan covers immunizations and the associated office visit with no deductible, coinsurance, or copay required. Following is a list of immunizations and the ages at which AccessWV covers them.

  - Polio (IPV): At 2 months, 4 months, 6-18 months, and 4-6 years.
  - Diphtheria-Tetanus-Pertussis (DTaP): At 2 months, 4 months, 6 months, 15-18 months, and 4-6 years.
  - Tetanus-Diphtheria (Td): At 11-16 years.
  - Measles-Mumps-Rubella (MMR): At 12-15 months and EITHER 4-6 years OR 11-12 years.
  - Haemophilus Influenzae type b (Hib): At 2 months, 4 months, 6 months, and 12-15 months; OR 2 months, 4 months, and 12-15 months, depending on the vaccine type.
  - Hepatitis B: At birth-2 months, 1-4 months, and 6-18 months. If missed, 3 doses starting at age 11 years.
  - Chicken Pox (VZV): At 12-18 months. If missed, between ages 11 and 12 years.
  - Hepatitis A: At 24 months-12 years in selected areas.
  - Pneumococcal disease (Prevnar<sup>TM</sup>): At 2 months, 4 months, 6 months, and 12-15 months. If missed, at discretion of health care provider. Also see "Well Child Care".
  
- ◆ **Services marked with a ◆ require precertification by Wells Fargo.**

**Adults and Children Ages 17 and Over.** AccessWV covers immunizations as recommended by the American Academy of Family Physicians at 100 percent with no deductible or coinsurance required, when received from WV network providers. The associated office visit is subject to the applicable copay. Other immunizations when received from WV network providers are covered at 80 percent after the in-network deductible is met.

- **Inpatient Hospital and Related Services.** Confinement in a WV network hospital including semi-private room, special care units, confinement for detoxification, and related services and supplies during the confinement are covered at 80 percent after the in-network deductible is met. **While precertification is not required, Wells Fargo TPA must be notified of all inpatient stays in WV hospitals in order to determine the need for case management.**
- ◆ **Inpatient Medical Rehabilitation Services.** When ordered by a physician, services in a WV network facility are covered at 80 percent after the in-network deductible is met. A benefit limit of 150 days per member per plan year applies. **Precertification by Wells Fargo TPA is required.**
- **Kidney Disease Screening.** The following laboratory tests to screen for kidney disease are covered at 80 percent with WV network providers after the in-network deductible is met:
  - Urine albumin
  - Urine protein
  - Serum creatinine

No diagnosis is needed for these services to be covered. The associated office visit is covered subject to the “Preventive Care” office visit copay and is not subject to the deductible. Blood pressure testing related to the screening is covered as part of the office visit.

- **Mammogram.** An annual routine mammogram to detect breast abnormalities is covered at 100 percent when received from a WV network provider with no coinsurance or deductible required. The related office visit expenses are subject to the applicable copayment. When billed with a medical diagnosis (instead of as a screening test), a mammogram is considered a diagnostic test, and is covered at 80 percent after the in-network deductible is met.
- **Massage Therapy.** Services of a licensed massage therapist for treatment of neuromuscular-skeletal conditions are covered under the "Outpatient Therapies" benefit (see below) when ordered by a physician. Combined coverage for these therapies is limited to a maximum of 20 visits per member per plan year. Services are covered at 80 percent from a WV network provider after the in-network deductible is met.
- **Mastectomy.** If you are receiving benefits in connection with a mastectomy due to cancer and elect breast reconstruction in connection with such benefits, you are entitled to the following:
  - Reconstruction of the breast on which the mastectomy was performed;
  - Reconstructive surgery of the other breast to present a symmetrical appearance; and
  - Prostheses and coverage for physical complications at all stages of the mastectomy procedure including lymphedema.

◆ **Services marked with a ◆ require precertification by Wells Fargo.**

- **Maternity.** See “Maternity Care” on page 40 for details.

### **Mental Health Services.**

- ◆ **Inpatient Care.** Inpatient and outpatient partial hospitalization day programs for mental health and chemical dependency services are limited to a maximum of 30 days per member per plan year. For outpatient partial/day programs, two (2) outpatient days are counted as one (1) inpatient day when applying the 30-day maximum. Catastrophic cases will be assigned to a nurse case manager. For these extreme medical conditions, the case manager may, based on medical documentation, recommend additional treatment. These services, when received from a WV network provider, are covered at 80 percent after the in-network deductible is met. **Precertification from Wells Fargo TPA is required for inpatient mental and chemical dependency services and for outpatient partial hospitalization day programs.**
- **Outpatient Care.** Outpatient mental health and chemical dependency services are limited to a maximum of 20 visits per member per plan year for short-term individual and/or group outpatient mental health and chemical dependency services. This benefit includes evaluation and referral, diagnostic, therapeutic, and crisis intervention services performed on an outpatient basis (including a physician’s office). Catastrophic cases will be assigned to a nurse case manager. For these extreme medical conditions, the case manager may, based on medical documentation, recommend additional treatment beyond the 20 visits. Outpatient mental health and chemical dependency services, when received from a WV network provider, are covered at 80 percent after the in-network deductible is met.
- **MRA.** Magnetic Resonance Angiography services when performed on an outpatient basis by a WV network provider are covered at 80 percent after the in-network deductible is met.
- **MRI.** Magnetic Resonance Imaging services when performed on an outpatient basis by a WV network provider are covered at 80 percent after the in-network deductible is met.
- ◆ **Neuromuscular Stimulators and Bone Growth Stimulators.** With a WV network provider, these are covered at 80 percent after the in-network deductible is met. **Precertification from Wells Fargo TPA is required for coverage.**
- **Oral Surgery.** Coverage limited to extraction of impacted teeth, orthognathism and medically necessary ridge reconstruction. When received from a WV network provider, coverage is at 80 percent after the in-network deductible is met. Voluntary preauthorization is recommended for orthognathic procedures and ridge reconstruction procedures to assure that the procedure will be eligible for coverage. Dental implants are not covered.
- ◆ **Organ Transplants.** See “Organ Transplant Benefits” on page 41 for details.
  - ◆ **Services marked with a ◆ require precertification by Wells Fargo.**

- **Outpatient Diagnostic and Therapeutic Services.** Laboratory, diagnostic tests, and therapeutic treatments, when ordered by a physician, are covered at 80 percent after the in-network deductible is met, when these services are obtained from WV network providers. Services such as chemotherapy, radiation therapy and preadmission testing are included in this category.
- ◆ **Outpatient Surgery ("Ambulatory Surgery").** When performed in a WV network hospital or alternative facility, this service is covered at 80 percent after the in-network deductible and a \$50 copay are met. When performed in a physician's office, the \$50 copay does not apply. **Certain outpatient surgical procedures require precertification by Wells Fargo TPA.**
- **Outpatient Therapies.** Coverage for the following outpatient therapies is combined into a single benefit: acupuncture, chiropractic treatment, massage therapy, occupational therapy, osteopathic manipulation, physical therapy, speech therapy and vision therapy. The benefit is limited to a maximum of 20 visits per member per plan year for all of the therapies combined. Case management by Wells Fargo TPA is required for more than 20 visits. When received from WV network providers, services are covered at 80 percent after the in-network deductible is met.
  - **Acupuncture.** Services of a licensed WV network acupuncturist for treatment of medical conditions are covered at 80 percent after the in-network deductible is met. Office visits are covered with a \$15 copay, and treatments are covered at 80 percent after the in-network deductible is met. These services are subject to the "Outpatient Therapies" limit. Contact Wells Fargo TPA for additional benefit limitations.
  - **Chiropractic Treatment.** Services of a chiropractor for treatment of neuromuscular-skeletal conditions are included in the "Outpatient Therapies" benefit and are covered at 80 percent after the in-network deductible is met. Chiropractic services are subject to the "Outpatient Therapies" limit. Office visits are subject to a \$15 copay, and x-rays are covered at 80 percent after the in-network deductible is met. Maintenance services are not covered. Voluntary preauthorization is recommended for services for children under age 16 to assure they will be eligible for coverage.
  - **Massage Therapy.** When ordered by a physician, services of a licensed massage therapist, who is a WV network provider, are covered at 80 percent after the in-network deductible is met. These services are subject to the "Outpatient Therapies" limit.
  - **Occupational Therapy.** When ordered by a physician, occupational therapy from a WV network provider is covered at 80 percent after the in-network deductible is met. These services are subject to the "Outpatient Therapies" limit.
  - **Osteopathic Manipulations.** Services of WV network osteopathic physician to eliminate or alleviate somatic dysfunction and related disorders are covered at 80 percent after the in-network deductible is met. These services are subject to the "Outpatient Therapies" limit.
- ◆ **Services marked with a ◆ require precertification by Wells Fargo**

- **Outpatient Physical Therapy.** When ordered by a physician, outpatient physical therapy from a WV network provider is covered at 80 percent after the in-network deductible is met. These services are subject to the "Outpatient Therapies" limit
- **Outpatient Speech Therapy.** When ordered by a physician, outpatient speech therapy from a WV network provider is covered at 80 percent after the in-network deductible is met. These services are subject to the "Outpatient Therapies" limit.
- **Vision Therapy.** When received from a West Virginia network provider, vision therapy is covered at 80 percent after the in-network deductible is met. These services are subject to the "Outpatient Therapies" limit. Contact Wells Fargo TPA for voluntary preauthorization of these services to assure that they will be eligible for coverage.
- ◆ **Pain Management Services.** When received from a WV network provider, pain management services are covered at 80 percent after the in-network deductible is met. **Precertification by Wells Fargo TPA is required only for Multidisciplinary Pain Management Programs.**
- **Pap Smear.** An annual Pap smear and the associated office visit to screen for cervical abnormalities are covered. With a WV network provider, the Pap Smear is covered at 100 percent with no deductible or coinsurance. The associated office visit is subject to a \$10 "Preventive Care" office visit copay. When billed with a medical diagnosis (instead of as a screening test), the Pap Smear is considered a diagnostic test and is covered at 80 percent after the in-network deductible is met.
- **Physician Office Visits (Preventive Care).** With WV network providers, these visits are subject to a \$10 copay. They are not subject to the deductible. When there is no illness present, office visits for the following covered services are considered "Preventive Care": colorectal cancer screening, hypertension screening, immunizations for persons ages 17 and over, kidney disease screening, screening mammograms, annual Pap smears, prostate cancer screening, and routine periodic physical exams (adults).
- **Physician Office Visits (Treatment for Illness, Injury, or Medical Condition).** With WV network providers, these visits require a \$15 copay and are not subject to the deductible.
- **Professional Services of a Physician or Other Licensed Provider for Treatment of Illness, Injury or Medical Condition.** Includes outpatient and inpatient services (such as surgery, anesthesia, radiology, and office visits). With WV network providers, office visits for preventive or specialty care are subject to the applicable copay (see above). Other services from WV network providers are covered at 80 percent after the in-network deductible is met.
- **Prostate Cancer Screening.** Coverage is provided for an annual office visit and exam to detect prostate cancer in men ages 50 and over. With WV network providers, the PSA blood test associated with this screening is covered at 100 percent with no deductible or coinsurance. The associated office visit is subject to a \$10 "Preventive Care" office visit copay.
  - ◆ **Services marked with a ◆ require precertification by Wells Fargo.**

- **Routine Periodic Physicals (Adults).** AccessWV covers a routine physical exam once every two years for adults ages 18 and over. Exams may be provided more often if the patient's medical history indicates a need. With WV network providers, routine physicals are subject to the \$10 "Preventive Care" office visit copay. This office visit generally includes but is not limited to:

- height and weight measurement
- blood pressure check
- health risk and prevention counseling, and
- physical examination

Diagnostic testing, lab and x-rays, provided in conjunction with a periodic physical are covered, if medically necessary, and billed with a medical diagnosis. With WV network providers, these services are covered at 80 percent after the in-network deductible. Only the screenings specifically listed in this "What is Covered" section will be covered as routine screenings.

- **Second Surgical Opinions.** Office visits with WV network providers for second surgical opinions are subject to a \$15 copay per visit with no deductible. If required by Wells Fargo TPA, second surgical opinions from WV network providers are covered in full; no copay is required.

- ◆ **Skilled Nursing Facility Services.** Confinement in a network skilled nursing facility in WV including semi-private room, related services and supplies is covered at 80 percent after the in-network deductible is met. Confinement must be prescribed by a physician in lieu of hospitalization. Coverage is limited to 100 days per member per plan year. **Precertification by Wells Fargo TPA is required.**

- **Well Child Care.** For children through age 16, AccessWV covers routine office visits for preventive care as recommended by the American Academy of Pediatrics. These visits are covered at 100 percent of allowed charges and are not subject to copays, coinsurance or the deductible. This office visit generally includes, but is not limited to:

- height and weight measurement,
- blood pressure check,
- vision and hearing screening,
- developmental/behavioral assessment, and
- physical examination.

"Well Child Care" office visits are recommended by the American Academy of Pediatrics at the following ages:

- Infancy: 1 month, 2 months, 4 months, 6 months, 9 months and 12 months.
- Early childhood: 15 months, 18 months, 24 months, 3 years and 4 years.
- Late childhood: 5 years, 6 years, 8 years, 10 years, 11 years and 12 years.
- Adolescence: 13 years, 14 years, 15 years and 16 years.

There is a \$10 copayment for routine preventive care office visits for adolescents over the age of 16 with WV network providers. No deductible applies.

- ◆ **Services marked with a ◆ require precertification by Wells Fargo.**

## SPECIAL BENEFITS

### MATERNITY CARE

AccessWV provides coverage for maternity-related professional and facility services, including prenatal care, midwife services and birthing centers. Maternity-related services are covered only for the policyholder or the policyholder's enrolled spouse.

Contact Wells Fargo TPA at 1-866-864-6142 during the first trimester of your pregnancy or as soon as your pregnancy is confirmed. Wells Fargo TPA can assist you in identifying possible factors that may put you at risk for premature labor and delivery. If risk factors are identified, Wells Fargo TPA nurses will work with you and your doctor to help safeguard the health of mother and baby. You will need to contact Wells Fargo TPA anytime you are admitted to the hospital during your pregnancy and within 48 hours of your admission for delivery, even if you are discharged in less than 48 hours.

#### Payment Level

When received from WV network providers, maternity services for routine prenatal care, delivery and follow-up are paid at 100 percent of allowed charges under a global fee after the in-network deductible has been met. An obstetrical profile and one ultrasound are also paid at 100 percent of allowed charges after the deductible is met. Other maternity services, including hospital charges and anesthesia services, are paid at the regular AccessWV level of 80 percent of allowed charges after the in-network deductible is met.

Prior authorization is required for maternity services received outside of West Virginia. If prior authorization is granted, payment is at the out-of-state benefit rate and varies depending upon whether the provider is in-network or out-of-network. Please see your **Summary of Benefits**. Benefits for maternity services received out-of-state without prior authorization are subject to a penalty. See "Benefits for Services Received Outside of West Virginia" on page 43.

#### Maternity Pre-Payment Benefit

If your WV network provider requests a deposit for maternity care before delivery, AccessWV will make an advance payment of up to \$500. This will be deducted from the global fee paid after delivery. To receive this benefit, please contact Wells Fargo TPA and request a Maternity Pre-Payment form.

#### High Risk Birth Score Program

For infants identified at birth as being at risk for health problems, AccessWV will pay for six office visits between the age of two weeks and 24 months in addition to AccessWV's regular Well Child Care benefits. The additional visits are paid at 100 percent of allowed charges and are not subject to the deductible. Wells Fargo TPA will notify families who qualify for this benefit.

### **Enrolling Your Newborn**

Please be sure you remember to add your newborn to your coverage by completing a "Change of Status" Form. Request a "Change of Status" Form by calling the Plan Administrator (PEIA). See the "Eligibility & Membership" section for more information.

### **Nursery Charges**

If the baby is enrolled for coverage under AccessWV, charges for the newborn nursery care will be paid in the baby's name. If the baby is not enrolled for coverage under AccessWV, charges for a normal, healthy newborn's nursery care will be covered as part of the mother's maternity benefit. If the newborn is covered under another plan, coordination of benefits rules will apply.

### **Statement of Rights under the Newborns' and Mothers' Health Protection Act**

AccessWV's maternity benefit meets or exceeds all of the requirements of the Newborns' and Mothers' Health Protection Act. Under federal law, health insurance coverage generally may not restrict benefits for any hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a vaginal delivery, or less than 96 hours following a delivery by Caesarean section. However, the plan or issuer may pay for a shorter stay if the attending provider (e.g., your physician, nurse midwife, or physician assistant), after consultation with the mother, discharges the mother or newborn earlier. Also, under federal law, plans and issuers may not set the level of benefits or out-of-pocket costs so that any later portion of the 48-hour (or 96-hour) stay is treated in a manner less favorable to the mother or newborn than any earlier portion of the stay. In addition, a plan or issuer may not, under federal law, require that a physician or other health care provider obtain authorization for prescribing a length of stay of up to 48 hours (or 96 hours). However, to use certain providers or facilities, or to reduce your out-of-pocket costs, you may be required to obtain prior authorization. For information on prior authorization, contact Wells Fargo TPA.

### **ORGAN TRANSPLANT BENEFITS**

Organ transplants are covered when deemed medically necessary and non-experimental. They are subject to precertification and case management by Wells Fargo TPA. You should contact Wells Fargo TPA as soon as you learn that you or a member of your family covered by AccessWV may need a transplant.

All transplants require precertification for determination of medical necessity. When it is determined by your physician that you are a potential candidate for any type of transplant, Wells Fargo TPA should be contacted immediately. They will identify Centers of Excellence available to you through the Plan Administrator's Organ Transplant Network with experience in the specific type of transplant you require. You should advise your physician that Wells Fargo TPA needs to coordinate all phases of the care related to the transplant including:

- initial phase when considering a transplant procedure,
- initial workup for the transplant,
- performance of the procedure, and
- care following the transplant.

Any services and supplies that are required for donor/procurement as a result of a surgical transplant procedure for a member will be covered. Benefits for such charges, services and supplies are not provided under AccessWV, if benefits are provided under a group plan or any group or individual contract, or any arrangement of coverage for individuals in a group (whether on an insured or uninsured basis), including any prepayment coverage. Testing for persons other than the chosen donor is not covered.

### **Organ Transplant Network**

AccessWV uses network providers for organ transplant services. This helps to control health care costs for you and the plan.

Through its Plan Administrator, AccessWV uses a specialized transplant network called LifeTrac, as well as special contracts with West Virginia University hospitals for bone marrow transplants, and with Charleston Area Medical Center for kidney transplants. Wells Fargo TPA will work with patients and physicians to determine which network facility best serves the patient's medical needs.

To receive the in-network benefit, the transplant must be received from a WV provider, if the service is available in West Virginia. If the transplant service is not available in West Virginia, out-of-state services will be covered at the West Virginia network benefit level, if the transplant is arranged and approved by Wells Fargo TPA and is received from a provider in the Organ Transplant Network.

### **Benefits for Approved Services from the Organ Transplant Network**

Once you have met the annual in-network deductible and reached your out-of-pocket maximum, services will be covered at 100 percent and you will pay no more coinsurance for pre-transplant, transplant, and follow-up services. Copayments for office visits and other services will still apply. Coverage will be provided up to the annual medical benefit maximum or the combined medical and pharmacy lifetime benefit maximum, whichever occurs first. Services must be arranged and approved by Wells Fargo.

### **Travel Allowance for Approved Services from the Organ Transplant Network**

Because network facilities may be located some distance from the patient's home, benefits include up to \$5,000 for patient travel, lodging and meals, after the in-network deductible has been met. A portion of this benefit is available to cover the travel, lodging and meals for a member of the patient's family or a friend providing support. Receipts are required for payment; mileage and cost estimates are not acceptable.

### **Medical Case Management**

Well Fargo offers support and assistance in evaluating treatment options and referrals to the prescription drug administrator for needed pharmaceuticals related to the transplant. Management begins early when the potential need for a transplant is identified, and continues through the surgery and follow-up. When the need for a transplant presents itself, call Wells Fargo TPA at 1-866-864-6142 (at the prompt, press 3). You should contact Wells Fargo TPA as soon as you learn that you or a family member covered by AccessWV may need a transplant. All transplants must be precertified through Wells Fargo TPA.

### **Organ Transplants Not Arranged through Wells Fargo TPA**

Members who choose to receive an organ transplant that has not been arranged by Wells Fargo TPA will have reduced benefits. If the transplant is received from the Lifetrac network, the out-of-state network benefit will apply subject to a penalty for failure to obtain prior authorization. In this case, AccessWV will pay 50 percent after the member has met the in-network medical deductible, the \$7,500 additional transplant deductible and the \$1,000 penalty for failure to obtain prior authorization for inpatient care.

If the member receives the transplant at a facility that is not in the AccessWV Organ Transplant Network, AccessWV will pay 60 percent of the fee it would have paid in a network facility after the member pays the out-of-network medical deductible and an additional \$10,000 transplant deductible. Since the fee on which AccessWV pays may be below the charges of the transplant providers, the member will be subject to balance billing.

No travel benefits will be provided for transplants that have not been arranged through Wells Fargo TPA (except medically necessary ambulance transport).

### **Transplant-Related Prescription Drugs**

AccessWV covers transplant-related immunosuppressant prescription drugs at 100 percent, after you have met your prescription drug deductible (if the prescriptions are filled at a network pharmacy) Coverage will be provided up to the annual pharmacy benefit maximum or the combined medical and pharmacy lifetime maximum which ever occurs first. These drugs are covered through the Prescription Drug Plan and processed by the prescription drug administrator, Express Scripts, Inc. Details of the Prescription Drug Plan are found in the “Prescription Drug Benefits” section starting on page 50.

Medical case management of transplant patients includes referral to the prescription drug administrator for waiver of copayments on transplant-related immunosuppressant drugs. Wells Fargo TPA will make arrangements with the prescription drug administrator to waive copayments on drugs used to sustain the transplant.

## **BENEFITS FOR SERVICES RECEIVED OUTSIDE WEST VIRGINIA**

In general, services received out-of-state require higher member cost-sharing than services received from WV network providers. For the full out-of-state benefit to apply, these services must receive prior authorization from Wells Fargo TPA. If you do not receive prior authorization, out-of-state services will be covered at a lower rate.

### **Out-of-State Services with Network Providers**

In general, the member's share of costs is 30 percent when services are received from out-of-state network providers and prior authorization has been obtained from Wells Fargo TPA. Services that are covered in full or that require only a copayment when received from West Virginia network providers require 30 percent coinsurance when received from out-of-state network

providers with prior authorization. The exception is well child care, which is covered in full. Please see your **Summary of Benefits**.

The in-network deductible applies to these out-of-state services. This means AccessWV's share of costs is 70 percent, after the member meets the in-network deductible. Some services require a copayment in addition to the coinsurance. See below for highlights of the benefit differences when services are received from WV network providers and when they are received from out-of-state network providers with prior authorization.

Service	Member's Share of Costs	
	WV Network Providers	Out-of-State Network Providers (with Prior Authorization)
Office visits—primary or specialty care	\$15	30% coinsurance*
Routine physicals	\$10	30% coinsurance*
Preventive services (mammograms, Pap smears, etc.)	\$0, covered in full	30% coinsurance*
Prenatal care	\$0*	30% coinsurance*
All services with coinsurance	20% coinsurance*	30% coinsurance*
Ambulatory/outpatient surgery	\$50 copay + 20% coinsurance*	\$75 copay + 30% coinsurance*

\* In-network deductible applies.

Without prior authorization, the member's coinsurance for services received from out-of-state network providers will increase to 50 percent. An additional penalty of \$1,000 will apply to all hospital stays. Emergency care is not required to have prior authorization.

**Services from Out-of-Network Providers**

In general, the members' share of costs is 40 percent when services are received from out-of-network providers and prior authorization has been obtained from Wells Fargo TPA. Services that are covered in full or that require only a copayment when received from West Virginia network providers require 40 percent coinsurance when received from out-of-state network providers with prior authorization. The exception is well child care, which is covered in full. Please see your **Summary of Benefits**.

The out-of-network deductible applies to these out-of-network services. This means AccessWV's share of costs is 60 percent, after the member meets the out-of-network deductible.

In addition to the 40 percent coinsurance, the following inpatient services require a \$500 copay after the out-of-network deductible is met: inpatient hospital care, maternity care (delivery), rehabilitation facility, skilled nursing facility, inpatient mental health & chemical dependency services and inpatient detoxification. The copayment for ambulatory/outpatient surgery is \$100 when this service is received from an out-of-network provider. See below for highlights of the benefit differences when services are received from WV network providers and when they are received out-of-network with prior authorization.

Service	Member's Share of Costs	
	WV Network Providers	Out-of-Network Providers (With Prior Authorization)
Office visits—primary or specialty care	\$15	40% coinsurance*
Routine physicals	\$10	40% coinsurance*
Preventive services (mammograms, Pap smears, etc.)	\$0, covered in full	40% coinsurance*
Prenatal care	\$0*	40% coinsurance*
All services with coinsurance	20% coinsurance*	40% coinsurance**
Inpatient services	20% coinsurance*	\$500 copay + 40% coinsurance**
Ambulatory/outpatient surgery	\$50 copay + 20% coinsurance*	\$100 copay + 40% coinsurance**

\* after the in-network deductible

\*\* after the out-of-network deductible

Without prior authorization, there is no change to the cost sharing level. However, AccessWV changes the basis for its payment from the "reasonable and customary" amount to the PEIA reimbursement schedule. This leaves the member open to balance billing for the charges above AccessWV's allowed amount.

**SPECIAL PROGRAMS**

**Face-to-Face Care Management: Diabetes**

AccessWV’s Face-to-Face Diabetes Program is available statewide (subject to the availability of pharmacists) for those members who have diabetes. Under the program, members with diabetes agree to make regular visits to a participating pharmacist of their choosing for counseling and health education services. The pharmacist works with the member to ensure he/she gets the best diabetes care possible by monitoring:

- recommended testing and treatment of diabetes
- the member’s currently prescribed medicines and knowledge about how to take them
- physical activity and nutrition plan to assist the member in achieving optimal health

Members benefit from participating in the Face-to-Face Diabetes Program by not only improving their health and quality of life but also by saving money, since cost-sharing is waived for some prescription drugs, lab tests and supplies. AccessWV benefits from the member's better management of his or her illness through fewer health care costs from diabetes or its complications. **For an application packet, please contact the Plan Administrator at 1-888-680-7342 ext. 207.**

**Renal Care Management**

AccessWV’s Renal Care Management Program is handled by Wells Fargo TPA. The Renal Care Management Nurse works with members and their health care teams to coordinate quality, cost-effective care. Participation is open to any AccessWV member who is at risk for or who has been diagnosed with kidney disease. In addition, program information is mailed to potential participants who are identified through routine claims analysis or through the Face-to-Face Diabetes Programs.

Members may reach the Renal Care Management Nurse by calling 304 353-8746 or toll-free 1-800-624-8605 ext. 8746.

### **Other Care Management Services**

Care management extends the traditional utilization management process to incorporate a review and action plan for the current medical issue as well as a consideration of the impact of the member's other disease processes and environmental and social issues. Care management services are offered to members with various medical conditions who might benefit from these services. Services are provided by Wells Fargo TPA nurses.

### **WHAT IS NOT COVERED**

Some services are not covered by AccessWV regardless of medical necessity. Specific exclusions are listed below. If you have questions, please contact Wells Fargo TPA at 1-866-864-6142. The following services are NOT covered:

1. Aqua therapy.
2. Biofeedback, except in the case of mental health services.
3. Birth control drugs, devices, and services for dependent children.
4. Breast pumps.
5. Chemical dependency treatments when a patient leaves the hospital or facility against medical advice.
6. Coma stimulation.
7. Cosmetic or reconstructive surgery when not required as the result of accidental injury or disease or not performed to correct birth defects. Services resulting from or related to these excluded services also are not covered.
8. Custodial care, intermediate care (such as residential treatment centers), domiciliary care, respite care, rest cures, or other services primarily to assist in the activities of daily living, or for behavioral modification.
9. Dental implants, whether medically indicated or not.
10. Dental services including dental implants, routine dental care, x-rays, treatment of cysts or abscesses associated with the teeth, or any other dentistry and dental procedures.
11. Daily living skills training.
12. Duplicate testing, interpretation or handling fees.
13. Education, training and/or cognitive services, unless specifically listed as covered services.
14. Elective abortions.
15. Expenses for which the patient is not responsible, such as patient discounts and contractual discounts.
16. Expenses incurred as a result of illegal action, while incarcerated or while under the control of the court system.
17. Experimental, investigational or unproven services, unless pre-approved by Wells Fargo TPA.
18. Fertility drugs and services.
19. Foot care. Routine foot care including any of the following:

- Removal in whole or in part of: corns, calluses (thickening of the skin due to friction, pressure, or other irritation), hyperplasia (overgrowth of the skin), or hypertrophy (growth of tissue under the skin)
  - Cutting, trimming, or partial removal of toenails
  - Treatment of flat feet, fallen arches, or weak feet
  - Strapping or taping of the feet
20. Genetic testing.
  21. Glucose monitoring devices, except Bayer Ascensia models covered under the prescription drug benefit.
  22. Homeopathic medicine.
  23. Hospital days associated with non-emergency weekend admissions or other unauthorized hospital days prior to scheduled surgery.
  24. Hypnosis.
  25. Incidental surgery performed during medically necessary surgery.
  26. Infertility and sterility services of *in vitro* fertilization and gamete intrafallopian transfer (GIFT), embryo transport, surrogate parenting, and donor semen, any other method of artificial insemination, and any other related services.
  27. Maintenance chiropractic services.
  28. Marriage counseling.
  29. Medical equipment, appliances or supplies of the following types:
    - augmentative communication devices
    - bathroom scales
    - educational equipment
    - environmental control equipment such as air conditioners, humidifiers or dehumidifiers, air cleaners or filters, portable heaters, or dust extractors
    - equipment or supplies which are primarily for patient comfort or convenience, such as bathtub lifts or seats; massage devices; elevators; stair lifts; escalators; hydraulic van or car lifts; orthopedic mattresses; walking canes with seats; trapeze bars; child strollers; lift chairs; recliners; contour chairs; adjustable beds; or tilt stands
    - equipment which is widely available over the counter such as wrist stabilizers and knee supports
    - exercise equipment such as exercycles; parallel bars; walking, climbing or skiing machines
    - hearing aids
    - hygienic equipment such as bed baths, commodes, and toilet seats
    - motorized scooters
    - nutritional supplements, food liquidizers or food processors
    - orthopedic shoes, unless attached to a brace
    - over-the-door and/or gravity traction
    - professional medical equipment such as blood pressure kits or stethoscopes
    - supplies such as tape, alcohol, Q-tips/swabs, gauze, bandages, thermometers aspirin, diapers (adult or infant), heating pads or ice bags
    - vibrators
    - whirlpool pumps or equipment

- wigs or wig styling
30. Medical rehabilitation and any other services that are primarily educational or cognitive in nature.
  31. Mental health or chemical dependency services to treat mental illnesses which will not substantially improve beyond the patient's current level of functioning.
  32. Optical services. Routine eye examinations, refractions, eye glasses, contact lenses and fittings. Glasses and/or contact lenses following cataract surgery are not covered.
  33. Orientation therapy.
  34. Orthodontia services.
  35. Orthotripsy.
  36. Physical examinations and routine office visits except those covered under the "Routine Periodic Physicals" benefit.
  37. Personal comfort and convenience items or services (whether on an inpatient or outpatient basis) such as television, telephone, barber or beauty service, guest services, and similar incidental services and supplies, even when prescribed by a physician.
  38. Physical conditioning and work hardening. Expenses related to physical conditioning programs and work hardening such as athletic training, body building, exercise, fitness, flexibility, diversion, or general motivation.
  39. Physical, psychiatric, or psychological examinations, testing, or treatments not otherwise covered under the plan, when such services are:
    - conducted for purposes of medical research;
    - for participation in athletics;
    - needed for marriage or adoption proceedings;
    - related to employment;
    - related to judicial or administrative proceedings or orders;
    - to obtain or maintain a license or official document of any type; or
    - to obtain or maintain insurance.
  40. Pregnancy-related conditions for dependent children.
  41. Provider charges for phone calls, prescription refills, or physician-to-patient phone consultations.
  42. Radial keratotomy and other surgery to correct vision.
  43. Reversal of sterilization and associated services and expenses.
  44. Safety devices. Devices used specifically for safety or to affect performance primarily in sports related activities.
  45. Screenings, except those specifically listed as covered benefits.
  46. Services rendered by a provider with the same legal residence as a member, or who is a member of the policyholder's family. This includes spouse, brother, sister, parent, or child.
  47. Services rendered outside the scope of a provider's license.
  48. Sex transformation operations and associated services and expenses.
  49. Skilled nursing services provided in the home, except intermittent visits covered under the "Home Health Services" benefit.
  50. Stimulation therapy.
  51. Take-home drugs provided at discharge from a hospital.
  52. TMJ. Treatment of temporomandibular joint (TMJ) disorders. Including intraoral prosthetic devices or any other method of treatment to alter vertical dimension or for

temporomandibular joint dysfunction not caused by documented organic disease or acute physical trauma.

53. The difference between private and semi-private room charges.
54. Therapy and related services for a patient showing no progress.
55. Therapies rendered outside the United States that are not medically recognized within the United States.
56. Transportation other than medically necessary emergency ambulance services, or as approved under the "Organ Transplant Network" benefit.
57. War-related injuries or illnesses. Treatment in a state or federal hospital for military or service-related injuries or disabilities.
58. Weight loss. Health services and associated expenses intended primarily for the treatment of obesity and morbid obesity, including wiring of the jaw, weight control programs, weight control drugs, screening for weight control programs, and services of a similar nature.
59. Work-related injury or illness.

## How to File a Claim

### FILING A MEDICAL CLAIM

Medical claims are processed by Wells Fargo TPA and should be submitted to:

**Wells Fargo TPA  
P.O. Box 2451  
Charleston, WV 25329-2451**

This post office box should be used only for AccessWV claims. Please do not submit AccessWV claims to other Wells Fargo TPA office boxes. This will only delay their processing. To process a medical claim, Wells Fargo TPA requires a complete itemization of charges including:

1. patient's name
2. nature of the illness or injury
3. date(s) of service
4. type of service(s)
5. charge for each service
6. diagnosis and procedure codes
7. identification number of the provider, and
8. medical ID number of the policyholder

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

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

If your claim is for an illness or injury wrongfully or negligently caused by someone else, and you expect to be reimbursed by another party or insurance plan, you must file a claim with AccessWV within six (6) months of the date of service to ensure that the covered services will be paid. Later, if you receive payment for the expenses, you will have to repay the amount you received from AccessWV. See "Subrogation and Reimbursement" on page 73 for details.

### **Claims Incurred Outside of the U.S.A.**

If you or a covered dependent incur medical expenses while outside the United States, you may be required to pay the provider yourself. Request an itemized bill containing all the information listed above from your provider and submit the bill along with a claim form to Wells Fargo TPA or the prescription drug administrator. Wells Fargo TPA or the prescription drug administrator will determine, through a local banking institution, the currency exchange rate and you will be reimbursed according to the terms of AccessWV.

### **Appealing a Claim or Denial of Medical Service**

If you do not agree with how a medical claim has been paid or a decision that has been made regarding your medical benefits coverage, you may appeal the decision. Please see "Your Right to Appeal Decisions Made by AccessWV" on page 66.

## **Prescription Drug Benefits**

Along with your medical coverage, you also have prescription drug coverage. The prescription drug program is administered by Express Scripts, Inc ("Express Scripts"). There are three parts to the program:

- The Retail Pharmacy Program gives you access to local participating pharmacies to get your prescriptions filled.
- The Express Scripts Mail Service Pharmacy Program lets you order your prescriptions through the mail, saving you time and money by having your maintenance medications delivered to your door.
- The CuraScript Specialty Medication Program provides your common specialty medications through the mail, saving you time by having your medications delivered to your door or to your physician's office.

Your prescription drug benefits pay for a wide range of medications, with differing copays depending on where you purchase those drugs, and how large a supply you buy.

## WHAT YOU PAY

### **Pharmacy Deductible**

During any plan year, if you or your eligible dependents incur expenses for covered prescription drugs, you must meet a pharmacy deductible before the plan begins to pay. The pharmacy deductibles for individual and family coverage are shown in the **Summary of Benefits**. You will pay the deductible amount before the plan begins to pay.

The family deductible is twice the individual deductible. The family deductible is divided up among the family members. No one member of the family will pay more than the individual deductible. Once that person has met the individual deductible, the plan will begin paying on that person. When another member of the family meets the individual deductible, then the plan will begin paying on the entire family. Alternatively, all members of the family may contribute to the family deductible with no one person meeting the individual deductible. Once the family deductible is met, the plan pays on all members of the family. After the deductible is met, you will pay copays based on the amount and type of drug you are taking. The chart on page 52 shows the copays.

### **Copays**

Under your prescription drug plan, once you meet your deductible, you pay a copay to obtain drugs. Copays are the portion of the cost that, under your plan, you are required to pay for new or refill prescriptions until your drug out-of-pocket maximum is met. The rest of the cost is paid by AccessWV. Several factors determine your copay.

### **Generic Drugs**

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

### **West Virginia Preferred Drug List (WVPDL) ("Formulary")**

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

Here's how the copay structure works:

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

Sometimes your doctor may prescribe a medication to be “dispensed as written” when a WVPDL brand name or generic alternative drug is available. As part of your AccessWV coverage, an Express Scripts pharmacist or your retail pharmacist may discuss with your doctor whether an alternative formulary or generic drug might be appropriate for you. Your doctor always makes the final decision on your medication, and you can always choose to keep the original prescription at the higher copay.

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

If you have any questions about the copay structure or about the Formulary, please call Express Scripts Member Services at 1-877-256-4680.

<b>Prescription Drug Copayments</b>			
	<b>Up to 34 day supply</b>	<b>35 to 68 day supply*</b>	<b>69 to 90 day supply*</b>
<b>Generic drug</b>	\$5	\$10	\$15
<b>Brand name drug on WV Preferred Drug List</b>	\$15	\$30	\$45
<b>Brand name drug <u>not</u> on WV Preferred Drug List</b>	\$50	\$100	\$150
<b>Common Specialty Medications**</b>	\$50	Not available	Not available
* For maintenance medications only. See the "Maintenance Medications" section for the list of qualifying medications. You may be able to get a discount on your maintenance medications through a Retail Maintenance Network Pharmacy or through Mail Service. Read on for details.			
**Should your doctor prescribe or you request the brand name specialty medication when a generic drug is available, you must pay the difference in price, plus the applicable Specialty Medication copayment.			
Should your doctor prescribe or you request the brand name drug when a generic is available, you must pay the difference in price, plus the applicable generic copayment.			

**BENEFIT LIMITS****Six-Month Waiting Period for Pre-Existing Conditions**

If you have a pre-existing condition that requires a six-month waiting period before claims will be paid for your condition, your pharmacist must receive a prior authorization before *any* prescription can be filled. This may require a 24-hour wait before the pharmacist receives the approval or denial. If coverage is denied due to the waiting period, you will be required to pay the full amount for the prescription. This applies only to prescriptions that relate to the pre-existing condition. New prescriptions for other illness or injury will be paid as outlined.

**Pharmacy Out-of-Pocket Maximum**

AccessWV has a pharmacy out-of-pocket maximum of \$2,000 for individual coverage and \$4,000 for family coverage. The out-of-pocket maximum only includes actually copays, not deductibles or other charges and is separate from your medical out-of-pocket maximum.

Only your copayments for generic, brand formulary or non formulary drugs count toward your out-of-pocket maximum. The \$3 copay for use of an out of network pharmacy and your costs when requesting a brand name drug instead of a generic are not counted.

Once you have met the drug out-of-pocket maximum, you are eligible to have AccessWV cover the entire cost of your prescriptions for the balance of the plan year until you reach the annual drug benefit maximum of \$25,000 per member per plan year or the combined lifetime medical and drug benefit maximum of \$1,000,000 per member. Certain restrictions apply. You must use an in-network pharmacy. If you choose to use an out-of-network pharmacy or request a brand name drug when a generic is available, you will still incur costs.

**Annual Pharmacy Benefit Maximum**

AccessWV has an annual benefit limit of \$25,000 per member for each plan year for pharmacy benefits. Annual benefit maximums include only the actual dollars paid by the plan on behalf of the member (not the member's share of costs.) Once the annual pharmacy limit is reached, AccessWV will no longer pay benefits for prescription drugs for that member for that plan year.

Once the annual benefit maximum is reached, the member must continue to pay premiums to maintain membership with AccessWV. If the member chooses to cancel coverage, he or she must wait 12 months after termination of coverage to re-apply to AccessWV and will be subject to a waiting period for pre-existing conditions.

Medical benefits have a separate \$200,000 benefit maximum per member per plan year. See "Benefit Limits" on page 20.

**Lifetime Combined Benefit Maximum**

AccessWV will pay a maximum of \$1,000,000 in total benefits per member during each member's lifetime. This maximum includes benefits paid for medical services and prescription drugs. Once this maximum is reached, the member's coverage will be terminated by the Plan. If

the member is the policyholder, coverage will be terminated for the policyholder and dependents. If the dependent reaches the maximum, the dependent will be removed from coverage.

## GETTING YOUR PRESCRIPTIONS FILLED

### **Using a Retail Network Pharmacy**

Express Scripts has a nationwide network of pharmacies. To get a prescription filled, simply present your medical/prescription drug ID card at a participating Express Scripts pharmacy. You can purchase both acute and maintenance medications at an Express Scripts network pharmacy. You may refill your prescriptions when 75 percent of your medication is used up.

Your ID card contains personalized information that identifies you as an AccessWV member, and ensures that you receive the correct coverage for your prescription drugs. If you use an Express Scripts pharmacy, you do not have to file a claim form. The pharmacist will file the claim for you online, and will let you know your portion of the cost.

If you use a network pharmacy and choose not to have the pharmacist file the claim for you online, you will pay 100 percent of the prescription price at the time of purchase. You may submit the receipt with a completed claim form to Express Scripts for reimbursement. The prescription receipt must be attached to the form. You will usually be reimbursed within 21 days from receipt of your claim form. You will be reimbursed the amount AccessWV would have paid, less your required copay, your deductible (if applicable), and a \$3 processing fee. This reimbursement may be less than you paid for the prescription. If you need claim forms, call Express Scripts Member Services at 1-877-256-4680 or visit their website at [www.express-scripts.com](http://www.express-scripts.com).

To find the participating pharmacies nearest you, call Express Scripts Member Services at 1-877-256-4680 and use the voice-activated Pharmacy Locator System. If you have Internet access, you can find a pharmacy online at [www.express-scripts.com](http://www.express-scripts.com).

### **Using the Retail Maintenance Network**

If you take a drug on a long-term basis, you may be able to purchase a 90-day supply of that drug if it is on the maintenance list (see the “Maintenance Medications” list later in this section.). AccessWV offers a Retail Maintenance Network of pharmacies that will fill your 90-day prescription for just two copays. You can buy two months and get one month free. Check with your local pharmacist to verify participation in the Retail Maintenance Network.

### **Using Non-Network Pharmacies**

If you use a non-participating pharmacy, you will pay 100 percent of the prescription price at the time of purchase, and submit a completed claim form to Express Scripts. The prescription receipt must be attached to the form. You will usually be reimbursed within 21 days from receipt of your claim form. You will be reimbursed the amount AccessWV would have paid at a participating pharmacy, less your required copay, your deductible (if applicable), and a \$3 fee. This reimbursement may be less than you paid for the prescription. If you need claim forms, call

Express Scripts Member Services at 1-877-256-4680 or visit their website at [www.express-scripts.com](http://www.express-scripts.com).

**Using the Express Scripts Mail Service Pharmacy Program**

Express Scripts provides a convenient mail service pharmacy program for AccessWV members. You may use the mail service pharmacy if you are taking medication to treat an ongoing health condition, such as high blood pressure, asthma, or diabetes.

When you use the mail service pharmacy, you can order up to a 90-day supply of a medication on the maintenance list, as prescribed by your doctor, and pay only two copays. You may refill your prescription when 66 percent of the medication is used up. Express Scripts’ licensed professionals fill every prescription following strict quality and safety controls. If you have questions about your prescription, registered pharmacists are available around the clock to consult with you.

<b>Maintenance Drug Copayments</b>		
<b>Via Retail Maintenance Network or Mail Service Pharmacy</b>		
	<b>Up to 34 day supply</b>	<b>35 to 90 day supply*</b>
<b>Generic drug</b>	\$5	\$10
<b>Brand name drug on WV Preferred Drug List</b>	\$15	\$30
<b>Brand name drug <u>not</u> on WV Preferred Drug List</b>	\$50	\$100
* For maintenance medications only. See the “Maintenance Medications” section for the list of qualifying medications.		
Should your doctor prescribe or you request the brand name drug when a generic is available, you must pay the difference in price, plus the applicable copayment.		

**New Prescriptions and the Mail Service Pharmacy**

If you want to use the mail service pharmacy the first time you are prescribed a medication that you will need on an ongoing basis, ask your doctor for two prescriptions: the first for a 14-day supply to be filled at a participating retail pharmacy; the second, for up to a 90-day supply, to be filled through the mail service pharmacy.

There are several ways to submit your mail service prescriptions. Just follow the steps below. Some restrictions apply.

- **Ordering new prescriptions.** Ask your doctor to prescribe your medication for up to a 90-day supply for maintenance medications, plus refills if appropriate. Mail your prescription and required copay along with an order form in the envelope provided. Or ask your doctor to fax your order to 1-800-636-9494. You will need to give your doctor your member ID number located on your ID card.

- **Refilling your medication.** A few simple precautions will help ensure you do not run out of your prescription. Remember to reorder on or after the refill date indicated on the refill slip. Or reorder when you have less than 14 days of medication left.
  - **Refills online:** Log on to Express Scripts' website at [www.express-scripts.com](http://www.express-scripts.com). Have your member ID number, the prescription number (the 9-digit number on your refill slip), and your credit card ready when you log on.
  - **Refills by phone:** Call 1-877-256-4680 and use the automated refill system. Have your member ID number, refill slip with the prescription number, and your credit card ready.
  - **Refills by mail:** Use the refill and order forms provided with your medication. Mail them with your copy.
- **Delivery of your medication.** Prescription orders receive prompt attention and, after processing, are usually sent to you by U.S. mail or UPS within two weeks. Your enclosed medication will include instructions for refills, if applicable. Your package may also include information about the purpose of the medication, correct dosages, and other important details.
- **Paying for your medication.** You may pay by check, money order, VISA, MasterCard, Discover or American Express. Debit cards are not accepted for payment.

*The pharmacist's judgment and dispensing restrictions, such as quantities allowable, govern certain controlled substances and other prescribed drugs. Federal law prohibits the return of any dispensed prescription medicines.*

## PRIOR AUTHORIZATION FOR SPECIFIED DRUGS

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

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

The medications listed below require prior authorization:

1. adalimumab (Humira<sup>®</sup>)\*
2. anakinra (Kineret<sup>®</sup>)\*
3. becaplermin (Regranex<sup>®</sup>)
4. botulinum toxin Type A (Botox<sup>®</sup>)\*
5. Brand-name medically necessary prescriptions. If the medication your doctor prescribes is a multi-source drug (that is, more than one manufacturer markets the drug), and there is an FDA-approved or "A-B rated" generic on the market, then AccessWV will pay only for the generic version, unless your physician provides medical justification for coverage of the brand-name drug. If prior authorization is granted, these drugs will be covered as non-preferred brand-name drugs.
6. ciclopirox (Penlac<sup>®</sup>)
7. erythroid stimulants (Epogen<sup>®</sup>, Procrit<sup>®</sup>, Aranesp<sup>®</sup>)\*
8. etanercept (Enbrel<sup>®</sup>)\*
9. fentanyl (Actiq<sup>®</sup> and Duragesic<sup>®</sup>)
10. fluconazole (Diflucan<sup>®</sup>)
11. growth hormones\*
12. inhaled insulin (Exubera<sup>®</sup>)
13. itraconazole (Sporanox<sup>®</sup>)
14. legend oral contraceptives for dependents (covered for treatment of medical conditions only)
15. leuprolide (Lupron<sup>®</sup>, Lupron Depot<sup>®</sup>)\*
16. modafinil (Provigil<sup>®</sup>) for adults (*for pharmacy benefits, AccessWV defines "adults" as 19 years of age and older.*)
17. botulinum toxin Type B (Myobloc<sup>®</sup>)\*
18. oxycodone hydrochloride (Oxycontin<sup>®</sup>)
19. tazarotene (Tazorac<sup>®</sup>)
20. terbinafine (Lamisil<sup>®</sup>)
21. teriparatide (Forteo<sup>®</sup>)\*
22. tretinoin cream (e.g. Retin-A) for individuals 27 years of age or older
23. topiramate (Topamax<sup>®</sup>)
24. vacation supplies of medication for foreign travel (allow 7 days for processing)
25. voriconazole (VFEND<sup>®</sup>)
26. zonisamide (Zonegran<sup>®</sup>)

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

This list is subject to change, if circumstances arise which require adjustment. If there are additions to the list, changes will be communicated to affected members and will be included in the next edition of the Policy. For up-to-date information on drugs requiring prior authorization, please call AccessWV customer service on 1-888-680-7342 ext. 207.

If you wish to request a supply of medication for use during foreign travel, you must provide official documentation of this travel with your request. Please send to: AccessWV Customer

Service, c/o PEIA; State Capitol Complex, Building 5, Room 1001; 1900 Kanawha Boulevard East; Charleston, WV 25305.

## DRUGS WITH SPECIAL LIMITATIONS

### Step Therapy

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

To promote use of cost-effective first-line therapy, AccessWV uses step therapy in the following therapeutic classes:

- Angiotensin-Converting Enzyme (ACE) Inhibitors (Accuretic<sup>®</sup>, Accupril<sup>®</sup>, Aceon<sup>®</sup>, Altace<sup>®</sup>, Capoten<sup>®</sup>, Capozide<sup>®</sup>, Lexxel<sup>®</sup>, Lotesin/HCT<sup>®</sup>, Lotrel<sup>®</sup>, Mavik<sup>®</sup>, Monopril/HCT<sup>®</sup>, Prinivil<sup>®</sup>, Prinizide<sup>®</sup>, Tarka<sup>®</sup>, Uniretic<sup>®</sup>, Univasc<sup>®</sup>, Vasotec<sup>®</sup>, Vaseretic<sup>®</sup>)
- Angiotensin II Receptor Antagonists (Atacand/HCT<sup>®</sup>, Teveten/HCT<sup>®</sup>, Avapro<sup>®</sup>, Cozaar<sup>®</sup>, Benicar/HCT<sup>®</sup>, Micardis/HCT<sup>®</sup>, Diovan/HCT<sup>®</sup>, Avalide<sup>®</sup>, Hyzaar<sup>®</sup>)
- Anti-depressants (Cymbalta<sup>®</sup>, Effexor/XR<sup>®</sup>, Symbyax<sup>®</sup>, Wellbutrin XL<sup>®</sup>)
- Anti-hypertensives (Covera HS<sup>®</sup>, Verelan PM<sup>®</sup>, Norvasc<sup>®</sup>, Cardene SR<sup>®</sup>, Sular<sup>®</sup>, DynaCirc CR<sup>®</sup>)
- Beta Blockers (Sectral<sup>®</sup>, Tenormin<sup>®</sup>, Kerlone<sup>®</sup>, Zebeta<sup>®</sup>, Coreg<sup>®</sup>, Trandate<sup>®</sup>, Lopressor<sup>®</sup>, Toprol XL<sup>®</sup>, Corgard<sup>®</sup>, Levatol<sup>®</sup>, Visken<sup>®</sup>, Inderal<sup>®</sup>, Inderal<sup>®</sup> LA, InnoPran XL<sup>®</sup>, Blocadren<sup>®</sup>, Tenoretic<sup>®</sup>, Ziac<sup>®</sup>, Lopressor<sup>®</sup> HCT, Corzide<sup>®</sup>, Inderide<sup>®</sup>, Timolide<sup>®</sup>)
- Bisphosphonates (Fosamax<sup>®</sup>, Fosamax Plus D<sup>™</sup>, Actonel<sup>®</sup>, Actonel<sup>®</sup> with Calcium, Boniva<sup>®</sup>)
- Cholesterol-lowering medications (Advicor<sup>®</sup>, Altoprev<sup>®</sup>, Caduet<sup>®</sup>, Crestor<sup>®</sup>, Lescol<sup>®</sup>, Lipitor<sup>®</sup>, Pravachol<sup>®</sup>, Vytorin<sup>®</sup>, Zetia<sup>®</sup>)
- Inspra<sup>®</sup>
- Leukotriene Inhibitors (e.g., Accolate<sup>®</sup>, Singulair<sup>®</sup>)
- Lyrica<sup>®</sup>
- Nasal Steroids (Rhinocort Aqua<sup>™</sup>, Flonase<sup>®</sup>, Beconase AQ<sup>®</sup>, Nasacort AQ<sup>®</sup>, Nasarel<sup>®</sup>, Nasonex<sup>®</sup>)
- Non Sedating Antihistamines (Zyrtec<sup>®</sup>, Allegra<sup>®</sup>, Clarinex<sup>®</sup>, Clarinex<sup>®</sup> Reditabs<sup>®</sup>)
- Non-Steroidal Anti-Inflammatory Drugs (brand-name NSAID e.g., Celebrex<sup>®</sup>, Arthrotec<sup>®</sup>, Mobic<sup>®</sup>)
- Overactive Bladder (Ditropan<sup>®</sup>, Ditropan XL<sup>®</sup>, Oxytrol<sup>®</sup>, Detrol<sup>®</sup>, Detrol LA<sup>®</sup>, Sanctura<sup>®</sup>, Vesicare<sup>®</sup>, Enablex<sup>®</sup>)
- Proton Pump Inhibitors (e.g., Prilosec<sup>®</sup>, Prevacid<sup>®</sup>, Nexium<sup>®</sup>, Aciphex<sup>®</sup>, Protonix<sup>®</sup>, Zegerid<sup>®</sup>)
- Sedative Hypnotics (Ambien<sup>®</sup>, Ambien CR<sup>™</sup>, Sonata<sup>®</sup>, Lunesta<sup>™</sup>, Rozerem<sup>™</sup>)

- Selective Serotonin Reuptake Inhibitors (e.g., Celexa<sup>®</sup>, Lexapro<sup>®</sup>, Luvox<sup>®</sup>, Paxil<sup>®</sup>, Paxil CR<sup>®</sup>, Prozac<sup>®</sup>, Prozac Weekly<sup>®</sup>, Zoloft<sup>®</sup>)
- Straterra<sup>®</sup>
- Xopenex<sup>®</sup>

This list is subject to change if circumstances arise which require adjustment. If a therapeutic class is added, the change will be communicated to affected members and will be included in the next edition of the Policy. If you would like an update on drugs requiring step therapy, please call AccessWV customer service on 1-888-680-7342 ext. 207.

### Quantity Limits

Under the AccessWV Prescription Drug Program, certain drugs have preset coverage limitations (quantity limits). Quantity limits ensure that the quantity of units supplied in each prescription remains consistent with clinical dosing guidelines and AccessWV's benefit design. Quantity limits encourage safe, effective and economic use of drugs and ensure that members receive quality care. Select medications from the quantity limit list are provided in the chart below. If you are taking one of the medications listed below and you need to get more of the medication than AccessWV allows, ask your pharmacist or doctor to call RDT to discuss your refill options.

1. Anzemet<sup>®</sup>, Emend<sup>®</sup>, Kytril<sup>®</sup>, Zofran<sup>®</sup> coverage limitations:
  - Anzemet<sup>®</sup> is limited to 1 tablet per prescription.
  - Emend<sup>®</sup> 40 mg is limited to 1 capsule per prescription.
  - Emend<sup>®</sup> 80mg is limited to 2 capsules per prescription.
  - Emend<sup>®</sup> 125mg is limited to 1 capsule per prescription.
  - Emend<sup>®</sup> Tri-fold Pack is limited to 1 package per prescription.
  - Kytril<sup>®</sup> is limited to 2 tablets per prescription.
  - Zofran<sup>®</sup> 24 mg is limited to 1 tablet per prescription.
  - Zofran<sup>®</sup> 4 mg and 8 mg are limited to 12 tablets per prescription.
  - Zofran<sup>®</sup> Solution is limited to 3 bottles per prescription.
2. Diflucan<sup>®</sup> 150 mg is limited to two tablets per prescription.
3. Migraine medications. Coverage is limited to quantities listed in the following chart.
4. New drugs approved by the FDA that have not yet been reviewed by Express Scripts' Pharmacy and Therapeutics Committee will have a non-preferred status. AccessWV reserves the right to exclude a drug or technology from coverage until it has been proven effective.
5. Sedative hypnotics (Ambien<sup>®</sup>, Ambien CR<sup>™</sup>, Sonata<sup>®</sup>, Lunesta<sup>™</sup> and Rozerem<sup>™</sup>.) Coverage is limited to 15 tablets per 30 days.
6. Tamiflu<sup>®</sup> and Relenza<sup>®</sup>. Coverage is limited to one course of treatment within 180 days. Additional quantities require prior authorization from RDT.
7. Toradol. Coverage is limited to one course of treatment (5 days) per 90-day period.

<b>Generic Name</b>	<b>Brand Name</b>	<b>Quantity Limit for Dispensing</b>	<b>Total Quantity Limit within 28-Day Period</b>
Almotriptan tablets 6.25 mg, 12.5 mg	Axert <sup>®</sup> - Pharmacia	6 tablets	18 tablets
Dihydroergotamine nasal spray	Migranal <sup>®</sup> - Novartis	4 spray devices	2 kits = 8 unit dose sprays
Eletriptan tablets 20mg, 40mg	Relpax <sup>®</sup> - Pfizer	6 tablets	18 tablets
Frovatriptan tablets 2.5 mg	Frova <sup>®</sup> - ELAN	9 tablets	27 tablets
Naratriptan tablets 1 mg, 2.5 mg	Amerge <sup>®</sup> - GSK	9 tablets	18 tablets
Rizatriptan tablets 5 mg, 10 mg, orally disintegrating tablets	Maxalt-MLT <sup>®</sup> - Merck	6 tablets	24 tablets
Rizatriptan tablets 5 mg, 10 mg	Maxalt <sup>®</sup> - Merck	6 tablets	24 tablets
Sumatriptan injection syringes	Imitrex <sup>®</sup> - GSK	1 kit (2 syringes)	8 kits = 16 injections
Sumatriptan injection vials	Imitrex <sup>®</sup> - GSK	2 vials	16 vials
Sumatriptan nasal spray 20 mg	Imitrex <sup>®</sup> - GSK	6 spray devices	3 boxes = 18 unit dose spray devices
Sumatriptan nasal spray 5 mg	Imitrex <sup>®</sup> - GSK	6 spray devices	6 boxes = 36 unit dose spray devices
Sumatriptan tablets 25 mg, 50 mg, 100 mg	Imitrex <sup>®</sup> - GSK	9 tablets	18 tablets
Zolmitriptan tablets 2.5 mg, 5 mg, orally disintegrating tablets	Zomig-ZMT <sup>®</sup> - AstraZeneca	6 tablets for 2.5 mg 3 tablets for 5 mg	18 tablets
Zolmitriptan tablets 2.5 mg, 5 mg	Zomig <sup>®</sup> - AstraZeneca	6 tablets for 2.5 mg 3 tablets for 5 mg	18 tablets

## MAINTENANCE MEDICATIONS

You may receive up to a 90-day supply of ONLY the medications and classes listed below.

- |  |  |
|--|--|
| 1. alendronate sodium (Fosamax <sup>®</sup> )  | 22. gastrointestinal, colitis  |
| 2. antiarthritics                              | 23. glaucoma agents  |
| 3. anticoagulants                              | 24. gout medications   |
| 4. anticonvulsants                             | 25. hormones, misc.  |
| 5. antidementia drugs                          | 26. immunosuppressive agents   |
| 6. antihypertensives                           | 27. legend vitamins (including legend hematinics, vitamin K)                     |
| 7. antiparkinsonism agents                     | 28. leukotriene receptor antagonists (asthma agents)                             |
| 8. antispasmodics: urinary tract               | 29. lipotropics (cholesterol lowering agents)                                    |
| 9. benign prostatic hypertrophy/micturation    | 30. mucolytics (pulmonary agents)  |
| 10. bronchodilators                            | 31. oral contraceptives  |
| 11. calcitonin (Miacalcin <sup>®</sup> )       | 32. legend potassium   |
| 12. cardiovascular agents                      | 33. raloxifene (Evista <sup>®</sup> )  |
| 13. cholinergic stimulants (urinary retention) | 34. risedronate (Actonel <sup>®</sup> )  |
| 14. corticosteroids, bronchial                 | 35. selective serotonin reuptake inhibitors (antidepressants in this class only) |
| 15. cromolyn sodium (Intal <sup>®</sup> )      | 36. thyroid medications  |
| 16. diabetic therapies                         | 37. tuberculosis medications   |
| 17. digestants                                 | 38. xanthines (asthma agents)  |
| 18. disposable needles and syringes            |  |
| 19. diuretics                                  |  |
| 20. enzymes, systemic                          |  |
| 21. estrogens and progestins                   |  |

## COMMON SPECIALTY MEDICATIONS

AccessWV uses CuraScript as the exclusive pharmacy for common specialty medications. This means you will only be able to purchase these specialty medications through CuraScript. The medication will be mailed to either your home or physician's office. Most often these are self-administered injections. After you have met your prescription drug deductible, the copay will be \$50 for any medications in this class. Please refer to the list of the most "Common Specialty Medications" in the chart below. These drugs are not available in 90-day supplies.

In addition to providing these specialty medications to our members, CuraScript offers:

- a Patient Care Coordinator who serves as your personal advocate and point of contact.
- delivery of your specialty medications directly to you or your doctor.
- supplies to administer your medications — at no additional cost.
- care management programs to help you get the most from your medications.

If you are prescribed one of these common specialty medications, call CuraScript toll-free at 1-866-413-4135 (8 a.m. – 9 p.m., Eastern time, Monday-Friday and 9 a.m. – 1 p.m., Eastern time,

Saturday). A Patient Care Coordinator will contact your physician and work with you to schedule a delivery time for the medication.

### Common Specialty Medications List

Drug Name	Category	Drug Name	Category
Acthar	Multiple Sclerosis	Myobloc [PA]	Neurologic
Aldurazyme	Mucopolysaccharidosis	Neulasta	Neutropenia
Aranesp [PA]	Anemia	Neumega	Hematopoietic
Arixtra	Anti-Coagulant	Neupogen	Neutropenia
Avonex	Multiple Sclerosis	Nexavar	Anti-Neoplastic; Immunosuppressant
Betaseron	Multiple Sclerosis	Norditropin [PA]	Growth Hormone
Botox [PA]	Migraine, Cerebral Palsy	Nutropin [PA]	Growth Hormone
Cerezyme	Gaucher Disease	Pegasys	Hepatitis C
Copaxone	Multiple Sclerosis	Peg-Intron	Hepatitis C
Copegus	Hepatitis C	Procrit [PA]	Anemia
Desferal	Diagnostic	Protropin [PA]	Growth Hormone
Enbrel [PA]	Rheumatoid Arthritis	Pulmozyme	Cystic Fibrosis
Epogen [PA]	Anemia	Rebetol	Hepatitis C
Fabrazyme	Fabry Disease	Rebetron	Hepatitis C
Forteo [PA]	Osteoporosis	Rebif	Multiple Sclerosis
Fragmin	Anti-Coagulant	Revlimid	Anti-Neoplastic; Immunosuppressant
Fuzeon	HIV	Ribavirin	Hepatitis C
Genotropin [PA]	Growth Hormone	Rimso-50	Anti-Neoplastic
Geref [PA]	Growth Hormone	Roferon-A	Anti-Neoplastic
Gleevec	Anti-Neoplastic	Saizen [PA]	Growth Hormone
Humatrope [PA]	Growth Hormone	Sensipar	Hyperparathyroidism
Humira [PA]	Rheumatoid Arthritis	Serostim [PA]	Growth Hormone
Increlex [PA]	Insulin-like Growth Factor	Sutent	Anti-Neoplastic
Infergen	Hepatitis C	Tarceva	Anti-Neoplastic
Innohep	Anti-Coagulant	Temodar	Anti-Neoplastic
Intron A	Interferons	Tev-Tropin [PA]	Growth Hormone
Iressa	Anti-Neoplastic	Thalomid	Anti-Neoplastic
Kineret [PA]	Rheumatoid Arthritis	Thyrogen Kit	Diagnostic
Leukine	Hematopoietic	Tobi	Cystic Fibrosis
Leuprolide [PA]	Anti-Neoplastic	Xeloda	Anti-Neoplastic
Lovenox	Anti-Coagulant	Zavesca	Gaucher Disease
Lupron [PA]	Anti-Neoplastic	Zorbtive [PA]	Growth Hormone
Lupron Depot [PA]	Endometriosis, Anti-Neoplastic, Precocious Puberty		

(PA) This drug requires Prior Authorization from RDT.

This list is not all inclusive and is subject to change.

**DIABETES MANAGEMENT**

- **Blood Glucose Monitors:** Covered diabetic members can receive a free Bayer Ascensia Breeze2<sup>®</sup> or Ascensia Contour<sup>®</sup> blood glucose monitor with a current prescription. Simply ask your pharmacist, and he or she will contact Bayer by fax or mail to request the monitor.
- **Glucose Test Strips:** The plan covers only Bayer Ascensia<sup>®</sup> Autodisc or Ascensia<sup>®</sup> Microfill test strips at the preferred copay of \$15 per 34-day supply. Other brands require a 100 percent copay; that is, you will pay the full cost for them.
- **Needles/Syringes and Lancets:** You can obtain a supply of disposable needles/syringes and lancets for the copays listed below:

Coverage	Needles/Syringes	Lancets
<i>At the retail pharmacy</i>		
Up to 34 day supply	\$10	\$5
35 to 68 day supply	\$20	\$10
69 to 90 day supply	\$30	\$15
<i>Through Retail Maintenance Network and Mail Service Pharmacy</i>		
Up to 34 day supply	\$10	\$5
35 to 90 day supply	\$20	\$10

**Appealing a Claim or Denial of a Prescription Drug**

If you do not agree with how a prescription drug claim has been paid or a decision that has been made regarding your drug coverage, you may appeal the decision. Please see "Your Right to Appeal Decisions Made by AccessWV" on page 66.

**DRUGS THAT ARE NOT COVERED**

The AccessWV Pharmacy Benefit does not cover the following medications or services:

1. Anorexients (any drug used for the purpose of weight loss)
2. Anti-wrinkle agents (e.g., Renova<sup>®</sup>)
3. Birth control drugs or contraceptive devices for dependent children
4. Bleaching agents (e.g., Eldopaque<sup>®</sup>, Eldoquin Forte<sup>®</sup>, Melanex<sup>®</sup>, Nuquin<sup>®</sup>, Solaquin<sup>®</sup>)
5. Charges for the administration or injection of any drug
6. Drugs dispensed by a hospital, clinic or physician's office
7. Drugs labeled "*Caution-limited by federal law to investigational use*" or experimental drugs not approved by the FDA, even though a charge is made to the individual
8. Drugs requiring prior authorization when prescribed for uses not approved by the FDA
9. Drugs requiring a prescription by state law (state controlled), but not by federal law

10. Erectile dysfunction medications
11. Fertility drugs
12. Fioricet<sup>®</sup> with Codeine
13. Fiorinal<sup>®</sup> with Codeine
14. Hair growth stimulants
15. Homeopathic medications
16. Medication which is to be taken by or administered to an individual, in whole or in part, while he or she is a patient in a hospital, sanitarium, or extended care facility
17. Medication for which the cost is recoverable under any Workers' Compensation or occupational disease law, through any state or governmental agency, or medication furnished by any other drug or medical service for which no charge is made to the member
18. Non-legend drugs (except when included in a compound with a legend drug)
19. Pentazocine/Acetaminophen (Talacen<sup>®</sup>)
20. Prescription drug charges not filed within 6 months of the purchase date, if AccessWV is the primary insurer, or within 6 months of the processing date on the Explanation of Benefits (EOB) from the other plan, if AccessWV is secondary
21. Replacement medications for lost or stolen drugs
22. Requests for more than a 90-day supply of maintenance medications, or requests for more than a 34-day supply of short-term medications
23. Stadol<sup>®</sup> Nasal Spray
24. Therapeutic devices or appliances, including support garments and other non-medicinal substances, regardless of intended use, except those specifically listed as covered
25. Tobacco cessation drugs

**Note:** Immunizations, biological sera, blood or blood products, Hyalgan<sup>®</sup>, Synvisc<sup>®</sup>, Remicade<sup>®</sup>, Synagis<sup>®</sup>, Xolair<sup>®</sup>, Amevive<sup>®</sup>, and Raptiva<sup>®</sup> are not covered under the AccessWV Pharmacy Benefit, but are covered under the medical plan. For information, call the medical claims administrator, Wells Fargo TPA, at 1-866-864-6142.

## **OTHER IMPORTANT FEATURES OF YOUR PRESCRIPTION DRUG PROGRAM**

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

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

When your prescriptions are filled at one of Express Scripts' mail service pharmacies or at a participating retail pharmacy, pharmacists use the health and prescription information on file for you to consider many important clinical factors including drug selection, dosing, interactions, duration of therapy and allergies. Express Scripts' pharmacists may also use information received from your out-of-network retail pharmacy.

### **Drug Utilization Review**

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

### **Education and Safety**

You will receive information about critical topics like drug interactions and possible side effects with every new prescription Express Scripts mails. Your retail pharmacy may also provide you with drug information.

By visiting [www.express-scripts.com](http://www.express-scripts.com), you also can access other health-related information. Click on Drug Information or Health Information to browse information relative to specific health interests, get safety tips and answers to the most commonly asked medication questions, or just keep up with timely health issues. To view health information personalized to fit your interests, register with [www.express-scripts.com](http://www.express-scripts.com). Any written health information cannot replace the expertise and advice of health care practitioners who have direct contact with a patient. All Express Scripts health information is designed to help you communicate more effectively with your doctor and, as a result, understand your situation and choices more completely.

### **Health Management**

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

### **Coordination of Benefits**

If another insurance carrier is the primary insurer for a policyholder or a dependent, AccessWV will pursue coordination of benefits.

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

1. Completed Express Scripts claim form;
2. Receipt from the pharmacy; and
3. Explanation of Benefits from the primary plan or a pharmacy printout that shows the amount paid by the primary plan.

You will usually be reimbursed within 21 days from receipt of your claim form. If you need claims forms, call Express Scripts Member Services at 1-877-256-4680 or visit their website at [www.express-scripts.com](http://www.express-scripts.com).

## **Your Right to Appeal Decisions Made by AccessWV**

### **KINDS OF APPEALS**

As a member of AccessWV, you or your representative may make an appeal if you do not agree with a decision made by the Plan. There are several kinds of appeals. These include:

- Medical management (expedited)
- Medical management (standard)
- Administrative (including claims denial)

Medical management appeals are concerned with:

- Precertification or prior authorization for out-state services
- Continued stays in health care facilities and continuation of other services, such as rehabilitation therapies, where AccessWV has denied a service the member's provider believes is necessary; and
- Pharmacy benefits issues such as prior authorization, step therapy and quantity limits

An expedited review may be requested by the member's provider if waiting for a standard decision could seriously jeopardize the member's health or ability to function.

Administrative appeals are concerned with the enforcement of program rules and the details of Plan coverage; for example, the amount that has been paid for a claim, whether or not a service is covered, the application of a waiting period, the denial or termination of coverage, etc.

### **LEVELS OF APPEAL**

The AccessWV Grievance process provides for three formal levels of appeal.

- Level 1: Appeal to the Plan Administrator or its third party administrators (TPA's)
- Level 2: Appeal to the AccessWV Executive Director
- Level 3: Appeal to the AccessWV Grievance Committee

Before a formal appeal is initiated at Level 1, the member, applicant or his/her representative may informally request a reconsideration by the Plan Administrator or its TPA.

## MEDICAL MANAGEMENT APPEALS (EXPEDITED)

*When there are issues of medical necessity, the member's provider may request an expedited appeal, if the provider indicates that waiting for a standard decision could seriously harm the patient's health or ability to function.*

*The member's provider is highly involved in all appeals of medical management decisions.*

**Informal Review.** The member's provider may ask for an immediate reconsideration of the decision. The TPA provider who made the decision will review it and discuss the findings with the member's provider within one business day.

**Level 1 (Plan Administrator).** The request for an immediate Level 1 appeal is made to PEIA's TPA responsible for the denial of service. (Wells Fargo TPA or the Rational Drug Therapy Program). The request may be made by telephone or fax and should be made within 48 hours of the denial. The TPA responsible for the denial then works with the member or member's representative to obtain any additional information and attempts to resolve the appeal at this level within 24-48 hours for an urgent situation and within 5 days for a non-urgent situation, provided that all supporting documents can be obtained. The result is communicated to the member or member's representative by telephone with a written determination within two business days.

**Level 2 (AccessWV Office).** All expedited appeals not resolved in favor of the member at Level 1 will, if requested by the member or member's provider, receive a Level 2 review which includes an external medical review. This level of appeal may be requested by telephone or fax to the AccessWV office and should be made within 48 hours of the previous determination. A decision will be rendered within 5 working days provided that all necessary supporting documents have been obtained. The result will be communicated to the member or member's representative by telephone with a written determination within two business days.

**Level 3 (AccessWV Grievance Committee).** This level of appeal may be requested by telephone or fax and should be made within 48 hours of the previous adverse determination. Upon request for Level 3 review, the Grievance Committee will seek an independent external medical opinion on the matter, which will be arranged through the Executive Director. A decision will be rendered within 5 working days provided that all necessary supporting documents have been obtained. The result will be communicated to the member or member's representative by telephone with a written determination within two business days. This request is directed to the Grievance Committee in care of the AccessWV Office.

<b>Contact Information for Medical Management Appeals</b>				
<b>Organization</b>	<b>Kind of Issue</b>	<b>Phone</b>	<b>Fax</b>	<b>Mailing Address</b>
Wells Fargo TPA	Utilization Management (Including Precertification, Out-of-State Services, Continuation of Care, etc.)	1-866-864-6142	304-353-8732	Wells Fargo TPA P.O. Box 2451 Charleston, WV 25329-2451
Rational Drug Therapy Program	Drug Prior Authorization (Error or Denial)	1-800-847-3859	1-800-831-7787	Rational Drug Therapy Program WVU School of Pharmacy PO Box 9511, HSCN Morgantown, WV 26506
AccessWV Office	Level 2 Appeal	1-866-445-8491	304-558-8362	AccessWV P.O. Box 50540 Charleston, WV 25305
AccessWV Grievance Committee	Level 3 Appeal	1 866-445-8491	304-558-8362	Grievance Committee AccessWV PO Box 50540 Charleston, WV 25305

### **MEDICAL MANAGEMENT APPEALS (STANDARD)**

*The member's provider is highly involved in all appeals of medical management decisions.*

**Informal Review.** If AccessWV does not precertify or grant prior authorization for a requested service or prescription drug, the member or member's representative may request a reconsideration. The provider who made the decision will contact the member's provider within one day of the request for reconsideration. If the reconsideration is not favorable, a formal Level 1 appeal may be made.

**Level 1 (Plan Administrator).** Request for an appeal, accompanied by all supporting material, should be submitted in writing to the appropriate TPA within 60 days of the initial determination. Written notice of the Level 1 determination will be sent within 30 days. See above chart for all contact information.

**Level 2 (AccessWV Office).** If the decision at Level 1 is not in favor the member, the member or the member's representative may request an additional review by writing to AccessWV's Executive Director within 60 days. A medical review will be arranged by the Executive Director. Decision at this level will be rendered within 30 days and will be communicated in writing.

**Level 3 (AccessWV Grievance Committee).** Request for a Level 3 appeal must be made to the Grievance Committee in writing within 60 days of the unfavorable Level 2 appeal. The Grievance Committee will seek an independent external medical opinion on the matter. The

decision at this level will be rendered within 30 working days and will be communicated in writing.

**ADMINISTRATIVE APPEALS (INCLUDING CLAIMS DENIAL)**

If you think that an error has been made in processing your claim or reviewing a service, the first step is to call Wells Fargo TPA (for medical claims) or Express Scripts (for pharmacy claims) to verify that a mistake has been made.

If your issue is related to eligibility for AccessWV or another administrative issue, you should call the Plan Administrator at 1-888-680-7342 ext. 207 to see if the issue can be resolved by telephone.

<b>Contact Information for Administrative Appeals</b>		
<b>Issue</b>	<b>Where to Call</b>	<b>Where to Write</b>
<b>Administrative concern (eligibility, billing, etc)</b>	Plan Administrator (PEIA) 1-888-680-7342 ext. 207	AccessWV, c/o PEIA Capitol Complex Building 5, Room 1001 Charleston, WV 25305
<b>Medical claim denial or error</b>	Wells Fargo TPA 1-866-864-6142	Well Fargo P.O. Box 2451 Charleston, WV 25329-2451
<b>Pharmacy claim denial or error</b>	Express Scripts 1-877-256-4680	Express Scripts, Inc. Clinical Appeals-(Client WVA) BL0390 6625 W. 78 <sup>th</sup> Street Bloomington, MN 55439

If your issue cannot be resolved by phone, the next step is to appeal in writing within 60 days of the claim payment or denial or the eligibility decision to the Plan Administrator, Wells Fargo TPA, or Express Scripts. Explain what you think the problem is, and why you disagree with the decision. They will respond to you by reprocessing the claim and/or sending you a letter with their response.

If you are not satisfied with the resolution, the second step is to appeal in writing to the Executive Director of AccessWV. Your or your representative must request a review in writing within sixty (60) days of getting the decision from PEIA, Wells Fargo TPA, or Express Scripts. Facts, issues, comments, letters, Explanation of Benefits (EOBs), and all pertinent information about the case should be included. This second step appeal should be mailed to:

**Executive Director: AccessWV  
1124 Smith Street  
P.O. Box 50540  
Charleston, WV 25305-0540**

When your request for review arrives, AccessWV will reconsider the entire case. A written decision will be sent to you or your representative within 30 days of receipt of your appeal.

If you are not satisfied with the decision at Level 2, you or your representative may make a Level 3 appeal. This will be a review by the AccessWV Grievance Committee. The request for this review must be made in writing within 60 days of the Level 2 decision and should be addressed to the Grievance Committee.

**Grievance Committee: AccessWV  
1124 Smith Street  
P.O. Box 50540  
Charleston, WV 25305-0540**

The Grievance Committee will review your case and make a decision within 30 days of receiving your appeal. The decision will be sent to you in writing.

### **Additional Recourse**

Once a Level 3 appeal has been made and the Grievance Committee has made the determination on behalf of AccessWV, there is no other internal level of appeal available. If the member or applicant is not satisfied with the outcome of the appeal at Level 3, he or she may request a hearing by the West Virginia Offices of Insurance Commissioner (Level 4 appeal). If the member or applicant is not satisfied with the decision made by the WV Offices of the Insurance Commissioner, he or she may further contest the decision through judicial review in Circuit Court (Level 5 appeal).

A copy of the full AccessWV Grievance Procedure will be mailed to you upon request.

## **Other Information**

### **PROHIBITION AGAINST BALANCE BILLING**

Any West Virginia health care provider who treats an AccessWV member must accept assignment of benefits and cannot balance bill the member for any portion of charges over and above the PEIA fee allowance or for any discount amount applied to a provider's charge or payment. This is known as the "prohibition against balance billing." The prohibition against balance billing applies when services are provided in West Virginia. Remember, you are always responsible for deductibles, copays, coinsurance amounts and non-covered services.

### **NEW TECHNOLOGIES**

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

## **PATIENT AUDIT PROGRAM**

The Patient Audit Program offers rewards when you help detect and correct mistakes on your health care bills. Examine your medical bills for these two types of mistakes:

- Charges for services not received
- Overcharges or overpayments resulting from clerical error or miscalculation

Reported errors must be at least \$50 to qualify for the Patient Audit Program and must be submitted within 60 days of the processing date on the Explanation of Benefits (EOB). Complete the Patient Audit Report Form from the Plan Administrator (PEIA) and submit it, along with an itemized bill from the provider, the corrected bill (or explanation of disagreement), and a copy of the EOB, to the Plan Administrator (PEIA).

PEIA, Wells Fargo TPA or Express Scripts will investigate and recover the overpayment, if justified, from the provider of services. When the overpayment is processed you will be paid 50 percent of the recovered amount, up to \$1,000 per plan year.

## **HEALTH CARE FRAUD AND ABUSE**

AccessWV reports suspected fraud to the WV Offices of the Insurance Commissioner.

Examples of provider fraud:

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

Examples of member fraud:

- Providing false information when applying for AccessWV coverage
- Forging prescriptions or selling prescription drugs
- "Loaning" or using another's member identification card

## **How to Report Health Care Fraud and Abuse**

If you suspect health care fraud, please call AccessWV's Plan Administrator toll free on 1-888-680-7342 and ask for the Special Investigations Team. You will be asked to provide as much information as possible. The Plan Administrator will investigate your concern and, if appropriate, refer the information to the appropriate legal authorities.

## COORDINATION OF BENEFITS

In its effort to control health care costs, AccessWV has a coordination of benefits (COB) provision. Under this provision, when a person covered by AccessWV also has coverage under another policy (or policies), there are certain rules determining which policy is required to pay benefits first. The policy paying first is called the primary plan, and any other applicable policy is called the secondary plan. The Plan Administrator (PEIA), on AccessWV's behalf, will request information about other coverage using a questionnaire mailed to the policyholder. If the policyholder fails to respond to the questionnaire, claims will be denied until the information is received.

If you have health insurance coverage in addition to the AccessWV Plan, it is important to understand how the coordination of benefits provision works. AccessWV will be the secondary plan. Commonly under these circumstances, AccessWV will pay little or nothing of the balance of your medical bill. If, after reviewing this section, you have questions concerning how AccessWV's coordination of benefits provision may affect you, contact AccessWV Customer Service at 1-888-680-7342 extension 207.

**Note:** In general, eligibility for other coverage makes one ineligible for AccessWV. However, a member may maintain other coverage for the period of time he or she is satisfying a preexisting condition waiting period under AccessWV. A member may also maintain AccessWV coverage for the period of time he or she is satisfying a preexisting condition waiting period under another health insurance policy intended to replace the AccessWV policy.

### Coordinating AccessWV Benefits with Other Plans

AccessWV is the payer of last resort of benefits whenever any other benefit or source of third-party payment is available. Benefits otherwise payable under plan coverage shall be reduced by all amounts paid or payable:

- through any other insurance coverage.
- by all hospital and medical expense benefits paid or payable under any workers' compensation coverage, automobile medical payment or liability insurance, whether provided on the basis of fault or no-fault.
- by any hospital or medical benefits paid or payable under or provided pursuant to any state or federal law or program.

### How Coordination of Benefits Works

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 benefits paid by the primary plan. The amount that AccessWV will pay as a secondary plan depends on what the primary plan pays.

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

AccessWV, then AccessWV will pay the difference up to what it would have paid had there been no other insurance.

## **RECOVERY OF INCORRECT PAYMENTS**

If AccessWV or Wells Fargo TPA discovers that a claim has been incorrectly paid, or that the charges were excessive or for non-covered services, Wells Fargo TPA has the right to recover the payments from any person or any entity. You must cooperate fully to help recover any such payment.

AccessWV will deduct overpayments from a provider's check to recover incorrect payments. This provision shall not limit any other remedy provided by law.

This situation may occur if you become retroactively eligible for Medicare, Medicaid, or the WV Children's Health Insurance Program when you are enrolled in AccessWV. Since you lose eligibility for AccessWV once you are granted membership in these program, your coverage is cancelled retroactively. If AccessWV has paid claims during the period in which you are not entitled to membership, an attempt will be made to recover these payments. You must cooperate fully to help recover these payments. Any premiums you paid during this period will be used to offset any unrecoverable payments.

### **Subrogation and Reimbursement**

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

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

- Payments made directly by the person who is liable for an AccessWV member's sickness, injury, disease or disability, or any insurance company which pays on behalf of that person, or any other payments on his or her behalf.
- Any payments, settlements, judgments, or arbitration awards paid by any insurance company under an uninsured or underinsured motorist policy or medical pay provisions on the member's behalf.

- Any payments from any source designed or intended to compensate an AccessWV member for sickness, injury, disease, or disability sustained as the result of the negligence or wrongful action or alleged negligence or wrongful action of another person.

It is the obligation of the AccessWV member to:

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

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

- AccessWV withholding payment of further benefits; and
- An obligation by the AccessWV member to pay costs, attorneys' fees and other expenses incurred by AccessWV in obtaining the required information or reimbursement.

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

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

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

## **AMENDING THE BENEFIT PLAN**

The benefits, premiums, cost-sharing and other plan details will be reviewed at least annually by AccessWV's Board of Directors. Notice of any changes will be conveyed to members at least 30 days prior to their implementation.

AccessWV reserves the right to amend all or any portion of this Policy in order to reflect changes required by court decisions, legislation, actions by the Board, actions by the Executive Director or for any other matters as are appropriate. The Policy will be amended within a reasonable time of any such actions.

All changes to benefits and premiums must be filed with and approved by the West Virginia Offices of the Insurance Commissioner.

## NOTICE OF PRIVACY PRACTICES

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

**If you have questions about this notice, please contact the person listed under "Whom to Contact" at the end of this notice.**

### **Summary**

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

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

### **Kinds of Information to Which This Notice Applies**

This notice applies to any information in our possession that would allow someone to identify you and learn something about your health. It does not apply to information that contains nothing that could reasonably be used to identify you.

### **Who Must Abide by This Notice**

- AccessWV
- All employees, staff, students, volunteers and other personnel whose work is under the direct control of AccessWV

The people and organizations to whom this notice applies (referred to as “we,” “our,” and “us”) have agreed to abide by its terms. We may share your information with each other for purposes of treatment, and as necessary for payment and operations activities as described below.

### **Our Legal Duties**

- We are required by law to maintain the privacy of your health information.
- We are required to provide this notice of our privacy practices and legal duties regarding health information to anyone who asks for it.
- We are required to abide by the terms of this notice until we officially adopt a new notice.

### **How We May Use or Disclose Your Health Information**

We may use your health information, or disclose it to others, for a number of different reasons. This notice describes these reasons. For each reason, we have written a brief explanation. We also provide some examples. These examples do not include all of the specific ways we may use or disclose your information. But any time we use your information, or disclose it to someone else, it will fit one of the reasons listed below. We may also enter into agreements with business partners to perform any or all of the tasks we describe below. The business partner may use or disclose your health information in the same manner as if we were doing it directly, and any agreement we enter with a business partner will require that your privacy be protected the same as if AccessWV were using or disclosing the information directly.

**1. Treatment.** We may use your health information to provide you with medical care and services. This means that our employees, staff, students, volunteers and others whose work is under our direct control may read your health information to learn about your medical condition and use it to help you make decisions about your care. We will also disclose your information to others to provide you with options for medical treatment or services. For instance, we may use health information to identify members with certain chronic illnesses, and send information to them or to their doctors regarding treatment alternatives.

**2. Payment.** We will use your health information, and disclose it to others, as necessary to make payment for the health care services you receive. For instance, our customer service administrator or claims processing administrator may use your health information to help pay your claims. And we may send information about you and your claim payments to the doctor or hospital that provided you with the health care services. We will also send you information about claims we pay and claims we do not pay (called an “explanation of benefits”). The explanation of benefits will include information about claims we receive for the policyholder and each dependent enrolled together under a single contract or identification number. Under certain circumstances, you may receive this information confidentially: see the “Confidential Communication” section in this notice. We may also disclose some of your health information to companies with whom we contract for payment-related services. For instance, if you owe us money, we may give information about you to a collection company with which we contract to collect bills for us. We will not use or disclose more information for payment purposes than is necessary.

**3. Health Care Operations.** We may use your health information for activities that are necessary to operate this organization. This includes reading your health information to review the performance of our staff. We may also use your information and the information of other members to plan what services we need to provide, expand, or reduce. We may also provide health information to students who are authorized to receive training here. We may disclose your health information as necessary to others with whom we contract to provide administrative services or health care coverage. This includes our administrative services partner (PEIA), and its third-party administrators, lawyers, auditors, accreditation services, and consultants, for instance.

**4. Legal Requirement to Disclose Information.** We will disclose your information when we are required by law to do so. This includes reporting information to government agencies that have the legal responsibility to monitor the state health care system. For instance, we may be required to disclose your health information, and the information of others, if we are audited by state auditors. We will also disclose your health information when we are required to do so by a court order or other judicial or administrative process.

**5. Public Health Activities.** We will disclose your health information when required to do so for public health purposes. This includes reporting certain diseases, births, deaths, and reactions to certain medications. It may also include notifying people who have been exposed to a disease.

**6. To Report Abuse.** We may disclose your health information when the information relates to a victim of abuse, neglect or domestic violence. We will make this report only in accordance with laws that require or allow such reporting, or with your permission.

**7. Law Enforcement.** We may disclose your health information for law enforcement purposes. This includes providing information to help locate a suspect, fugitive, material witness or missing person, or in connection with suspected criminal activity. We must also disclose your health information to a federal agency investigating our compliance with federal privacy regulations.

**8. Specialized Purposes.** We may disclose the health information of members of the armed forces as authorized by military command authorities. We may disclose your health information for a number of other specialized purposes. We will only disclose as much information as is necessary for the purpose. For instance, we may disclose your information to coroners, medical examiners and funeral directors; to organ procurement organizations (for organ, eye, or tissue donation); or for national security, intelligence, and protection of the president. We also may disclose health information about an inmate to a correctional institution or to law enforcement officials, to provide the inmate with health care, to protect the health and safety of the inmate and others, and for the safety, administration, and maintenance of the correctional institution.

**9. To Avert a Serious Threat.** We may disclose your health information if we decide that the disclosure is necessary to prevent serious harm to the public or to an individual. The disclosure will only be made to someone who is able to prevent or reduce the threat.

**10. Family and Friends.** We may disclose your health information to a member of your family or to someone else who is involved in your medical care or payment for care. This may include telling a family member about the status of a claim, or what benefits you are eligible to receive. In the event of a disaster, we may provide information about you to a disaster relief organization so they can notify your family of your condition and location. We will not disclose your information to family or friends if you object.

**11. Research.** We may disclose your health information in connection with medical research projects. Federal rules govern any disclosure of your health information for research purposes without your authorization.

**12. Information to Members.** We may use your health information to provide you with additional information. This may include sending newsletters or other information to your address. This may also include giving you information about treatment options, alternative settings for care, or other health-related options that we cover.

## YOUR RIGHTS

**1. Authorization.** We may use or disclose your health information for any purpose that is listed in this notice without your written authorization. We will not use or disclose your health information for any other reason without your authorization. If you authorize us to use or disclose your health information in additional circumstances you have the right to revoke the authorization at any time. For information about how to authorize us to use or disclose your health information, or about how to revoke an authorization, contact the person listed under “Whom to Contact” at the end of this notice. You may not revoke an authorization for us to use and disclose your information to the extent that we have taken action in reliance on the authorization. If the authorization is to permit disclosure of your information to an insurance company, as a condition of obtaining coverage, other law may allow the insurer to continue to use your information to contest claims or your coverage, even after you have revoked the authorization.

**2. Request Restrictions.** You have the right to ask us to restrict how we use or disclose your health information. We will consider your request. But we are not required to agree. If we do agree, we will comply with the request unless the information is needed to provide you with emergency treatment. We cannot agree to restrict disclosures that are required by law.

**3. Confidential Communication.** If you believe that the disclosure of certain information could endanger you, you have the right to ask us to communicate with you at a special address or by a special means. For example, you may ask us to send explanations of benefits that contain your health information to a different address rather than to your home. Or you may ask us to speak to you personally on the telephone rather than sending your health information by mail. We will agree to any reasonable request.

**4. Inspect and Receive a Copy of Health Information.** You have a right to inspect the health information about you that we have in our records, and to receive a copy of it. This right is limited to information about you that is kept in records that are used to make decisions about you. For instance, this includes claim and enrollment records. If you want to review or receive a copy of these records, you must make the request in writing. We may charge a fee for the cost of copying and mailing the records. To ask to inspect your records, or to receive a copy, contact the person listed under “Whom to Contact” at the end of this notice. We will respond to your request within 30 days. We may deny you access to certain information. If we do, we will give you the reason, in writing. We will also explain how you may appeal the decision.

**5. Amend Health Information.** You have the right to ask us to amend health information about you which you believe is not correct, or not complete. You must make this request in writing, and give us the reason you believe the information is not correct or complete. We will respond to your request in writing within 30 days. We may deny your request if we did not create the information, if it is not part of the records we use to make decisions about you, if the information is something you would not be permitted to inspect or copy, or if it is complete and accurate.

**6. Accounting of Disclosures.** You have a right to receive an accounting of certain disclosures of your information to others. This accounting will list the times we have given your health information to others. The list will include dates of the disclosures, the names of the people or organizations to whom the information was disclosed, a description of the information, and the reason. We will provide the first list of disclosures you request at no charge. We may charge you for any additional lists you request during the following 12 months. You must tell us the time period you want the list to cover. You may not request a time period longer than six years. Disclosures for the following reasons will not be included on the list: disclosures for treatment, payment, or health care operations; disclosures for national security purposes; disclosures to correctional or law enforcement personnel; disclosures that you have authorized; and disclosures made directly to you.

**7. Paper Copy of this Privacy Notice.** You have a right to receive a paper copy of this notice. If you have received this notice electronically, you may receive a paper copy by contacting the person listed under “Whom to Contact” at the end of this notice.

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

#### **OUR RIGHT TO CHANGE THIS NOTICE**

We reserve the right to change our privacy practices, as described in this notice, at any time. We reserve the right to apply these changes to any health information which we already have, as well

as to health information we receive in the future. Before we make any change in the privacy practices described in this notice, we will write a new notice that includes the change. The new notice will include an effective date. We will mail the new notice to all policyholders within 60 days of the effective date.

**Whom to Contact**

Contact the person listed below:

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

**Privacy Officer**  
**AccessWV**  
**PO Box 50540**  
**Charleston, WV 25305-0540**  
**1-866-445-8491**  
**1-304-558-8264**

Copies of this notice are also available at the reception desk of the AccessWV office at 1124 Smith Street, Charleston, WV 25305-0540. This notice is also available on our web site: [www.accesswv.org](http://www.accesswv.org)

**WHERE TO CALL WITH QUESTIONS**

**Eligibility Issues**

PEIA 1-304-558-7850 ext. 207 or 1-888-680-7342 ext. 207 (toll-free) or on the web at [www.wvpeia.com](http://www.wvpeia.com)

**Billing Issues**

PEIA 1-304-558-7850 ext. 207 or 1-888-680-7342 ext. 207 (toll-free) or on the web at [www.wvpeia.com](http://www.wvpeia.com)

**Health Claims and Benefits**

Wells Fargo TPA 1-866-864-6142 (toll-free) or on the web at [www.wellsfargo.com/tpa](http://www.wellsfargo.com/tpa)

**Required Pre-Service Review: Precertification, Prior Authorization for Out-of-State Care, and Notification**

Wells Fargo TPA 1-866-864-6142 (toll-free) or on the web at [www.wellsfargo.com/tpa](http://www.wellsfargo.com/tpa)

**Medical Case Management**

Wells Fargo TPA 1-866-864-6142 (toll-free) or on the web at [www.wellsfargo.com/tpa](http://www.wellsfargo.com/tpa)

**Voluntary Preauthorization**

Wells Fargo TPA 1-866-864-6142 (toll-free) or on the web at [www.wellsfargo.com/tpa](http://www.wellsfargo.com/tpa)

**Prescription Drug Benefits and Claims**

Express Scripts 1-877-256-4680 (toll-free) or on the web at [www.express-scripts.com](http://www.express-scripts.com)

**Second and Third Level Appeals**

AccessWV 1-304-558-8264 or 1-866-445-8491 (toll-free) or on the web at [www.accesswv.org](http://www.accesswv.org)

**Subrogation and Recovery**

Beacon Recovery Group 1-800-874-0500 (toll-free)