



Dental/Vision
Member Handbook

Commonwealth of Virginia
Retiree Health Benefits Program

Department of
Human Resource Management

January 2001

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Dental/Vision Plan

IMPORTANT NOTICE

This booklet tells You what may be eligible for reimbursement under Your Dental/Vision Plan, administered by Trigon Blue Cross Blue Shield (the Company). This preface is part of this booklet and contains rules for interpreting this booklet. Throughout this booklet there are words which begin with capital letters. In most cases, these are defined terms. See the Definitions section for the meaning of these words.

Your coverage is limited to the dental and vision services specifically described in this booklet as eligible for reimbursement. There are specific Exclusions for which the program will never pay. Even more important, payment for covered services is almost always conditional. That is, payment may be reduced or even denied for those services You receive without observing all the conditions and limits under which they are covered.

Your dental and vision benefits are governed strictly by the written provisions of the Plan. Only those services specifically named or described in this booklet are covered. You are responsible for knowing what is covered and the limits and conditions of coverage. Furthermore, the terms and conditions of Your coverage can be changed without Your consent, if proper notice is given to You.

There are some rules which apply to all benefits. This information starts on page 4. Also, there are some services for which the Company will never pay (see Exclusions section, page 12). Finally, we have included some rules governing the Plan (see Basic Plan Provisions section, page 13). Also refer to the Definitions section beginning on page 18 for an explanation of many of the terms used in this booklet. These sections are important because they will be used to determine exactly what this Plan covers.

**READ THIS BOOKLET CAREFULLY BEFORE
RECEIVING SERVICES IF YOU EXPECT
PAYMENT UNDER THIS PLAN.**

SUMMARY OF BENEFITS

Dental/Vision Plan

	Covered Services	You Pay
Dental	Plan pays \$1,200 per member per calendar year: <ul style="list-style-type: none"> • Diagnostic and preventive services • Primary services 	\$0 20% AC*
Vision	Once every 24 months: Routine eye exam Eyeglass frames (one pair) Lenses <ul style="list-style-type: none"> • Single vision eyeglass lenses, or • Bifocal eyeglass lenses, or • Trifocal eyeglass lenses, or • Contact lenses (any type) 	Remaining cost after Plan pays \$40 Remaining cost after Plan pays \$50 Remaining cost after Plan pays \$35 Remaining cost after Plan pays \$50 Remaining cost after Plan pays \$70 Remaining cost after Plan pays \$100

*Allowable Charge (AC): See Definitions section.

WHO TO CONTACT FOR ASSISTANCE

Trigon Blue Cross Blue Shield

Member Services (804) 355-8506 in Richmond
1-800-552-2682 outside Richmond

Web Address <http://state.trigon.com>

Mailing Address Trigon Blue Cross Blue Shield
Member Services - Mail Drop 03K
P. O. Box 27401
Richmond, VA 23279

Department of Human Resource Management

Web Address www.dhrm.state.va.us/hbenefit.htm

GENERAL RULES GOVERNING BENEFITS

1) When a Charge Is Incurred

You incur the charge for a covered service on the day you receive the service.

2) When Benefits Start

Benefits will not be provided for any charges You incur before Your Effective Date.

3) Medically Necessary

Except for preventive dental services and routine eye examinations, benefits are covered only if they are Medically Necessary. Benefits will be denied if the Company determines, in its sole discretion, that care is not Medically Necessary.

4) When Benefits End

Benefits will not be provided for charges You incur after Your coverage ends.

5) Defining Services

When classifying a particular service, the Company will use the most recent edition of a book published by the American Medical Association entitled *Current Procedural Terminology* (CPT) and the American Dental Association entitled *Current Dental Terminology* (CDT). The Allowable Charge for a procedure will be based on the most inclusive code in *Current Procedural Terminology* or *Current Dental Terminology*. The Company alone will determine the most inclusive code. No benefits will be provided for lesser-included procedures or for procedures which are components of a more inclusive procedure.

6) Payment to Network Providers

The Company pays the Allowable Charge which remains after Your Coinsurance to the Network Provider.

When a Participant receives services from a Network Provider, the Company will make payment for these services directly to the Provider. But, if the Participant has already paid the Provider and the Provider tells the Company to do so, the Company will pay the Enrollee. A Provider who participates in one of the Company's Networks will accept the Company's allowance as payment in full for that service. Payment by the Company will relieve the Company and the Plan of any further liability for the service.

7) Out-of-Network Payments

When a Participant receives services from a Non-Network Provider, the Company may choose to make payment directly to the Enrollee or, at the Company's sole option, to any other person responsible for payment of the Provider's charge. Payment will be made only after the Company has received an itemized bill and the medical information the Company decides is necessary to process the claim. Payment will be made directly to the Enrollee. The Enrollee will also be responsible for the difference between the Plan's allowance and the Provider's charge. Payment by the Company will relieve it and the Plan of any further liability for the Non-Network Provider's services.

8) Appeals

You have the right to request the Company to review the denial or payment of any claim. There are strict limits on each stage of appeal. You will be notified of these limits in correspondence which denies Your claim. Look for and observe these strict time limits.

You must initiate an appeal to the Company within 60 days of the Company's denial of Your initial claim.

The Company will have previously reviewed Your medical records for any claim requiring a medical determination. If the Company denies a claim for medical reasons, You may request verbally or in writing that the Company review the claim.

If You are not satisfied with the results of the review, You may file a written appeal to the Company. The appeal must be written and include Your full name, the Enrollee's identification number (indicated on Your membership card), the date of the service, the name of the Provider for whose services payment was denied, and the reason You think the claim should be paid. You are responsible for providing the Company with all information necessary to review the denial of Your claim. The Company will review Your appeal and respond within 60 days of the Company's receipt of all information necessary to make a decision.

If You are not satisfied with the results of the first appeal, You may request a review by the Company's appeals committee. The request must be written and include Your full name, the Enrollee's identification number, the date of the service, the name of the Provider for whose services payment was denied, and the reason You think the claim should be paid. You are responsible for providing the Company with all information necessary to review the denial of Your claim. The committee will review Your appeal and respond within 60 days of the Company's receipt of all information necessary to make a decision. If, after review, the claim remains denied, that denial is final, unless You appeal that determination to the Commonwealth of Virginia, Department of Human Resource Management (Department).

In situations requiring immediate medical care, the Company provides a separate expedited emergency appeals process. You or Your Provider may request an expedited review. The Company will provide resolution within one business day of receipt of all information.

To appeal a claim decision made by the Company, You must submit to the director of the Department in writing, within 60 days of the Company's denial, Your full name, the Enrollee's identification number, the date of the service, the name of the Provider for whose services payment was denied, and the reason You think the claim should be paid. You are responsible for providing the Department with all information necessary to review the denial of Your claim. The Department will ask You to submit any additional information You wish to have considered in its review, and will give You the opportunity to explain, in person or by telephone, why You think the claim should be paid. Claims denied due to such things as contractual or eligibility issues will be reviewed by the director. Claims denied because the treatment provided was considered not medically necessary will be referred to an independent medical review organization. If, after review, the claim remains denied, that denial is final, unless You appeal that determination within 30 days as provided under the Administrative Process Act. You may obtain a "State Health Benefits Program Appeal Form" on the Web at www.dhrm.state.va.us/hbenefit.htm.

9) Coordination of Benefits

You are required to notify the Company that You are enrolled under another Health Benefit Plan. If You are eligible for coverage under two or more Health Benefit Plans, the Health Benefit Plans involved will share the responsibility for Your benefits according to these rules.

- A.** If the other Health Benefit Plan contains a coordination of benefits provision establishing the substantially same order of benefit determination rules as the ones in

this section, the following will apply in the order of priority listed:

(1) The Health Benefit Plan which lists the person receiving services as the Enrollee, insured or policyholder, not as a dependent, will provide Primary Coverage.¹

(2) Primary Coverage for an enrolled child will be the Health Benefit Plan which lists the parent whose month and day of birth occurs earliest in the calendar year as an Enrollee, insured, or policyholder, except in the following circumstances:

(a) When the parents are separated or divorced, Primary Coverage will be the Health Benefit Plan which covers the child as a dependent of the parent with custody. The Health Benefit Plan of the husband or wife of a remarried parent with custody may provide Primary Coverage if the remarried parent with custody does not have a Health Benefit Plan which covers the child.

(b) Despite sub-paragraph (a), if there is a court order which requires one parent to provide Hospital or Medical or Surgical coverage for the child, Primary Coverage will be that parent's Health Benefit Plan. If the specific terms of a court decree state that the parents will share joint custody and the court decree does not state that one of the parents is responsible for health care expenses of the child, then the rule set forth in the first sentence of paragraph a. (2), the birthday rule, will apply.

(3) If paragraphs (1) AND (2) do not apply, Primary Coverage will be the Health Benefit Plan which has covered the Participant for the longest uninterrupted period of time. There are two exceptions to this rule:

(a) The benefits of the Health Benefit Plan which covers the person as a working employee (or the employee's dependent) will be determined before those of the Health Benefit Plan which covers the person as a laid-off or retired employee (or the employee's dependent).

(b) The benefits of the Health Benefit Plan which covers the person as an employee (or the employee's dependent) will be determined before those of the Health Benefit Plan which covers the person under a right of continuation pursuant to federal or state law.

B. If a Health Benefit Plan does not have a coordination of benefits provision establishing substantially the same order of benefit determination rules as the ones in this section, that Health Benefit Plan will be the Primary Coverage.

C. If, under the priority rules, this Plan is the Primary Coverage, You will receive unreduced benefits for covered services to which You are entitled under this Plan.

D. If the other Health Benefit Plan is the Primary Coverage, Your benefits will be reduced so that the total benefit paid under this Plan and the other Health Benefit Plan will not exceed the benefits payable for covered services under this Plan absent the other

¹ There is one exception. If the person is also entitled to Medicare, and as a result of federal law Medicare is (1) secondary to the Health Benefit covering the person as a dependent; and (2) primary to the Health Benefit Plan covering the person as other than a Dependent (e.g., a retired employee), then the benefits of the Health Benefit Plan covering the person as a Dependent are determined before those of the Health Benefit Plan covering the person as other than a Dependent.

Health Benefit Plan. Benefits that would have been paid if You had filed a claim under the Primary Coverage will be counted and included as benefits provided. In a calendar year, benefits will be coordinated as claims are received.

- E. When a Health Benefit Plan provides benefits in the form of services, a reasonable cash value will be assigned to each covered service. This cash value will be considered a "benefit payment."
- F. At the option of the Company, payments may be made to anyone who paid for the coordinated services you received. These benefit payments by the Company are ones which normally would have been made to You or on Your behalf to a facility or Provider. The benefit payments made by the Company will satisfy the obligation to provide benefits for covered services.
- G. If the Company provided Primary Coverage and discovers later that it should have provided Secondary Coverage, the Company has the right to recover the excess payment from You or any other person or organization. If excess benefit payments are made on Your behalf, You must cooperate with the Company in exercising its right of recovery.
- H. You are obligated to supply the Company all information needed to administer this section. This must be done before You are entitled to receive benefits under this Plan. Further, You agree that the Company has the right to obtain or release information about covered services or benefits You have received. This right will be used only when working with another person or organization to settle payments for coordinated services. Your prior consent is not required.

7) Cancellation of Coverage by Enrollee

Under the Plan, coverage may be cancelled by completing an Enrollment/Waiver form. Cancellation of coverage is effective the first of the month after waiver is received. Cancellation of coverage will prevent You from re-enrolling in this Plan or any other Plan sponsored by the Department of Human Resource Management at any time.

8) Notice from the Company to You

A notice sent to You by the Company is considered "given" when delivered to the State or your Benefits Administrator at the address listed in the Company's records. If the Company must contact you directly, a notice sent to You by the Company is considered "given" when mailed to the Enrollee at the Enrollee's address listed in the Company's records. Be sure the Company has the Enrollee's current home address.

9) Notice from You to the Company

Notice by You or Your Benefits Administrator is considered "given" when delivered to the Company at the address on page 3 of this book. The Company will not be able to provide assistance unless the Enrollee's name and identification number are in the notice.

DENTAL BENEFITS

Services Which Are Eligible for Reimbursement

- 1) The following diagnostic and preventive dental services are eligible for reimbursement:
 - a. Oral examinations
 - b. Dental x-rays, but not x-rays for orthodontic purposes (cephalometric film)
 - c. Direct fluoride application to natural teeth
 - d. Prophylaxis (includes minor scaling and polishing)
 - e. Palliative emergency treatment
 - f. Space maintainers (not made of precious metals)
 - g. Biopsies of oral tissue
 - h. Pulp vitality tests
 - i. Dental pit/fissure sealants on first and second permanent molars
 - j. Bite planes or splints to increase the vertical dimension for temporomandibular joint or associated myofascial pain disorders
 - k. Occlusal adjustments for temporomandibular joint disorders
 - l. Occlusal night guards for demonstrated tooth wear due to bruxism

- 2) The following primary services are also eligible for reimbursement:
 - a. Maintenance services which are defined here to mean:
 - i. Fillings made up of amalgam or tooth color synthetics
 - ii. Root canal therapy
 - iii. Repair of broken removable dentures
 - iv. Recementing of existing crowns, inlays, and bridges
 - v. Dentist's Visits to Your home when Medically Necessary to render dental services which are eligible for reimbursement and, in fact, reimbursed
 - vi. Stainless steel crowns
 - vii. Sedative fillings

 - b. Oral surgical procedures listed in the most recent edition of the *Code of Dental Procedures and Nomenclature of the American Dental Association* except that any and all procedures performed for orthodontic purposes are not eligible for reimbursement. Covered oral surgical procedures consist of:
 - i. Simple extractions
 - ii. Surgical removal of teeth
 - iii. Excision, drainage, or removal of cysts, tumors, and abscesses in the mouth
 - iv. Apicoectomies
 - v. Hemisections or root amputations
 - vi. Treatment of fractures of the jaw
 - vii. Alveoplasties to prepare the gum ridge for dentures
 - viii. Frenectomies

 - c. Periodontic services which consist of:
 - i. Gingivectomy and gingivoplasty
 - ii. Scaling and root planing

- iii. Osseous surgery and grafts, including flap entry and closure
- iv. Surgical periodontic examinations
- v. Mucogingivoplastic surgery
- vi. Management of acute periodontal infection and oral lesions
- vii. Soft tissue grafts
- viii. Guided tissue regeneration
- ix. Supportive periodontal therapy
- x. Crown lengthening

d. General anesthesia services

Conditions for Reimbursement

Dental services must be:

- Billed for by a Provider in private practice;
- Services which the Provider is licensed to render; and
- Necessary for the restoration of function or maintenance of dental health.

Special Limits

- 1) Benefits are limited to \$1,200 per calendar year for all services.
- 2) Diagnostic and preventive services are limited to two (2) each of the following per calendar year:
 - Oral exams
 - Bitewing x-rays
 - Prophylaxis
 - Topical fluoride applications
 - Pulp vitality tests

In addition, one full mouth x-ray or panorex is covered every 36 months.

- 3) Benefits for fluoride applications and sealants are available only to Participants under age 19.
- 4) If general Anesthesia Services are rendered by the same dentist who performs the dental treatment, the Allowable Charge for the services will be 50% of the amount it would have been for them if rendered by someone else.
- 5) If You transfer from the care of one dentist to another during a course of treatment, the Company will only pay the amount it would pay to one dentist for the same treatment.
- 6) If more than one dentist renders services for one procedure, the Company will only pay the amount it would pay to one dentist for the same treatment.

Special Exclusions

The following dental services are not covered:

- 1) Services rendered by a dental or medical clinic maintained by Your employer, a mutual benefit association, labor union, trustee, or like person or group
- 2) Services related to genetic malformation
- 3) Services rendered to an Inpatient in a facility by a Dentist paid by that facility to perform such services
- 4) Gold foil restorations
- 5) Instruction in personal dental hygiene and care, including plaque control
- 6) Services rendered as part of optional plans of treatment, personalized restorations, or special techniques, unless approved by the Company in advance. If these procedures are not approved by the Company, the Company will pay only the Allowable Charges for the standard, less expensive procedures.

Reimbursement

The Company pays the remaining Allowable Charge after Your Coinsurance.

Coinsurance

Diagnostic and preventive services	None
Primary services	20% of Allowable Charge

VISION BENEFITS

Services Which Are Eligible for Reimbursement

- 1) Routine vision examination, once every 24 months
- 2) Frames (one pair every 24 months) and the following prescription lenses to correct refraction error (one pair of eyeglass lenses or any type of contact lenses every 24 months):
 - Single lenses, or
 - Bifocal lenses, or
 - Trifocal lenses, or
 - Contact lenses (hard, soft or disposable).

Conditions for Reimbursement

- 1) Vision services must be:
 - Billed for by a Provider in private practice; and
 - Services which the Provider is licensed to render.

Special Limits

- 1) Benefits will not be provided for more than the following in a 24 month period:
 - One routine vision examination, and
 - One pair of frames, and
 - One pair of non-contact lenses, regardless of the type of lenses, or \$100 of contact lenses (hard, soft, or disposable).
- 2) Sunglasses, even if by prescription, are excluded.

Reimbursement

- 1) For routine vision examination, up to \$40 per exam
- 2) For frames, up to \$50 per pair
- 3) For single lenses, \$35 per pair
- 4) For bifocal lenses, \$50 per pair
- 5) For trifocal lenses, \$70 per pair
- 6) For contact lenses, \$100

EXCLUSIONS

This is a list of services which are not, under any circumstances, eligible for reimbursement. Although these excluded services are not mentioned as limits in previous sections of this booklet, they in fact are limits on the services described earlier. Unless another type of service is specified, the word "services" means both services and supplies.

- 1) Services not specifically listed or described in this booklet as eligible for reimbursement.
- 2) Dental treatment, except services enumerated or described under the Dental Services section of this booklet.
- 3) Services provided by a member of Your immediate family and services rendered by a Provider or the Provider's employee to another Provider in the same practice.
- 4) Any payment or services provided or available to You:
 - a. Under a U.S. government program or a program for which the federal or state government pays all or part of the cost. This exclusion does not apply to health benefits Plans offered to either civilian employees or retired civilian employees of the federal or a state government. These latter Plans are subject to the rules explained in the Coordination of Benefits section of this booklet on page 5.
 - b. Under the Medicare program or under any similar program authorized by state or local laws or regulations or any future amendments to them. This exclusion does not apply to those laws or regulations which make the government program the secondary payor after benefits under this booklet have been provided.

This exclusion applies whether or not You waive Your rights under these laws, amendments, programs, or terms of employment.

- 5) Services for injuries or diseases related in any way to Your job when:
 - a. You receive payment from Your employer on account of the disease or injury;
 - b. Your employer is required by federal, state, or local laws or regulations to provide benefits to You, or
 - c. You could have received benefits for the injury or disease if You had complied with the laws and regulations.

This exclusion applies whether or not You have waived Your rights to payment for the services available. It also applies if Your employer (or Your employer's health benefits Company) reaches any settlement with You for an injury or disease related in any way to Your job.

- 6) Services for which a charge is not usually made. Also excluded are services for which You would not have been charged if You did not have dental and vision coverage.
- 7) Any service determined to be Experimental/Investigative by the Company, in its sole discretion, except for services associated with Clinical Trial Costs. Also excluded are services to treat routine complications of any Experimental/Investigative service, and services related to the Experimental/Investigative service.
- 8) Services for radial keratotomy and other surgical procedures to correct myopia.
- 9) Services for diseases contracted or injuries sustained as a result of any act of war (declared or undeclared), voluntary participation in civil disobedience, or other such activities.
- 10) Any service determined to be not Medically Necessary by the Company, in its sole discretion, for the treatment of an illness or injury.

BASIC PLAN PROVISIONS

1) The Department's Right to Change, End, and Interpret Benefits

This Plan is sponsored by the Commonwealth of Virginia, Department of Human Resource Management. The Department is authorized to, and reserves the right to change or terminate this Plan on behalf of the Commonwealth at any time. These retained rights extend, without limit, to all aspects of the Plan, including, for example, benefits, eligibility for benefits, Provider Networks, premiums, Coinsurance and contributions required of Participants. The Department is also authorized and empowered to exercise discretion in interpreting the terms of the Plan and such discretionary determination will be binding on all parties.

2) You and Your Provider

You have the right to select Your own Provider of care. Covered services and other covered items are subject to the provisions of the Plan. Neither the Company nor the State will be responsible for acts or omissions of any Provider. Neither the Company nor the State will be liable for the negligence, misconduct, malpractice, refusal or inability to provide covered services or other covered items, or any other failing of a Provider. Neither the Company nor the State will be liable for breach of contract because of anything done, or not done, by a Provider.

Similarly, the Company is obligated only to pay, in part, for covered services to the extent they are covered under the Plan. Neither the Company nor the State guarantees the availability of a Provider's service. Neither the Company nor the State will be responsible for acts or omissions of any Provider. Neither the Company nor the State will be liable for negligence, misconduct, malpractice, refusal or inability to render services, or any other failing of a Provider. Neither the Company nor the State will be liable for breach of contract because of anything done, or not done, by a Provider. The same limitations apply to things done or not done by an employee of a Provider.

You must tell the Provider that You are eligible for services. When You receive services, show Your health plan identification card. Show only Your current card.

3) Privacy Protection and Your Authorization

Information may be collected from other people and facilities. This is done in order to administer Your coverage. The information often comes from medical care facilities and medical professionals. Collected information is generally disclosed to others only in accordance with the guidelines set forth in the Virginia Insurance Information and Privacy Protection Act. A more detailed explanation of the Company's information practices is available upon request.

When You apply for coverage under the Plan, You agree that the Company may request any medical information or other records from any source when related to claims submitted to the Company for services You receive.

By accepting coverage under the Plan, You authorize any individual, association, or firm which has diagnosed or treated Your condition to furnish the Company with necessary information, records, or copies of records. This authorization extends to any person or organization which has any information or records related to the service received or to the diagnosis and treatment of Your condition.

If the Company asks for information and does not receive it, payment cannot be made. The claim will be processed only when the requested information or record has been received and reviewed.

Medical information is often highly confidential. You are entitled to review or receive only copies of medical information which applies to You. But, subject to the above, an Enrollee may review copies of medical records which pertain to enrolled dependent children under age 18.

4) The Personal Nature of These Benefits

Plan benefits are personal; that is, they are available only to You. You may not assign (give to another person) Your right to receive them. Prior payments to anyone will not constitute a waiver of or in any way restrict the Company's right to direct future payments to You or any other individual or facility, even if there has been an assignment of payment in the past. This paragraph will not apply to assignments made to dentists and oral surgeons.

You and the Company agree that other individuals, organizations, and health care practitioners will not be beneficiaries of the payments provided under this contract. This explanation of services and payments available to You is not intended for anyone else's benefit. As such, no one else (except for Your personal representative in case of Your death or mental incapacity) may assert any rights described in this booklet or provided under the Plan.

5) Proof of Loss

In many cases, the facility or Provider will submit Your claim to the Company. However, the Company cannot process claims for You unless there is satisfactory proof that the services You received are covered. In most cases, "satisfactory proof" is a fully itemized bill which gives Your name, date of the service, cost of the service, and the diagnosis for the condition. In some cases, the Company will need additional proof, such as medical information or explanations. Your cooperation may be requested. Your claim cannot be processed until the needed information is received. All claims information and explanations submitted to the Company must be in writing.

6) Prompt Filing of Claims

No claim will be paid if the Company receives it more than one year after the date on which the service was rendered. If the State terminates the Plan for any reason, no claim will be paid if the Company receives it later than 6 months following the Effective Date of termination. You are responsible for the timely submission of claims other than those submitted directly by Your Provider.

7) Payment Errors and Appeals

Every effort is made to process claims promptly and correctly. If payments are made to You, or on Your behalf, and the Company finds at a later date the payments were incorrect, the Company will pay any underpayment. Likewise, You must repay any overpayment. A written notice will be sent to the Enrollee if repayment is required. See Appeals under General Rules Governing Benefits, page 4, to appeal the denial or payment of a claim.

8) Benefits Administrator and Other Plan Information

Your Benefits Administrator is the appropriate person to assist You with Your health care benefits. Your Benefits Administrator may also provide You information about Your benefits.

If there is a conflict between what Your Benefits Administrator tells You and the Plan, Your benefits will, to the extent permitted by law, be determined on the basis of the language in this booklet. The Benefits Administrator is never the agent of the Company.

The Company may send notices intended for You to Your Benefits Administrator. You may be provided with another booklet, brochure, Participant communication, or other material which describes the benefits available under the Plan. In the event of conflict between this type of information and the Plan, Your benefits will be determined on the basis of the language in this booklet.

9) Continuation of Coverage

Extended Coverage

Extended Coverage is a term which describes coverage required of government employers under the provisions of the Public Health Service Act. These are the same provisions which apply to private employers under the Consolidated Omnibus Budget Reconciliation Act of 1986 (COBRA). Under certain circumstances, a Participant who would ordinarily lose coverage because of any of the Qualifying Events described below is a Qualified Beneficiary who may elect to continue coverage under the State Health Benefits Program for a period of up to 36 months at the Participant's own expense.

There is no State contribution toward Extended Coverage. A fee of 2% is added to the total monthly premium for health benefits. Extended Coverage may run concurrent with any other state-provided continuation such as that provided under long-term disability plans.

In the case of the following Qualifying Events, coverage may be continued up to 36 months at the individual's own expense.

- Death of the Participant under whose membership the affected person was enrolled as a spouse or as a dependent child.
- Divorce, when the affected person was enrolled as a spouse, or dependent child who loses eligibility as a result of the divorce.
- Loss of dependent child status by a person enrolled in health benefits through the State Health Benefits Program.

Eligibility for Extended Coverage ends at the earliest of any of the following:

- Failure to make a premium payment when due. (Partial payment is considered non-payment.)
- The Qualified Beneficiary becomes covered under any other group health plan which does not contain any exclusion or limitation regarding a pre-existing condition of such Qualified Beneficiary. This provision does not apply if the other coverage was in place prior to the Qualifying Event.
- Expiration of the 36-month continuation period.

Reduction or elimination of coverage in anticipation of an Extended Coverage Qualifying Event will not disqualify an otherwise eligible Qualified Beneficiary from receiving Extended Coverage. In the case of a divorce, the Plan will offer Extended Coverage effective on the date of the divorce, but not for any period between when the coverage was lost and the divorce became final.

Your Benefits Administrator will notify Your dependents of their continuation of coverage rights in the case of Your death. Your dependents must respond within 60 days of the State's notification or actual loss of coverage, whichever is later.

In the case of divorce or a change in dependent status (such as reaching the age limit) that results in a loss of coverage, covered dependents or the Participant are responsible for notifying their agency Benefits Administrator within 60 days of the Qualifying Event. If they do not meet this notification requirement, they will forfeit all of their Extended Coverage rights associated with these events.

Premiums for Extended Coverage are 102% of the premiums for regular coverage. By Extended Coverage rules, the affected person has 45 days from the date of the election to make payment.

10) Company's Continuing Rights

On occasion, the Company or the State may not insist on Your strict performance of all terms of this Plan. Failure to apply terms or conditions does not mean the Company or the State waives or gives up any future rights it may have. The Company or the State may later require strict performance of these terms or conditions.

11) Time Limits on Legal Actions and Limitation on Damages

No action at law or suit in equity may be brought against the Company or the State in any matter relating to (1) the Plan, (2) the Company's performance or the State's performance under the Plan; or (3) any statements made by a Participant, officer, or director of the Company or the State concerning the Plan or the benefits available if the matter in dispute occurred more than one year ago.

In the event You or Your representative sues the Company, the State, or any director, officer, or Participant of the Company or the State acting in a capacity as a director, officer, or Participant, Your damages will be limited to the amount of Your claim for covered services. The damages will not exceed the amount of any claim not properly paid as of the time the lawsuit is filed. In no event will this contract be interpreted so that punitive or indirect damages, legal fees, or damages for emotional distress or mental anguish are available.

12) Services After Amendment of This Plan

A change in this Plan will change benefits available to You on the effective date of the change. This means that Your coverage will change even if You are being treated for an ongoing condition.

13) Misrepresentation

A Participant's coverage can be canceled by the Company or the State if it finds that any information needed to accept the Participant or process a claim was deliberately misrepresented by, or with the knowledge of, the Participant. The Company or the State may also cancel coverage for any other family members enrolled with the Participant. When false or misleading information is discovered, the Company or the State may cancel coverage retroactive to the date of misrepresentation.

14) Non-Payment of Monthly Charges

If You are required to pay monthly charges to maintain coverage, and such charges are late, the Company has the right to suspend payment of your claims. The Company will not be responsible for claims for any period for which full monthly charges have not been paid. If

your monthly charges remain unpaid 31 days from the date due, the State may instruct the Company to cancel Your coverage.

15) Death of an Enrollee

Coverage will end for a dependent enrolled with the Enrollee if the Enrollee dies unless continuation of coverage is properly elected and maintained pursuant to Survivor benefits or paragraph **9)** of this section. Coverage for the dependent will end on the last day of the month in which the death occurs.

16) Divorce

Coverage will end for the enrolled spouse of an Enrollee on the last day of the month in which the final divorce decree is granted unless continuation of coverage is properly elected and maintained pursuant to paragraph **9)** of this section. Conversion privileges for the spouse will be extended if the spouse notifies the Company of the divorce in writing within 31 days after the end of the month in which the divorce is granted.

17) End of Dependent Coverage

When a dependent is no longer eligible for coverage, the dependent must notify the Company in writing that he/she wishes to continue coverage under another contract or certificate rather than through the State health benefits program. Conversion privileges for the dependent will be extended if the Company receives notice within 31 days after the end of the month in which the dependent ceased to be eligible for coverage under the State program.

18) Your Responsibility for Conversion

You are responsible for making arrangements for continuous coverage. When You are no longer eligible for coverage under this Plan, You must contact Your Benefits Administrator. You must give the Benefits Administrator an address at which You may be reached during the 3 months immediately following termination. The State will notify the Company. Only when the Company receives proper notice from the State can continuous coverage under this Plan or a non-group conversion policy be offered.

19) Conversion Privileges

When the Company is properly notified by the State that You are no longer eligible for coverage, the Company will contact the Enrollee by mail about coverage available under a non-group conversion policy. These conversion privileges are available only if the Company has the Enrollee's current address. You must respond to the Company's offer within 15 days from the date of the Company's offer, or within 31 days from the date your enrollment ends, whichever of the two provides You with the latest date by which to respond. If You accept the enrollment offer within the time allowed by the offer, there will be no lapse in coverage. Although coverage will be continuous, the new benefits will be different. Be sure to read the Company's offer carefully. It will outline the enrollment requirements, the time permitted to accept the offer, the benefits, and the rates for the new program.

DEFINITIONS

Throughout this booklet are words which begin with capital letters. In most cases, these are defined terms. This section gives You the meaning of most of these words.

1) Allowable Charge

With respect to any Provider's charge for Services rendered in the Company's Network, the Allowable Charge is:

- The amount set forth on the Network Schedule of Allowances, or
- The Provider's charge for that service, whichever is less.

With respect to any Provider's charge for Services not rendered in the Company's Network, the Allowable Charge is:

- The amount set forth on the Network Schedule of Allowances, or
- The Provider's charge for that service, whichever is less.

2) Benefit Period

This means a calendar year. It can also mean a part of a calendar year if Your Effective Date is other than January 1 or if Your enrollment ends other than on December 31. When You first enroll, the Benefit Period extends from your effective date to the next December 31. If your coverage is terminated for any reason, your Benefit Period will end on the same day your enrollment under this benefits section ends.

3) Benefits Administrator

Your Benefits Administrator is the person appointed to provide assistance with changes to Your health care benefits. Your specific contact depends on the retiree group You are part of when You retire.

- Retirees or Survivors of a Retiree or Active Employee with annuitant rights under the Virginia Retirement System (VRS) contact the VRS.
- Retirees under the Optional Retirement Plan (ORP) contact the last employing Agency's benefits office.
- Retirees in positions transferred from State to local entities (or vice versa) with State health care benefits contact the last employing Agency's benefits office.
- Survivors of a Retiree or Active Employee that were not designated for beneficiary or annuitant rights who are granted continuation of health care coverage based on legislation may contact the Department of Human Resource Management.

4) Coinsurance

This means the percentage of the Allowable Charge which You must pay for a covered service. Some services are listed as paid at less than 100%. Your Coinsurance for a service which is listed as paid at less than 100% of the Allowable Charge is the difference between 100% of the Allowable Charge and the percentage listed. In some cases, You will be required to pay amounts in excess of 100% of the Allowable Charge. These amounts are not part of your Coinsurance. Providers who do not participate in the Network or contract with the Company may bill You for more than 100% of the Allowable Charge. Your Coinsurance does not include the amounts these facilities or professionals may charge in excess of 100% of the Allowable Charge.

5) Company

This word means the third party administrator under contract with the Department of Human Resource Management to develop and administer provider networks, process claims, provide customer service, and such other functions as are necessary to make health benefits available to Participants. For dental and vision services, the Company is Trigon Blue Cross Blue Shield.

6) Department

The Department denotes the Department of Human Resource Management (DHRM) and is the Commonwealth of Virginia's central source for information regarding its employee work force and employment opportunities.

7) Effective Date

This is the date Your coverage begins under the Plan.

8) Enrollee

This word means the person who applies for coverage in the health benefits program and in whose name the coverage is obtained.

9) Exclusions

This word means services which are not covered under any circumstances.

10) Health Benefit Plan

A Plan or program offering benefits for any type of health care service is considered a Health Benefit Plan when it is group or blanket insurance or a Blue Cross, Blue Shield, group practice, individual practice, or any other pre-payment arrangement (including this Plan) when an employer contributes any portion of the premium or an employer, association, or other group contracts for the coverage on Your behalf. A Plan or program offering benefits for any type of health care service is considered a Health Benefit Plan if it is provided in whole or in part by any labor-management trustee plan, union welfare plan, employer organization plan, or Participant benefit organization plan or by any governmental program or any coverage required or provided by law or statute.

The term Health Benefit Plan refers to each Plan or program separately. It also refers to any portion of a Plan or program which reserves the right to take into account benefits of other Health Benefit Plans when determining its own benefits. If a Health Benefit Plan has a coordination of benefits provision which applies to only part of its services, the terms of this section will be applied separately to that part and to any other part.

The term Health Benefit Plan as defined here does not include a prepaid health care services contract or accident and sickness policy which is individually underwritten, and individually issued, and provides only for accident and sickness benefits, and is paid for entirely by the Enrollee.

11) Medically Necessary

Required to identify or treat an illness or injury that a Provider has diagnosed or reasonably suspects. To be Medically Necessary, the service must:

- Be consistent with the diagnosis of your condition;
- Be in accordance with standards of good medical practice;

- Not be for the convenience of the patient, the patient's family, or the Provider; and
- Be the most suitable, cost-effective supply or level of service which can be safely provided to You.

12) Medicare

Medicare means the health insurance program established by Title XVIII of the Social Security Act of 1965, as amended.

13) Network and Non-Network Provider

A Network Provider is one that is listed as a Network Provider by the Company. A Network Provider must be listed as such at the time You receive the service for which coverage is sought. Any other Provider is a Non-Network Provider.

14) Network Schedule of Allowances

This term means the maximum allowances for Services which are performed by Network Providers.

15) Participant

This means the Enrollee or eligible family members while enrolled in a Plan.

16) Plan

Plan, in this booklet, means the Dental/Vision Plan.

17) Primary Coverage

This means the Health Benefit Plan which will provide benefits first. It does not matter whether or not You have filed a claim for benefits with the primary Health Benefit Plan. If You are eligible for coverage under two Health Benefit Plans, the Primary Coverage will be used to decide what Secondary Coverage benefits are available.

18) Provider

For the purposes of this Plan, this word means a properly licensed:

- Dentist;
- Doctor of Dental Surgery
- Doctor of Medicine (Ophthalmologist)
- Optician, or
- Optometrist.

19) Secondary Coverage

This is the Health Benefit Plan under which the benefits may be reduced to prevent duplicate or overlapping coverage.

20) State

This word means the Commonwealth of Virginia.

21) Visit

This means a brief period during which You meet with a Physician or another person whose services are eligible for reimbursement.

22) You, Your, or Yourself

These words refer to a Participant.

ELIGIBILITY

RETIREES

Classified employees and full-time faculty members who retire and are eligible for a monthly annuity or a periodic benefit and who are not deferring receipt of the retirement benefit are eligible for membership in the Dental/Vision Plan.

Dependents

The following dependents are also eligible for membership:

- The legally married spouse of an eligible retiree.
- The eligible retiree's unmarried biological or legally adopted child(ren).
- A child placed in an eligible retiree's home under a pre-adoptive agreement which has been approved by the Department of Human Resource Management. Such an agreement must, at a minimum, (1) stipulate that the biological parents have ceded all parental rights, including care, custody, and visitation, and (2) vest responsibility for the welfare of a child in a court or a public agency appointed by a court.
- Unmarried stepchildren living full time with the eligible retiree in a parent-child relationship **and** who are lawfully claimed as a dependent on the eligible retiree's federal income tax return.
- Disabled adult children who are certified as such by the Plan upon application by the eligible retiree filed within 31 days of the child's losing eligibility for membership due to age.
- Other children, on an exception basis approved by the Department of Human Resource Management, provided that the children are in the permanent custody of the eligible retiree pursuant to an order of a court.

Ineligible Persons

The following persons are never eligible for membership:

- A child who is married.
- A child who is self-supporting. A child who works full time is self-supporting for the purposes of the health benefits program, regardless of where the child lives and regardless of the child's eligibility for health insurance through the child's employer. The only exception is a child who was a full-time student during the spring semester, works full time only during the summer months, and becomes a full-time student again in the fall.
- A child over the age of 23, unless eligible through disability. (Eligibility may continue through the end of the calendar year in which the child turns 23.)*
- Stepchildren who do not live full time with the retiree; stepchildren living with the retiree who are not claimed as a dependent on the eligible retiree's federal income tax return.
- Parents.
- Grandparents.
- Brothers or sisters, unless found eligible by the Department of Human Resource Management as other children described above.
- Grandchildren, unless found eligible by the Department of Human Resource Management as other children described above.

* There is one exception. Surviving non-annuitant dependent children of an active or retired State employee are eligible for coverage up to the age of twenty-five if the dependent is a full-time college student. Coverage terminates when the dependent reaches age twenty-five or ceases to be a full-time college student.

- Ex-spouses. A court order or separation agreement which requires a retiree to provide coverage for an ex-spouse does not make an ex-spouse eligible for coverage through the health benefits program.

Enrollment and Plan or Membership Changes

- **Newly Retired:** Coverage for newly eligible retirees is effective the first of the month following the date active employment ends. Election to participate in the health benefits program must be made within 31 days of retirement.
- **Making Changes:** Membership and plan changes may be made the first of the month following receipt of an Enrollment/Waiver Form by your Benefits Administrator.
- **Termination of Coverage:** Coverage terminates the last day of the month in which a Participant loses eligibility.

RETIRED EMPLOYEES AND SURVIVING DEPENDENTS

- Medicare eligible retirees may continue coverage in the selected plan until a change is made or coverage terminates. Retirees may also continue health care coverage for their spouse and dependent children.
 - A surviving spouse with a survivor benefit may continue health care coverage as long as conditions outlined in the policies and procedures of the Department of Human Resource Management are met.
 - Eligible dependent children of a retiree or deceased retiree may be covered through the end of the year in which the child turns age 23 as long as the child is not self-supporting or married unless eligible through disability.*
- Health benefits for the surviving spouse and/or dependent children of an active or retired State employee who are non-annuitants are also eligible for coverage provided through the Retiree Health Benefits Program.
 - Coverage for the surviving spouse automatically terminates at remarriage; alternate health insurance coverage being obtained; or any applicable condition outlined in the policies and procedures of the Department of Human Resource Management.
 - Coverage for any surviving dependent children in this category automatically terminates at death; age twenty-one, unless the dependent is:
 - (a) a full-time college student, in which case the coverage shall not terminate until the dependent has either reached the age of twenty-five or ceases to be a full-time college student, whichever occurs first, or
 - (b) under a mental or physical disability, in which event coverage shall not terminate until three months following cessation of the disability; or any applicable condition outlined in the policies and procedures of the Department of Human Resource Management.

* There is one exception. Surviving non-annuitant dependent children of an active or retired State employee are eligible for coverage up to the age of twenty-five if the dependent is a full-time college student. Coverage terminates when the dependent reaches age twenty-five or ceases to be a full-time college student.

- Special rules apply to employees and/or their covered dependents when the employee is disabled or killed in the line of duty.
 - Coverage for the surviving spouse automatically terminates upon alternate health insurance coverage being obtained or any applicable condition outlined in the policies and procedures of the Department of Human Resource Management.
 - Coverage for any surviving dependent children in this category automatically terminates at death; age twenty-one, unless the dependent is:
 - (a)** a full-time college student, in which case the coverage shall not terminate until the dependent has either reached the age of twenty-five or ceases to be a full-time college student, whichever occurs first, or
 - (b)** under a mental or physical disability, in which event coverage shall not terminate until three months following cessation of the disability; or any applicable condition outlined in the policies and procedures of the Department of Human Resource Management.

STATUTORY BENEFITS

The following must, by statute, be offered to Medicare-eligible retirees in the State retiree health benefits program. This may also be referred to as mandated benefits. The text below has been excerpted from the Code of Virginia, § 2.1-20.1. This information will be updated each July 30. Statutory benefits are believed to have been incorporated into the State retiree health benefits program for plans offered to Medicare-eligible retirees.

E. Provisions shall be made for retired employees to obtain coverage under the above plan, including, as an option, coverage for vision and dental care. The Commonwealth may, but shall not be obligated to, pay all or any portion of the cost thereof.

L. 1. The Department of Human Resource Management shall appoint an Ombudsman to promote and protect the interests of covered employees under any state employee's health plan.

2. The Ombudsman shall:

a. Assist covered employees in understanding their rights and the processes available to them according to their state health plan.

b. Answer inquiries from covered employees by telephone and electronic mail.

c. Provide to covered employees information concerning the state health plans.

d. Develop information on the types of health plans available, including benefits and complaint procedures and appeals.

e. Make available, either separately or through an existing Internet web site utilized by the Department of Human Resource Management, information as set forth in clause d and such additional information as deemed appropriate.

f. Maintain data on inquiries received, the types of assistance requested, any actions taken and the disposition of each such matter.

g. Upon request, assist covered employees in using the procedures and processes available to them from their health plan, including all appeal procedures. Such assistance may require the review of health care records of a covered employee, which shall be done only with that employee's express written consent. The confidentiality of any such medical records shall be maintained in accordance with the confidentiality and disclosure laws of the Commonwealth.

h. Ensure that covered employees have access to the services provided by the Ombudsman and that the covered employees receive timely responses from the Ombudsman or his representatives to the inquiries.

i. Report annually on his activities to the standing committees of the General Assembly having jurisdiction over insurance and over health and the Joint Commission on Health Care by December 1 of each year.

M. 1. The plan established by the Department of Human Resource Management shall not refuse to accept or make reimbursement pursuant to an assignment of benefits made to a dentist or oral surgeon by a covered employee.

2. For purposes of this subsection, "assignment of benefits" means the transfer of dental care coverage reimbursement benefits or other rights under the plan. The assignment of benefits shall not be effective until the covered employee notifies the plan in writing of the assignment. Any group health insurance plan established by the Department of Human Resource Management that contains a coordination of benefits provision shall provide written notification to any eligible employee as a prominent part of its enrollment materials that if such eligible employee is covered under another group accident and sickness insurance policy, group accident and sickness subscription contract, or group health care plan for health care services, that insurance policy, subscription contract or health care plan may have primary responsibility for the covered expenses of other family members enrolled with the eligible employee. Such written notification shall describe generally the conditions upon which the other coverage would be primary for dependent children enrolled under the eligible employee's coverage and the method by which the eligible enrollee may verify from the plan which coverage would have primary responsibility for the covered expenses of each family member.

§ [38.2-3407.13:1](#). Coordination of benefits; notice of priority of coverage.

Each (i) insurer issuing individual or group accident and sickness insurance policies providing hospital, medical and surgical or major medical coverage on an expense-incurred basis, (ii) corporation providing individual or group accident and sickness subscription contracts, and (iii) health maintenance organization providing a health care plan for health care services, whose policy, contract or plan, including any certificate or evidence of coverage issued in connection with any such policy, contract or plan, contains a coordination of benefits provision shall provide written notification to the insured, subscriber or member as a prominent part of its enrollment materials that if such insured, subscriber or member is covered under another group accident and sickness insurance policy, group accident and sickness subscription contract, or group health care plan for health care services, that insurance policy, subscription contract or health care plan may have primary responsibility for the covered expenses of other family members enrolled with the insured, subscriber or member. Such written notification shall describe generally the conditions upon which the other coverage would be primary for dependent children enrolled under the insured's, subscriber's, or member's coverage and the method by which the insured, subscriber or member may verify from the insurer, corporation or health maintenance organization which coverage would have primary responsibility for the covered expenses of each family member. The provisions of this section shall not be construed to abrogate any coordination of benefits provision authorized pursuant to subsection B of § 38.2-3405.

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