



HIGHMARK BLUE CROSS BLUE SHIELD WEST VIRGINIA  
614 MARKET STREET  
PARKERSBURG, WEST VIRGINIA 26101

ENDORSEMENT

Providing for Whole Health Balance Program Benefits

This Endorsement is issued to be attached to and form part of the following Highmark Blue Cross Blue Shield West Virginia Policies:

Medigap Blue w/MM with Rx  
Medigap Blue - S65 Conversions  
Medigap Blue - Bluefield Senior 65  
Medigap Blue - Supplement Area B  
Medigap Blue - Supplement Area C  
Medigap Blue - Mgtm Supplemental  
Medigap Blue - Supplement Area A  
Medigap Blue Plan A  
Medigap Blue Plan C  
Php Medigap Blue  
Medigap Blue - Supplemental  
Medigap Blue Plan F  
Medigap Blue Plan I with Rx  
Medigap Blue - Old High Option with Rx  
Medigap Blue - Old High Option  
Medigap Blue - Old Low Option  
Medigap Blue Plan I  
Medigap Blue Plan N  
Medigap Blue Plan Fhd  
Medigap Blue Plan D  
Medigap Blue Plan G

**WHB/MB/HBCBSWV-1**

27828 (R8-18)

Notwithstanding any provisions to the contrary, said Policy is modified by adding the following new section:

**“SECTION E. WHOLE HEALTH BALANCE PROGRAM**

**A. ELIGIBILITY AND ENROLLMENT**

Eligibility for the Whole Health Balance Program (“Program”) is limited to current Policyholders who elect to enroll in the Program. Enrollment in the Program is optional and must be requested by the Policyholder, in writing. Requests for enrollment in the Program can be made at the time of application for coverage under the Policy or at any time subsequent thereafter during which coverage remains in effect.

Once the Plan accepts the written request of the Policyholder for enrollment in the Program, the Policyholder’s enrollment in the Program will remain in effect until such time as:

- a. the Policy terminates;
- b. the Policyholder fails to pay the required monthly Program subscription fee; or
- c. the Policyholder notifies the Plan, in writing, of the intent to terminate enrollment in the Program.

The right of the Policyholder to terminate enrollment in the Program may only be made once the current period of enrollment in the Program has been in effect for a minimum of six (6) consecutive calendar months.

**B. BENEFITS**

During any continued period of enrollment in the Program, the coverage under this Policy will provide benefits and/or access to the following services:

1. Dental services not covered by Medicare
  - a. Coverage for one (1) oral examination and cleaning every six (6) months subject to Policyholder copayment liability of \$30 for each covered examination.
  - b. Coverage of radiographic examinations consisting of one (1) set of bitewing x-rays every calendar year and full mouth x-rays every five (5) years subject to a Policyholder copayment liability of \$25 for each covered examination.

To be eligible for benefits, all dental services covered under the Program must be rendered by a dentist who participates in the United Concordia Advantage Plus network or is another dental provider identified by the Plan.

2. Vision services and products not covered by Medicare

- a. Coverage of one (1) routine eye examination, including refraction, every calendar year.
- b. Coverage of one (1) pair of Davis Vision Fashion Collection standard eyeglass frames and standard plastic lenses or contact lenses every calendar year.

Davis Vision Fashion Collection eyeglass frames, standard plastic lenses and contact lenses are covered in full. Purchases of non-Davis Vision Fashion Collection eyeglass frames, eyeglass lenses and contact lenses are covered under the Program but only up to a benefit maximum of \$100.

To be eligible for benefits, all vision services and products covered under the Program must be received from a Davis Vision network provider or another vision provider identified by the Plan.

3. Hearing aids and services

- a. Coverage for one (1) routine hearing examination every calendar year subject to Policyholder copayment liability of \$40 for each covered examination.
- b. Coverage for up to two (2) hearing aids every calendar year subject to a Policyholder copayment liability of \$699 for each TruHearing Advanced hearing aid and \$999 for each TruHearing Premium hearing aid. Hearing aid benefits include up to three (3) additional TruHearing provider visits within the first year of purchase and forty-eight (48) batteries for each covered hearing aid.

To be eligible for benefits, all hearing aids and services covered under the Program must be received from a TruHearing network provider or another hearing provider identified by the Plan.

4. Health and wellness education services.

A membership providing access to designated fitness centers identified by the Plan which include fitness classes such as SilverSneakers Fitness program and other health and wellness educational opportunities.

**C. PROGRAM SUBSCRIPTION FEE**

The monthly subscription fee applicable to the Program made available through this Endorsement is that fee amount approved by the West Virginia Department of Insurance Commissioner. Upon enrollment into the Program, the Policyholder agrees to pay the Plan the applicable monthly Program subscription fee of [\$34.50] in advance, as billed.

The Plan, subject to the approval of the West Virginia Department of Insurance Commissioner, may modify:

1. the terms and conditions of the Program set forth in this Endorsement issued by the Plan; and/or
2. the monthly Program subscription fee.

Any such modification of the terms and conditions of the Program set forth in this Endorsement or the monthly Program subscription fee shall become applicable for Policyholders to whom this Endorsement has been issued on the effective date of the modification, whether or not such Policyholders have paid monthly Program subscription fees in advance.

The Plan also reserves the right to terminate the Program, in its entirety, upon prior notice to all Policyholders who have elected to enroll.

**D. CLAIMS AND PAYMENT OF PROGRAM BENEFITS**

Upon acceptance of the Policyholder's request to be enrolled in the Program, the Plan shall issue to the Policyholder an Identification Card acknowledging the enrollment. To receive Program benefits, the Policyholder is required to present this Identification Card to participating Program services and products providers identified by the Plan.

All claims for benefits to be paid by the Plan for services and products covered under this Program will be submitted by Program service and product providers directly to the Plan. Policyholders are not required to submit claims or seek reimbursement from the Plan for those amounts. Policyholders are still responsible for all required Program benefit copayments and any amounts in excess of any stated maximum Program benefit amount. Policyholders are required to pay those amounts directly to the Program provider from which the Program covered service or product was received.

Except as stated in this Endorsement, the Policy remains unchanged.

This Endorsement is effective on the date set forth in the notice of enrollment confirmation issued by the Plan or the date of issue of your Policy, whichever is later.

HIGHMARK INC., d/b/a  
HIGHMARK BLUE CROSS BLUE SHIELD WEST VIRGINIA:

  
James L. Fawcett, President



## Discrimination is Against the Law

The Claims Administrator/Insurer complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. The Claims Administrator/Insurer does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex. The Claims Administrator/Insurer:

- Provides free aids and services to people with disabilities to communicate effectively with us, such as:
  - Qualified sign language interpreters
  - Written information in other formats (large print, audio, accessible electronic formats, other formats)
- Provides free language services to people whose primary language is not English, such as:
  - Qualified interpreters
  - Information written in other languages

If you need these services, contact the Civil Rights Coordinator.

If you believe that the Claims Administrator/Insurer has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance with: Civil Rights Coordinator, P.O. Box 22492, Pittsburgh, PA 15222, Phone: 1-866-286-8295, TTY: 711, Fax: 412-544-2475, email: [CivilRightsCoordinator@highmarkhealth.org](mailto:CivilRightsCoordinator@highmarkhealth.org). You can file a grievance in person or by mail, fax, or email. If you need help filing a grievance, the Civil Rights Coordinator is available to help you. You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights electronically through the Office for Civil Rights Complaint Portal, available at <https://ocrportal.hhs.gov/ocr/portal/lobby.jsf>, or by mail or phone at:

U.S. Department of Health and Human Services

200 Independence Avenue, SW

Room 509F, HHH Building

Washington, D.C. 20201

1-800-368-1019, 800-537-7697 (TDD)

Complaint forms are available at <http://www.hhs.gov/ocr/office/file/index.html>.

Insurance or benefit/claims administration may be provided by Highmark, Highmark Choice Company, Highmark Coverage Advantage, Highmark Health Insurance Company, First Priority Life Insurance Company, First Priority Health, Highmark Benefits Group, Highmark Select Resources, Highmark Senior Solutions Company or Highmark Senior Health Company, all of which are independent licensees of the Blue Cross and Blue Shield Association, an association of independent Blue Cross and Blue Shield plans.

ATTENTION: If you speak English, language assistance services, free of charge, are available to you. Call the number on the back of your ID card (TTY: 711).

ATENCIÓN: Si usted habla español, servicios de asistencia lingüística, de forma gratuita, están disponibles para usted. Llame al número en la parte posterior de su tarjeta de identificación (TTY: 711).

请注意：如果您说中文，可向您提供免费语言协助服务。

请拨打您的身份证背面的号码 (TTY: 711)。

CHÚ Ý: Nếu quý vị nói tiếng Việt, chúng tôi cung cấp dịch vụ hỗ trợ ngôn ngữ miễn phí cho quý vị. Xin gọi số điện thoại ở mặt sau thẻ ID của quý vị (TTY: 711).

알림: 한국어를 사용하시는 분들을 위해 무료 통역이 제공됩니다. ID 카드 뒷면에 있는 번호로 전화하십시오 (TTY: 711).

ATENSYON: Kung nagsasalita ka ng Tagalog, may makukuha kang mga libreng serbisyong tulong sa wika. Tawagan ang numero sa likod ng iyong ID card (TTY: 711).

ВНИМАНИЕ: Если вы говорите по-русски, вы можете воспользоваться бесплатными услугами языковой поддержки. Позвоните по номеру, указанному на обороте вашей идентификационной карты (номер для текст-телефонных устройств (TTY): 711).

تنبيه: إذا كنت تتحدث اللغة العربية، فهناك خدمات المساعدة في اللغة المجانية متاحة لك. اتصل بالرقم الموجود خلف بطاقة هويتك (جهاز الاتصال لذوي صعوبات السمع والنطق: 711).

ATTENTION: Si c'est créole que vous connaissez, il y a un certain service de langues qui est gratis et disponible pour vous-même. Composez le numéro qui est au dos de votre carte d'identité. (TTY: 711).

ATTENTION: Si vous parlez français, les services d'assistance linguistique, gratuitement, sont à votre disposition. Appelez le numéro au dos de votre carte d'identité (TTY: 711).

UWAGA: Dla osób mówiących po polsku dostępna jest bezpłatna pomoc językowa. Zadzwoń pod numer podany na odwrocie karty ubezpieczenia zdrowotnego (TTY: 711).

ATENÇÃO: Se a sua língua é o português, temos atendimento gratuito para você no seu idioma. Ligue para o número no verso da sua identidade (TTY: 711).

ATTENZIONE: se parla italiano, per lei sono disponibili servizi di assistenza linguistica a titolo gratuito. Contatti il numero riportato sul retro della sua carta d'identità (TTY: 711).

ACHTUNG: Wenn Sie Deutsch sprechen, steht Ihnen unsere fremdsprachliche Unterstützung kostenlos zur Verfügung. Rufen Sie dazu die auf der Rückseite Ihres Versicherungsausweises (TTY: 711) aufgeführte Nummer an.

注：日本語が母国語の方は言語アシスタンス・サービスを無料でご利用いただけます。ID カードの裏に明記されている番号に電話をおかけください (TTY: 711)。

توجه : اگر شما به زبان فارسی صحبت می کنید، خدمات کمک زبان، به صورت رایگان، در دسترس شماست. با شماره واقع در پشت کارت شناسایی خود ( TTY: 711 ) تماس بگیرید.