Transparency In Coverage

A. Out-of-Network Liability and Balance Billing

CMS Description of Item - Balance billing occurs when an out-of-network provider bills an enrollee for charges – other than copayments, coinsurance, or any amounts that may remain on a deductible.

Piedmont's PPO Plans

If the member chooses one of Piedmont's PPO plans, the highest level of Benefits is available when you obtain Covered Services from Piedmont Providers. The Benefits are called "In-Plan" Benefits. For receipt of In-Plan Benefits when required Services are not available from Piedmont Providers the Participant (or his or her Piedmont Physician) shall contact Piedmont and provide information that the required Covered Services needed by the Participant are not available from Piedmont Providers. In that case, Piedmont will review the information with you and/or your Piedmont Physician as necessary and work with you and/or your Piedmont Physician to arrange for the Services to be provided as In-Plan Benefits by referral Providers outside the Service Area (or outside Piedmont's Network of Providers) with whom Piedmont has made arrangements to provide these Covered Services.

This Benefit Plan is a Network product that allows Participants to receive most Services either from non-Piedmont Providers or Piedmont Providers. A Participant who receives Covered Services from Providers other than Piedmont Providers (non-Piedmont Providers) will be subject to a reduced level of Benefits (which may result in no Benefits for some Services). These reduced Benefits are called "Out-of-Plan" Benefits. Coverage for both "In- Plan" and "Out-of-Plan" Benefits is described on the Schedule of Benefits that is a part of your Policy.

You have the option to receive Services from Piedmont or non-Piedmont Providers. When you choose to receive Services from a non-Piedmont Provider, then you are considered "Out-of-Plan" or "Out-of-Network." You have access to the same Covered Services as provided in this Policy; however, different Copayment, Deductible and/or Coinsurance amounts or Benefits maximums are listed on your Schedule of Benefits for Out-of-Plan services that will apply. If you receive Services without the proper authorization, you are considered "Out-of-Plan." These are listed in the "How to Use Your Benefits" Section of this Policy.

When you receive care or treatment from a non-Piedmont Provider, you may be responsible for all claims filing and preauthorization if this Provider does not agree to do so on your behalf. In addition, you may be balance billed by non-Piedmont Providers as described below.

Balance Billing - Piedmont's payment for Covered Services is based on an Allowable Charge. When Services are received from a Piedmont Provider who has agreed to Piedmont's negotiated rate, Participants are not responsible for the difference between the negotiated rate and the billed amount. This amount is "written off" by the Piedmont Provider. For Out-of-Plan Covered Services, the Benefit payable is based on an Allowable Charge that Piedmont has determined to be applicable to non-Piedmont Providers. Balance billing is when the non-

Piedmont Provider bills you for the amounts over and above Piedmont's Allowable Charge. You are responsible for the amounts above the Allowable Charge in addition to any Copayment, Deductible and/or Coinsurance amounts. Balance billed amounts do not count towards the Out-of-Pocket Limit maximum.

The Copayment amounts and Coinsurance percentages for Emergency services received from a non-Piedmont Provider are the same as the Copayment amounts and Coinsurance percentages for Emergency services received from a Piedmont Provider. Medically Necessary services will be covered whether you get care from an in-network or out-of-network Provider. Emergency care you get from an out-of-network Provider will be covered as an in-network service, but you may have to pay the difference between the out-of-network Provider's charge and the maximum allowed amount, as well as any applicable Coinsurance, Copayment or Deductible.

Piedmont's HMO Plans
If the member chooses one of Piedmont's HMO plans, there are no benefits provided for Out-of-Plan or Out-of-Network services, except in cases of Emergency services or in cases where Piedmont has issued a referral. This means that members who go to an Out-of-Plan provider, without having a Piedmont referral or being an Emergency situation, will have to pay all charges out of pocket for the services they receive.

Allowable Charge means the amount determined by Piedmont as payable for a specified Covered Service or the Provider's actual charge for that Service, whichever is less. Piedmont will not pay more than its Allowable Charge for any Covered Service. You will only have to pay your Copayment, Deductible, and/or Coinsurance and will not be balance billed by Piedmont Providers for amounts above the Allowable Charge. When seeing a non-Piedmont Provider due to a Piedmont preauthorized referral or an Emergency, Participants are responsible for billed charges in excess of the Allowable Charge. Amounts above the Allowable Charge do not apply toward the maximum Out-of-Pocket Limit.

The Copayment amounts and Coinsurance percentages for Emergency services received from a non-Piedmont Provider are the same as the Copayment amounts and Coinsurance percentages for Emergency services received from a Piedmont Provider. Medically Necessary services will be covered whether you get care from an in-network or out-of-network Provider. Emergency care you get from an out-of-network Provider will be covered as an in-network service, but you may have to pay the difference between the out-of-network Provider's charge and the maximum allowed amount, as well as any applicable Coinsurance, Copayment or Deductible.

B. Enrollee Claims Submission

CMS Description of Item - An enrollee, instead of the provider, submits a claim to the issuer, requesting payment for services that have been received.

Piedmont's PPO and HMO Plans
Piedmont In-Plan providers file claims for members after they receive services. When you receive care or treatment from a non-Piedmont Provider (Piedmont HMO plans do not provide benefits for Out-of-Network services unless in Emergency situations or with a Piedmont

referral or authorization), you may be responsible for all claims filing and preauthorization if this Provider does not agree to do so on your behalf. In addition, you may be balance billed by non-Piedmont Providers.

Written notice of a claim must be given within 20 days after a Covered loss starts or as soon as reasonably possible. The notice can be given to Piedmont at 2316 Atherholt Road, Lynchburg, VA 24501, or to Piedmont's agent. Notice should include the name of the Insured, and Claimant if other than the Insured, and the Policy number.

When Piedmont receives a notice of claim, it will send the Participant forms for filing proof of loss. If these forms are not given to the Participant within 15 days after the giving of such notice, then the Participant shall meet the proof of loss requirements by giving Piedmont a written statement of the nature and extent of the loss within the time limit stated in the Proofs of Loss Section.

If the Policy provides for periodic payment for a continuing loss, written proof of loss must be given to Piedmont within 90 days after the end of each period for which Piedmont is liable. For any other loss, written proof must be given within 90 days after such loss. If it was not reasonably possible to give written proof in the time required, Piedmont shall not reduce or deny the claim for this reason if the proof is filed as soon as reasonably possible. In any event, except in the absence of legal capacity, the proof required must be given no later than one year from the time specified.

Benefits will be paid to the Insured. Loss of life Benefits are payable in accordance with the beneficiary designation in effect at the time of payment. If none is then in effect, the Benefits will be paid to the Insured's estate. Any other Benefits unpaid at death may be paid, at Piedmont's option, either to the Insured's beneficiary or the Insured's estate.

Any Participant-submitted Prescription Drug claims must be submitted on a Piedmont claim form, with receipts and a written explanation attached, within 60 days of the date the prescription was filled in order to be covered under this Policy.

C. Grace Periods and Claims Pending Policies During the Grace Period

CMS Description of Item - A QHP issuer must provide a grace period of three consecutive months if an enrollee receiving advance payments of the premium tax credit has previously paid at least one full month's premium during the benefit year. During the grace period, the QHP issuer must provide an explanation of the 90 day grace period for enrollees with premium tax credits pursuant to 45 CFR 156.270(d).

Piedmont's PPO and HMO Plans

Only Participants for whom Piedmont has received the required Premiums shall be entitled to Covered Services, and then only for the period(s) for which such payment(s) is / are received. Except as otherwise provided in this paragraph, the Insured must pay the required Premium for Coverage in full on or before the 1st day of each month preceding the next month's Coverage. There is one exception. A grace period will be granted for payment of every Premium except

the first Premium. The grace period is an additional period of time during which Coverage remains in effect and refers to either the 31-day grace period for individuals not receiving advance payments of the Premium tax credit APTC), or the 3-month grace period required for individuals receiving APTC. Coverage will remain in force during the grace period, unless you provide Piedmont with notice of your wish to discontinue Coverage in advance of the date of discontinuance.

Grace period for recipients of advance payments of the premium tax credit.
Piedmont provides a grace period of 3 months for an enrollee, who when failing to timely pay premiums, is receiving advance payments of the premium tax credit. During the grace period, Piedmont will:

(1) Pay all appropriate claims for services rendered to the enrollee during the first month of the grace period and may pend claims for services rendered to the enrollee in the second and third months of the grace period;

(2) Notify HHS of such non-payment; and,

(3) Notify providers of the possibility for denied claims when an enrollee is in the second and third months of the grace period.

If the Participant does receive APTC, a grace period of three consecutive months is allowed for individuals who have previously paid at least one month's Premium in a Benefit year. During the grace period, we must apply any payment received to the first billing cycle in which payment was delinquent and continue to collect the APTC. If the required full Premium is not paid before the end of the grace period, the last day of Coverage will be the last day of the first month of the 3-month grace period. We must pay claims during the first 31 days of the grace period but may pend claims in the second and third months. You will be responsible for any claims incurred after 31 days of the 3 month grace period, if premiums dur are not paid within the final 2 months of the grace period.

Grace period for recipients not receiving advance payments of the premium tax credit.
If the Participant does not receive APTC, the grace period will begin on the Premium due date and continue for 31 days, unless you provide Piedmont with notice of your wish to discontinue Coverage in advance of the date of discontinuance. If you do not make the full payment of any Premium due during the grace period, the Policy will be terminated at the end of the Grace Period.

D. Retroactive Denials

CMS Description of Item - A retroactive denial is the reversal of a previously paid claim, through which the enrollee then becomes responsible for payment.

Piedmont's PPO and HMO Plans
Piedmont may deny a claim after the member has received services from a provider. This could happen in cases of loss of coverage due to non-payment of premium or loss of eligibility of

coverage. It could also occur if Piedmont performs a retrospective review of medical records or services to determine Medical Necessity. A retrospective review could also include determining that a true emergency situation existed for Emergency Room or Urgent Care Center visits.

Members should try to prevent retroactive denials of claims by always paying their premiums on time and notifying the Marketplace of any change in circumstances. The member should also become familiar with Piedmont's preauthorization procedures to prevent retroactive denials.

E. Enrollee Recoupment of Overpayments

CMS Description of Item - Enrollee recoupment of overpayments is the refund of a premium overpayment by the enrollee due to the over-billing by the issuer.

Piedmont's PPO and HMO Plans
Premium(s) shall mean the monthly payment due from the Insured to Piedmont as specified in the Policy and related documents as a condition precedent for Insureds to receive Coverage. Members should contact Piedmont if they think that they have paid more premium than what they believe is due and therefore ask Piedmont for a refund.

F. Medical Necessity and Prior Authorization Timeframes and Enrollee Responsibilities

CMS Description of Item –

1. Medical necessity is used to describe care that is reasonable, necessary, and/or appropriate, based on evidence-based clinical standards of care.
2. Prior authorization is a process through which an issuer approves a request to access a covered benefit before the insured accesses the benefit.

Piedmont's PPO and HMO Plans
Medically Necessary services or Medical Necessity refers to those Covered Services that Piedmont determines are: (1) consistent with the diagnosis and treatment of the Insured's condition; (2) are appropriate given the circumstances and the symptoms; (3) are provided to treat the condition, illness, disease or injury; (4) are in accordance with standards of good medical practice; (5) are not primarily for the convenience of the Insured or the Provider; and (6) with respect to Inpatient care, are provided to treat a condition requiring acute care as a bed patient. Piedmont will determine the Medical Necessity of a given service or procedure.

It is the member's responsibility to obtain preauthorization before treatment is received for services that require it. Piedmont requires Providers (or Participants acting on their own behalf) to make preauthorization arrangements during regular business hours. Piedmont's preauthorization is not required for Emergencies anytime or Urgent Care situations after hours.

Certain Covered Services will require preauthorization by Piedmont, except in an Emergency or Urgent Care situations after hours (see below). Your Piedmont Physician will work with you and Piedmont to handle these preauthorization requirements. Examples of these Services are as follows:

1. Referrals for Covered Services to Providers who are not Piedmont Providers.
2. Transplants.
3. Non-Emergency Inpatient procedures, Outpatient services at a skilled medical facility (including a Hospital), and diagnostic testing / X-rays at a skilled medical facility (including a Hospital).
4. Non-Emergency MRI and related diagnostic procedures.
5. Non-Emergency ambulance and air ambulance transportation.
6. Home health services, home infusion therapy services, hospice services, and durable medical equipment or services, any of which costs in excess of $200.
7. Physical therapy, occupational therapy, and speech therapy services.
8. Specialty prescription drugs.

You or your Piedmont Provider must submit documentation, including a treatment plan when requested, to Piedmont for Services requiring preauthorization. Piedmont will establish that the appropriate level of criteria have been met and, if so, provide an authorization to the Provider from whom you plan to receive Services.

A Participant is not required to receive a referral or authorization from the Primary Care Physician or Piedmont before receiving obstetrical or gynecological care from a Provider who specializes in obstetrics or gynecological care. Obstetrical and gynecological care that the Participant may receive from a Provider without the Primary Care Physician's or Piedmont's prior authorization includes ordering related obstetrical and gynecological items and services that are Covered Benefits.

When you require resuscitation, Emergency treatment, or your life is endangered, Piedmont does not require prior authorization before you call: (1) an Emergency 911 system; or (2) other state, county or municipal Emergency medical system.

Emergency services provided to the Insured in the Emergency department of a Hospital or other skilled medical facility are Covered Benefits:

(a) Without regard to whether the Provider furnishing the Emergency services is a Piedmont Provider with respect to the services;

(b) Without the need for preauthorization by Piedmont, even if a non-Piedmont Provider provides the Emergency Services; and

(c) If a non-Piedmont Provider provides the Emergency Services, without imposing any administrative requirement or limitation on Coverage that is more restrictive than the requirements or limitations that apply to Emergency services received from Piedmont Providers.

If your Piedmont Physician feels that you need to see a Physician or other medical professional who is not a Piedmont Provider and you believe these Services may be eligible for In-Plan Benefits, then your Physician must submit medical information, in writing, to Piedmont. Retroactive requests for consideration at the In-Plan Benefit level will not be considered. Covered Services from non-Piedmont Providers must be preauthorized by Piedmont in order to receive In-Plan Benefits. Piedmont has the right to determine where the Service can be provided for Coverage when a Piedmont Provider cannot render the Service.

1. Post-Service and Pre-Service Claims Review:

Piedmont will review a:

- Post-service claim within: 30 days after Piedmont receives it; and
- Pre-service claim within: 15 days after Piedmont receives it.

A "post-service claim" is any claim under this Policy for a Benefit for which the Participant does not need approval before receiving the Benefit. Most claims under this Policy are post-service claims.

A "pre-service claim" is any claim under this Policy for a Benefit for which the Participant must receive approval (preauthorization) before receiving the Benefit.

Piedmont may extend the time to review a claim for an additional 15 days if it: (1) decides that an extension is necessary for reasons beyond Piedmont's control; (2) notifies you of the reason for the extension in writing before the initial review period ends; and (3) tells you when Piedmont expects to make its final decision. If the extension is because Piedmont did not receive necessary information, the extension notice will describe the needed information. You will have 45 days after you receive such an extension notice to provide the information. Piedmont's time to review a claim is "tolled" or stops between the date it sends the extension notice and the date Piedmont receives the requested information.

2. Urgent Care Claims Review:

Except as otherwise provided in this section, Piedmont will review an Urgent Care Claim within 72 hours after receipt.

For the purposes of this paragraph and the "Claims and Eligibility Appeals" and "Claims Notices" paragraphs of this Section, an "Urgent Care Claim" is any claim for a Benefit for which the application of post-service or pre-service time frames:

- Could seriously jeopardize the Participant's life, health, or ability to regain maximum function; or
- Would, in the opinion of a Physician who is knowledgeable about the Participant's medical condition, subject that Participant to severe pain that cannot be adequately managed without the Benefit.

Piedmont will notify the claimant of a Benefit determination (whether adverse or not) with respect to an Urgent Care Claim as soon as possible, taking into account the medical exigencies, but not later than 24 hours after Piedmont receives the claim, unless the claimant fails to provide sufficient information to determine whether, or to what extent, Benefits are Covered or payable under this Policy.

Piedmont will apply the standard of "a prudent layperson who possesses an average knowledge of health and medicine" when it determines whether your claim is an Urgent Care Claim. However, if the Physician who is knowledgeable about your medical condition advises Piedmont that your claim is an Urgent Care Claim, then Piedmont will treat it as such.

Piedmont may extend the time to review an Urgent Care Claim up to 48 hours if it: (1) does not receive information that it needs to determine whether the claim is covered; and (2) tells you what information Piedmont needs to complete its claims review. Piedmont will provide this notice within 24 hours after it receives its Urgent Care Claim. You will have 48 hours to provide the necessary information. For an Urgent Care Claim, Piedmont will notify you of its decision no more than 48 hours after: (1) Piedmont receives the requested information; or (2) the extension period ends, whichever is earlier.

G. Drug Exceptions Timeframes and Enrollee Responsibilities

CMS Description of Item – Issuers' exceptions processes allow enrollees to request and gain access to drugs not listed on the plan's formulary, pursuant to 45 CFR 156.122(c).

Piedmont's PPO and HMO Plans
Your prescription drug Coverage is limited to only those drugs listed on Piedmont's formulary. Piedmont's formulary is reviewed by a pharmacy & therapeutics committee of our Pharmacy Benefit Manager (PBM) as required by state and federal laws and regulations. Most prescription drugs are listed on this formulary; however, certain prescription drugs with clinically equivalent alternatives may be excluded. Piedmont may add or delete prescription drugs from the formulary from time to time. A description of the formulary is available upon request by calling Piedmont's Customer Service Department at 800-400-7247 (or local at 434-947-4463) and at www.pchp.net. Two exceptions to the formulary requirement are:

- You may obtain Coverage without additional cost sharing beyond that which is required of formulary prescription drugs for a non-formulary drug if Piedmont determines, after consulting with the prescribing Physician, the formulary drugs are inappropriate therapy for your condition.

- You may obtain Coverage without additional cost sharing beyond that which is required of formulary prescription drugs for a non-formulary drug if:

    - You have been taking or using the non-formulary prescription drug for at least six months prior to its exclusion from the formulary; and

- The prescribing Physician determines that either the formulary drugs are inappropriate therapy for your condition, or that changing drug therapy presents a significant health risk.

You may use the prior authorization process to request a non-formulary drug and Piedmont will act on your request within one business day of its receipt.

H. Information on Explanation of Benefits (EOBs)

CMS Description of Item – An EOB is a statement an issuer sends the enrollee to explain what medical treatments and/or services it paid for on an enrollee's behalf, the issuer's payment, and the enrollee's financial responsibility pursuant to the terms of the policy.

Piedmont's PPO and HMO Plans
Piedmont will send an Explanation of Benefits (EOB) document to the member after the member receives a service. The EOB will provide details on the following items concerning the health care service:

- Piedmont contact information if the member has any Questions;
- Claim detail showing the service provided, the provider, the dates of service, billed amounts, provider discounts, allowed amounts, non-covered amounts, other insurance amounts, benefit that is payable, the deductible applied, the copay applied, the coinsurance applied, the member portion due, and code descriptions;
- Accumulator descriptions including the Amount, Amount Met, and Amount Remaining of Deductibles and Out-of-Pocket Maximums.

I. Coordination of Benefits (COB)

CMS Description of Item – Coordination of benefits exists when an enrollee is also covered by another plan and determines which plan pays first.

Piedmont's PPO Plans
Insurance With Other Companies: If there is other valid coverage, not with this Company, providing benefits for the same loss on a provision of service basis or on an expense incurred basis and of which this Company has not been given written notice prior to the occurrence or commencement of loss, the only liability under any expense incurred coverage of this Policy shall be for such proportion of the loss as the amount which would otherwise have been payable under this Policy plus the total of the like amounts under all such other valid coverages for the same loss of which this Company had notice bears to the total like amounts under all valid coverages for such loss, and for the return of such portion of the Premiums paid as shall exceed the pro rata portion for the amount so determined. For the purpose of applying this provision when other coverage is on a provision of service basis, the "like amount" of such other coverage shall be taken as the amount which the services rendered would have cost in the absence of such coverage.

Piedmont's HMO Plans
Special Coordination of Benefits (COB) rules apply when you or members of your family

have additional Coverage through other health insurance Plans, including but not limited to:

- Group and individual insurance Plans, group Blue Cross Blue Shield, health maintenance organization, and other prepaid coverage;
- Labor management trustee plans, union welfare plans, employer welfare plans, employer organization plans, or Employee Benefit organization plans; and
- Coverage under any tax-supported or government program to the extent permitted by law.

When the COB provision applies, the insurance carriers involved will coordinate the benefits payable. The COB provision is meant to prevent duplicate payments for the same services.

If You have two insurance Plans, one of the Plans will be considered the primary Plan and the other Plan will be the secondary Plan. The primary Plan is the Plan which will process claims for benefits first (as though no other coverage exists), and the secondary Plan will coordinate its payment so as not to duplicate benefits provided by the primary Plan.

Coordination with Group Coverage

Coverage under this Plan is always secondary to any Group Coverage.

Whenever the benefits under any other Plan are payable without regard to benefits payable under this Plan, this Plan is secondary. Services that are not eligible for benefits under both Plans will not be subject to coordination of benefits.

When this Plan is secondary, the value of Covered Services will be based on Our Allowable Charge to determine Our liability. When providing secondary coverage, the aggregate of benefits under both Plans for the coordinated services will not exceed Our Allowable Charge for those coordinated services. If benefits are provided in the form of services by the primary carrier, as with a health maintenance organization, the value of the coordinated services is based upon Our Allowable Charge for the service. We may coordinate the benefits We would have paid so that the sum of Our benefits and the value of the coordinated services reduced by any applicable Deductible, Copayment or Coinsurance of the primary carrier does not exceed Our Allowable Charge.

No limitations will be extended because of coordination of benefits. All dollar amount and visit limits still apply, even when We are the secondary carrier. You may not elect to file Your claims only with Us in order to obtain primary benefits when the other carrier would otherwise be the primary carrier.

Coordination with Plans other than Group Coverage

When a Participant is also enrolled in another non-group health Plan, one Coverage will be primary and one will be secondary. The decision of which Coverage will be primary or secondary is made using the order of Benefit determination rules listed below:

- If the other Coverage does not have COB rules substantially similar to Piedmont's, the other Coverage will be primary.

- If a Participant is enrolled as: (1) the named insured under one coverage; and (2) a Dependent under another, then generally the one that covers him or her as the named insured will be primary.

- If a Participant is the named insured under both coverages, generally the one that covers him or her for the longer period of time will be primary.

- If the Participant is enrolled as a dependent child under both coverages (e.g. when both parents cover their child), typically the coverage of the parent whose birthday falls earliest in the Benefit Year will be the primary.

- Special rules apply when a Participant is enrolled as a dependent child under two Coverages and the child's parents are separated or divorced. Generally, the coverage of the parent or stepparent with primary custody will be primary. However, if a court order requires one parent to provide for medical expenses for the child, that parent's coverage will be primary. If a court order that states the parents share joint custody without designating that one of the parents is responsible for medical expenses, the coverage of the parent whose birthday falls earliest in the Benefit Year will be primary.

Coordination with Medicare

Any benefits covered under both this Plan and Medicare will be paid pursuant to Medicare Secondary Payor legislation, regulations, and Centers for Medicare and Medicaid Services guidelines, subject to federal court decisions. Federal law controls whenever there is a conflict among state law, Plan provisions, and federal law.

Except when federal law requires the Plan to be the primary payor, the benefits under this Plan for members age 65 and older, or members otherwise eligible for Medicare, do not duplicate any benefit for which members are entitled under Medicare. Where Medicare is the responsible payor, all sums payable by Medicare for services provided to members shall be reimbursed by or on behalf of the members to the Plan, to the extent the Plan has made payment for such services. For the purpose of the calculation of benefits, if the Member has not enrolled in the Medicare Part B, We will calculate benefits as if they had enrolled. This provision is applicable only to those eligible for Medicare due to age.