SMALL GROUP

Expanded Choice POS
2024 Evidence of Coverage

PIEDMONT
COMMUNITY HEALTH PLAN

PIEDMONT COMMUNITY HEALTHCARE HMO, INC.
2316 Atherholt Rd., Lynchburg, VA 24501
(800) 400-7247 or (434) 947-4463

Cover Page

IMPORTANT INFORMATION REGARDING YOUR INSURANCE.

THIS IS THE EVIDENCE OF COVERAGE FOR HEALTH MAINTENANCE ORGANIZATION (HMO) INSURANCE – POINT OF SERVICE PLAN

GUARANTEED RENEWABILITY

We shall renew or continue in force such Coverage with respect to all insureds at the option of the employer except:

1. For nonpayment of the required Premiums by the policyholder, or contract holder, or where We have not received timely premium payments;
2. When We are ceasing to offer Coverage in the small group market in accordance with subdivisions 9 and 10 of 38.2-3432.1;
3. For fraud or misrepresentation by the employer, with respect to their Coverage;
4. With regard to Coverage provided to an eligible employee, for fraud or misrepresentation by the employee with regard to his or her Coverage;
5. For failure to comply with contribution and participation requirements defined by Us; and
6. For failure to comply with our provisions that have been approved by the Commission.
7. When there is no longer a Subscriber under this COC who lives, works, or resides in the Service Area.

NOTICE: This Policy does not provide the ACA-required minimum essential pediatric oral health Benefits. Stand-alone dental coverage that includes such Benefits must be available to You for purchase separately from a qualified stand-alone dental plan.

THE COVERAGE STATED IN THIS EOC MAY NOT APPLY WHEN YOU HAVE A CLAIM! PLEASE READ!

This Evidence of Coverage was issued based on the information entered in Your HMO enrollment application, a copy of which is attached to the Policy. If You know of any misstatement in Your application, You should advise Us immediately regarding the incorrect or omitted information; otherwise, Your Evidence of Coverage may not be a valid contract.

THIS EVIDENCE OF COVERAGE IS NOT A MEDICARE SUPPLEMENT INSURANCE POLICY

If You are Medicare-eligible, review the "Guide to Health Insurance for People with Medicare" available from Your Employer/Group. If You need to contact someone about Your Coverage, You can contact Your agent, Your Plan administrator, or Us directly at:

Piedmont Community Healthcare HMO, Inc.
Customer Service Department

2316 Atherholt Road

Lynchburg, Virginia 24501
Locally: (434) 947-4463
Toll free: (800) 400-7247
Fax: (434) 947-3670
Website: www.pchp.net

GEOGRAPHICAL SERVICE AREA

The Service Area for this Evidence of Coverage includes: the cities of Bristol, Buena Vista, Charlottesville, Chesapeake, Covington, Danville, Galax, Hampton, Harrisonburg, Lexington, Lynchburg, Martinsville, Newport News, Norton, Poquoson, Radford, Roanoke, Salem, Staunton, Suffolk, Waynesboro, and Williamsburg; and the counties of Accomack, Albemarle, Alleghany, Amherst, Appomattox, Augusta, Bedford, Bland, Botetourt, Buchanan, Buckingham, Campbell, Carroll, Charles City, Craig, Culpeper, Dickenson, Floyd, Fluvanna, Franklin, Giles, Gloucester, Grayson, Greene, Henry, Isle of Wight, James City, King and Queen, Lee, Madison, Mathews, Middlesex, Montgomery, Nelson, New Kent, Northampton, Orange, Patrick, Pittsylvania, Prince Edward, Pulaski, Rappahannock, Roanoke, Rockbridge, Rockingham, Russell, Scott, Smyth, Surry, Tazewell, Washington, Wise, Wythe, and York; all in the Commonwealth of Virginia.

PIEDMONT
COMMUNITY HEALTHCARE HMO, INC.

TABLE OF CONTENTS

SECTION I: Definitions

Actively at Work means an Employee of the Employer or Group who works at least 30 hours per week for or on behalf of the Employer or Group at his or her full rate of pay. The term also includes those Employees temporarily absent from work due to health-related condition; but, only to the extent that the period of the Employee's absence does not exceed the amount of the Employee's accrued vacation time, sick time, and approved leave under the Family and Medical Leave Act of 1993 (FMLA).

Allowable Charge means the amount determined by Us as payable for a Covered Service or the Provider's charge for that service, whichever is less. We will never pay more than the Allowable Charge for any Covered Service.

Balance Bill(ing) means a bill sent from an Out-of-Network Provider for health care services provided to the Covered Person after the Provider's billed amount is not fully reimbursed by Us, exclusive of applicable cost-sharing requirements.

Behavioral Health Treatment means professional, counseling, and guidance services, and treatment programs that are necessary to develop, maintain, or restore, to the maximum extent practicable, the functioning of an individual.

Benefit(s) or Covered Benefit(s) means those health care services to which an enrollee is entitled under the terms of a health Benefit Plan; it also means the payouts to Providers that We are contractually obligated to make pursuant to a Covered Person's Coverage.

Benefit Year means the length of time we will cover Benefits for Covered Services. For Calendar Year plans, the Benefit Year starts on January 1st and ends on December 31st. For Plan Year plans, the Benefit Year starts on Your Group's effective or renewal date and lasts for 12 months. (See Your employer for details.) If Your Coverage ends before the end of the year, then Your Benefit Year also ends.

Child or Children means the Subscriber's Child (biological or adopted) and/or the Child (biological or adopted) of the Subscriber's spouse if the Subscriber's spouse is also covered under the contract or EOC. Child includes a son, daughter, stepchild, adopted child, including a child placed for adoption, foster child, or any other child eligible for coverage under the health Benefit plan. Except as noted in the "Eligibility" section of the EOC, there is no requirement that the: Child be financially dependent on an individual covered under the contract or EOC; Child share a residence with an individual covered under the contract or EOC; Child meet student status requirements; Child be unmarried; Child not be employed; or any combination of these factors. The "Limiting Age" of a Child otherwise eligible for Coverage under the EOC is age 26.

Coinsurance means a fixed percentage of the Allowable Charge a Covered Person must pay out-of-pocket for a Covered Service.

Coordination of Benefits (COB) sets out rules for the order of payment of Covered Charges when a Plan Participant has health insurance Coverage with two or more plans, including Medicare. When a Plan Participant is covered by this Plan and another Plan, the Plans will coordinate benefits when a claim is received**.** .

Copayment means the amount a Covered Person must pay out-of-pocket for a Covered Service to receive that service at the time the service is provided.

Cost-Sharing Requirement means a Covered Person's deductible, copayment amount, or coinsurance rate, , or similar charges; and any other expenditure required of an insured individual which is a qualified medical expense for EHBs covered under the Plan. Cost-Sharing does not include balance billing amounts for Out-of-Network Providers other than those services described in 38.2-3445.01.

Covered Person means the Subscriber or a covered Dependent for whom required Premiums have been paid and for whom insurance coverage under the Policy remains in force.

Coverage or **Covered Service(s)** means those Medically Necessary Primary Care, Specialty Care, Inpatient, Outpatient and Hospital and medical services which Covered Persons are entitled to receive and that are: (i) listed as covered in this EOC; (ii) performed, prescribed, or directed by an In-Network Provider or by an Out-of-Network Provider for Out-of-Network benefits (unless a prior authorization has been obtained from Us or for Emergency or Urgent Care Services); and (iii) subject to the terms, conditions, definitions, limitations, and exclusions described in this EOC, the Group Enrollment Agreement and related documents.

Deductible(s) means the amount a Covered Person is required to pay out-of-pocket for a Covered Service or Covered Services before We begin to pay the costs associated with the service(s).

Dependent(s) means the Subscriber's Child, spouse, Domestic Partner, or other class of persons subject to the applicable terms of the Policy and who meets all the eligibility requirements of this EOC; is enrolled hereunder; and for whom the payment of a Premium required under the EOC and the Group Enrollment Agreement has actually been received by Us.

Emergency Medical Condition or **Emergencies** means, regardless of the final diagnosis rendered to a covered person, a sudden onset of a medical condition that: (a) manifests itself by acute symptoms of sufficient severity, including severe pain; and (b) the absence of immediate medical attention of which could reasonably be expected by a prudent layperson who possesses an average knowledge of health and medicine to result in: (1) serious jeopardy to the mental or physical health of the individual; (2) danger of serious impairment of the individual's bodily functions; (3) serious dysfunction of any bodily organ or part; or (4) in the case of a pregnant woman, serious jeopardy to the health of the fetus.

Emergency services means those health care services that are rendered by affiliated or nonaffiliated Providers after the sudden onset of an Emergency Medical Condition. Emergency services will include Covered Services from Out-of-Network Providers. Emergency services, with respect to an Emergency medical condition, will mean: (1) a medical screening examination within the capability of the Emergency department of a

Hospital or an independent freestanding Emergency department, including ancillary services routinely available to the Emergency department to evaluate such Emergency Medical Condition; (2) within the capabilities of the staff/facilities available at the Hospital or the independent freestanding Emergency department such further medical examination and treatment as required to Stabilize the patient (regardless of the department of the Hospital in which such further examination or treatment is furnished); and (3) inclusion of additional services. The term "Emergency Services" shall include, unless each of the conditions in (2) above are met, in addition to the items and services described in (1) above, items and services (a) for which Benefits are provided or covered under the plan or coverage; and (b) that are furnished by a nonparticipating provider or nonparticipating Emergency Facility (regardless of the department of the Hospital in which such items or services are furnished) after the Participant is Stabilized and as part of outpatient observation or an Inpatient or Outpatient stay with respect to the visit in which such services described above are furnished.

Employee will mean any individual: (1) Actively at Work; and (2) who receives compensation from his or her Employer or Group for work performed for or on behalf of the Employer or Group, under that Employer's/Group's direction or control. Employee does not include an individual who works on a part-time basis or as an independent contractor or subcontractor, or who is no longer Actively at Work.

Essential Health Benefits means ambulatory patient services; Emergency services; Hospitalization; maternity and newborn care; mental health and substance use disorder services, including Behavioral Health Treatment; Prescription Drugs; rehabilitative and habilitative services and devices; laboratory services; preventive and wellness services and chronic disease management; and pediatric services, including oral and vision care. This definition will always follow the requirements laid out by the Secretary of the US Department of Health and Human Services (HHS) pursuant to the authority of the Affordable Care Act.

Evidence of Coverage or **EOC** means this document, the Schedule of Benefits, the Subscriber's Enrollment Application, and any Amendment or related document issued in conjunction with this document, setting out the Coverage and other rights to which You are entitled.

Excluded Services (Exclusion) means health care services Your Plan doesn't cover.

Experimental/Investigational means any service or supply which is determined to be experimental or investigational in Our sole discretion (subject to all appeals available to You). We will apply the following criteria in exercising Our discretion. A service or supply will be Experimental/Investigational if We determine that any one of the following criteria is not satisfied:

A) Any supply or drug used must have received final approval to market by the United States (US) Food and Drug Administration (FDA) for the particular indication or application in question. Moreover, quantities of any drug or medication used, except those drugs used in the treatment of cancer pain and prescribed in compliance with established statutes pertaining to patients with intractable cancer pain, must be within recommended maximum daily dose or duration established by the FDA or any of the standard reference compendia defined below. There are two exceptions which apply

when a drug has received final approval to market by the FDA, but not for the particular indication or application in question.

1) This criterion will be satisfied if the use of the drug is recognized for treatment of the indication or application in any of the following resources:
   - The following three standard reference compendia defined below:
     a) American Hospital Formulary Service Drug Information;
     b) National Comprehensive Cancer Network's Drugs & Biologics Compendium; or
     c) Elsevier Gold Standard's Clinical Pharmacology.
   - In substantially accepted peer-reviewed medical literature. Peer-reviewed medical literature means a scientific study published only after having been critically reviewed for scientific accuracy, validity, and reliability by unbiased independent experts. This study must appear in a journal that has been determined by the International Committee of Medical Journal Editors to have met the Uniform Requirements for Manuscripts submitted to biomedical journals. Peer-reviewed medical literature does not include publications or supplements to publications that are sponsored to a significant extent by a pharmaceutical manufacturing company or health carrier; or
2) In the case where the drug is being used for the treatment of a specific type of cancer, this criterion will be satisfied if the use of the drug is recognized as safe and effective for treatment of the specific type of cancer in any of the standard reference compendia.

B) There must be enough information in the peer-reviewed medical and scientific literature to let Us judge the safety and efficacy.

C) The available scientific evidence must show a good effect on health outcomes outside a research setting.

D) The service or supply must be as safe and effective outside a research setting as current diagnostic or therapeutic options.

Facility means an institution providing health care related services or a health care setting, including hospitals and other licensed inpatient centers; ambulatory surgical or treatment centers; skilled nursing centers; residential treatment centers; diagnostic, laboratory, and imaging centers; and rehabilitation and other therapeutic health settings.

Family Unit refers to the Subscriber and the Subscriber's Dependents covered under the same Plan for the same Benefit Year.

Group Enrollment Agreement means the policy of insurance coverage between Us and the Subscriber's Employer or Group, of which this EOC is a part.

Hospital means a skilled medical facility or hospital licensed under the appropriate state law as a general acute care facility and eligible for participation under the programs established by Titles XVIII and XIX of the Social Security Act.

In-Network Physician means a Physician who has independently contracted with Us or Our

designee to provide medical services to Covered Persons.

In-Network Provider means: a medical group; In-Network Physician; Hospital; skilled nursing facility; pharmacy; or any other duly licensed institution or health professional that has contracted with Us or Our designee, contractor, or subcontractor to provide Covered Services to Covered Persons and be reimbursed by Us at a contracted rate as payment in full for the Covered Services, including applicable cost-sharing requirements.. A list of In-Network Providers is made available to each Covered Person upon enrollment and is available upon request from Us and viewable online at **www.pchp.net**. We will revise the list as We deem necessary or at such other time as applicable law requires.

Inpatient means a Covered Person who (1) has been admitted to a Hospital or skilled medical facility or skilled nursing facility; (2) is confined to a bed there; (3) and receives meals and other care in that facility.

Limiting Age means the age after which a Subscriber's Dependent Child is no longer eligible for Coverage under this EOC. The Limiting Age for Dependent Children is the last day of the calendar year in which he/she reaches age 26.

Medical Director means a duly licensed Physician, or his or her designee, who has been assigned by Us to perform the functions required under this EOC.

Medically Necessary services or **Medical Necessity** refers to those Covered Services that We determine are:
(1) consistent with the diagnosis and treatment of the Covered Person's condition;
(2) are appropriate and necessary given the circumstances and the symptoms;
(3) are provided to diagnose or treat the condition, illness, disease or injury;
(4) are in accordance with generally accepted standards of good medical practice; and
(5) are not primarily for the convenience of the Covered Person or the Provider.

Network or **In-Network** refers to the Covered Person's Primary Care Physician (PCP) and the Hospital and Specialty Physicians affiliated with the PCP, as set forth in the Provider Directory supplied by Us.

Open Enrollment Period means a period of time no longer than sixty (60) days, up to 30 days prior to the group's renewal date and up to 30 days following the renewal date, during which any eligible Subscribers and Dependents can apply for or change Coverage. Open Enrollment occurs only once per year. Your employer will notify you when Open Enrollment is available.

Out-of-Network or **Nonparticipating Provider** means a Provider that is not contracted with Piedmont.

Out-of-Pocket Maximum or **Maximum Out-of-Pocket (MOOP)** means the maximum amount a Covered Person must pay in cost-sharing requirements for covered benefits in a Benefit Year, after which the carrier covers the entirety of the allowed amount of covered benefits under the contract of coverage.

Outpatient means a Covered Person who is receiving care but has not been admitted to a Hospital or skilled medical facility or skilled nursing facility.

Pharmacy Care means medications prescribed by a licensed Physician and any health-related services deemed Medically Necessary to determine the need or effectiveness of the medications.

Physician (Doctor) means a person who is certified or licensed under the laws of the state to provide medical services within the scope of such certification or licensure, such as a Doctor of Medicine (MD) or a Doctor of Osteopathy (DO). Any other health care provider or allied practitioner who is mandated by state law and who acts within the scope of their license will be considered on the same basis as a Physician, including a chiropractor, optometrist, optician, professional counselor, psychologist, clinical social worker, podiatrist, physical therapist, athletic trainer (provided that such service is performance in an office setting), chiropodist, clinical nurse specialist, audiologist, speech pathologist, certified nurse, midwife or advanced practice registered nurse, marriage and family therapist or licensed acupuncturist. Physician includes Primary Care Physician (PCP), Specialist Physician, nurse practitioner or any other advanced practice registered nurse, physician assistant and any other Provider(s) as defined in this EOC.

Piedmont means Piedmont Community Healthcare HMO, Inc.

Plan shall mean the Employer's/Group's Coverage insured by Us and evidenced by the: (1) Group Enrollment Agreement; (2) EOC; (3) Schedule of Benefits; (4) any enrollment applications; and (5) any attachments and amendments or exhibits thereto.

Plan Participant(s) means the Subscriber, the Subscriber's legal spouse, and eligible Child(ren) who: (1) meet all the eligibility requirements provided for in this EOC; (2) are validly enrolled hereunder; and (3) for whom the payment of the Premium required under the Group Enrollment Agreement and this EOC has actually been received by Piedmont. This assumes the Employer's/Group's Plan provides Coverage for spouses and/or Children.

Policy means the Policy between Us and the Subscriber's employer, of which this Evidence of Coverage is a part.

Premium(s) means the monthly payment due from the Employer/Group to Us as specified in the Group Enrollment Agreement as a condition precedent for Covered Persons to receive Coverage. The Group/Employer shall contribute all or a portion of the Premium as set forth in the Plan.

Prescription Drugs are pharmaceutical drugs that legally require a medical prescription to be dispensed. Listed below are the Prescription Drug tiers that exist under this Policy:

- **Generic Drugs (Tier 1)** are non-brand drugs (including specialty drugs and therapeutic biological products), sold at a lower cost than the equivalent brand. A generic drug is the therapeutic equivalent of a brand name drug, i.e., it contains the same active ingredients and is identical in strength, concentration, and dosage form.

- **Preferred Drugs (Tier 2)** are brand name drugs (including specialty drugs and therapeutic biological products) listed on the formulary at a higher tier than generic drugs. These drugs have been reviewed by a Pharmacy and Therapeutics Committee to insure high standards for clinical efficacy and safety. These are the lower cost brand name drugs in a therapeutic category.

- **Non-Preferred Drugs (Tier 3)** are brand name drugs (including specialty drugs and therapeutic biological products) listed on the formulary at a higher tier than generic or preferred drugs. These drugs are classified as higher cost drugs in a therapeutic category. Non-preferred products are usually those for which there is a preferred alternative or generic option available.

- **Specialty Drugs (Tier 4)** are higher cost, injected, infused, oral or inhaled medications (including therapeutic biological products) that are used to treat chronic or complex illnesses or conditions and are on the formulary at the two highest tiers.

  Preferred Specialty Drugs are the lower cost brand name drugs in the Specialty Drugs therapeutic category. Non-preferred Specialty Drugs are classified as higher cost drugs in the Specialty Drugs therapeutic category. Specialty Drugs may have special handling, storage and shipping requirements, such as temperature control. Specialty Drugs may require nursing services or special programs to encourage patient compliance. The specialty pharmacy will fill both retail and mail order prescriptions, although the ability to provide a 90-day supply of a specialty drug may be limited by the storage requirements of that particular drug.

Preventive Services means:

(1) evidence-based items or services for which a rating of A or B is in effect in the recommendations of the U.S. Preventive Services Task Force with respect to the individual involved;

(2) immunizations for routine use in children, adolescents, and adults for which a recommendation of the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention is in effect with respect to the individual involved;

(3) evidence-informed preventive care and screenings provided for in comprehensive guidelines supported by the Health Resources and Services Administration with respect to infants, children, and adolescents; and

(4) evidence-informed preventive care and screenings recommended in comprehensive guidelines supported by the Health Resources and Services Administration with respect to women.

For purposes of this definition, a recommendation of the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention is considered in effect after it has been adopted by the Director of the Centers for Disease Control and Prevention, and a recommendation is considered to be for routine use if it is listed on the Immunization Schedules of the Centers for Disease Control and Prevention.

Primary Care Physician or **PCP** means the In-Network Physician You select to provide primary health care and to coordinate the other Covered Services You may require. PCPs include internists, family/general practitioners, pediatricians, and geriatricians. Each Covered Person may choose any available PCP in accordance with the terms and conditions of this EOC.

Prosthetic Device means an artificial device to replace, in whole or in part, a limb. Component means the materials and equipment needed to ensure the comfort and functioning of a Prosthetic Device.

Provider(s) means any professional organization, association or entity which furnishes or

causes to be furnished primary or specialty care services, Hospital services or ancillary medical services.

Psychiatric Care means direct or consultative services provided by a psychiatrist licensed in the state in which the psychiatrist practices.

Psychological Care means direct or consultative services provided by a psychologist licensed in the state in which the psychologist practices.

Service Area means the geographic area within which Covered Services are available. The Service Area is specifically set forth on Page 2 of this EOC, but it may be updated from time to time. Information about the current Service Area is available from Piedmont on request or viewable online at www.pchp.net.

Specialist Physician means a medical professional other than a PCP (family, general, internal medicine and pediatric Physicians) providing specialty medical services to Covered Persons. This includes professionals providing Urgent Care and chiropractic services.

Stabilize means with respect to an emergency medical condition, to provide such medical treatment as may be necessary to assure, within reasonable medical probability, that no material deterioration of the condition is likely to result from or occur during the transfer of the individual from a facility, or, with respect to a pregnant woman, that the woman has delivered, including the placenta.

Subscriber means the eligible Employee: (1) as defined in the Group Enrollment Agreement; (2) who has elected Coverage for himself and his or her family members who are Covered Persons (if any); (3) who meet the eligibility requirements of this EOC and enroll hereunder; and (4) for whom the Premiums required by the Group Enrollment Agreement shall have been paid to and received by Us.

Surgical or Ancillary Services means Covered professional services and equipment and devices, including telemedicine services, surgery with preoperative and post operative services, anesthesiology, pathology, radiology and imaging services, hospitalist services, and laboratory services, regardless of whether or not the Provider furnishing such items or services is at the Facility.

Therapeutic Care means services provided by licensed or certified speech therapists, occupational therapists, physical therapists, or clinical social workers.

Urgent Care means care for a health problem usually marked by rapid onset of persistent or unusual discomfort associated with an illness or injury. These problems may include: high fever; vomiting; sprains; or minor cuts. An Urgent Care situation is distinguished from an Emergency medical condition, and it may be handled through the Covered Person's PCP if available, or through an Urgent Care center.

Usual and Customary means the amount charged for a medical service in a geographic area based on what providers in the area usually charge for the same or similar service. This amount is sometimes used to determine the Allowable Charge.

We, Our, Us refers to Piedmont Community Healthcare HMO, Inc.

You, Your, Yourself refers to the Subscriber or Plan Participant.

SECTION II: Responsibilities

This Evidence of Coverage is part of the Group Enrollment Agreement between Us and Your Employer/Group.

A. Your Responsibilities

You assume certain responsibilities by partnering with Us to protect Your health. It is important You understand these responsibilities.

Choose a Primary Care Physician. Upon enrollment, You and all family members that are Covered Persons under Your Coverage are encouraged to select an In-Network PCP. We cannot guarantee the continued availability of a particular In-Network Provider as a PCP. If You want a different PCP, then You may request another PCP from among those available.

Know Your Primary Care Physician. You should establish a personal and continuous relationship with Your selected PCP. Maintaining this relationship is an essential part of health care.

Changing the Primary Care Physician. If You cannot establish a satisfactory relationship with Your PCP, then You may change to another available PCP. The change will be effective upon receipt of notice of the change. Acceptance of the change is subject to the availability of the newly selected PCP. We will not honor a request for a retroactive change in PCP (i.e., the request is made after Services from such PCP are provided).

Choose Your Treating Providers. Our agreements with Our Network of Providers should not be understood as a guarantee or warranty of the professional services of such Providers. The choice of PCP, In-Network Provider, or any other Provider, and the decision to receive or decline health care services from such Provider, is Your sole responsibility.

Changes in Coverage. Any change in employment or number of Dependents or other Covered Persons under Your Coverage may affect Coverage. Please make sure You notify Us as soon as possible, but no more than 31 days after any of the following occur:

1. Change in marital status;
2. Covered Person loses eligibility for enrollment (e.g., marriage, exceeding the Limiting Age, divorce, etc.);
3. New Covered Person becomes eligible (e.g., newborns or legally adopted Children);
4. Change in name, address or phone number;
5. Change in Subscriber's employment;
6. Subscriber assumes permanent residence outside the Service Area;
7. Death of a Subscriber; or
8. Availability of other health Coverage.

Failure to provide proper notice of changes in Coverage may affect Your Coverage. We are not responsible for any lapse in Coverage due to Your failure or Your Employer or Group's failure to provide proper notice of a change in Coverage as required.

Your Identification Card (ID Card). We will issue each Covered Person an ID card. You must present Your ID card whenever You receive Covered Services. ID cards are not transferable. Unauthorized use of a Covered Person's ID card by any person may result in termination of Your enrollment by Us. The ID card serves only to identify You and confers no automatic right to Covered Services or Benefits. To be entitled to Covered Services or Benefits, an ID cardholder must be a Covered Person on whose behalf all applicable Premiums have been paid. You will be obligated to pay for services which are not recognized Covered Services under this EOC. The Covered Person must always carry their Piedmont ID card with them to assure prompt receipt of Covered Services. If a card is lost or stolen, please notify Us immediately. ID cards remain the property of Piedmont, and all ID cards must be returned to Piedmont or destroyed upon termination of Your Coverage.

Work as a partner with Piedmont. To maintain good health and use the system properly and efficiently. You should:

- Select a Primary Care Physician (PCP).
- Transfer previous medical records to Your PCP.
- Be on time for appointments.
- Notify Your PCP or any other In-Network Provider promptly to cancel or reschedule an appointment.
- Obtain Covered Services through In-Network Providers for the highest level of Benefits.
- Obtain prior authorization before treatment is received for Covered Services that require it.
- Obtain a formal prior authorization referral from Us or Your PCP before treatment is received from Out-of-Network Providers, if care from Out-of-Network Providers is necessary. Failure to obtain the prior authorization will result in a reduced level of Benefits called Out-of-Network Benefits.
- Follow special procedures when dealing with Emergency and Urgent Care situations in and out of the Service Area.
- Follow guidance given by the PCP or other In-Network Provider.
- Make the lifestyle changes recommended by the In-Network Physician or Piedmont.
- Know prescribed medications, reasons for taking them, and procedures for taking them.
- Learn to differentiate between true Emergency situations and Urgent Care needs; and how to handle them.
- Pay Copayments, Coinsurance, and/or Deductibles at the time the Covered Service is rendered.
- Make sure to notify Us of any change in name, address, phone number, or Covered Person's eligibility.
- Utilize grievance and appeal procedures discussed further in this Policy to resolve concerns and complaints.
- Provide Us with (1) requested information, including medical records; (2) Physician statements regarding care and treatment; and (3) any information regarding Your or the Covered Person's physical condition.
- Provide Us with the necessary information so Coordination of Benefits may take place.

B. Piedmont's Responsibilities

We will provide health care Benefits according to this EOC and agree to:

- Provide each Covered Person with a Piedmont ID card.
- Provide all Benefits described in this EOC subject to its terms, conditions, limitations, and exclusions.
- Keep You informed regarding changes in procedures, Benefits, and In-Network Providers. We do not guarantee the continued availability of a particular In-Network Provider.
- Keep all medical records confidential in accordance with federal and state privacy protection laws.
- Provide courteous, prompt resolution of questions, concerns, complaints or appeals.
- Allow continuation of your group Coverage without a break in Coverage on loss of eligibility as provided herein.
- Assist in getting an appointment with and changing Providers in Piedmont's Network when requested.
- Make Network arrangements so the In-Network Physician (or another Physician with whom the In-Network Physician has made arrangements) is available 24/7 to refer or direct for prompt medical care where there is an immediate, urgent need or Emergency.
- Always have Piedmont's or its designee's personnel available for prior authorization when it is required. We require Providers (or a Covered Person acting on their own behalf) to make prior authorization arrangements during regular business hours. Our preauthorization is not required for Emergencies anytime or Urgent Care situations after hours.
- Offer the right to make recommendations about rights and responsibilities.

Special Limitations - Rights of the Covered Person, and obligations of Piedmont, are subject to the following special limitations:

To the extent a natural disaster, war, riot, civil insurrection, epidemic or any other or similar event outside Our control results in Our facilities, personnel, or financial resources being unavailable, or We otherwise are unavailable to provide or arrange for the provision of Covered Services, We will make good faith efforts to provide or arrange for the provision of Covered Services, as practical. These efforts will be according to Our best judgment, considering the Covered Services. Piedmont and the Providers will incur no liability or obligation for delay, or failure to provide or arrange for health services if such failure or delay is caused by such an event.

C. Important Information Regarding Your Insurance

In the event You need to contact someone about Your Coverage, or if You need to request a copy of the List of In-Network Providers (viewable at www.pchp.net), You can always contact Your agent, Your Plan administrator, or Piedmont directly at:

Piedmont Community Healthcare HMO, Inc.
Customer Service Department

2316 Atherholt Road
Lynchburg, Virginia 24501
Locally: (434) 947-4463
Toll free: (800) 400-7247 (TTY:711)
Fax: (434) 947-3670
Website: www.pchp.net

Multi-language Interpreter Services – Interpreters are available to answer any questions you may have about our health and drug plans. To reach an interpreter, call us at (434) 947-4463 or toll free at 1-800-400-7247 during normal business hours. A representative who speaks English will conference in an interpreter who can assist during the call. This is a free service.

TTY Services – TTY users should call 711 for assistance. This is a free service.

Non-Discrimination and Language Assistance

We comply with applicable Federal civil rights laws and do not discriminate on the basis of race, color, national origin, age, disability, or sex. We do not exclude people or treat them differently because of race, color, national origin, age, disability, or sex.

Piedmont:

- 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 services to people who are Deaf or Hard-of-Hearing. Contact Piedmont using the 711 relay service.
- 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 Our Customer Service at 1-800-400-7247, Option 2(TTY: 711).

If You believe that We have 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 Our Grievance Coordinator by mail or phone:

Grievance Coordinator
Piedmont Community Health Plan
2316 Atherholt Road
Lynchburg, VA 24501
434-947-4463, Option 2, or 800-400-7247, Option 2 (TTY: 711)

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.

Language Assistance

Piedmont customer service has free language interpreter services available for non-English speakers. See information above in this section for details.

English

ATTENTION: If you speak English, language assistance services, free of charge, are available to you. Call 1-800-400-7247 (TTY: 711).

Español (Spanish)

ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-800-400-7247 (TTY: 711).

한국어 (Korean)

주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 1-800-400-7247 (TTY: 711)번으로 전화해 주십시오.

Tiếng Việt (Vietnamese)

CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số 1-800-400-7247 (TTY: 711).

Tagalog (Tagalog - Filipino)

PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tumawag sa 1-800-400-7247 (TTY: 711).

العربية (Arabic)

ملحوظة: إذا كنت تتحدث انكر اللغة، فإن خدمات المساعدة اللغوية تتوافر لك بالمجان. اتصل برقم 1-7247-400-800

رقم هاتف الصم والبكم: -711 .)

繁體中文 (Chinese)

注意：如果您使用繁體中文，您可以免費獲得語言援助服務。請致電1-800-400-7247（TTY：711）。

Français (French)

ATTENTION : Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le 1-800-400-7247 (ATS : 711).

বা া া লা (Bengali)

লক্ষ্য করুনু যদিু আপদন বু লু, কথু বলতেু পু তেুন, েুু হতল
দনু খেুচু য় ভু ষু সহু য়েু পদেুতষবু উপলব্ধ আতেু। ফ ন করুন ১-800- 400-7247 (TTY: 711)।

Bàsɔ̀ɔ̀-wùɖù-po-nyɔ̀ (Bassa)

Dè ɖɛ nià kɛ dyéɖé gbo: Ɔ jǔ ké m̀ [Bàsɔ́ɔ̀-wùɖù-po-nyɔ̀] jǔ ní, nìí, à wuɖu kà kò ɖò po-poɔ̀ ɓɛ́ìn m̀ gbo kpáa. Đá 1-800-400-7247 (TTY:711)

èdè Yorùbá (Yoruba)

AKIYESI: Ti o ba nso ede Yoruba ofe ni iranlowo lori ede wa fun yin o. E pe ero ibanisoro yi 1-800-400-7247 (TTY: 711).

Deutsch (German)

ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Rufnummer: 1-800-400-7247 (TTY: 711).

اردو (Urdu)

خبردار: اگر آپ اردو بولتے ہیں، تو آپ کو زبان کی مدد کی خدمات مفت میں دستیاب ہیں ۔ کال کریں .(TTY: 711) 1-800-400-7247

ह दी (Hindi)

ध्यू न दू: यदद आप द दू बू लतू ु त आपकू ललए मूफू्त मू भू षू स ु यत स वू एिू उपलबू्ध
ु। 1-800-400-7247 (TTY: 711) पर कॉल करें।

فارسی (Persian/Farsi)

توجه: اگر به زبان فارسی گفتگو می کنید، تسهیالت زبانی بصورت رایگان برای شما فراهم می باشد. با (TTY: 711) 1-800-400-7247 تماس بگیرید.

አማርኛ (Amharic)

ማስታወሻ: የሚናገሩት ቋንቋ አማርኛ ከሆነ የትርጉም እርዳታ ድርጅቶች፣ በነጻ ሊያግዝዎት ተዘጋጀተዋል፡ ወደ ሚከተለው ቁጥር ይደውሉ 1-800-400-7247 (መስማት ለተሳናቸው: 711).

Igbo asusu (Ibo)

Ige nti: O buru na asu Ibo asusu, enyemaka diri gi site na call 1-800-400-7247 (TTY: 711).

Русский (Russian)

ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните 1-800-400-7247 (телетайп: 711).

If You have been unable to contact or obtain satisfaction from Piedmont or the agent, You may contact the Virginia State Corporation Commission's Bureau of Insurance at:

Post Office Box 1157
Richmond, Virginia 23218-1157
Local: (804) 371-9741
Toll Free: (800) 552-7945
National Toll Free: (877) 310-6560
Fax: (804) 371-9944
Email: bureauofinsurance@scc.virginia.gov

Complaints regarding Your Coverage may also be directed to the Office of Licensure and Certification of the Virginia Department of Health located at 9960 Mayland Drive, Suite 401, Henrico, Virginia 23233-1463. You may call them at **(800) 955-1819**, or email mchip@vdh.virginia.gov.

The Department of Medical Assistance Services (located at 600 East Broad Street, Richmond, VA 23219) will be the payor of last resort.

Written correspondence is preferable so that a record of Your inquiry is maintained. When contacting Your agent, Piedmont, or the Bureau of Insurance, please have your policy number (on Your ID card) available. We recommend that You review Our grievance procedure and make use of it before taking any other action.

We will issue to Your Employer or Group a Group Enrollment Agreement. The Group Enrollment Agreement, Evidence of Coverage, Schedule of Benefits, and Our customer service department are the best resources for information about Your Coverage. It is Your responsibility to know and understand Your Benefits.

This Evidence of Coverage is not a complete description of Your Coverage. This document summarizes certain applicable provisions from the Group Enrollment Agreement between Your Employer/Group and Us. By being an Evidence of Coverage holder, You agree to abide by applicable terms and conditions of the Group Enrollment Agreement and Evidence of Coverage.

Together, the Group Enrollment Agreement and its amendments, this Evidence of Coverage, its attachments and any amendments, the Schedule of Benefits, and the Subscriber's and Employer's/Group's Enrollment Applications, constitute the entire contractual agreement between You and Us for the provision of health insurance.

No oral statement of any person, including Our employees, will modify or otherwise affect the Benefits, limitations, and exclusions of the EOC, convey or void any Coverage, increase or reduce any Benefits under this EOC, or be used in support or defense of a claim under this Coverage.

All statements made by a Subscriber in connection with the application for enrollment shall be considered representations and not warranties.

No statement made by the Subscriber in connection with the application for enrollment shall be the basis for voiding Coverage or denying a claim after the Evidence of Coverage has been in force for 2 years from its effective date, and unless the statement was material to the risk and contained in a written application.

D. Regulatory Agencies

As a Managed Care Health Insurance Plan (MCHIP) operating in the Commonwealth of Virginia, Piedmont is subject to regulation by both the Virginia State Corporation Commission Bureau of Insurance (pursuant to Title 38.2 of the Code of Virginia) and the Virginia Department of Health (pursuant to Title 32.1 of the Code of Virginia).

SECTION III: How to Use Your Benefits

A. Choosing A Primary Care Physician (PCP)

Upon Your enrollment in Coverage, each Covered Person whose Coverage arises through this Policy may select a PCP. We may choose a PCP if You do not choose one.

A Covered Person may select as his or her PCP any qualified Physician available to provide Covered Services in Our Network. A list of Our In-Network Providers is available upon request or viewable online at www.pchp.net.

You may select as Your enrolled Dependent Child's PCP any Physician in Our Network who specializes in pediatrics if the Physician is available to accept the Child as a patient.

Notice of these available Primary Care Physicians shall be provided to each Subscriber at the time of enrollment and will otherwise be available upon request or viewable online at www.pchp.net.

If You are not satisfied with Your PCP, then You may request another PCP from those available in Our Network. Such change is effective upon receipt of notice of the change. We will not honor a request for a retroactive change in PCP. We do not guarantee availability of an In-Network Provider.

B. Covered Providers

This Plan is a Point of Service plan. The highest level of Benefits is available when You obtain Covered Services from In-Network Providers. The Benefits are called "In-Network" Benefits. Referrals are not needed for an office visit to an In-Network Specialist Provider, including behavioral health Providers. For receipt of In-Network Benefits when required Services are not available from In-Network Providers, the Covered Person (or his or her In-Network Physician) will contact Us and provide information that the required Covered Services needed by the Covered Person are not available from In-Network Providers. In that case, We will review the information with You and/or Your In-Network Physician as necessary and work with You and/or Your In-Network Physician to arrange for the Services to be provided as In-Network Benefits by referral providers outside the Service Area (or outside Our Network of Providers) with whom We have made arrangements to provide these Covered Services.

Please note, specific procedures and services as well as all in-patient care and services require prior authorization by the plan to be considered for coverage regardless of the network status of the provider or facility.

If You have an ongoing special condition as determined by Us that causes You to see an Out-of-Network Specialist Physician often, You may receive a standing referral. We or your PCP working in association with Us will refer You to another Out-of-Network Specialist Physician for treatment of the ongoing special condition. "Special condition" means a condition or disease that is (1) life-threatening, degenerative, chronic, or disabling and (2) requires specialized medical care over a prolonged period of time. The standing referral will allow the Out-of-Network Specialist Physician to treat You without obtaining further

referrals. The Out-of-Network Specialist Physician may authorize referrals, procedures, tests, and other medical services related to the special condition.

If You have been diagnosed with cancer, You may receive a standing referral to a board-certified physician in pain management or an oncologist for cancer treatment. The board-certified physician in pain management or oncologist will consult on a regular basis with Your PCP and any oncologist providing care to You concerning the plan of pain management. The board-certified physician in pain management or oncologist cannot authorize referrals or other health care services which are not related to Your cancer treatment.

This Benefit Plan is a network product that allows Covered Persons to receive most Services either from In-Network or Out-of-Network Providers. A Covered Person who receives Covered Services from Providers other than In-Network Providers (Out-of-Network Providers) will be subject to a reduced level of Benefits. These reduced Benefits are called "Out-of-Network" Benefits. Coverage for both "In-Network" and "Out-of-Network" Benefits are described on the Schedule of Benefits that is a part of this EOC.

Out-of-Network cost sharing for In-Network settings – When using any In-Network Provider, Covered Services provided by an Out-of-Network ancillary Provider are covered as In-Network services. We will count cost sharing paid by the Covered Person for the Covered Service by the Out-of-Network ancillary provider at the In-Network setting towards the In-Network annual Out-of-Pocket maximum.

An office visit to an In-Network Physician does not require an authorization or notification to Us. An In-Network Physician may perform the following procedures or diagnostic exams in his/her office without a prior authorization from Us:

1. Routine laboratory services referred to an In-Network Provider or in the Physician's office, except for genetic testing which would require a prior authorization.
2. X-rays.
3. Prescriptions for most medications.
4. Minor surgical procedures.
5. Routine supplies used in conjunction with the Physician's Services. Examples are antiseptics, test supplies, gloves, and ace bandages.

These are general guidelines. Please contact Us to verify preauthorization requirements for specific services and procedures.

C. Services Requiring Prior Authorization

Certain Covered Services will require prior authorization by Us, except in an Emergency or Urgent Care situation after hours (see below). The In-Network Physician will work with You or the Covered Person and Us to handle these prior authorization requirements. The responsibility for obtaining the required authorization is that of the In-Network Provider or facility.

If You choose to see an Out-of-Network provider, they may assist in obtaining required authorization, however, the responsibility for obtaining authorization ultimately will be Yours. If prior authorization is required and not obtained by an Out-of-Network Provider or facility, the Provider or facility may pursue payment from You for any unpaid amounts.

We will not require prior authorization for the interhospital transfer of (1) a newborn infant experiencing a life-threatening emergency condition, or (2) the hospitalized mother of such newborn infant to accompany the infant.

Examples of these Covered Services include, but are not limited to, the following:

1. Referrals for Covered Services to all Providers who are Out-of-Network Providers in order to obtain In-Network Benefits. Failure to obtain the prior authorization will result in a reduced level of Benefits called Out-of-Network Benefits;
2. Transplant services;
3. Clinical trials;
4. Durable medical equipment (DME) requires preauthorization depending on the type of equipment or supply (based on CPT code). Repair and replacement of DME follows the same guidelines.
5. Certain medications, including but not limited to:
    - Chemotherapy;
    - Infusion therapy
    - Injections
6. Inpatient Hospital (except for routine vaginal/C-section deliveries at In-Network Hospitals;
7. Partial Hospitalization;
8. Acute rehabilitation;
9. Skilled nursing facility;
10. Long-term acute care Hospital;
11. Inpatient detox, residential treatment, partial hospital and intensive outpatient for substance use;
12. Select imaging and advanced imaging services
13. Certain outpatient surgeries and procedures, including those performed in the Outpatient Hospital or ambulatory surgery center setting and oral surgery;
14. Experimental and investigational services;
15. Gender affirmation procedures;
16. Radiation therapy; and
17. Select pain management procedures

You or the Provider must submit documentation, including a treatment plan when requested, for Covered Services requiring prior authorization. We will establish that the appropriate level of criteria have been met and, if so, provide an authorization to the requestor.

Contact Piedmont Customer Service by calling (800) 400-7247 (TTY: 711) or visit our website at pchp.net to obtain further information on which services require prior authorization.

Prior authorization is Our certification of Medical Necessity and not a guarantee of

payment. For Benefits to be Covered Services, on the date the Covered Person gets service:

1. The Covered Person must be eligible for Benefits;
2. Premium must be paid for the time period that services are given, or paid within any applicable grace period;
3. The service or supply must be a Covered Service under Your Policy;
4. The service cannot be subject to an exclusion under Your Policy; and
5. The Covered Person must not have exceeded any applicable limits under Your Policy.

D. Obstetrical and Gynecological Care Does Not Require Prior Authorization

A Covered Person is not required to receive a referral or preauthorization from their PCP before receiving obstetrical or gynecological care from an In-Network Provider specializing in obstetrics or gynecological care, which includes ordering related obstetrical and gynecological items and services that are Covered Benefits.

E. Emergency Services Do Not Require A Network Provider or Prior Authorization

When the Covered Person requires resuscitation, Emergency treatment, or his/her life is endangered, We do not require prior authorization before he/she calls:

1. an Emergency 911 system; or
2. other state, county, or municipal Emergency medical system.

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

1. Without regard to the final diagnosis rendered to the covered person or whether the health care Provider furnishing the Emergency services is an In-Network Provider with respect to the services;
2. Without the need for any prior authorization determination by Us, even if an Out-of-Network Provider provides the Emergency Services; and
3. If an Out-of-Network 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 In-Network Providers.
4. If such services are provided Out-of-Network, We will pay the Out-of-Network Provider in accordance with provisions under the section "Balance Billing Prohibited for Certain Services" less any cost-sharing requirement. Any such cost-sharing requirement will not exceed the cost-sharing requirement that would apply if such services were provided In-Network.

The Copayment amounts and Coinsurance percentages for Emergency services received from an Out-of-Network Provider are the same as the Copayment amounts and Coinsurance percentages for Emergency services received from an In-Network Provider.

F. Prior Authorization For Services From Out-of-Network Providers

If the In-Network Physician feels that the Covered Person needs to see a Physician or other medical professional who is an Out-of-Network Provider and the Covered Person believes these Services may be eligible for In-Network Benefits, then the Physician must submit medical information, in writing, to Us. Retroactive requests for consideration at the In-Network Benefit level will not be considered. Prior authorization from Us is required for Covered Services from Out-of-Network Providers to receive In-Network Benefits. We have the right to determine where the Covered Service can be provided when an In-Network Provider cannot provide the Covered Service.

G. Continuity/Transition of Care

The Transition Assistance Program provides a process that allows continued care for Covered Persons when:

- Their PCP or other provider is terminated from provider networks included in the Covered Person's plan
- They are a newly Covered Person and their treating provider is not a participating provider within provider networks included in the Covered Person's plan
- Continuity of care is at risk for reasons over which the Covered Person has no control.

A Covered Person may request Continuity/Transition of Care using the Continuity/Transition of Care Request Form:

- If the Covered Person is in an active course of treatment from the provider prior to the notice of termination. Completion of Covered Services may be provided for a period of time necessary to complete a course of treatment and to arrange for a safe transfer to another provider;
- If the Covered Person is in an active course of treatment for any behavioral health condition;
- If the Covered Person is pregnant, regardless of trimester;
- If the Covered Person has a terminal illness;
- If the Covered Person has a newborn child between the ages of birth and 36 months.
- Completion of covered services may be provided for a period of time necessary to complete a course of treatment and to arrange for a safe transfer to another provider;
- If the Covered Person has a surgery or other procedure that has been authorized by the previous plan or its delegated provider and is scheduled to occur within 180 days of the effective date of coverage for a newly Covered Person.

Upon completion and submission of a Continuity/Transition of Care Request Form for a situation as detailed above, the Covered Person may receive the following as applicable:

1. Covered Services from an In-Network Provider shall be permitted to continue for a period of 90 days from the date of such Provider's termination as an In-Network Provider, except when the Provider is terminated for cause
2. A Covered Person who has been medically confirmed to be pregnant at the time of the In-Network Provider's termination of participation as an In-Network Provider has the

option to continue receiving Covered Services from that Provider, except when the Provider is terminated for cause. This continuation of maternity coverage shall, at the Covered Person's option, continue through the provision of postpartum care directly related to the delivery.

3. A Covered Person determined to be terminally ill (as defined by Section 1861 (dd) (3)of the United States Social Security Act) at the time of his/her In-Network Provider's termination of participation as an In-Network Provider has the option to continue receiving Covered Services directly related to treatment of the terminal illness from this Provider for the remainder of his/her life, except when the Provider is terminated for cause.
4. A Covered Person who has been determined by a medical professional to have a life-threatening condition at the time of his/her In-Network Provider's termination of participation as an In-Network Provider has the option to continue receiving Covered Services from this Provider for up to 180 days for care directly related to the life-threatening condition.
5. A Covered Person who is admitted to and receiving treatment in any In-Network Inpatient Facility at the time of his/her In-Network provider's termination of participation as an In-Network Provider shall be permitted to continue receiving Covered Services from this Provider until the Covered Person is discharged from the In-Network Inpatient Facility.

When reasonable and feasible, it is expected that the member will transition their care to an In-Network Provider over the time permitted for a period of covered services.

The continuity of care provided for in this Continuity/Transition of Care subsection is not available if either (a) We terminate the In-Network Provider (including the PCP) from the Network "for cause;" or (b) if You cease to be an eligible Subscriber. We will pay the Provider for Covered Services received under this subsection according to Our agreement with the Provider in effect immediately before the termination of the Provider as an In-Network Provider.

H. Case Management

We may offer case management for any Covered Person with complex diagnoses, frequent readmissions, and diagnoses identified by Us as amenable to case management coordination. Our case management personnel will become involved with management of any Covered Person's care in the Inpatient setting and the Outpatient setting. These personnel will work in the community in a cooperative manner with Physicians and providers involved in the care.

I. Utilization Management Program

The Utilization Management (UM) program consists of the following:

1. Prior authorization for certain non-Emergency services before Covered Services are provided;
2. Retrospective review of the Medical Necessity of medical services provided on an Emergency basis;
3. Concurrent review, based on the admitting diagnosis of services requested by the attending Physician; and
4. Certification of services and planning for discharge from a facility or cessation of medical treatment.

The Utilization Management (UM) program evaluates the appropriateness and/or Medical Necessity of healthcare services to determine what is payable under this EOC. The goal of the UM program is to ensure the most medically appropriate services are rendered to patients in the most appropriate clinical setting.

Some services require Our prior authorization before they are received. If Our requirements for prior authorization are not followed, We may not pay for these services. Typically, In-Network Providers know which services require prior authorization and will get one when needed. The PCP and other In-Network Providers have been given detailed information about Our prior authorization procedures and they are responsible for meeting these requirements and obtaining the needed prior authorization. Since the prior authorization is the responsibility of Our In-Network Providers, any reduction or denial of Benefits due to not obtaining a prior authorization should not affect You.

Most Out-of-Network providers will try to assist in requesting Authorizations, however, if a Covered Person requires treatment at an Out-of-Network Provider, You are responsible for assuring all required Authorizations are received, as needed, for coverage.

UM decision making is based only on the appropriateness of the care and service(s) requested and existence of coverage. We do not reward or compensate practitioners or other individuals conducting utilization review for issuing denials of coverage or service. Financial incentives for UM decision makers do not encourage decisions that result in underutilization.

SECTION IV: What You Pay for Benefits

All Covered Services or supplies the Covered Person receives are subject to the terms, conditions, definitions, limitations, and exclusions described elsewhere in this EOC and in the Group Enrollment Agreement between Us and Your Employer/Group. We will only pay for Medically Necessary Covered Services. Additionally, We will only pay the charges incurred when the Covered Person is eligible for the Covered Services received (e.g., Premiums have been paid by the Covered Person or on their behalf).

To the extent permitted by federal law and regulation, when calculating a Covered Person's overall contribution to any Out-of-Pocket maximum or any cost-sharing requirement under this Plan, We will include any amounts paid by the Covered Person, or on their behalf by another person.

A. Deductible (When Applicable)

1. **Deductible Amount.** This is an amount of charges for Covered Services for which no Benefits will be paid. Before Benefits can be paid in a Benefit Year, You must meet the Deductible shown in the Schedule of Benefits. Covered Services that are subject to a Copayment rather than Coinsurance will not be subject to the Deductible.
2. **Family Unit Limit.** When all of the Covered Persons of a Single-Family Unit have collectively incurred the total dollar amount shown in the Schedule of Benefits toward their Family Benefit Year Deductibles, then the Deductibles for the Family Unit will be considered satisfied for that Benefit Year. No individual family member will pay more than the "per person" amount shown in the Schedule of Benefits. Any amounts of Deductible paid more than the Family Unit Limit in a Benefit Year will be promptly reimbursed to You.

B. Copayment/Coinsurance Amounts

For Benefits with only Copayment responsibilities, the Covered Person will pay a specific Copayment amount at the time the Covered Service is provided. The remainder of the Benefits will be covered in full up to the Allowable Charge (as defined in Section IV(E) below).

For Benefits with Coinsurance responsibilities, the Covered Person will pay a percentage of the Allowable Charge. The remainder of the Benefits will be covered in full up to the Allowable Charge.

Qualified medical expense means an expense paid by the insured person for medical care for her/himself, Covered souse, and Covered Dependent(s) that are not compensated for by insurance or otherwise.

For insurance plans with Deductibles, the Coinsurance applies after the applicable Deductible has been satisfied if the Covered Service is subject to the Deductible. When seeing an Out-of-Network Provider due to a Piedmont prior authorization from Us, the Covered Person will be responsible for billed charges more than the Allowable Charge. Amounts above the Allowable Charge do not apply toward the Maximum Out-of-Pocket limit (as defined in Section IV(D) below).

For some insurance Plans, the Copayment, Deductible, and Coinsurance may all apply to Benefits, however, the Copayment and Coinsurance will not apply to the same Benefit. In these instances, We will cover Benefits up to the Allowable Charge following the applicable Copayment, Deductible and/or Coinsurance amounts as described on the Schedule of Benefits.

C. Benefit Payment

Each Benefit Year, We will pay Benefits for those Covered Services a Covered Person receives once the Deductible is met. Payment will be made based on the amounts shown in the Schedule of Benefits. Benefits will not be paid more than the limits listed in this EOC or the Schedule of Benefits.

D. Out-of-Pocket Maximum

Covered Services are payable as shown in the Schedule of Benefits until any Out-of-Pocket Maximum shown in the Schedule of Benefits is reached. Then, Allowable Charges incurred by a Covered Person will be payable at 100% (except for those charges excluded from the Out-of-Pocket Maximum as set forth below) for the remainder of that Benefit Year.

We will maintain records showing the amount of Cost Shares paid by a Family Unit of Covered Persons during the Benefit Year. When a Family Unit reaches the Out-of-Pocket Maximum, Allowable Charges incurred by any Covered Person will be payable at 100% (except for those charges excluded from the Out-of-Pocket Maximum as set forth below) for the remainder of that Benefit Year. We will provide written notice to You within 30 days after the Out-of-Pocket Maximum is reached for Cost Shares and will not charge any further Cost Shares to that Family Unit of Covered Persons for the remainder of the Benefit Year. Any excess Cost Shares received after such notice will be promptly refunded.

Charges excluded from the Out-of-Pocket Maximum are:

- Non-Covered Services described in this EOC;
- Charges more than any Benefit limitations; and
- Amounts above the Allowable Charge.

Once You have met Your Out-of-Pocket Maximum for the Benefit Year, You will still have cost obligations for the 3 items listed above.

E. Allowable Charge

You will only have to pay your Copayment, Deductible, and/or Coinsurance and will not be balance billed by In-Network Providers for amounts above the Allowable Charge. When seeing an Out-of-Network Provider due to a prior authorization from us, Covered Persons are responsible for billed charges in excess of the Allowable Charge. Amounts above the Allowable Charge do not apply toward the Out-of-Pocket Maximum.

F. Balance Billing Prohibited for Certain Services

No Out-of-Network Provider will Balance Bill a Covered Person for:

- Emergency Services (including air ambulance) provided to a Covered Person (Balance Billing by Out-of-Network Emergency or non-Emergency air ambulance services is prohibited provided that such services would otherwise be covered if received from an In-Network Provider); or
- Nonemergency services provided to a Covered Person at an In-Network Facility if the nonemergency services involve surgical or ancillary Services provided by an Out-of-Network Provider.

A Covered Person that receives services described above satisfies their obligation to pay for the services if he/she pays the In-Network cost-sharing requirement specified in this EOC The Covered Person's obligation will be determined using Our median In-Network contracted rate for the same or similar service in the same or similar geographical area. We will provide an explanation of benefits to the Covered Person and the Out-of-Network Provider that reflects the cost-sharing requirement determined under this subsection.

We and the Out-of-Network Provider will ensure that the Covered Person incurs no greater cost than the amount determined under the subsection above and will not Balance Bill or otherwise attempt to collect from the Covered Person any amount greater than such amount. Additional amounts owed to health care Providers through good faith negotiations or arbitration will be Our sole responsibility, unless We are prohibited from providing the additional benefits under 26 U.S.C. 304 § 223(c)(2) or any other federal or state law. Nothing in this subsection will preclude a Provider from collecting a past due balance on a cost-sharing requirement with interest.

We will treat any Cost-Sharing Requirement determined above in the same manner as the Cost-Sharing Requirement for health care services provided by an In-Network Provider and will apply any cost-sharing amount paid by a Covered Person for such services toward the In-Network Maximum Out-of-Pocket payment obligation.

If the Covered Person pays the Out-of-Network Provider an amount that exceeds the amount determined above, the Provider will refund the excess amount to the Covered Person within 30 business days of receipt. The Provider will pay the Covered Person interest computed daily at an annual legal rate of interest of six percent beginning on the first calendar day after the 30 business days for any unrefunded payments.

The amount paid to an Out-of-Network Provider for health care services described in the two bullet points above will be a Usual and Customary amount. Within 30 calendar days of receipt of a clean claim from an Out-of-Network Provider, We will offer to pay the Provider a Usual and Customary amount. If the Out-of-Network Provider disputes Our payment, the Provider will notify Us no later than 30 calendar days after receipt of Our payment or payment notification. If the Out-of-Network Provider disputes Our initial offer, We and the Provider will have 30 calendar days from the initial offer to negotiate in good faith. If We and the Provider do not agree to a commercially reasonable payment amount within 30 calendar days and either party chooses to pursue further action to resolve the dispute, the dispute will be resolved through an arbitration process regulated by the Commission.

We will make payments for services described in the two bullet points above directly to the Provider.

We will make available through electronic and other methods of communication generally used by a Provider to verify enrollee eligibility and Benefits information regarding whether a Covered Person's health plan is subject to the requirements of this section.

SECTION V: What is Covered

We cover only those Medically Necessary Services. Just because the Provider prescribes the service does not necessarily mean that the service is "Medically Necessary." We will make all determinations required for the administration of the EOC. This includes determinations about Medical Necessity and Covered Services. Medical Necessity is to be determined in accordance with accepted standards of medical care as determined by Us. Each Covered Person has a right to appeal any adverse claims determination made by Us. The appeals process is described in Section VII of this EOC.

A. Acupuncture

Acupuncture means a service where the Physician applies acupuncture therapy by inserting one or more fine needles, which are twirled or manipulated by hand, into the patient as dictated by acupuncture meridian for the relief of symptoms.

Your Plan includes Benefits for Medically Necessary Acupuncture services when provided by a Physician licensed to perform such services, Prior Authorization is required by Us and We will Determine Medical Necessity according to our clinical guidelines. This Coverage does not Include herbs or nutritional supplements. Your cost-sharing for this service will be applied the same as any other Specialist office visit.

Acupuncture therapy is limited to 20 visits per Benefit Year.

B. Allergy Treatment

Allergy testing, diagnosis, and Medically Necessary treatment (including allergy serum and allergy shots) are Covered Services, including doctor office visits.

C. Ambulance (Including Air Ambulance) Services

Medically Necessary professional ambulance services are Covered Services if We authorize these services in advance. Coverage only includes one-way transportation for services to or from the nearest Hospital or skilled medical care facility where necessary treatment can be provided. In an Emergency, authorization in advance of receiving these services is not required and services are available 24 hours a day, 7 days a week.

Air ambulance services, including fixed wing or rotary wing, are Covered Services when prior authorization by Us is obtained or without prior authorization in cases of Medical Necessity requiring resuscitation or emergency relief or where human life is endangered, and ground or water transportation is not appropriate. In cases of Medical Necessity, only those air ambulance services required to take such Covered Person to the geographically closest Hospital capable of treating the Covered Person's Medically Necessary condition will be covered.

Reimbursement will be made directly to the Provider when We are presented with an assignment of benefits by the person or entity providing such services. Balance Billing by Out-of-Network Emergency or non-Emergency air ambulance services is prohibited provided that such services would otherwise be covered if received from an In-Network Provider. You

can find more information regarding services where Balance Billing is prohibited in Section IV, Subsection F of this Policy.

D. Chemotherapy

Chemotherapy, the treatment of an illness or disease by chemical or biological antineoplastic agents, is covered when administered as part of a Doctor's visit, home care visit, or at an Outpatient facility. This includes coverage for cancer chemotherapy drugs administered orally and intravenously or by injection. Cost-sharing (Copayments, Coinsurance and/or Deductible amounts) for orally administered chemotherapy drugs and cancer chemotherapy drugs will not be greater than cost-sharing for intravenously or by injection administered drugs.

E. Clinical Trials for Life-Threatening Diseases/Conditions

This EOC includes Coverage of routine patient costs of qualified individuals associated with approved clinical trials for life-threatening diseases or conditions. We will not deny a qualified individual participation in an approved clinical trial, deny or limit, or impose additional conditions on the Coverage of routine patient costs for items or services furnished in connection with participation in the approved clinical trial. We will not discriminate against the individual based on the individual's participation in the approved clinical trial. Routine patient costs do not include the cost of experimental/investigational items, devices, or services; the cost of items and services provided solely to satisfy data collection and analysis needs not used in direct clinical management; or the cost for a service that is inconsistent with a particular diagnosis's widely accepted and established standards of care.

An "approved clinical trial" means a phase I, phase II, phase III, or phase IV clinical trial that is conducted in relation to the prevention, detection, or treatment of cancer or other life-threatening disease or condition, and the study or investigation is (1) a federally funded or approved trial, (2) conducted under an Investigational new drug application reviewed by the U.S. Food and Drug Administration, or (3) a drug trial that is exempt from having an Investigational new drug application. "Life threatening condition" means any disease or condition from which the likelihood of death is probable unless the course of disease or condition is interrupted. In all cases, Coverage for any clinical trial for such life-threatening diseases or conditions is available only if:

a. There is no clearly superior non-Investigational treatment alternative;
b. The available clinical or pre-clinical data provides a reasonable expectation the life-threatening disease treatment will be at least as effective as the non-Investigational alternative;
c. You and the Physician who furnishes Covered Services to You conclude that participation in the clinical trial would be appropriate under the terms and conditions contained in Your Piedmont Coverage; and
d. The facility and personnel providing the treatment are capable of doing so by virtue of their experience, training, and expertise.

To qualify for consideration as a Covered Service, the treatment to be provided must be a clinical trial approved or funded by:

a. The National Institutes of Health (NIH). (Includes the National Cancer Institute (NCI));
b. The Centers for Disease Control and Prevention;
c. The Agency for Health Care Research and Quality;
d. The Centers for Medicare and Medicaid Services;
e. Cooperative group or center of any of the entities described in (a) through (d) or the Department of Defense or the Department of Veterans Affairs;
f. A qualified non-governmental research entity identified in the guidelines issued by the National Institutes of Health for center support grants;
g. The Department of Veterans Affairs, the Department of Defense, or the Department of Energy as long as the study or investigation has been reviewed and approved through a system of peer review that the Secretary determines 1) to be comparable to the system of peer review of studies and investigations used by the National Institutes of Health, and 2) assures unbiased review of the highest scientific standards by qualified individuals who have no interest in the outcome of the review;
h. An NCI cooperative group (i.e., a formal Network of facilities that collaborates on research projects and has an established US National Institutes of Health-approved peer review program operating within the group, such as: the NCI Clinical Cooperative Group and NCI Community Clinical Oncology Program, or an NCI center);
i. The US FDA in the form of an investigational new drug application; or
j. An institutional review board of an institution in the Commonwealth of Virginia that has a multiple project assurance contract (i.e., a contract between an institution and the US HHS that defines the relationship of the institution to the HHS and sets out the responsibilities of the institution and the procedures that will be used by the institution to protect human subjects) approved by the NCI's Office of Protection for Research Risks.

Our payment for Covered Services the Covered Person receives during participation in clinical trials for treatment studies on life threatening diseases will be determined in the same manner as We determine payment for other Covered Services. Durational limits, dollar limits, Deductibles, Copayments, Coinsurance, and Allowable Charge limits for these services will be no less favorable than for other Covered Services. Covered Services mean Medically Necessary health care services that are incurred as a result of the treatment being provided for the purposes of a clinical trial. Covered Services do not include (1) the costs of non-health care services that Covered Persons may be required to receive as a result of the treatment being provided for the purposes of a clinical trial, (2) the costs associated with managing the research associated with the clinical trial, or (3) the costs of the experimental/Investigational drug or device.

F. Diabetes Care Management

We cover medical supplies, equipment, and education for diabetes care for all diabetics. This includes Coverage for the following:

- Medically Necessary insulin pumps;

- Home blood glucose monitors, lancets, blood glucose test strips, syringes, and hypodermic needles when purchased from a pharmacy; and
- Outpatient self-management training and education performed in-person; including medical nutrition therapy, when provided by a certified, licensed, or registered health care professional.
- Diabetic education may be received from pharmacies that are authorized to perform this service.

The cost-sharing payment for a covered prescription insulin drug is limited to a $50 maximum per 30-day supply. "Prescription insulin drug" means a prescription drug that contains insulin and is used to treat diabetes. “Cost-sharing payment” means the total amount a Covered Person is required to pay at the point of sale in order to receive a prescription drug that is covered under the Covered Person's health plan.

We will not repair or replace lost or damaged equipment due to neglect or abuse.

Routine diabetic foot care is also a Covered Service, including treatment of corns, calluses, and toenail care.

G. Diagnostic Services

Diagnostic services including, but not limited to, x-rays, radiology (including mammograms), ultrasound, nuclear medicine, EKGs, EEGs, echocardiograms, hearing and vision tests for a medical condition or injury (not for screenings or preventive care), MRA, MRI, MRS, CTA, PET/CT Fusion scans, CT scans, SPECT scans, QCT Bone Densitometry, diagnostic CT Colonography, nuclear cardiology, BRCA and fetal screenings, and non-preventive diagnostic colonoscopy and diagnostic mammography performed in an Inpatient or Outpatient facility are covered under the Inpatient or Outpatient facility Benefit. Preventive screening mammography and screening colonoscopy services may be covered without requirement of further payment. Diagnostic tests include lab and pathology services as well as the professional services for test interpretation, x-ray reading, lab interpretation and scan reading. Diagnostic tests are covered in both an Inpatient and Outpatient setting. We cover diagnostic sleep testing and treatment (see Subsection I. Durable Medical Equipment and Supplies within Section V: What is Covered for specifics).

Diagnostic Imaging Services and Tests include but are not limited to:

- X-rays and regular imaging services;
- Ultrasound;
- Electrocardiograms (EKG);
- Electroencephalography (EEG);
- Echocardiograms;
- Radiology including mammograms and nuclear medicine;
- Hearing and vision tests for a medical condition or injury;
- Tests ordered before a surgery or admission;
- Professional services for test and lab interpretation, and X-ray and scan reading.

Advanced Imaging Services include but are not limited to:

- CT Scans;

- CTA Scans;
- Magnetic Resonance Imaging (MRI);
- Magnetic Resonance Angiography (MRA);
- Magnetic Resonance Spectroscopy (MRS);
- Nuclear Cardiology;
- PET Scans;
- PET/CT Fusion Scan;
- QCT Bone Densitometry;
- Diagnostic CT Colonography;
- Single Photon Emission Computed Tomography (SPECT) Scans.

H. Dialysis

We cover services for acute and chronic (end stage) renal disease, including:

- hemodialysis;
- home intermittent peritoneal dialysis (IPD);
- home continuous cycling peritoneal dialysis (CCPD); and
- home continuous ambulatory peritoneal dialysis (CAPD).

Home dialysis equipment, supplies, and training for chronic (end stage) renal disease are Covered Benefits. In addition, dialysis treatments are covered in an Outpatient dialysis facility or Doctor's office.

I. Doctor Visits and Services

We cover visits to a doctor's office (including second surgical opinions), including:

- office visits to a PCP, a Specialist Physician, NP, PA and any other Provider(s) as defined in this EOC;
- Doctor's visits to the Covered Person's home;
- visits to an Urgent Care center for urgent but non-emergent care;
- visits to a Hospital Outpatient department;
- visits to the Emergency room;
- visits to Retail Health Clinics (walk-ins) for routine care and common illnesses;
- visits for shots needed for treatment (including allergy shots); and
- interactive telemedicine services, including online visits with the Doctor by a webcam, chat or voice, and providing remote patient monitoring services.

Online visits do not include:

- reporting normal lab or other rest results;
- requesting office visits;
- getting answers to billing;
- insurance coverage or payment questions;
- asking for referrals to Doctors outside the online care panel;
- Benefit prior authorization; or

- Doctor to Doctor discussions.

Specialist office visits include office surgeries and second surgical opinions. Physician (Doctor) includes Primary Care Physician (PCP), Specialist Physician, NP, PA and any other Provider(s) as defined in this EOC.

J. Durable Medical Equipment and Supplies

Rental of Medically Necessary durable medical equipment and medical devices (or purchase, if such purchase would be less than rental cost as determined by Us) is a Covered Service, when:

- meant for repeated use and is not disposable;
- has no other use than medical;
- is meant for use outside a medical facility; and
- is only for the use of the patient.

Covered durable medical equipment, including the cost of fitting, adjustment, and repair, is listed below:

- Hospital-type beds;
- Bedside commode, shower chair, and tub rails;
- Canes, crutches, walkers, slings, splints, cervical collars, and traction apparatus;
- Wheelchairs and medically necessary wheelchair accessories and supplies;
- Oxygen and oxygen equipment for administration, including devices and supplies for sleep treatment such as APAP, CPAP, BPAP and oral devices, oxygen concentrator, ventilator;
- Colostomy and other related ostomy supplies, including bags, flanges, and belts; *
- Indwelling catheters, straight catheters, and catheter bags; *
- Respirators;
- Jobst stockings or equivalent when prescribed by a vascular surgeon prior to or following vascular surgery;
- The first pair of contact lenses or eyeglasses following approved cataract surgery without implant or for the treatment of accidental eye injury;
- Prosthetic devices and components, including artificial limbs and components Medically Necessary for daily living, breast prosthesis following a mastectomy, restoration prosthesis (composite facial prosthesis), cochlear implants, orthopedic braces, leg braces including attached or built-up shoes attached to a leg brace, molded or therapeutic shoes for diabetics with peripheral vascular disease; arm braces, back braces, neck braces, head halters, catheters and related supplies and splints;
- Two bras or camisoles per year (two total) following mastectomy;
- Nebulizers;
- One wig per Benefit Year following chemotherapy or other cancer treatment;
- Negative pressure wound therapy devices or" wound VAC";
- Orthotics (braces, boots, splints), other than foot orthotics; including a custom made rigid or semi-rigid supportive device used to support, align, prevent, or correct deformities or to improve

the function of movable parts of the body, or which limits or stops motion of a weak or diseased body part.

- Phototherapy lights; and
- Lymphedema sleeves.

Benefits also include the supplies and equipment needed for the use of the durable medical equipment (for example, battery for a powered wheelchair). Those supplies noted with a "*" to be purchased in quantities or units equivalent to a 30-day supply.

We cover maintenance and necessary repairs of durable medical equipment except when damage is due to neglect. We will not replace lost durable medical equipment. Any durable medical equipment not listed above is not a Covered Service. This includes but is not limited to TENS units.

Coverage is also included for the repair, fitting, adjustments, and replacement of a prosthetic device. In addition, We cover components for artificial limbs.

We will consider replacement of durable medical equipment if:

1. Non-repairable as deemed by the manufacturer; or
2. Cost of repairs exceed replacement costs; or
3. No longer functional as deemed by manufacturer or durable medical equipment Provider; or
4. The warranty has expired.

K. Early Intervention Services

Benefits for Medically Necessary speech and language therapy, occupational therapy, physical therapy, and assistive technology services and devices are Covered Benefits if the Dependent Child is: (1) from birth to age 3; and (2) certified by the Department of Behavioral Health and Development Services as eligible for services under Part H of the Individuals with Disabilities Education Act. Medically Necessary early intervention services for the population certified by the Department of Behavioral Health and Development Services means those services designed to help an individual attain or retain the capability to function age-appropriately within his/her environment, and will include services that enhance functional ability without effecting a cure. No therapy visit maximum applies to occupational, physical or speech therapy services received under this Benefit.

L. Emergency and Urgent Care Services

When the Covered Person requires resuscitation, Emergency treatment, or the Covered Person's life is endangered, We do not require prior authorization before the Covered Person calls: (1) an Emergency 911 system; or (2) other state, county or municipal emergency medical system. We cover emergency room professional and facility services including diagnostic x-ray, lab services, medical supplies, and advanced diagnostic imaging, such as MRIs and CAT scans, to evaluate and treat a patient with an Emergency Medical Condition.

Emergency services, including professional and facility services, provided to a Covered Person in the emergency department of a Hospital, an independent freestanding

Emergency department, or other skilled medical facility are Covered Benefits:

1. Without regard to the final diagnosis rendered to the Covered Person or whether the Provider furnishing the Emergency services is an In-Network Provider with respect to the services;
2. Without the need for Our prior authorization, even if an Out-of-Network Provider provides the Emergency Services; and
3. If an Out-of-Network 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 In-Network Providers.
4. If such services are provided Out-of-Network, the health carrier shall pay the Out-of-Network provider in accordance with provisions under the section "Balance Billing Prohibited for Certain Services" less any cost-sharing requirement. Any such cost-sharing requirement shall not exceed the cost-sharing requirement that would apply if such services were provided In-Network.

Emergency services will include Covered Services from Out-of-Network Providers. Emergency services, with respect to an Emergency medical condition, will mean: (1) a medical screening examination within the capability of the Emergency department of a Hospital or an independent freestanding Emergency department, including ancillary services routinely available to the Emergency department to evaluate such Emergency Medical Condition; (2) within the capabilities of the staff/facilities available at the Hospital or the independent freestanding Emergency department such further medical examination and treatment as required to Stabilize the patient (regardless of the department of the Hospital in which such further examination or treatment is furnished); and (3) inclusion of additional services. The term "Emergency Services" shall include, unless each of the conditions in (2) above are met, in addition to the items and services described in (1) above, items and services (a) for which Benefits are provided or covered under the plan or coverage; and (b) that are furnished by a nonparticipating provider or nonparticipating Emergency Facility (regardless of the department of the Hospital in which such items or services are furnished) after the Participant is Stabilized and as part of outpatient observation or an Inpatient or Outpatient stay with respect to the visit in which such services described above are furnished.

The Copayment amounts and Coinsurance percentages for Emergency Services received from an Out-of-Network Provider are the same as the Copayment amounts and Coinsurance percentages for Emergency Services received from an In-Network Provider. Medically Necessary Emergency Services will be covered whether the Covered Person gets care from an In-Network or Out-of-Network Provider. Emergency care from an Out-of-Network Provider will be covered as an In-Network service.

Emergency and Urgent Care Services Within the Service Area

- Medical Care is available through Physicians in Piedmont's Network 24/7. If the Covered Person needs medical care, call the In-Network Physician immediately for instructions on how to receive care.
- If the Emergency requires immediate action, the Covered Person should be taken to the nearest appropriate Hospital or skilled medical facility.
- Emergency Services provided within Our Service Area will include Covered Services from Out-of-Network Providers.

Emergency and Urgent Care Services Outside the Service Area

a. We cover Urgent Care and Emergency services outside the Service Area if the Covered Person sustains an injury or becomes ill while temporarily away from the Service Area. Accordingly, Benefits for these services are limited to care required immediately and unexpectedly. Elective care is covered as an Out-of-Network Service. Benefits for maternity care or childbirth include normal term delivery outside the Service Area but these services will be covered as an Out-of-Network Benefit. In-Network Benefits do include earlier complications of pregnancy or unexpected delivery occurring outside the Service Area.

b. If an Emergency or Urgent Care situation occurs when a Covered Person is temporarily outside the Service Area, please obtain care at the nearest Hospital or skilled medical facility. The Covered Person or his/her representative is responsible for notifying Us within 24 hours, on the next working day, or as soon as he/she is physically/mentally capable of doing so.

c. Benefits for continuing or follow-up treatment are covered at the In-Network level of Benefits until the provider determines the patient is able to travel using non-medical or non-emergency medical transport. This is subject to all provisions of this EOC.

Notification for Emergency Services

In the event of an Emergency requiring Hospitalization, or for which Outpatient Emergency Services are necessary, the Covered Person or his/her representative must notify Us within 24 hours after care is commenced, on the next working day, or as soon as he/she is physically/mentally capable of doing so.

M. Gender Identity / Transgender Services

Piedmont will cover any medical treatment prescribed by a licensed physician for treatment of gender dysphoria so as not to discriminate on the basis of gender identity or being a transgender individual.

"Gender identity" means an individual's internal sense of gender, which may be male, female, neither, or a combination of male and female and which may be different from an individual's sex assigned at birth.

"Transgender individual" means an individual whose gender identity is different from the sex assigned to that individual at birth.

A prior authorization is required by Piedmont to determine Medical Necessity. Medically Necessary transition-related care includes:

1. outpatient psychotherapy and mental health services for gender dysphoria and associated co-morbid psychiatric diagnoses;
2. continuous hormone replacement therapy;
3. outpatient laboratory testing to monitor continuous hormone therapy; and
4. gender reassignment surgeries.

N. Gene Therapy Services

Your Plan includes Benefits for select gene therapy services, when Piedmont approves the Benefits in advance through prior authorization. To be eligible for Coverage, services must be Medically Necessary and performed by an approved Provider at an approved treatment center. Even if a Provider is an In-Network Provider for other services it may not be an approved Provider for certain gene therapy services. Please call us to find out which Providers are approved Providers.

Services Not Eligible for Coverage

Your Plan does not include Benefits for the following:

1. Services determined to be Experimental / Investigational;
2. Services provided by a non-approved Provider or at a non-approved Facility; or
3. Services not approved in advance through prior authorization.

O. Hearing Services

We cover infant hearing examinations for covered newborn Children when performed by a Provider, including screenings for congenital cytomegalovirus for newborns who fail the newborn hearing screens. Coverage is for infant hearing screenings and all necessary audiological examinations provided pursuant to: (1) applicable law or regulation of the Commonwealth of Virginia using any technology approved by the FDA; and (2) as recommended by the National Joint Committee in Infant Hearing in its most current position statement addressing early hearing detection and intervention programs. Subject to the EOC's terms and conditions, this coverage includes any follow-up audiological examinations as recommended by a Physician or audiologist and performed by a licensed audiologist to confirm the existence or absence of hearing loss. All other hearing services and supplies, except for cochlear implants, and hearing aids for children shown below, are not covered.

"Hearing aid" means any wearable, non-disposable instrument or device designed or offered to aid or compensate for impaired human hearing and any parts, attachments, or accessories, including earmolds, but excluding batteries and cords. Hearing aids are not to be considered durable medical equipment

"Related services" includes earmolds, initial batteries, and other necessary equipment, maintenance, and adaptation training.

Piedmont also covers hearing aids and related services for children 18 years of age or younger when an otolaryngologist recommends such hearing aids and related services. Such recommended services and equipment may be provided or dispensed by an otolaryngologist, licensed audiologist, or licensed hearing aid specialist. The coverage includes one hearing aid per hearing-impaired ear, up to a cost of $1,500, every 24 months. If the cost of one hearing aid exceeds the $1,500 limit, Piedmont will pay $1,500 as provided above, then the remaining balance will be the responsibility of the individual or their parent/guardian. For HSA plans, the plan deductible is applied first.

P. Hemophilia

Treatment of **hemophilia and other congenital bleeding disorders** is a Covered Service. Benefits include Coverage for expenses incurred in connection with the treatment of routine bleeding episodes, including:

- coverage for the purchase of blood;

- the administration of blood products; and
- blood infusion equipment required for a home treatment program of routine bleeding episodes associated with hemophilia and other congenital bleeding disorders when the home treatment program is under the supervision of a state-approved hemophilia treatment center.

For the purposes of this subsection, the following terms have the following meanings:

- "Blood infusion equipment" includes, but is not limited to, syringes and needles.
- "Blood product" includes, but is not limited to, Factor VII, Factor VIII, Factor IX, and cryoprecipitate.
- "Hemophilia" means a lifelong hereditary bleeding disorder usually affecting males that results in prolonged bleeding primarily into the joints and muscles.
- "Home treatment program" means a program where the Covered Person or family members are trained to provide infusion therapy at home to achieve optimal health and cost effectiveness.
- "State-approved hemophilia treatment center" means a Hospital or clinic that receives federal or state Maternal and Child Health Bureau, and/or Centers for Disease Control funds to conduct comprehensive care for persons with hemophilia and other congenital bleeding disorders.

Q. Home Health Care

- **Home Health Services**. Home health services covers treatment provided in the Covered Person's home on a part-time or intermittent basis if provided by a licensed health care professional, including nurse, therapist, or home health aide. This includes:
    - intermittent skilled nursing care by an R.N. or L.P.N.;
    - home health aide services when receiving skilled nursing or therapy services; physical, occupational, and speech or therapy;
    - medical/social services;
    - diagnostic services;
    - nutritional guidance;
    - durable medical equipment;
    - training of the patient and/or Family/caregiver;
    - habilitative and short-term rehabilitative services (subject to the limitations set forth in this EOC and does not include manipulation therapy when given in the home);
    - home infusion therapy as described in this section under **Paragraph R. Infusion Therapy**;
    - medical supplies; and
    - other Medically Necessary services and supplies.

  Home health services are only covered for care and treatment of an injury or illness when Hospital or skilled nursing facility confinement would otherwise be required. These services are only covered when the Covered Person's condition confines him/her to home except for brief absences.

The following are not Covered Services:

- homemaker services;
- food and home-delivered meals;
- custodial care (including Outpatient custodial care);
- respite care; and/or
- other non-medical services.

- **Home Health Limits: Maximum of 100 visits per Benefit Year. This home health care visit limit applies to any combination of physical, occupational, speech therapy, or cardiac rehabilitation received in the home instead of any individual therapy limits. This home health care limit does not apply to home infusion therapy or home dialysis**. Physical, speech, and occupational therapy services provided as part of home care are not subject to separate visit limits for therapy services.
- **House Calls.** House calls determined to be Medically Necessary by the In-Network PCP and Us are Covered Services.
- **Remote Patient Monitoring Services using Telemedicine.** Remote Patient Monitoring Services using Telemedicine are Covered Services and means the delivery of home health services using telecommunications technology to enhance the delivery of home health care, including monitoring of clinical patient data such as weight, blood pressure, pulse, pulse oximetry, blood glucose, and other condition-specific data; medication adherence monitoring; and interactive video conferencing with or without digital image upload.

R. Hospice Services

Hospice services are Covered Services when:

- A Provider that We determine is a licensed hospice provides these services. "Hospice Services" means a coordinated program of home and Inpatient care provided directly or under the direction of a licensed hospice. This includes palliative and supportive physical, psychological, psychosocial, and other health services to individuals with a terminal illness utilizing a medically directed interdisciplinary team;
- The Covered Person has a terminal illness. For the purposes of this Subsection, "terminal illness" means a condition diagnosed as terminal by a licensed Physician and whose life expectancy is six months or less;
- The Covered Person elects to receive palliative care rather than curative care. This means that the Covered Person elects treatment directed at controlling pain, relieving other symptoms, and focusing on special needs related to the stress of the dying process. Palliative care does not include treatment aimed at investigation and intervention for the purpose of cure or prolongation of life; and
- We authorize the services provided.

Covered Hospice Services include:

- Skilled nursing care, including IV therapy services;
- Drugs and other Outpatient prescription medications for palliative care and pain management;
- Services of a medical social worker;

- Services of a home health aide or homemaker and in-home Hospice;
- Short-term Inpatient Hospital care, including both respite care and procedures necessary for pain control and acute chronic symptom management. "Respite care" means non-acute Inpatient care for the Covered Person in order to provide the Covered Person's primary caregiver a temporary break from caregiving responsibilities. Respite care may be provided only on an intermittent, non-routine and occasional basis.
- Physical, speech, or occupational therapy (services provided as part of hospice care are not subject to separate visit limits for therapy services);

- Durable medical equipment;
- Routine medical supplies;
- Routine lab services;
- Counseling, including nutritional counseling with respect to the Covered Person's care and death; and
- Bereavement counseling for immediate Family members both before and after the Covered Person's death.

S. Hospital Services

Covered Services include the Hospital and Physicians' services when the Covered Person is treated on an Outpatient basis, or when he/she is an Inpatient because of illness, injury, or pregnancy. This includes Inpatient rehabilitative or habilitative services and devices when Medically Necessary. Covered Services include:

- anesthesia services in an Inpatient or Outpatient facility setting as well as services rendered by an anesthesiologist;
- blood and blood products;
- medical and surgical dressings and supplies, casts, splints, diagnostic services, and therapy services.

We also cover Medically Necessary Outpatient services at an ambulatory surgery center or an Outpatient Hospital facility, including the facility fee, anesthesia, Physician/surgical services, and blood and blood products and its administration.

We cover surgery charges when treatment is received at an: (1) Inpatient; (2) Outpatient or ambulatory surgery facility; or (3) Physician's office. We cover Medically Necessary care in a semi-private room or intensive or special care unit. This includes:

- the Covered Person's bed;
- meals;
- special diets;
- general nursing services;
- drugs;
- injectable drugs;
- blood, oxygen; and
- nuclear medicine.

We cover a private room charge if the Covered Person needs a private room because he/she

has a highly contagious condition or are at greater risk of contracting an infectious disease because of the medical condition. Otherwise, Inpatient Benefits would cover the Hospital's charges for a semi-private room. If chosen to occupy a private room, the Covered Person will be responsible for paying the daily difference between the semi-private and private room rates in addition to any Copayment and Coinsurance.

- Inpatient services and supplies furnished by a Hospital are Covered Services and require prior authorization. We reserve the right to determine whether the continuation of any Hospital admission is Medically Necessary. Special rules

  apply in Emergencies and for transplant services. We will not require prior authorization for the interhospital transfer of (1) a newborn infant experiencing a life-threatening emergency condition or (2) the hospitalized mother of such newborn infant to accompany the infant.
- The room and board and nursing care furnished by a skilled nursing facility are Covered Services when:
  - The Covered Person is confined as a bed patient in the facility;
  - The attending Physician completes a treatment plan that describes the type of care that is needed; and
  - We authorize the services provided.

Custodial or residential care in a skilled nursing facility or any other facility is not a Covered Service.

- For certain conditions, the law mandates a minimum Inpatient length of stay. We will provide the following Benefits for Inpatient services received:
  - Benefits are provided for a minimum Inpatient stay of 48 hours for a covered radical or modified radical mastectomy. Benefits are also covered for a minimum Inpatient stay of 24 hours for a covered total mastectomy or a partial mastectomy with lymph node dissection for the treatment of breast cancer unless the treating Physician, consulting with the Covered Person, determines a shorter Inpatient stay is appropriate.
  - Benefits are provided for a minimum Inpatient stay of 48 hours for a covered vaginal hysterectomy. Benefits are also covered for a minimum Inpatient stay of 23 hours for a covered laparoscopy-assisted vaginal hysterectomy unless the treating Physician, consulting with the Covered Person, determines that a shorter Inpatient stay is appropriate.
  - Benefits are provided for a minimum Inpatient stay of 48 hours (vaginal delivery) or 96 hours (Caesarean section delivery) for these Covered Services unless the treating Physician, consulting with the Covered Person, determines that a shorter Inpatient stay is appropriate.

T. Individual Case Management

We may elect to offer Benefits for services pursuant to an approved alternative treatment plan for a Covered Person whose condition would otherwise require continued long-term Inpatient care. We will provide these alternative Benefits:

- at Our discretion;
- only when and for so long as We determine (consulting with the In-Network Physician) the alternative services are Medically Necessary and cost-effective; and
- the total Benefits paid for such services do not exceed the maximum Benefits the Covered Person would otherwise be entitled under this EOC and the Schedule of Benefits, absent alternative Benefits.

If We elect to provide alternative Benefits for a Covered Person in one instance, that election will not obligate Us to provide the same or similar Benefits for any Covered Person in any other instance. Nor, shall it be construed as a waiver of Our right to administer this EOC in strict accordance with its express terms.

U. Infusion Services

Covered Services include:

- drug infusion therapy, blood products, and injectables that are not self-administered;
- Total Parenteral Nutrition (TPN);
- enteral nutrition therapy;
- antibiotic therapy;
- pain care;
- infusion of special medical formulas as a critical source of nutrition for a Covered Person with inborn errors of amino acid or organic acid metabolism, metabolic abnormality or severe protein or soy allergies;
- chemotherapy;
- nursing;
- durable medical equipment; and
- drugs that are delivered and administered by a health care Provider as part of a Doctor's visit, home care visit, or at an Outpatient facility. These services include coverage of all medications administered intravenously and/or parenterally.

V. Lymphedema

Treatment of **lymphedema** is a Covered Service. If prescribed by a Provider legally authorized to prescribe or provide these items for the treatment of lymphedema, the Benefits are:

- equipment;
- supplies;
- complex decongestive therapy; and
- Outpatient self-management training and education.

W. Maternity Care

1. **Pregnancy and Childbirth**. Covered Services are:

- Pregnancy testing;
- maternity care;
- maternity-related checkups; and
- breast pumps (limit of one pump per pregnancy); and
- pre-natal and post-natal care for a female Covered Person, including a covered Dependent who becomes pregnant.

Coverage is included for victims of rape or incest. Services related to surrogacy if the Covered Person is not the surrogate are not Covered Services. Elective abortions are not Covered Services; this limitation shall not apply to an abortion performed (1) when the life of the mother is endangered by a physical disorder, physical illness, or physical injury, including a life-endangering physical condition caused by or arising from the pregnancy itself, or (2) when the pregnancy is the result of an alleged act of rape or incest.

Maternity care includes the following services:

- Hospital services, including use of delivery room;
- Physician services, including operations and special procedures such as Caesarean section;
- Home setting covered with nurse midwives; also includes delivery at freestanding birthing center;
- Anesthesia services to provide partial or complete loss of sensation before delivery;
- Hospital services for routine nursery care for the newborn during the mother's normal Hospital stay;
- Prenatal and postnatal care services for pregnancy, including pregnancy testing, and complications of pregnancy for which Hospitalization is necessary;
- Initial examination of a newborn and circumcision of a covered male Dependent;
- Postnatal care services for baby including:
    - behavioral assessments and measurements;
    - screenings for blood pressure and hearing;
    - Hemoglobinopathies screening;
    - Gonorrhea prophylactic medication;
    - Hypothyroidism screening;
    - Phenylketonuria (PKU) screening;
    - Rh incompatibility screening; and
    - Covered US Preventive Services Task Force Grades A and B recommendations for which there is **no cost-sharing for required preventive services**;
- Necessary care and treatment of medically diagnosed congenital defects and birth abnormalities;
- Screening for pregnant women for anemia, gestational diabetes, Hepatitis B, Rh incompatibility, asymptomatic bacteriuria, and urinary tract or other infection.
- folic acid supplements for pregnant Covered Persons;
- expanded tobacco intervention and counseling for pregnant users;

- Inpatient and outpatient dental, oral surgical, and orthodontic services that are Medically Necessary for the treatment of medically diagnosed cleft lip, cleft palate, or ectodermal dysplasia;
- Fetal screenings, i.e., tests for the genetic and/or chromosomal status of the fetus. The term also means anatomical, biochemical or biophysical tests, to better define the likelihood of genetic and/or chromosomal anomalies;
- Medically Necessary diagnostic genetic testing and counseling; and
- Injectables; x-ray; and laboratory services.
- We will not require prior authorization for the interhospital transfer of (1) a newborn infant experiencing a life-threatening emergency condition or (2) the hospitalized mother of such newborn infant to accompany the infant.

- **There is no cost-sharing for required preventive services.**

The Newborns' and Mothers' Health Protection Act was signed into federal law on September 26, 1996. It provides important protections for mothers and their newborn Children. It discusses the length of Hospital stay following Childbirth. Group health Plans and health insurance issuers generally may not, under federal law, restrict Benefits for any Hospital length of stay in connection with Childbirth for the mother or newborn Child to: (1) less than 48 hours following a vaginal delivery; or (2) less than 96 hours following a cesarean section. However, federal law generally does not prohibit the mother's or newborn's attending physician, after consulting with the mother, from discharging the mother or her newborn earlier than 48 hours (or 96 hours as applicable).

Obstetrical services will include **postpartum services** for Inpatient care, in a Physician's office, and a home visit or visits, provided that these services are in accordance with the medical criteria outlined in: (1) the most current version of or an official update to the "Guidelines for Perinatal Care" prepared by the American Academy of Pediatrics and the American College of Obstetricians and Gynecologists; or (2) the "Standards for Obstetrical-Gynecological Services" prepared by the American College of Obstetricians and Gynecologists. This Coverage will be provided incorporating any changes in these Guidelines or Standards within a maximum of 6 months of the publication of these Guidelines or Standards or any official amendment to them.

2. **Family Planning**. Voluntary Family Planning services are Covered Services. Covered Services include vasectomies and all of the required guidelines of the Affordable Care Act concerning Women's Preventive Care Services. Covered Services do not include any drug for: impotence; or to enhance arousal, libido or sexual response.

3. **Infertility Services**. We cover services to diagnose and treat conditions resulting in infertility. All other infertility services, including treatment to promote conception by artificial means and medications, are not Covered Services.
4. **Sterilization Services**. Benefits include sterilization services and services to reverse a non-elective sterilization that resulted from an illness or injury. Reversals of elective sterilizations are not covered. Sterilizations for women are covered under the "Preventive Care Services" Benefit.

X. Medical and Surgical Supplies and Medications

Medical and Surgical supplies that serve only a medical purpose, are used once, and are purchased (not rented), are Covered Services if prescribed by a covered Provider. Examples include:

- Hypodermic needles, syringes, surgical dressings, splints, and other similar items that serve only a medical purpose;
- Oxygen and equipment (respirators) for its administration;
- Prescription medications provided by the Physician; and
- Prescription medications infused through IV therapy in the Physician's office or Outpatient facility.

Certain medical supplies may be covered under the prescription drug Benefit when purchased or supplied by a pharmacy. Please see the Subsection X below on Prescription Drug Services for more information.

Y. Mental/Behavioral Health and Substance Use Disorder Services

We will provide mental/behavioral health and substance use disorder services equal to the Coverage for medical and surgical Benefits with respect to financial requirements and treatment limitations.

Mental Health Parity and Addiction Equity Act

The Mental Health Parity and Addiction Equity Act provides for parity in the application of aggregate treatment limitations (day or visit limits) on Mental Health and Substance Use Disorder Benefits with day or visit limits on medical and surgical Benefits. A Plan that does not impose day or visit limits on medical and surgical Benefits may not impose such day or visit limits on Mental Health and Substance Use Disorder Benefits offered under the Plan. Also, the Plan may not impose Deductibles, Copayment, Coinsurance, and out of pocket expenses on Mental Health and Substance Use Disorder Benefits that are more restrictive than Deductibles, Copayment, Coinsurance and out of pocket expenses applicable to other medical and surgical Benefits. Medical Necessity criteria are available upon request.

As set forth in Your Schedule of Benefits form, visit limits will not apply in connection with the treatment of Mental Health/Substance Use Disorder conditions and You will pay the Copayment or Coinsurance listed under Mental Health/Substance Use Disorder for treating any such conditions.

As required for other medical and surgical facility Benefits, We require preauthorization for any Inpatient or Outpatient mental/behavioral health and substance use disorder facility services. We also require prior authorization for any Inpatient or Outpatient services, and office visits from Out-of-Network Providers. Coverage includes:

- Inpatient services for substance use disorder;
- eating disorders and other like conditions provided in a Hospital or treatment facility, including a residential treatment facility (RTF), that is licensed to provide a continuous, structured program of treatment and rehabilitation, including 24 hour-a-

day nursing care;

- Individualized and intensive treatment includes observation and assessment by a psychiatrist at least weekly;
- rehabilitation;
- therapy;
- education; and
- recreational or social activities.

Care from a residential treatment facility (RTF) or other non-skilled, sub-acute setting will not be covered if the services are merely custodial, residential, or domiciliary in nature.

Mental/behavioral health or substance use disorder Inpatient care Coverage includes:

- individual and group psychotherapy;
- psychological testing;
- counseling with family members to assist with the patient's diagnosis and treatment;
- behavioral health, rehabilitation, and convulsive therapy treatment;
- detoxification; and
- Hospital and Inpatient professional services and charges in any Hospital or facility required by state law.

Mental/behavioral health or substance use disorder Outpatient care Coverage includes:

- diagnosis and treatment of psychiatric conditions such as:
    - individual and group psychotherapy;
    - psychological testing; and
    - any applicable professional services and Physician charges.

A partial day Hospitalization program must be licensed or approved by the state. Partial Hospitalization means a licensed or approved day or evening treatment program that includes the major diagnostic, medical, psychiatric and psychosocial rehabilitation treatment modalities designed for patients with mental, emotional, or nervous disorders, and alcohol or other drug dependence who require coordinated, intensive, comprehensive and multi-disciplinary treatment. Such a program will provide treatment over a period of six or more continuous hours per day to individuals or groups of individuals who are not admitted as Inpatients. This also includes intensive Outpatient programs for the treatment of alcohol or other drug dependence which provide treatment over a period of three or more continuous hours per day to individuals or groups of individuals who are not admitted as Inpatients.

Office or Outpatient facility visits to the Covered Person's Physician to ensure the medication(s) the Covered Person is taking for a mental/behavioral health or substance use disorder problem are working properly and the dosage(s) are correct are considered Covered Services.

We provide coverage for mobile crisis response services and support and stabilization services provided in a residential crisis stabilization unit to the extent that such services are covered in other settings or modalities, regardless of any difference in billing codes.

"Mobile crisis response services" means services delivered to provide for rapid response to,

assessment of, and early intervention for individuals experiencing an acute mental health crisis that are deployed at the location of the individual.

"Residential crisis stabilization unit" means a short-term residential program providing support and stabilization for individuals who are experiencing an acute mental health crisis.

Diagnosis and treatment of **Autism Spectrum Disorder** of any age is a Covered Service, including applied behavior analysis (ABA) services. Applied behavior analysis means the design, implementation, and evaluation of environmental modifications, using behavioral stimuli and consequences, to produce socially significant improvement in human behavior, including the use of direct observation, measurement, and functional analysis of the

relationship between environment and behavior. Physical, speech, and occupational therapy services for the treatment of Autism Spectrum Disorder are not subject to separate visit limits for therapy services.

Autism Spectrum Disorder means any pervasive developmental disorder or autism spectrum disorder, as defined in the most recent edition or the most recent edition at the time of diagnosis of the Diagnostic and Statistical Manual of Mental Disorders of the American Psychiatric Association. Autism spectrum disorder diagnosis means Medically Necessary assessments, evaluations, or tests to diagnose whether an individual has an Autism Spectrum Disorder. Medically Necessary means in accordance with the generally accepted standards of mental disorder or condition care and clinically appropriate in terms of type, frequency, site, and duration, based upon evidence and reasonably expected to do any of the following:

- Prevent the onset of an illness, condition, injury, or disability;
- Reduce or ameliorate the physical, mental, or developmental effects of an illness, condition, injury, or disability;
- Assist to achieve or maintain maximum functional capacity in performing daily activities, taking into account both the functional capacity of the individual and the functional capacities that are appropriate for individuals of the same age.

Autism Spectrum Disorder treatment will be identified in a treatment plan. This includes the following care prescribed or ordered for a Covered Person diagnosed with Autism Spectrum Disorder by a licensed Physician or a licensed psychologist who determines the care to be Medically Necessary:

- Behavioral Health Treatment;
- Pharmacy Care;
- Psychiatric Care;
- Psychological Care;
- Therapeutic Care; and
- Applied behavior analysis when provided or supervised by a licensed and board certified behavior analyst. The prescribing practitioner shall be independent of the Provider of applied behavior analysis.

Z. New Technology

We regularly evaluate new and existing technologies for inclusion as a Covered Service. Confirmation that the appropriate regulatory body has assessed such new or existing

technology must occur prior to approval, where required by law. To be considered Covered Services, new and existing technologies must demonstrate a marked improvement in health outcomes, health risks, and health benefits when compared with established procedures and products based on clinical evidence reported by Peer Reviewed Medical Literature.

AA. Oral Surgery; Dental Services

No dental services are Covered Services under this EOC. The only exception is the limited oral surgical procedures and dental services described in this paragraph. Services of a cosmetic nature are not Covered Services. Services that We determine are functional repairs necessary for working properly are Covered Services. This includes:

- a surgery or procedure to correct deformity caused by disease, trauma, or a previous therapeutic process;
- surgeries or procedures to correct congenital abnormalities that cause functional impairment; or
- surgeries or procedures on newborn Children to correct congenital abnormalities.

The following specific procedures are Covered Services or non-Covered Services, as noted below:

1. Medically Necessary dental services resulting from an accidental dental injury, regardless of the date of such injury, are Covered Services. Our Prior authorization is not required for Emergency or Urgent Care situations; it is required for other non-emergent dental procedures resulting from an accidental dental injury.
2. Dental services for an injury that results from chewing or biting are not Covered Services.
3. The cost of dental services and dental appliances are Covered Services only when required to diagnose or treat an accidental injury to the teeth. Repair of dental appliances damaged as a result of accidental injury to the jaw, mouth or face are Covered Services. Major adult dental care and adult orthodontia are covered as Medically Necessary as a result of an accidental injury.
4. Dental services and dental appliances furnished to a newborn or any Covered Person when required to treat medically diagnosed cleft lip, cleft palate, or ectodermal dysplasia are Covered Services.
5. Dental services to prepare the mouth for medical services and treatments such as radiation therapy to treat cancer and prepare for transplants are Covered Services, including dental x-rays, extractions, and anesthesia. Also covered is treatment of non-dental lesions, such as removal of tumor and biopsies, as well as incision and drainage of infection of soft tissue not including odontogenic cysts or abscesses.
6. Orthognathic surgeries required because of a medical condition or injury which prevents normal function of the joint or bone and is deemed Medically Necessary to attain functional capacity of the affected part are Covered Services. Related appliances, however, are not Covered Services. Bone or joint treatment involving a bone or joint of the head, neck, face, or jaw is covered like any other bone or joint of the skeletal system. The treatment must be Medically Necessary and be required because of a medical condition or

injury that prevents normal function of the joint or bone. Coverage includes outpatient surgical or inpatient settings.

7. All oral surgical services for extractions of impacted wisdom teeth are **not** Covered Services.
8. Maxillary or mandibular frenectomy are Covered Services when not related to a dental procedure.
9. Alveolectomy is a Covered Service when related to tooth extraction.
10. Surgical services on the hard or soft tissue in the mouth are Covered Services when the main purpose is not to treat or help the teeth and supporting structures.
11. We cover Medically Necessary general anesthesia and Hospitalization or Outpatient facility charges by a facility licensed to provide Outpatient surgical procedures for dental care provided to any Covered Person who is:
    a. determined by a licensed dentist, in consultation with the treating Physician, to require general anesthesia and admission to a Hospital or Outpatient surgery facility to provide dental care effectively and safely; and
    b. under the age of 5, or severely disabled, or has a medical condition and requires admission to a Hospital or Outpatient surgery facility and general anesthesia for dental care.

We require prior authorization to the same extent required for other procedures or admissions. Only the services of Providers and facilities licensed to provide anesthesia services are Covered Services. Except as otherwise provided as a Covered Service in this Section, the underlying dental care provided incidental to anesthesia, Hospitalization, or Outpatient surgery, is not covered. For the purposes of determining whether: (1) general anesthesia, (2) Hospital admission, or (3) Outpatient surgery is Medically Necessary under this Subsection, We will consider whether the Covered Person's age, physical condition or mental condition requires the utilization of general anesthesia and the admission to a Hospital or Outpatient surgery facility to provide the underlying dental care safely.

BB. Prescription Drug Services

Medically Necessary prescribed "legend drugs" (defined as drugs not available over the counter) incidental to Outpatient care are Covered Services. Diabetic supplies to treat diabetes are covered under the Prescription Drug Benefit. This includes self-injectable insulin, syringes, needles, lancets, test strips, and home blood glucose monitors. The cost-sharing payment for a covered prescription insulin drug is limited to a $50 maximum per 30-day supply. "Prescription insulin drug" means a prescription drug that contains insulin and is used to treat diabetes. "Cost-sharing payment" means the total amount a covered person is required to pay at the point of sale in order to receive a prescription drug that is covered under the Covered Person's health plan. Benefits are also available for Flu shots, including administration.

For each prescription, We will cover up to a 31-day or 120-unit supply, whichever is less, for the applicable Copayment, Deductible and/or Coinsurance amount. Additional Copayments, Deductible and/or Coinsurance amount and authorization are required for quantities that exceed unit supply limits. Our program requires "mandatory" generic substitution if the FDA has determined the generic equivalent to the brand product. Generic drugs will be dispensed

except when a Physician requires brand name drugs. In this case, the Covered Person will still have to pay the difference between the brand name drug and the generic drug, in addition to the appropriate Copayment, Deductible and/or Coinsurance amount. If the Physician does not require a brand name drug, the Covered Person may request a brand name drug and pay the difference between the brand name drug and the generic drug. This is in addition to the appropriate Copayment, Deductible and/or Coinsurance amount.

Medication Synchronization: We will permit and apply a prorated daily cost-sharing rate to prescriptions that are dispensed by a Network pharmacy for a partial supply if the Covered Person requests or agrees to a partial supply to synchronize their medication, and the prescribing Provider or the pharmacist determines the fill or refill to be in their best interest. We will allow a pharmacy to override any denial codes indicating that a prescription is being

refilled too soon for the purposes of synchronizing the medications. Dispensing fees for partially filled or refilled prescriptions will be paid in full for each prescription dispensed, regardless of any prorated Copayment or fee paid for synchronization services.

The Prescription Drug Benefits cover prescriptions obtained from a pharmacist and includes injections administered at authorized pharmacies. Self-administered injectable drugs that do not need administration or monitoring by a Provider in an office or facility setting are also Covered Services. Simply choose a retail pharmacy that participates in Our pharmacy Network and show Your ID card to receive Benefits unless: (1) the drug is subject to restricted distribution by the FDA; or (2) special handling, Provider coordination, or patient education is required for the drug and cannot be provided by a retail pharmacy. Covered Services also include a mail order Benefit for maintenance medications. Prescriptions can be filled through the mail or at certain participating pharmacies that have contracted to fill mail order prescriptions. See your Network Directory for a listing of walk-in 90-day pharmacies.

Formulary: The Prescription Drug coverage is limited to only those drugs listed on Our formulary. Our formulary is reviewed at least annually 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. We may add or delete Prescription Drugs from the formulary from time to time. A description of the formulary is available upon request by calling Our customer service department at **800-400-7247 (or local at 434-947-4463)** and at https://pchp.net/index.php/group-coverage-members/commercial-prescription-drugs.html.

We will provide to each affected Covered Person at least 30 days prior written notice of a modification to a formulary that results in the movement of a Prescription Drug to a tier with higher cost-sharing requirements. This notice does not apply to modifications that occur at the time of coverage renewal.

Step Therapy Protocols and Step Therapy Exceptions: Step therapy protocol means a protocol setting the sequence in which Prescription Drugs for a specified medical condition and medically appropriate for a particular patient are covered under a health benefit plan. Step therapy is a process where We require one drug, drug regimen, or treatment be used prior to use of another drug, drug regimen, or treatment for safety and/or cost-effectiveness when clinically similar results may be anticipated. We and Our Pharmacy Benefits Manager (PBM) have established guidelines in place that make sure certain drugs are prescribed

correctly.

We and Our PBM ensure that Our step therapy protocols:

1. Are developed and endorsed by a multidisciplinary panel of experts that manages conflicts of interest among the members of the writing and review groups by requiring members to disclose to the carrier any potential conflict of interest, including carriers and pharmaceutical manufacturers, and recuse themselves of voting if they have a conflict of interest;
2. Are based on peer-reviewed research and medical practice, and may also consider published clinical practice guidelines established for relevant patient subgroups in addition to or in the absence of peer-reviewed research; and
3. Are continually updated based on a review of new evidence, research, and newly developed treatments.

Step therapy exception means overriding a step therapy protocol in favor of immediate coverage of the Provider's selected Prescription Drug provided that such drug is covered under the health benefit plan, which determination is based on a review of the patient's or prescribing Provider's request for an override, along with supporting rationale and documentation. Drug samples are not considered trial and failure of a Preferred Drug.

When coverage of a Prescription Drug for the treatment of any medical condition is restricted for use by Us or Our PBM through the use of a step therapy protocol, the Covered Person and prescribing Provider will have access to a clear, readily accessible, and convenient process to request a step therapy exception. We will use Our existing exception request process shown below for Prescription Drugs not included on the formulary as the process for requesting a step therapy exception.

A step therapy exception request will be granted if the prescribing Provider's submitted justification and supporting clinical documentation, if needed, are determined to support the prescribing Provider's statement that:

1. The required prescription drug is contraindicated;
2. The required drug would be ineffective based on the known clinical characteristics of the patient and the known characteristics of the Prescription Drug regimen;
3. The patient has tried the step therapy-required Prescription Drug while under their current or a previous health benefit plan, and such Prescription Drug was discontinued due to lack of efficacy or effectiveness, diminished effect, or an adverse event; or
4. The patient is currently receiving a positive therapeutic outcome on a Prescription Drug recommended by his/her Provider for the medical condition under consideration while on a current or the immediately preceding health benefit plan.

Upon the granting of a step therapy exception, We and Our PBM will authorize coverage for the Prescription Drug prescribed by the Covered Person’s treating Provider, provided that the Prescription Drug is covered under Our formulary. We or Our PBM will respond to a step therapy exception request within 72 hours of receipt, including hours on weekends, to notify the Covered Person that the request is approved, denied, or requires supplementation. In cases where exigent circumstances exist, We will respond within 24 hours of receipt,

including hours on weekends, that the request is approved, denied, or requires supplementation. The Covered Person may appeal any step therapy exception request denial through Our existing appeal procedures located later in this EOC.

Exception Request for Prescription Drugs Not Included on the Formulary: We have a process in place for any Covered Person, a designated representative, the prescribing Physician, or other prescriber to request and gain access to clinically appropriate drugs not otherwise covered on Our formulary. A Formulary Exception request may be submitted to allow a Covered Person to obtain coverage for a drug by phone or fax.

An Exception Request Form is available online at https://pchp.net/index.php/group-coverage-

members/commercial-member-forms.html. Forms may be faxed to CVS/Caremark at 1-855-245-2134. Exception requests may also be communicated by phone to CVS/Caremark at 1-855-582-2022. Please note that this exception process only applies to drugs not included on the formulary. If a Covered Person has been denied Coverage for a drug included on the formulary, You have the right to a full and fair appeal of Our decision and should follow the appeal process described later in the EOC.

We will act on this standard exception request within one (1) business day of receipt of the request. We will cover the Prescription Drug only if we agree that it is Medically Necessary and appropriate over the other drugs that are on the formulary. We will make a coverage determination and notify the appropriate requester within 72 hours following receipt of the request. If We approve the coverage of the drug, coverage of the drug will be provided for the duration of the prescription, including refills. If We deny coverage of the drug, We have a process in place to allow the request to be reviewed by an independent review organization as described under "External Exception Request Review" in this Section.

Any Covered Person, a designated representative, the prescribing Physician, or other prescriber may also submit a request for a Prescription Drug that is not on the formulary based on exigent circumstances. Exigent circumstances exist if he/she is suffering from a health condition that may seriously jeopardize life, health, or ability to regain maximum function, or if he/she is undergoing a current course of treatment using a drug not on the formulary. We will make a coverage decision within 24 hours of receipt of the request. If We approve the request, coverage of the drug will be provided for the duration of the exigency. If We deny the request, We have a process in place to allow the request to be reviewed by an independent review organization as described under "External Exception Request Review" in this Section.

External Exception Request Review: If We deny an appeal of a standard or expedited request, We have a process in place to allow the request to be reviewed by an independent review organization. Notification of a decision on an external exception request will be given to the Covered Person, representative, or Physician no later than 72 hours following receipt of the request if the original request was a standard request. If the original request was an expedited request notification will be given no later than 24 hours following receipt of the request. If an external exception request is approved, We will provide coverage for the non-formulary drug for the duration of the prescription, and without additional cost-sharing beyond that provided for formulary Prescription Drugs in the Covered Benefits. For expedited exception requests Coverage of the non-formulary drug will be provided for the duration of the need and without additional cost-sharing beyond that provided for formulary

Prescription Drugs in the Covered Benefits.

There are two exceptions to the formulary requirement:

1. Coverage may be obtained without additional cost-sharing beyond that which is required of formulary Prescription Drugs for a non-formulary drug if We determine, after consulting with the prescribing Physician, the formulary drugs are inappropriate therapy for the condition.
2. Coverage may be obtained without additional cost-sharing beyond that which is required of formulary Prescription Drugs for a non-formulary drug if:
    - The Covered Person has 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 the condition, or that changing drug therapy presents a significant health risk.

Medically Necessary Formula and Enteral Nutrition Products means any liquid or solid formulation of formula and enteral nutrition products for Covered Persons requiring treatment for an inherited metabolic disorder and for which the Covered Person's Physician has issued a written order stating that the formula or enteral nutrition product is Medically Necessary and has been proven effective as a treatment regimen for the Covered Person and that the formula or enteral nutrition product is a critical source of nutrition as certified by the Physician by diagnosis. The Medically Necessary formula or enteral products do not need to be the Covered Person's primary source of nutrition. **Inherited Metabolic Disorder** means an inherited enzymatic disorder caused by single gene defects involved in the metabolism of amino, organic, or fatty acids.

We classify Medically Necessary formula and enteral nutrition products as medicine and include coverage for Medically Necessary formula and enteral nutrition products on the same terms and subject to the same conditions imposed on other medicines covered under the plan.

This coverage shall:

- Apply to the partial or exclusive feeding of a Covered Person by means of oral intake or enteral feeding by tube;
- Include coverage for any medical equipment, supplies, and services that are required to administer the covered formula or enteral nutrition products;
- Apply only when the formula and enteral nutrition products are:
    - furnished pursuant to the prescription or order of a Physician or other health care professional qualified to make such prescription or order for the management of an inherited metabolic disorder; and
    - used under medical supervision, which may include a home setting; and
    - Not apply to nutritional supplements taken electively.

We also cover medical food products or supplements prescribed by a Doctor and Medically Necessary only for: (1) nutrition infusion in the home; and (2) special medical formulas if they are a critical source of nutrition for a Covered Person with inborn errors of amino acid or organic acid metabolism, metabolic abnormality or severe protein or soy allergies.

We also cover Prescription Drugs and devices approved by the FDA for use as contraceptives. This includes Coverage for office visits associated with contraceptive

management. Coverage is also provided for up to a 12-month supply of FDA-approved, self-administered hormonal contraceptives, when dispensed or furnished at one time for a Covered Person by a Provider or pharmacy, or at a location licensed or otherwise authorized to dispense drugs or supplies.

Benefits will not be denied for any Drugs that have been approved by the USFDA to treat (i) cancer because the Drug has not been approved by the USFDA for that specific type of cancer for which the Drug has been prescribed, or (ii) a covered indication if the Drug has been approved by the USFDA for at least one indication, if the Drug is recognized in standard reference compendia as safe and effective for treatment of that specific type of cancer, or that covered indication, respectively.

Coverage will be provided for otherwise covered prescribed pain-relieving agents approved by the FDA for use, either on an Inpatient or Outpatient basis, by patients with intractable cancer pain. Coverage will not be denied on the basis that the prescription exceeds the recommended dosage of the pain-relieving agent. The pain-relieving agent must be prescribed in compliance with established statutes pertaining to patients with intractable cancer pain and in accordance with federal and state law.

Prescription Drugs received from a Physician will be covered as other medical services or supplies. Prescription Drugs received from the Hospital will be covered as a Hospital service.

We do not provide Coverage for any of the following:

1. Any legend drug prescribed prior to Your joining this Plan. However, You may get a new prescription after enrolling with Piedmont and receive Coverage for conditions not excluded under this EOC;
2. Over the counter drugs, unless recommended by the US Preventive Services Task Force and prescribed by a Physician;
3. Drugs prescribed primarily for a cosmetic purpose, including but not limited to: (1) Retin-A, when used for any purpose other than treatment for severe acne; and (2) minoxidil, when used to treat baldness;
4. Drugs and medications for conditions excluded under this EOC;
5. Injectable Prescription Drugs that are supplied by a Provider other than a pharmacy that is not an In-Network Provider;
6. Drugs and medications that are: (1) Experimental; (2) Investigational, or (3) not approved by the FDA for the purpose prescribed (except that Benefits for drugs that have been approved by the FDA for use in the treatment of cancer will not be denied on the basis that the drug has not been approved by the FDA for treatment of the specific type of cancer for which the drug has been prescribed, provided that the drug has been recognized as safe and effective for treatment of that specific type of cancer in the American Hospital Formulary Service Drug Information, the National Comprehensive Cancer Network's Drug & Biologics Compendium, or the Elsevier Gold Standard's Clinical Pharmacology);
7. DESI drugs (i.e., drugs which are of questionable therapeutic value as designated by the FDA's Federal Drug Efficacy Study);

8. Any refill dispensed after one year from the date of the original prescription order;
9. Medicine covered by workers' compensation, Occupational Disease Law, state or government agencies;
10. Any other drug not on Our formulary deemed not Medically Necessary by Us;
11. Infertility drugs; and
12. Any drug for impotence or to enhance arousal, libido, or sexual response.

Maintenance Medications: Maintenance medications are those taken routinely to treat or control a chronic illness. Examples of such illnesses are heart disease, high blood pressure, or diabetes. In addition to the pharmacy, maintenance medications may be purchased through

the mail order Benefit. This allows receipt of a 90-day or 360-unit supply, whichever costs less, of a maintenance medication prescription through the mail for the applicable Copayment, Deductible and/or Coinsurance amount. We require additional Copayments, Deductibles and/or Coinsurance amounts and authorization for quantities exceeding unit supply limits. 75% of the prescription must be used before ordering refills.

To receive maintenance medication by mail:

- Ask the Physician to prescribe a 90-day supply of the maintenance medication plus refills. If the medicine is needed immediately, ask the Physician for two prescriptions: one to be filled right away and another to provide to the mail order pharmacy.
- Complete the mail order prescription form and include the written prescription. This is required for the first order of each different prescription medication.
- Mail the form, written prescription, and payment to cover the amount of the Copayment, Deductible and/or Coinsurance amount.
- Refills can be ordered by mail, telephone, or online. Contact information is listed on the mail order form.

NOTE: We also have special arrangements with certain participating pharmacies that allow a 90-day or 360-unit maintenance medication prescription on location. This means the written prescription does not need to be mailed. Simply visit one of the participating 90-day pharmacy locations to fill the prescription. These are listed in Your Network Directory and on Our website at **www.pchp.net.**

Benefits are provided for prescriptions filled at a pharmacy that is an Out-of-Network Provider if that pharmacy or its intermediary agrees in writing to accept the same reimbursement terms as a pharmacy that is an In-Network Provider. Specialty Drugs must be purchased from the Pharmacy Benefit Manager's Specialty Pharmacy, unless another Pharmacy or its intermediary has sent previous notification to plan or PBM of its agreement to accept reimbursement for its services at rates applicable to the PBM's Specialty Pharmacy.

Any Covered Person-submitted claims must be submitted on Our 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 EOC.

We do not prescribe drugs or seek to improperly influence Providers who do. From time-to-

time, We may receive payments from prescription drug manufacturers. This is based on the volume of a particular drug or series of drugs that Providers have prescribed for use by Our Covered Persons collectively. We use these payments to reduce administrative expenses. We do not credit the payments against an individual's or Providers past, present, or future claims costs. We will take these payments into account when We determine future cost trend factors for Premiums or rates.

CC. Preventive Care Services

We cover the following preventive care services in accordance with state and federal regulations. **These services are not subject to cost-sharing provisions** (e.g., a Deductible, Copayment amount or Coinsurance percentage) when received from an In-Network Physician or other In-Network Provider:

1. Evidenced-based items or services that have in effect a rating of "A" or "B" in the current recommendations of the US Preventive Services Task Force. Examples include screenings for breast cancer, cervical cancer, colorectal cancer, high blood pressure, type 2 diabetes mellitus, cholesterol, and child and adult obesity.
2. Immunizations for children, adolescents, and adults recommended by the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention.
3. With respect to adults, evidence-based items or services that have a rating of "A" or "B" from the U.S. Preventive Services Task Force. This includes screening for abdominal aortic aneurysm, alcohol misuse, colorectal cancer, high blood pressure, type 2 diabetes, cholesterol, depression, Hepatitis B and C, HIV, lung cancer, obesity, syphilis, and tobacco use. Also included are counseling for alcohol misuse, nutrition, obesity, sexually transmitted infection prevention, and smoking and tobacco cessation products, including Prescription Drugs that help stop smoking or reduce dependence on tobacco products. This includes smoking cessation products and over the counter nicotine replacement products (limited to nicotine patches and gum) when obtained with a prescription. This also covers aspirin use to prevent cardiovascular disease.
4. With respect to infants, Children, and adolescents, preventive care and screenings provided for in the comprehensive guidelines supported by the Health Resources and Services Administration and have a rating of "A" or "B" from the U.S. Preventive Services Task Force. Examples include assessments for alcohol and drug use, behavioral, oral health risk, medical history, BMI measurements, screenings for autism (18 and 24 months), blood pressure, cervical dysplasia, depression, development, dyslipidemia, hematocrit or hemoglobin, Hepatitis B, HIV, lead, obesity, sexually transmitted infection (STI), tuberculin, hearing and vision. Also included are counseling for obesity and STI, screening for suicide risk and anxiety, and supplements for fluoride chemoprevention and iron.
5. One PSA test in a 12-month period and digital rectal examinations for Covered Persons age 50 and over, and persons age 40 and over who are at high risk for prostate cancer. PSA testing means the analysis of a blood sample to determine the level of prostate specific antigen.
6. One screening mammogram for Covered Persons between the ages of 35 to 39; a screening mammogram each year for Covered Persons age 40 and over.
7. Annual Pap smears including coverage for annual testing performed by any FDA-approved gynecologic cytology screening technologies.
8. Colorectal cancer screening. Preventive colonoscopy including follow-up

colonoscopies following a positive non-invasive stool-based screening test. Benefit also includes polyp removal during or anesthesia provided in connection with a preventive screening colonoscopy. Services are included in accordance with the most recently published recommendations established by the American College of Gastroenterology, in consultation with the American Cancer Society, for the ages, family histories, and frequencies referenced in the recommendations including:

a) an annual fecal occult blood test;
b) flexible sigmoidoscopy or screening colonoscopy;
c) radiologic imaging in appropriate circumstances.

9. Preventive nutritional counseling and smoking/tobacco cessation counseling.

10. Prescription Drugs and over-the-counter items identified as an A or B recommendation by the U.S. Preventive Services Task Force when prescribed by a Provider including aspirin, folic acid supplement for pregnancy, and bowel preparations (certain age, gender, and quantity limitations apply).
11. With respect to women, such additional preventive care and screenings, not described in paragraph (1) above, as provided for in comprehensive guidelines supported by the Health Resources and Services Administration, including:

    a. Well-Woman Visits: An annual Well-Woman preventive care visit for adult women to obtain the recommended preventive services that are age and developmentally appropriate, including preconception and prenatal care is covered at 100% as a preventive care service. The allowed frequency is annual, although HHS recognizes several visits may be needed to obtain all necessary recommended preventive services, depending on: a woman's health status; health needs; and other risk factors. Included are screenings for BRCA risk assessment and genetic testing, breast cancer mammography, cervical cancer, osteoporosis, counseling for breast cancer genetic testing (BRCA), and breast cancer chemoprevention.

    b. Screening for Gestational Diabetes: Screening for gestational diabetes is covered at 100% as a preventive care service. The allowed frequency is in pregnant women between 24 and 28 weeks of gestation and at the first prenatal visit for pregnant women identified to be at high risk for diabetes.

    c. Human Papillomavirus (HPV) Testing: High-risk human papillomavirus DNA testing in women with normal cytology results is covered at 100% as a preventive care service. Screening is recommended to begin at 30 years of age and should occur no more frequently than every 3 years.

    d. Counseling and Screening for Sexually Transmitted Infections (STIs): Counseling and screening for sexually transmitted infections (STIs) for all sexually active women is covered at 100% as a preventive care service annually.

    e. Counseling and Screening for Human Immune-Deficiency Virus (HIV): Counseling and screening for human immune-deficiency virus infection for all sexually active women is covered at 100% as a preventive care service annually.

f. Contraception Methods and Counseling (Females only): All FDA approved contraceptive methods, sterilization procedures/treatments, and patient education and counseling for all women with reproductive capacity are covered at 100% as a preventive care service, including drugs, injectables, patches, rings and devices such as diaphragms, IUDs, and implants. The frequency is as prescribed. We will cover pharmacy prescription generic oral contraceptives and those brands which do not have generic equivalents at 100% as a preventive care service through Our Network retail pharmacies or mail order. Brand contraceptives with a generic equivalent will be covered subject to the appropriate Plan Prescription Drug Copayment. Over-the-

counter contraceptives are not covered. Medical/surgical type contraceptives/sterilizations (office/facility based medical and surgical) will be covered at 100% as a preventive care service. Our standard medical management, Network, and formulary restrictions apply. Coverage is also provided for up to a 12-month supply of FDA-approved, self-administered hormonal contraceptives, when dispensed or furnished at one time for a Covered Person by a Provider or pharmacy, or at a location licensed or otherwise authorized to dispense drugs or supplies.

g. Breastfeeding Support, Supplies, and Counseling: Comprehensive lactation support and counseling, by a trained Provider during pregnancy and/or in the postpartum period, and costs for renting breastfeeding equipment are covered at 100% as a preventive care service. **Benefits for breast pumps are limited to one pump per pregnancy**. Frequency is in conjunction with each birth. Our standard medical management and Network restrictions apply.

h. Screening and Counseling for Interpersonal and Domestic Violence: Screening and counseling for interpersonal and domestic violence are covered at 100% as a preventive care service annually.

You may contact Us at **434-947-4463** or toll free at **1-800-400-7247** for more information about preventive care services, or visit the following websites for current federal government recommendations:

http://www.healthcare.gov/center/regulations/prevention.html

http://www.uspreventiveservicestaskforce.org/Page/Name/uspstf-a-and-b-recommendations/

http://www.cdc.gov/vaccines/acip/

http://www.hrsa.gov/womensguidelines/

If the preventive care service described in subparagraphs (1) through (4) above:

1. Is billed separately from an office visit, then cost-sharing requirements may be imposed on the office visit;
2. Is not billed separately from the office visit and the primary purpose of the office

visit is delivery of the preventive care service, then cost-sharing requirements may not be imposed on the office visit; or

3. Is not billed separately from an office visit and the primary purpose of the office visit is not delivery of the preventive care services, then cost-sharing requirements may be imposed on the office visit.

Cost-sharing requirements for treatment not described in subparagraphs (1) through (4) above may be imposed even if that treatment results from an item or service described in those subparagraphs.

Preventive care services that are not provided as described in this EOC are not covered.

We follow the guidelines established by the Center for Disease Control and Prevention, the Health Resources and Services Administration, and the American Academy of Family Physicians which may change from time to time.

DD. Private Duty Nursing

Private Duty Nursing includes medically skilled services of a licensed RN or LPN in the home. Benefits are limited to 16 hours per Benefit Year.

EE. Radiation Therapy

Radiation therapy and its administration, including rental or cost of radioactive materials, which is for treatment of an illness or disease by x-ray, radium, cobalt, high energy particle sources, or radioactive isotopes is covered. Services include treatment (teletherapy, brachytherapy and intraoperative radiation, photon or high energy particle sources), materials and supplies needed, administration, treatment planning, and certain other Covered Services.

Standard of clinical evidence for decisions on coverage for proton radiation therapy:

"Proton radiation therapy" means the advanced form of radiation therapy treatment that utilizes protons as an alternative radiation delivery method for the treatment of tumors.

"Radiation therapy treatment" means a cancer treatment through which a dose of radiation to induce tumor cell death is delivered by means of proton radiation therapy, intensity modulated radiation therapy, brachytherapy, stereotactic body radiation therapy, three-dimensional conformal radiation therapy, or other forms of therapy using radiation.

The Plan will not hold proton radiation therapy to a higher standard of clinical evidence for decisions regarding Coverage under the Plan than is applied for decisions regarding Coverage of other types of radiation therapy treatment. Nothing in this section will be construed to mandate the Coverage of proton radiation therapy under the Plan.

FF. Reconstructive Surgery

Covered Services for reconstructive surgery are to correct: congenital abnormalities that cause functional impairment; newborn congenital defects and birth abnormalities; significant deformities caused by congenital or developmental abnormalities, disease, trauma, or

previous therapeutic process to create a more normal appearance (other than for orthognathic surgery), and reconstructive breast surgery following a mastectomy. Coverage includes:

- Inpatient and Outpatient dental, oral surgical, and orthodontic services that are Medically Necessary for the treatment of medically diagnosed cleft lip, cleft palate or ectodermal dysplasia;
- reconstruction of the breast on which the mastectomy has been performed;
- reconstructive breast surgery done at the same time as a mastectomy or following a mastectomy to reestablish symmetry between two breasts
- surgery and reconstruction of the unaffected breast to produce a symmetrical appearance; and
- prostheses and physical complications of all stages of mastectomy, including lymphedemas;

in a manner determined in consultation with the attending Physician and the Covered Person. Hospital stays must be no less than 48 hours for radical and no less than 24 hours for total or partial mastectomy with lymph node dissection.

GG. Rehabilitative and Habilitative Services

Habilitative services include Coverage for health care services that help a person keep, learn, or improve skills and functioning needed for daily living, such as therapy for a Child who is not walking at the expected age. Rehabilitative services include Coverage for therapies to restore and in some cases, maintain, capabilities lost due to: disease; illness; injury; or in the case of speech therapy, due to congenital anomaly or prior medical treatment.

We cover Inpatient and Outpatient facility devices and professional services for habilitative and rehabilitative services, including medical devices, along with the following therapies when treatment is Medically Necessary for the Covered Person's condition and provided by a licensed therapist:

- Cardiac rehabilitative/habilitative therapy is covered. This is the process of restoring, maintaining, teaching, or improving the physiological, psychological, social and vocational capabilities of patients with heart disease. Benefits are available for medical evaluation, training, supervised exercise, and psychosocial support to care for the Covered Person after a cardiac event (heart problem). Benefits do not include home programs (other than home health care services), on-going conditioning, or maintenance care.

- Physical therapy is covered. This is treatment provided by a licensed therapist by physical means to relieve or ease pain. teach, keep, improve or restore function or health, and prevent disability after an illness, injury, or loss of an arm or leg, including hydrotherapy, heat, physical agents, bio-mechanical and neuro-physiological principles and devices, as well as treatment of lymphedema. Rehabilitative physical therapy services must involve setting goals attainable in a reasonable period of time.
- Occupational therapy is covered. This is treatment to teach, keep, improve or restore a physically disabled person's ability to perform activities such as: walking; eating; drinking; dressing; toileting; transferring from wheelchair to bed; bathing, and job

related activities. Rehabilitative occupational therapy services must involve setting goals attainable in a reasonable period of time.

Regarding item numbers 2 and 3 above, rehabilitative physical and occupational therapy is limited to 30 visits per Benefit Year combined and habilitative physical and occupational therapy is limited to 30 visits per Benefit Year combined.

- Respiratory therapy is covered. This includes:
  - introduction into the lungs of dry or moist gasses;
  - non-pressurized inhalation treatment;
  - intermittent positive pressure breathing treatment, air or oxygen, with or without nebulized medication, CPAP; CNP;
  - chest percussion;
  - therapeutic use of medical gases or aerosol drugs; and
  - equipment such as resuscitators, oxygen tents, and incentive spirometers; and
  - bronchopulmonary drainage and breathing exercises, to treat illness or injury.
- Pulmonary rehabilitation is covered and includes Outpatient short-term respiratory care to restore the Covered Person's health after an illness or injury.
- Speech therapy and speech-language pathology (SLP) is covered. This includes treatment for the correction of a speech impairment, or services necessary to keep, improve or teach speech, which results from disease, surgery, injury, congenital anomaly, or prior medical treatment. This also includes services to identify, assess, and treat speech, language, and swallowing disorders in children and adults. Therapy will develop or treat communication or swallowing skills to correct a speech impairment. Therapy services are also covered, which include to keep, learn or improve skills needed for daily living, such as therapy for a Child who is not talking at the expected age.
  - **Rehabilitative speech therapy and speech language pathology are limited to 30 visits per Benefit Year, and habilitative speech therapy and speech language pathology are limited to 30 visits per Benefit Year.**
- Chiropractic / Osteopathic / Manipulation therapy is covered. It includes therapy to treat problems of the bones, joints, and the back. The two therapies are similar, but chiropractic therapy focuses on the joints of the spine and the nervous system, while osteopathic therapy also focuses on the joints and surrounding muscles, tendons and ligaments. Habilitative Services for therapy to treat problems of the bones, joints, and back include services that help the Covered Person keep or improve skills and functioning for daily living and includes services for people with disabilities in an Inpatient or Outpatient setting. Rehabilitative Services for therapy to treat problems of the bones, joints, and back must involve setting goals attainable in a reasonable period of time. Benefits will end when the progress toward the goal ends.
  - **Rehabilitative chiropractic / osteopathic / manipulation therapy is limited to 30 visits per Benefit Year, and habilitative chiropractic / osteopathic / manipulation therapy is limited to 30 visits per Benefit Year.**

HH. Services From Out-of-Network Providers

No Out-of-Network Provider shall balance bill a Covered Person for (1) emergency services provided to the Covered Person or (2) nonemergency services provided to a Covered Person at an In-Network facility if the nonemergency services involve surgical or ancillary services provided by an Out-of-Network provider. We will make payments for these services directly

to the Provider.

In the event a Covered Person that has obtained a prior authorization from Us receives Covered Services from an Out-of-Network Provider, We reserve the right to pay the Allowable Charge, less amounts You must pay under this EOC, for these Covered Services:

- directly to the Covered Person;
- the Out-of-Network Provider; or
- or any other person responsible for paying the Out-of-Network Provider's charge.

This is subject to applicable Virginia laws that require direct payment (e.g. dentists and oral surgeons who submit valid assignments of Benefits). You are responsible for any difference between the billed amount by the Out-of-Network Provider and Our payment to either You

or the Provider, except as provided in Section IV, Subsection F - Balance Billing Prohibited for Certain Services. It is Your responsibility to apply any payment You receive directly from Us to the Out-of-Network Provider's claim.

II. Skilled Nursing Facility

Coverage for stays at a skilled nursing facility requires prior authorization. The Covered Person's Physician must submit a plan of treatment that describes the type of care needed. The following items and services will be provided as an Inpatient in a skilled nursing bed of a skilled nursing facility:

- Room and board in semi-private accommodations;
- Skilled convalescent care and rehabilitative services; and
- Drugs, biologicals, and supplies furnished for use in the skilled nursing facility and other Medically Necessary services and supplies.

We cover a private room if a private room is needed because the Covered Person: (1) has a highly contagious condition; or (2) is at greater risk of contracting an infectious disease because of the medical condition. Otherwise, Inpatient Benefits cover the skilled nursing facility's charges for a semi-private room. If chosen to occupy a private room, You are responsible for paying: (1) the daily difference between the semi-private and private room rates; and (2) the Copayment/Deductible and Coinsurance (if any).

Custodial or residential care in a skilled nursing facility or any other facility is not covered except as rendered as part of Hospice care. **Benefits for a skilled nursing facility are limited to 100 days per admission, as deemed Medically Necessary.**

JJ. Spinal Manipulation and Other Manual Medical Interventions

We cover: (1) spinal manipulation (e.g., Chiropractic) services (manual medical interventions); (2) associated evaluation and management services, including manipulation of the spine and other joints; and (3) application of manual traction and soft tissue manipulations, e.g. massage or myofascial release.

Spinal manipulations or other manual medical interventions for an illness or injury other than musculoskeletal conditions are not covered. Spinal manipulation and other manual medical interventions are subject to a limit of 30 visits per Benefit Year.

KK. Surgery

We cover surgical services on an Inpatient or Outpatient basis, including office surgeries. Covered Services include:

- Accepted operative and cutting procedures;
- Surgeries and procedures to correct congenital abnormalities that cause functional impairment, congenital abnormalities in newborn children, or significant deformities caused by congenital or developmental abnormalities, disease, trauma, or previous therapeutic process in order to create a more normal appearance, other than for orthognathic surgery;
- Other invasive procedures, such as angiogram, arteriogram, amniocentesis, tap or puncture of brain or spine;
- Hypodermic needles, syringes, surgical dressings, splints, and other similar items that serve only a medical purpose;
- Blood and blood products;
- Services rendered by an anesthesiologist;
- Endoscopic exams, such as arthroscopy, bronchoscopy, colonoscopy, laparoscopy;
- Treatment of fractures and dislocations;
- Anesthesia and surgical support when Medically Necessary; and
- Medically Necessary pre-operative and post-operative care.

LL. Telemedicine Services

Telemedicine services as it pertains to the delivery of health care services, means the use of: (1) interactive audio; (2) interactive video; or (3) other electronic technology or media used, including interactive audio or video, for the purpose of diagnosing or treating a patient, providing remote patient monitoring services, consultation, or treatment a patient consulting with other health care providers regarding a patient's diagnosis, prescription of certain medications, or other treatment.

Telemedicine services do not include: (1) an audio-only telephone; (2) electronic mail message; (3) facsimile transmission; or (4) on-line questionnaire.

Remote patient monitoring services means the delivery of home health services using telecommunications technology to enhance the delivery of home health care, including monitoring of clinical patient data such as weight, blood pressure, pulse, pulse oximetry, blood glucose, and other condition-specific data; medication adherence monitoring; and interactive video conferencing with or without digital image upload.
Telemedicine services are Covered Benefits that do not require prior authorization.
Technical fees or costs for the provision of telemedicine services are not covered.

MM. TMJ Diagnostic and Surgical Procedures

Diagnostic and surgical treatment involving any bone or joint of the head, neck, face, or jaw is covered like any other bone or joint of the skeletal system. The treatment must be

Medically Necessary and be required because of a medical condition or injury that prevents normal function of the joint or bone and is deemed Medically Necessary to attain functional capacity of the affected part. Coverage includes Outpatient surgical or Inpatient settings.

Benefits are available to treat temporomandibular and craniomandibular disorders. Covered Services include removable appliances for temporomandibular joint (TMJ) repositioning and related surgery, medical care, and diagnostic services. Covered Services do not include fixed or removable appliances that involve movement or repositioning of the teeth, repair of teeth (fillings), or prosthetics (crowns, bridges, dentures).

NN. Transplants

We cover Medically Necessary human organ, tissue, and bone marrow/stem cell transplants and infusions when provided as part of: Physician services; Inpatient facility services; or Outpatient facility services. This includes autologous bone marrow transplants for breast cancer. We will provide Benefits for such Medically Necessary transplant services only when

a prior authorization has been obtained from Us for those services. We will also cover complications from the donor procedure for up to six weeks from the date of procurement. Benefits include coverage for necessary acquisition procedures, mobilization, harvest and storage, and include Medically Necessary preparatory myeloablative therapy, reduced intensity preparatory chemotherapy, radiation therapy, or a combination of these therapies.

Certain transplants are not covered if considered Experimental/Investigational or not Medically Necessary. All organ transplants are subject to prior authorization for Medical Necessity according to Our guidelines.

Relating to coverage for anatomical gift and organ, eye or tissue transplant, We will not:

- deny coverage to a Covered Person solely based on the person's disability;
- deny a person eligibility or continued eligibility to enroll or to renew coverage under the plan for the purpose of avoiding the nondiscrimination requirement;
- penalize a health care Provider, reduce or limit the reimbursement of a health care Provider, or provide monetary or nonmonetary incentives to a health care Provider to induce such health care Provider to act in a manner inconsistent with the nondiscrimination requirements; or
- reduce or limit coverage for services related to organ, eye, or tissue transplant for an eligible individual with a disability. "Eligible individual with a disability" means an eligible individual with a cognitive, developmental, intellectual, neurological, or physical disability.

When a human organ or tissue transplant is provided from a living donor to a Covered Person, both the recipient and the donor may receive Benefits. When a living donor who is not a Covered Person provides a human organ or tissue transplant to a Covered Person, the donor may receive Benefits of the health plan limited to those not available to the donor from any other source. This includes, but is not limited to, other health insurance, grants, foundations, or other government programs. No Benefits are provided any Covered Person who is donating the organ to someone who is not a Covered Person.

We also cover limited transportation/lodging costs, subject to prior approval, as follows:

We will cover your expenses up to the limits established by the United States Internal Revenue Service:

- If You need to travel 75 miles or more from Your permanent residence to the medical facility where the transplant will be performed, including transportation to and from the facility and lodging for You and one companion.
- If the individual receiving the transplant is a minor, then reasonable transportation/lodging costs may be covered for the Child and up to two (2) companions.

Non-covered expenses for transportation/lodging include, but are not limited to:

- Meals;
- Child care;
- Rental car, taxi, bus, or shuttle service without prior approval;
- Prepaid deposits;
- Services not directly related to transplant; and
- Travel costs for donor companion.

OO. Vision Services

We cover prescription glasses or contact lenses required as a result of surgery or for treatment of accidental eye injury. If related to the surgery or injury, includes cost of: (1) materials and fitting; (2) exams; and (3) replacement of eyeglasses or contact lenses.

We cover eyeglass or contact lens purchase and fitting under this Benefit if:

(1) Prescribed to replace the human lens lost due to surgery or injury;
(2) "Pinhole" glasses are prescribed after surgery for a detached retina; or
(3) Lenses are prescribed instead of surgery due to:
    a) Contact lenses used for treatment of infantile glaucoma;
    b) Corneal or scleral lenses prescribed in connection with keratoconus;
    c) Scleral lenses prescribed to retain moisture when normal tearing is not possible or is inadequate; or
    d) Corneal or scleral lenses are required to reduce a corneal irregularity other than astigmatism.

Adult Vision Covered Services include an annual routine eye examination and refraction, subject to a Copayment.

Services: (1) for vision training and orthoptics; (2) needed for employment; or (3) given by a medical department, clinic, or similar service provided or maintained by the employer or any government entity; and (4) Eyeglasses and eyewear are all Non-Covered Services, except the first pair of contact lenses or eyeglasses if: (a) following approved cataract surgery without implant; or (b) for the treatment of accidental injury.

Pediatric Vision Covered Services (up to end of the month the Covered Person turns

age 19) include one routine eye exam covered in full every Benefit Year at no charge from an In-Network Provider. For this exam, services include dilation if professionally indicated. Includes from an In-Network Provider: (1) one pair of standard single vision, bifocal, trifocal, or progressive eyeglass lenses and one standard frame from a limited collection every Benefit Year; or (2) contact lenses from a limited collection once every Benefit Year in lieu of eyeglasses. Any eligible Covered Person is eligible for these Benefits through the end of the month that he or she turns 19. Out-of-Network Benefits are not covered.

Contact lenses may be Medically Necessary and appropriate when the use of contact lenses, in lieu of eyeglasses, will result in significantly better visual and/or improved binocular function, including avoidance of diplopia or suppression. Contact lenses may be determined to be Medically Necessary in the treatment for: Keratoconus, Pathological Myopia, Aphakia, Anisometropia, Aniseikonia, Aniridia, Corneal Disorders, Post-traumatic Disorders, and Irregular Astigmatism.

Low vision is a significant loss of vision but not total blindness. Covered Services for low vision include an annual comprehensive low vision exam (instead of a routine eye exam), and low vision aids such as high-power spectacles, magnifiers, and telescopes, and follow-up care.

SECTION VI: What is Not Covered (Exclusions)

Below is a list of services and supplies that are specifically excluded from Coverage under this Plan. This is not an all-inclusive list. There may be other services that are not Covered if they do not meet the following criteria: (1) not Medically Necessary; (2) not a Covered Service (regardless of Medical Necessity) or (3) that is a direct result of receiving a non- Covered Service.

We will have the right to make the final decision about whether services or supplies are Medically Necessary and if they will be Covered by Your Plan.

The following services are specifically excluded from Coverage under this EOC:

1. **Abdominoplasty**, panniculectomy, abdominal sculpture, tummy tucks, abdominodermatolipectomy, and liposuction.
2. **Abortion**: We do not provide Benefits for procedures, equipment, services, supplies, or charges for abortions for which Federal funding is prohibited. Federal funding is allowed for abortions, where a pregnancy is the result of rape or incest, or for a pregnancy which, as certified by a Physician, places the woman in danger of death unless an abortion is performed.
3. **Acts of War, Disasters, or Nuclear Accidents**: In the event of a major disaster, epidemic, war, or other event beyond Our control, We will make a good faith effort to give You Covered Services. We will not be responsible for any delay or failure to give services due to lack of available Facilities or staff. Benefits will not be given for any illness or injury that is a result of war, service in the armed forces, a nuclear explosion, nuclear accident, release of nuclear energy, a riot, or civil disobedience.
4. **Administrative Charges**: Providers charges for: missed appointments; telephone calls and other means of electronic communication; form completion; copying and/or transfer of medical records; returned checks; stop-payment on checks; and other clerical charges, except for covered telemedicine services.
5. **Affiliated Providers**: Services received from a dental or medical department maintained by or on behalf of an employer, mutual benefit association, labor union, trust, academic institution, or similar person or group.
6. **Alternative/Complementary Medicine**: services or supplies related to alternative or complementary medicine. Services in this category may include, but are not limited to: neurofeedback/biofeedback therapy (except for the treatment of urinary incontinence); hypnosis; behavior training; recreational therapy (dance, arts, crafts, aquatic, gambling and nature therapy), except as provided in a residential treatment facility; hair analysis; naturopathy; thermography; orthomolecular therapy; contact reflex analysis, Bio-Energetical Synchronization Technique (BEST); iridology – study of the iris; Auditory Integration Therapy (AIT); colonic irrigation; magnetic innervation therapy; electromagnetic therapy; holistic medicine; homeopathic medicine; aroma therapy; Reiki therapy; massage and massage therapy; herbal, vitamin, or dietary products or therapies.
7. **Ambulance**: Usage is not covered when another type of transportation can be used without endangering the Covered Person's health. Any ambulance usage for the convenience of the Covered Person, Family or Physician is not a Covered Service.

Non-Covered Services for Ambulance include but are not limited to, trips to a Physician's office or clinic, or to a morgue or funeral home.

Coverage is not available for air ambulance transport from a Hospital capable of treating the patient because the patient and/or the patient's Family prefer a specific Hospital or Physician. Air ambulance services are not covered for transport to a Hospital that is not an acute care Hospital, such as a nursing facility, Physician's office, or Your home.

8. **Applied Behavioral Analysis**, except as required for coverage of Autism Spectrum Disorder or if determined to be Medically Necessary..
9. **Breast reductions**, unless related to surgical interventions following a mastectomy.
10. **Charges** more than any Benefit limitations (e.g. number of days, etc.) and amounts above the Allowable Charge for a service.
11. **Charges Not Supported by Medical Records**: Charges for services not described in the Covered Person's medical records.
12. **Clinical Trials**: We do not provide Benefits for procedures, equipment, services, supplies or charges for the following:
    - The Investigational item, device, or service; or
    - Items and services that given only to satisfy data collection and analysis needs and that are not used in the direct clinical management of the patient; or
    - A service that is clearly inconsistent with widely accepted and established standards of care for a particular diagnosis; or
    - Any item or service that is paid for, or should have been paid for, by the sponsor of the trial.
13. **Complications of Non-Covered Services**: Care for problems directly related to a service that is not covered by this Plan. Directly related means that the care took place as a direct result of the non-Covered Service and would not have taken place without the non-Covered Service.
14. **Supplies and devices for comfort or convenience only** (e.g. radio, television, telephone, and guest meals); and private rooms, unless a private room is Medically Necessary and a prior authorization has been provided by Us during Inpatient Hospitalization or Inpatient stay at a skilled nursing facility.
15. **Non-prescription and Over-the-counter contraception** methods and devices.
16. **Reconstructive or Cosmetic surgery, services, procedures, treatments, Prescription Drugs, equipment, or supplies** given for cosmetic services. This includes any service or supply that is a direct result of a non-Covered Service.

    Cosmetic surgeries, procedures, or services are performed to preserve, or change, how the Covered Person looks, including but not limited to: body piercing; tattooing; or removal of tattoos. No Benefits are available for surgery or treatments to change the texture or look of the Covered Person's skin or to change the size, shape or look of facial or body features (such as the Covered Person's nose, eyes, ears, cheeks, chin, chest, or breasts). However, this Exclusion does not apply to: (1) a surgery or procedure to correct deformity caused by disease, trauma, or a previous therapeutic process; (2) surgeries or procedures to correct congenital abnormalities that cause functional impairment, including newborn congenital abnormalities; and (3) reconstructive breast surgery due to a mastectomy. Botox, collagen, and other filler substances are not covered.

17. **Court Ordered Testing**: Court ordered testing or care unless Medically Necessary.
18. **Custodial care**, including Inpatient or Outpatient custodial care, nursing home care, respite care, rest cures, domiciliary or non-skilled convalescent care along with all related services, even when recommended by a professional or performed in a facility, such as a Hospital or skilled nursing facility, or at home. This exclusion does not apply to for hospice care services.
19. **Dental** services including, but not limited to:
    - Treatment of natural teeth due to diseases, routine preventive care;
    - Dental care, treatment, supplies, dental x-rays, oral surgeries, or extraction of erupted wisdom teeth, except to prepare the mouth for medical services and treatment, and treatment for biting or chewing injuries;
    - Dental or oral appliances or devices, including but not limited to, bite guards for teeth grinding, dental implants, dentures, oral appliances for snoring or sleep apnea unless Medically Necessary, and fixed or removable appliances that involve movement or repositioning of the teeth, repair of teeth (fillings), or prosthetics (crowns, bridges, dentures) for temporomandibular joint (TMJ) pain dysfunction;
    - Periodontal care, prosthodontic care or orthodontic care (except for Medically Necessary orthodontic care in cases of accidental injury or for cleft lip, cleft palate or ectodermal dysplasia);
    - Shortening of the mandible or maxillae for cosmetic purposes;
    - Diagnosis or treatment of natural disease processes of the teeth or surrounding tissue; or
    - Restorative services and supplies necessary to promptly repair, remove, or replace sound natural teeth; including the extraction of wisdom teeth unless impacted.
20. **Donor Benefits** are not available if the Covered Person is donating an organ to a non-covered individual. When the donor is a non-covered individual and the person receiving the organ is covered, the donor may receive Benefits of the health Plan, limited to Benefits that are not available to the donor from any other source.
21. **Donor Searches**: Coverage does not include Benefits for donor searches for organ or tissue transplants, including compatibility testing of potential donors who are not immediate blood-related Family members (parent, Child, sibling), except as required by law or specifically stated as a Covered Service.
22. **DME**, including exercise equipment; air conditioners, purifiers, and humidifiers; first aid supplies or general use items such as heating pads, thermometers, and bandages; hypoallergenic bed linens; raised toilet seats; shower chairs; whirlpool baths; waterbeds; handrails, ramps, elevators, and stair glides; adjustments made to vehicle; changes made to home or business; clothing articles, except those needed after surgery or injury; non-Medically Necessary enhancements of equipment and devices; or repair or replacement of equipment lost or damaged through neglect.
23. **Educational, Vocational, or Self-Training Services** or supplies, classes, programs, and support groups, except as otherwise specifically covered or when received as part of a covered wellness visit or screening. Covered Services include, but are not limited to:
    - prenatal courses;

- marital counseling; and
- self-help training and other non-medical self-care and those dealing with lifestyle changes.

24. Services for injuries or diseases related in any way to **employment**, when:
    - You receive payment from the employer because of the disease or injury;
    - The Employer provides Benefits to You; or
    - You could have received Benefits for the injury or disease if You had complied with applicable laws and regulations.

    This exclusion applies whether or not You have: waived Your rights to payment for the services available; or did not comply with procedures set out by the employer to receive these Benefits. It also applies if the employer (or employer's insurance company or group self-insurance association) reaches any settlement with You for an injury or disease related in any way to employment.
25. **Examinations**:
    - Required specifically for:
        - insurance;
        - employment;
        - school;
        - sports;
        - camp;
        - licensing;
        - adoption;
        - marriage;
    - Ordered by a third party;
    - Ordered by a court, including court-ordered care; or
    - Relating to research screenings.
26. **Experimental/Investigational Drugs, Items, Devices, Services, or Procedures**, and their complications, except for clinical trial costs required to be covered under law.
27. **Eye Exercises**, such as orthoptics and vision training/vision therapy.
28. **Eyeglasses and Contact Lenses for Adults**, except after a covered eye surgery or accidental eye injury.
29. **Eye surgery**, including services for radial keratotomy and other surgical procedures to correct refractive defects; Laser-Assisted In Situ Keratomileusis (LASIK) procedures.
30. **Family Planning Services**: The following are excluded:
    - Assisted reproductive technologies (ART) and related diagnostic tests and drugs, including artificial insemination, in vitro fertilization, zygote intrafallopian transfer (ZIFT), or gamete intrafallopian transfer (GIFT), or any other types of artificial or surgical means of conception including any drugs administered in connection with these procedures;
    - Drugs used to treat infertility;
    - Surrogate pregnancy expenses when the person is not covered under this plan;
    - Reversals of voluntarily induced sterilization and complications incidental to such procedures; or
    - Paternity testing.
31. **Foot care** (palliative or cosmetic), including:
    - cleaning and preventive foot care when there is no illness or injury to the foot;

- surgical treatment of flat foot conditions;
- subluxations of the foot;
- treatment of bunions only covered when associated with capsular or bone surgery;
- fallen arches;
- weak feet;
- Tarsalgia;
- Metatarsalgia;
- Hyperkeratoses;
- chronic foot strain;
- symptomatic complaints of the feet;
- foot orthotics, including support devices, arch supports, foot inserts, orthopedic or corrective shoes not part of leg brace and fitting, castings, and other services related to devices of the feet, unless used for a systemic illness affecting the lower limbs; and
- routine foot care, such as removal of corns or calluses and the trimming of toenails, except when these services are Medically Necessary.

32. **Fraud, Waste, Abuse, and Other Inappropriate Billing** Services from an Out-of-Network Provider that are determined to be not payable as a result of fraud, waste, abuse or inappropriate billing activities. This includes an Out-of-Network Provider's failure to submit medical records required to determine the appropriateness of a claim.
33. **Free Care**, including services the Covered Person would not have to pay for if not covered by this plan, such as government programs, services received in jail or prison, services from free clinics, and Workers' Compensation Benefits.
    - Care for military service-connected disabilities and conditions for which the Covered Person is legally entitled to health services and for which facilities are reasonably accessible.
34. **General**: Coverage does not include benefits for the following Services or treatment:
    - educational therapy;
    - vocational and recreational activities, except as provided in a residential treatment facility;
    - coma stimulation therapy;
    - remedial or special education services;
    - services directed toward making one's personality more forceful or dynamic;
    - consciousness raising;
    - vocational or religious counseling;
    - group socialization;
    - activities primarily of an educational nature;
    - vocational and recreational therapy, except as provided in a Residential Treatment Facility. Recreational therapy includes; but is not limited to, dance, art, crafts, aquatic, hydro, gambling and nature therapy;
    - coma stimulation therapy;
    - self-help training, and self-administered services, including biofeedback and related testing; behavioral modification; and
    - modalities which include: primal therapy; rolfing or structural integration, bioenergetics therapy; carbon dioxide therapy; guided imagery; Z-therapy; obesity control therapy; training analysis; sedac therapy; dance therapy; music

therapy and art therapy.

35. **Government Coverage**: To the extent that they are provided as benefits by any governmental unit, unless otherwise required by law or regulation.
36. **Group speech therapy**.
37. Medication and surgical procedures to treat or manage **Gynecomastia** for cosmetic purposes.
38. Care and treatment for **hair loss** including wigs, hair transplants or any drug that promises hair growth, whether or not prescribed by a Physician, are not covered, except for one wig after chemotherapy.
39. **Health club memberships**; **health spa charges**; **exercise equipment or classes**; charges from a **physical fitness instructor** or **personal trainer;** and any other charges for services, equipment, or facilities for developing or maintaining physical fitness, even when ordered by a Physician.
40. **Hearing aids** or the **examination** to prescribe or fit hearing aids, except as otherwise provided in the Policy under Hearing Services and Durable Medical Equipment and Supplies.
41. **Home Care Services** that are not rendered under an approved arrangement with a home health care Provider; homemaker services; housing; or food and home-delivered meals.
42. **Hyperhidrosis**: For treatment of hyperhidrosis (excessive sweating).
43. **Immunizations for travel or work**. Coverage does not include Benefits for immunizations required for travel or work unless such services are received as part of the covered preventive care services as defined in Section V of this EOC.
44. Surgical or medical treatment for **Infertility** is not covered. This includes: services; office visits; lab and diagnostic tests; and procedures to promote conception once an infertility diagnosis has been established; and reversal of voluntary sterilization. In the absence of a confirmed infertility diagnosis, coverage for these services ends when drugs are prescribed, or surgeries performed to correct the condition. Infertility services not specifically described as covered are not covered. This exclusion does not apply to services required to diagnose and treat conditions resulting in infertility.
45. **In-vitro fertilization (IVF) or pre-implant genetic diagnosis (PGD) of embryos**: Services or supplies for in-vitro fertilization (IVF) or pre-implant genetic diagnosis (PGD) of embryos, whether provided or not provided in connection with infertility treatment.
46. **Long-Term/Custodial Nursing Home care**.
47. Services and supplies deemed **not Medically Necessary**.
48. **Medical equipment, appliances, devices and supplies** that have both a therapeutic and non-therapeutic use. These include:
    - elastic or leather braces or supports;
    - corsets, or articles of clothing (unless required to recover from surgery or injury);
    - batteries (except for battery for a powered wheelchair) and battery chargers;
    - mattress or mattress covers;
    - other special supplies, appliances, and equipment such as office chairs, sun or heat lamps;
    - rental or purchase of Transcutaneous Electrical Nerve Stimulation (TENS)

units;

- orthotic shoe inserts;
- personal hygiene, comfort, and convenience items including but not limited to grab/tub bars, tub benches, telephone, television, guest meals and accommodations, take home medications, and supplies;
- an office visit for fitting for a non-covered device or supply is not covered.
- home improvement items, including but not limited to, escalators, stair glides or Emergency alert equipment; and
- expenses incurred at a health spa, gym or similar facility.

49. **Medicare Benefits** For benefits which are payable for the Covered Person enrolled in Medicare under Medicare Parts A and/or B except as required by law, as described in Section VII – H. Duplicate Coverage - Medicare . .
50. Charges for **Missed** or **Cancelled Appointments**.
51. Services for which there is **no financial responsibility**. We will not pay for, or reimburse, the cost of any Covered Service for which the Covered Person is not financially liable. Examples include:
    - charges for complimentary health screenings;
    - charges for Covered Services provided by an immediate family member; and
    - charges incurred as a donor for which another individual or entity has assumed financial responsibility (except when assumed by a "Plan," as defined in the "Coordination of Benefits" Subsection of this EOC, in which case that Subsection applies).
52. Medical **Nutritional Therapy** (Obesity) and **nutritional and/or dietary supplements**, except as described in this booklet or required by law. This exclusion includes but is not limited to nutritional formulas and dietary supplements that are available over the counter and do not require a written prescription.
53. **Over-the-counter convenience and hygienic items**.
54. **Paternity testing**: Your coverage does not include benefits for paternity testing.
55. **Penile implants** and related services.
56. **Personal Hygiene, Environmental Control or Convenience Items**. For personal hygiene, environmental control, or convenience items including but not limited to:
    - Air conditioners, humidifiers, air purifiers;
    - Health club membership, and physical fitness equipment such as a treadmill or exercise cycles;
    - charges from a physical fitness instructor or personal trainer, or any other charges for activities, equipment, or facilities used for developing or maintaining physical fitness, even if ordered by a Physician. This exclusion also applies to health spas or similar facility;
    - Special exercise testing or equipment solely to evaluate exercise competency or assist in an exercise program;
    - Charges from a health spa or similar facility;
    - Personal comfort and convenience items during an Inpatient stay, including but not limited to daily television rental, telephone services, cots or visitor's meals;
    - Charges for non-medical self-care;
    - Purchase or rental of supplies for common household use, such as water purifiers;

- Allergenic pillows, cervical neck pillows, special mattresses, or waterbeds;
- Sports helmets.

57. **Physician Stand-by Charges**: For stand-by charges of a Physician.
58. **Physician/Other Practitioners' Charges**: Physician/Other Practitioners' Charges including:
    - Physician or other practitioners' charges for consulting with the Covered Person by telephone, facsimile machine, electronic mail systems or other consultation or medical management service not involving direct (face-to-face) care with the patient. This does not include In-Network telemedicine services with interactive virtual visits.
    - Surcharges for furnishing and/or receiving medical records and reports.
    - Charges for doing research with Providers not directly responsible for the Covered Person's care.
    - Charges that are not documented in Provider records.
    - For membership, administrative, or access fees charged by Physicians or other Providers. Examples of administrative fees include, but are not limited to, fees charged for educational brochures or calling a patient to provide their test results.
59. **Prescription Drugs**: The Prescription Drug Benefits do not cover the following:
    - Administration Charges for the administration of any drug except for covered immunizations as approved by Us or the Pharmacy Benefits Manger (PBM).
    - Prescription drugs prescribed by a Provider that does not have the necessary qualifications, registrations and/or certifications as determined by Us.
    - Non-formulary drugs, except in certain circumstances described in coverage documents.
    - Compound drugs are not covered unless there is at least one ingredient that the Covered Person needs a prescription for, and the drug is not essentially a copy of a commercially available drug product.
    - Drugs given to the Covered Person or prescribed in a way that is against approved medical and professional standards of practice.
    - Charges for delivery of Prescription Drugs.
    - Drugs taken at the time and place where they are given or where the prescription order is issued. This includes samples given by a Doctor. This exclusion does not apply to drugs used with a diagnostic service, drugs given during chemotherapy as described in the "Chemotherapy" Section, or drugs covered under the "Medical and Surgical Supplies and Medications" Benefit – they are Covered Services.
    - Drugs that do not need a prescription by federal law (including drugs that need a prescription by State law, but not by federal law), except for injectable insulin. This exclusion does not apply to over-the-counter drugs that We must cover under federal law when recommended by the U.S. Preventive Services Task Force and prescribed by a Physician.
    - Drugs which are over any quantity or age limits set by the Plan.
    - Drugs in amounts over the quantity prescribed, or for any refill given more than one year after the date of the original prescription order.

- Items Covered as durable medical equipment (DME) - Therapeutic DME, devices and supplies except peak flow meters, spacers, and blood glucose monitors.
- Refills of lost or stolen drugs.
- Prescription drugs dispensed by any mail service program other than Our PBM's Home Delivery Mail Service, unless We must cover them by law.
- Drugs not approved by the FDA.
- Off label use, unless We must cover the use by law or if We, or the PBM, approve it.
- Drugs for Onychomycosis (toenail fungus) except when We allow it to treat individuals who are immuno-compromised or diabetic.
- Drugs, devices and products, or legend drugs with over the counter equivalents and any drugs, devices or products that are therapeutically comparable to an over the counter drug, device, or product. This includes prescription legend drugs when any version or strength becomes available over the counter.
- Drugs to treat sexual or erectile problems.
- Hypodermic syringes except when given for use with insulin and other covered self-injectable drugs and medicine.
- Any drug mainly used for weight loss.
- Drugs used for cosmetic purposes.
- Prescription drugs used to treat infertility.
- Charges for services not described in the Covered Person's medical records.
- Services We conclude are not Medically Necessary. This includes services that do not meet Our medical policy, clinical coverage, or Benefit policy guidelines.
- Nutritional and/or dietary supplements, except as described in this EOC or that We must cover by law. This exclusion includes, but is not limited to, nutritional formulas and dietary supplements that the Covered Person can buy over the counter and those the Covered Person can get without a written prescription or from a licensed pharmacist.
- Services prescribed, ordered, referred by or received from a member of Your immediate family, including Your spouse, Domestic Partner, Child, brother/stepbrother, sister/stepsister, parent/stepparent, in-law, or self.

60. **Private duty nursing** in an Inpatient setting.
61. **Prosthetics for Sports or Cosmetic Purposes**, including wigs and scalp hair prosthetics, except for wigs needed after cancer treatment.
62. Non-covered **Providers**, including massage therapists, and physical therapist technicians.
63. **Residential Accommodations**: Residential accommodations to treat medical or behavioral health conditions, except when provided in a Hospital, Hospice, Skilled Nursing Facility, or residential treatment center. This Exclusion includes procedures, equipment, services, supplies, or charges for the following:
    - Domiciliary care provided in a residential institution, treatment center, halfway house, or school because the individual's own home arrangements are not available or are unsuitable, and consist chiefly of room and board, even if therapy is included.

- Care provided or billed by a hotel, health resort, convalescent home, rest home, nursing home or other extended care facility home for the aged, infirmary, school infirmary, institution providing education in special environments, supervised living or halfway house, or any similar facility or institution.
- Services or care provided or billed by a school, custodial care center for the developmentally disabled, or outward-bound programs.

64. **Residential Care/Residential Treatment Centers**: Coverage does not include benefits for rest cures, custodial, residential, or domiciliary care and services. Whether care is considered residential will be determined based on factors such as whether the Covered Person receives active 24-hour skilled professional nursing care, daily Physician visits, daily assessments, and structured therapeutic services. A residential treatment center must qualify as a substance use disorder center providing a continuous, structured, 24 hour a day program of drug or alcohol treatment and rehabilitation including 24 hour a day nursing care.
65. **Services or supplies** if they are:
    - Ordered by a Physician whose services are not covered;
    - Not prescribed, performed, or directed by a Provider licensed to do so;
    - Received before the effective date of Coverage or after a Covered Person's Coverage ends;
    - Travel, whether or not recommended by a Physician, except the limited transportation/lodging costs as stated under Section V, JJ. Transplants, in this booklet;
    - Prescribed, ordered, referred by or given by an immediate family member; rendered by a Provider that is a member of the Covered Person's immediate family;
    - Services for which a charge is not usually made; or
    - Any types of health services, supplies, or treatments not specifically provided in this Policy. The term "services" as used in this Exclusions Section includes supplies or medical items.
66. **Skilled nursing facility stays** are not covered when the skilled nursing facility is used mainly for care of the aged, custodial or domiciliary care, a place for rest, educational, or similar services; a private room is not covered unless Medically Necessary.
67. Services related to **surrogacy** if the Covered Person is not the surrogate.
68. Non-interactive **telemedicine services**, such as audio-only telephone conversations, electronic mail message or fax transmissions.
69. **Therapy – Other:** We do not provide Benefits for procedures, equipment, services, supplies or charges for the following:
    - gastric electrical stimulation;
    - hippotherapy;
    - intestinal rehabilitation therapy;
    - prolotherapy;
    - recreational therapy, except as provided in a residential treatment facility; or
    - sensory integration therapy (SIT).

70. **Temporomandibular Joint (TMJ) Disorder Device**, appliances for TMJ pain dysfunction that reposition the teeth, fillings, or prosthetics. Covered services do not include fixed or removable appliance that involve movement or repositioning of the teeth repair of teeth (fillings) or prosthetics (crown, bridges, dentures), oral hygiene instructions, repair or replacement of lost/broken appliances are not a Covered Benefit, material(s) and the procedures used to prepare and place material(s) in the canals (root), root canal obstruction, internal root repair of perforation defects, incomplete endodontic, treatment and bleaching of discolored teeth.
71. **Transplant: Human Organ and Bone Marrow/Stem Cell/Cord Blood Exclusions**: Non-Covered Services for transportation and lodging include, but are not limited to:
    - Child care;
    - meals;
    - mileage within the medical transplant facility city;
    - rental cars, buses, taxis, or shuttle service, except as specifically approved by Us;
    - frequent flyer miles;
    - coupons, vouchers, or travel tickets;
    - prepayments or deposits;
    - services for a condition that is not directly related, or a direct result, of the transplant;
    - telephone calls;
    - laundry;
    - postage;
    - entertainment;
    - travel expenses for donor companion/caregiver (except for caregiver under age 18); and
    - return visits for the donor for a treatment of a condition found during the evaluation.
72. **Treatment of varicose veins or telangiectatic dermal veins (spider veins)** when services are rendered for cosmetic purposes.
73. **Adult Vision** services or supplies unless needed due to eye surgery or accidental injury, including:
    - routine vision care and materials except as outlined in Covered Services sections G. Diagnostic Services and OO. Vision Services in the coverage documents;
    - eyeglasses and eyewear, except as included under this plan in Covered Services section OO. Vision Services;
    - sunglasses; or
    - safety glasses and accompanying frames.
74. **Pediatric Vision Care**: Vision care services do not include services incurred for or in connection with any of the items below:
    - Vision care for a Covered Person age 19 and older, unless covered by the medical Benefits of this EOC.
    - For any condition, disease, defect, ailment, or injury arising out of and in the course of employment if benefits are available under the Workers'

Compensation Act or any similar law. This exclusion applies if a Covered Person receives the benefits in whole or in part. This exclusion also applies whether or not the Covered Person claims the benefits or compensation. It also applies whether or not the Covered Person recovers from any third party.

- To the extent that they are provided as benefits by any governmental unit, unless otherwise required by law or regulation.
- For which, the Covered Person has no legal obligation to pay in the absence of this or like coverage.
- For services or supplies prescribed, ordered, or referred by, or received from a member of the Covered Person's immediate family, including the Covered Person's spouse or Domestic Partner, Child, brother, sister, or parent.
- For completion of claim forms or charges for medical records or reports.
- For missed or cancelled appointments.
- For safety glasses and accompanying frames.
- For two pairs of glasses in lieu of bifocals.
- For Plano lenses (lenses that have no refractive power).
- For medical or surgical treatment of the eyes, including Inpatient or Outpatient Hospital vision care, except as specified in the "Covered Benefits" Section of this EOC.
- Lost or broken lenses or frames, unless the Covered Person has reached their normal interval for service when seeking replacements.
- For services or supplies not specifically listed in this EOC.
- Cosmetic lenses or options, such as special lens coatings or non-prescription lenses, unless specifically listed in this EOC.
- For services or supplies combined with any other offer, coupon, or in-store advertisement, or for certain brands of frames where the manufacturer does not allow discounts.
- Services and materials not meeting accepted standards of optometric practice or services that are not performed by a licensed Provider.
- Blended lenses.
- Oversize lenses.
- For sunglasses.

75. **Vision Orthoptic Training**: For vision orthoptic training. This exclusion does not apply to any Covered Person through the end of the month in which he or she turns age 19.
76. **Work related** injuries or illnesses, including those injuries that arise out of or in any way result from an illness or injury that is work-related; provided the employer provides, or is required to provide, workers' compensation or similar type coverage for such services. For any condition, disease, defect, ailment, or injury arising out of and in the course of employment if benefits are available under any Workers' Compensation Act or other similar law. If Workers' Compensation Act benefits are not available to You, then this Exclusion does not apply. This exclusion applies if You receive the benefits in whole or in part. This exclusion also applies whether or not You claim the benefits or compensation. It also applies whether or not You recover from any third party.

77. **Weight loss** programs, whether or not under medical supervision, except as stated as covered, including:
    - commercial weight loss and fasting programs;
    - bariatric surgery, including Roux-en-T, laparoscopic gastric bypass or other gastric bypass surgery, gastroplasty, or gastric banding procedures; or
    - drugs used mainly for weight loss.

SECTION VII: Eligibility and Other Terms and Conditions

A. Eligibility

Subscriber. To be eligible to enroll as a Subscriber, You must: (1) be entitled to participate in Your Employer's or Group's health Benefits Plan; and (2) otherwise comply with any probationary or other eligibility requirements established by the Employer/Group and identified in its Plan with Us (including, without limitation, any applicable Waiting Period), as evidenced in the Group Enrollment Agreement and other related documents.

Spouse. You may enroll Your legal spouse as a Covered Person during Your Open Enrollment Period or within 30 days of the date of Your marriage. To be eligible to enroll as a spouse, You must: (1) meet all eligibility requirements of Your Employer/Group, and (2) be the Subscriber's legal spouse. A person is not eligible for Coverage as a Subscriber's legal spouse if: (1) residing in a state facility; (2) a ward of the state; or (3) an individual on active duty with the military.

Domestic Partner. **Domestic Partner**, or **Domestic Partnership** means a person of the same or opposite sex that is certifying that he or she is Your sole Domestic Partner and has been for 12 months or more; he or she is mentally competent; he or she is not related to You by blood closer than permitted by state law for marriage; he or she is not married to anyone else; and he or she is financially interdependent on You.

For purposes of this Plan, a Domestic Partner will be treated the same as a spouse, and a Domestic Partner's Child, adopted Child, foster Child, or Child for whom a Domestic Partner has legal guardianship will be treated the same as any other Child.

Any federal or state law that applies to a Covered Person who is a spouse or Child under this Plan shall also apply to a Domestic Partner or Domestic Partner's Child who is a Covered Person under this Plan. This includes but is not limited to, COBRA, FMLA, and COB. A Domestic Partner's or a Domestic Partner's Child's coverage ends on the date of dissolution of the Domestic Partnership.

The Subscriber maintains a committed relationship with the Domestic Partner that is the functional equivalent of marriage as determined by the Employer and Piedmont upon submission of proper documentation by the Subscriber. Your employer may impose special requirements and will inform you of any action you need to take in order to enroll your Domestic Partner.

Child. To be eligible for coverage, a "Child" must be either: (1) Your biological, legally adopted, or foster Child; or (2) the biological, legally adopted, or foster Child of Your legal spouse if such spouse is also a Covered Person under the EOC. Child includes a son, daughter, step-Child, adopted Child, including a Child placed for adoption, foster Child, or any other Child eligible for coverage under the health Benefit plan. Except as noted below, there is no requirement the Child: be financially dependent on an individual covered under the EOC; share a residence with an individual covered under the EOC; meet student status requirements; be unmarried; not be employed; or any combination of these factors. The "Limiting Age" of a Child otherwise eligible for Coverage under the EOC is age 26.

Except as provided below with respect to the "Subscriber's Newborn Child Coverage," a spouse or Child not added to Your Coverage at the time of Open Enrollment: (1) may not be added to Your Coverage until the Employer's next Open Enrollment; or (2) in the case of newly eligible Covered Persons other than You, not added to Your Coverage within 30 days of the initial date of eligibility.

Unless legal guardianship is granted to You: (1) a grandchild of the Subscriber; or (2) another Child of the Subscriber; or (3) a grandchild or Child of his/her enrolled legal spouse, is not eligible for Coverage under the EOC.

Subscriber's Biological Newborn Child. If Your Group Plan provides "Child" Coverage for Your family members, then We will provide Benefits for Your newly born biological Child from the moment of birth. We ask that You notify Us in advance of the Child's birth so We may ensure the Child's claims are paid correctly when We receive them. However, a failure to notify Us in advance will not result in the denial of an otherwise valid claim for Covered Benefits.

Your Biological Newborn Child's coverage will be identical to Coverage provided to You; except that, regardless of whether the Coverage would otherwise be provided under the terms and conditions of this EOC, Coverage will be provided for:

1. Necessary care and treatment of: medically diagnosed congenital defects and birth abnormalities, with Coverage limits no more restrictive than for any injury or sickness covered under the EOC; and
2. Inpatient and Outpatient dental, oral surgical, and orthodontic services Medically Necessary for the treatment of: medically diagnosed cleft lip, cleft palate, or ectodermal dysplasia. These Inpatient and Outpatient services are subject to any: Deductible, Copayment, Co-insurance, or other cost-sharing, and policy or contract maximum provisions, provided the provisions are no more restrictive for these services than for any injury or sickness covered under the EOC.

If payment of a specific Premium is required to provide Coverage for the eligible Child, You must notify Us of the birth of the newly born Child and pay the required Premium (or have it paid on your behalf) within 31 days after the date of birth to have the Coverage continue beyond the initial 31-day period. If Your newborn Child's mother expects to receive Benefits from another carrier, but, You wish Your newborn Child's claims paid under this EOC, then We request You notify Us of that desire in advance of the Child's birth. This is so We may ensure the Child's claims are correctly paid when We receive them; but, a failure to notify Us in advance will not result in the denial of an otherwise valid claim for Covered Benefits.

Subscriber's Adopted Child. If Your Employer or Group Plan provides for "Child" Coverage, then when a Child has been placed with You for the purpose of legal adoption, that Child is eligible for Child Coverage from the date of such adoptive or parental placement. However, an application for that Child's Coverage must be submitted: within 30 days from the date of that eligibility; and along with proof that a legal adoption is pending. If a newborn infant is placed for legal adoption with You within 31 days of birth, We will consider this Child a newborn Child of Yours to the same extent as if that Child had been Your Newborn Biological Child.

Legal Guardianship of a Child. If Your Employer or Group Plan provides for "Child" Coverage, You may enroll a Child or a Child of Your legal spouse when You are the legal guardian of the Child. The Child for whom You are the Child's legal guardian will be added to Your Employer or Group Plan only during the Employer's or Group's Open Enrollment Period, or within 30 days of Your assumption of legal guardianship for the Child.

Handicapped Child. A Child unable to support himself or herself because of an intellectual or physical disability; and who has enrolled under the contract or EOC before attaining the Limiting Age, will not have his/her Coverage terminated under this EOC when reaching the Limiting Age if: (1) a qualified Physician furnishes proof of such handicap; and (2) You provide proof of dependency within 31 days of the Child's reaching the Limiting Age. We may require subsequent proof; but, not more frequently than annually after the two-year period following the Child attaining the Limiting Age. Coverage of the handicapped Child will continue for as long as the Child: (1) remains incapable of self-support because of an intellectual disability or physical handicap (as set forth above); (2) remains unmarried; and (3) remains dependent on You or Your enrolled legal spouse.

Termination of a Child's Coverage. Unless terminated earlier for other reasons specified in the EOC (e.g., Employer or Group cancels its Employer or Group Enrollment Agreement for Coverage), Coverage for an enrolled Child terminates on the last day of the calendar year in which he/she reaches the Limiting Age. When a Child is no longer eligible for Coverage, it is Your responsibility to send a notice of termination to Your Employer or Group; and Us. Coverage will terminate retroactively as of the date the Child was no longer eligible.

B. Enrollment

During the Employer's or Group's annual Open Enrollment Period, You may enroll any eligible Covered Person by: completing a Piedmont enrollment application; or a change form to be sent to Us by the Employer or Group. We cover newborn Children as described in Eligibility subsection above. No person is eligible to re-enroll in Piedmont who has had Coverage terminated as described hereafter in "Termination for Cause." Except as specifically provided below, any Covered Person not enrolled in Piedmont within 31 days after becoming eligible may not enroll until the Employer's or Group's next Open Enrollment Period.

Special Enrollment Periods are allowed due to certain losses of other qualifying Coverage and changes in family status; however, We do not provide benefits to individuals outside the service area. We allow a special enrollment period due to a loss of other qualifying Coverage if the Employee declined Coverage when first eligible for it: later loses the other qualifying Coverage; and requests enrollment no more than 30 days thereafter. This is called a qualifying event. Below are examples of qualifying events:

- Marital status change: marriage, divorce, or death of legal spouse.
- Covered Person status change: birth, adoption, custody, or placement of a foster Child.
- Employment status change: loss or gain of Coverage due to employment.
- Loss or gain of other Coverage.
- Loss of minimum essential Coverage.

- Termination of Employer contributions.
- Exhaustion of COBRA continuation Coverage.
- Court ordered Coverage change.

The effective date of Coverage for special enrollments will be the date of the qualifying event.

A qualified Employee or Dependent of a qualified Employee who has lost eligibility for: Medicaid or CHIP Coverage; or who has become eligible for state Premiums assistance under a Medicaid or CHIP program, is eligible for a special enrollment period and has 60 days from the date of the triggering event to select Coverage.

Qualified Medical Child Support Order. Federal law requires Your Employer or Group to comply with a qualified medical Child support order ("QMCSO"). A QMCSO is an order, judgment, or decree by which an Employee is required to include a Dependent Child under his or her group health care Coverage. A QMCSO can also enforce a state medical Child support law under section 1908 of the federal Social Security Act.

QMCSOs must be sent to Your Employer or Group. Upon receipt, Your Employer or Group will qualify the QMCSO and forward it to Us. If the order is qualified, You may cover Your Child, who is the subject of the order, under Your Employer or Group's Plan with Us. If You are not already enrolled with Us, You must purchase the Coverage before Your Child can enroll. You or Your Employer or Group must make required Premium payments for the Coverage as of the date specified in the QMCSO.

If a QMCSO issued in a divorce or legal separation proceeding requires You to provide health care Coverage to a Child not in your custody, You may do so. To be considered qualified, a medical Child support order must include:

- Name and last known address of the parent who is covered under the Plan;
- Name and last known address of each Child to be covered under the Plan;
- Type of Coverage to be provided to each Child; and
- Period of time the Coverage is to be provided.

C. Effective Date of Coverage

Time of Coverage: The Policy becomes effective at 12:01 a.m. on the effective date.

Subject to the payment of applicable Premiums and Our receipt of a completed enrollment application from or on behalf of each eligible person to be enrolled as a Covered Person in the Piedmont Plan, Coverage for Covered Persons will begin on the date agreed upon by Us and the Employer or Group.

- The Coverage of persons who enroll during the Employer's or Group's Open Enrollment period is effective as agreed upon by the Employer or Group and Us in the Group Enrollment Agreement.
- The effective date of Coverage of a Subscriber's newborn Child is described in the

Eligibility subsection above.

- Coverage of newly acquired Covered Persons who enroll in the Plan with Piedmont will become effective on the date of (1) the qualifying event following application, subject to the: enrollment limitations; eligibility requirements; and payment of Premiums referenced above.

D. Termination of Coverage

Time of Termination: The Policy terminates at 11:59 p.m. on the termination date.

The entire Group Enrollment Agreement, the Coverage of an individual Subscriber, or the family Coverage for Covered Persons of the individual Subscriber that is enrolled, may only be rescinded or voided if: (1) the individual Subscriber or Covered Person (or a person seeking Coverage on behalf of the individual) performs an act, practice, or omission that constitutes fraud; or (2) the individual Subscriber or Covered Person (or a person seeking Coverage on behalf of the individual) makes an intentional misrepresentation of material fact.

For purposes of this EOC, a "rescission" is a cancellation or discontinuance of Coverage that has retroactive effect. For example, a cancellation that treats this EOC and the Coverage as void from the time of Your or the Employer's/Group's enrollment in Coverage is a rescission. Any Premiums for Coverage after the effective date of a rescission of Coverage will be refunded to the individual or group that paid the Premiums. A cancellation or discontinuance of Coverage with only prospective effect is not a rescission. Neither is a cancellation or discontinuance that is effective retroactively because of a failure to pay the required Premiums or to make contributions toward the cost of Coverage in the manner required by the Group Enrollment Agreement or the EOC.

Covered Persons affected by a rescission of Coverage will be provided at least 30-days advance written notice of the rescission. Rescission is permitted only for an act, practice or omission that constitutes fraud or an intentional misrepresentation of a material fact. We will not rescind a Policy in the case of inadvertent misstatements of fact. Such notice shall at a minimum contain:

1. Clear identification of the alleged fraudulent act, practice or omission or the intentional misrepresentation of material fact;
2. An explanation as to why the act, practice, or omission was fraudulent or was an intentional misrepresentation of a material fact;
3. Notice that the Covered Person or the Covered Person's authorized representative, prior to the date the advance notice of the proposed rescission ends, may immediately file an internal appeal to request a reconsideration of the rescission;
4. A description of the health carrier's internal appeal process for rescissions, including any time limits applicable to those procedures; and
5. The date when the advance notice ends and the date back to which the coverage will be rescinded.

We will not terminate a Covered Person's Coverage on the basis of the status of their health

or because they have exercised his or her rights under the grievance or appeal systems described later in this EOC by registering a complaint against Us or an appeal of Our determination of Benefits.

The following paragraphs describe the circumstances under which We may terminate Coverage. All rights to Benefits, including Inpatient services, shall cease as of the effective date of such termination.

1. **Termination for Cause**. If Your Coverage is terminated for cause, then the Coverage for all Covered Persons enrolled in the Plan through that Subscriber is terminated as well. The Employer or Group must determine eligibility for other insurance Coverage if Our Coverage is terminated for cause. The conditions under which your Piedmont Coverage may be terminated "for cause" are as follows:

    a. If You permit the use of Your ID card by any other person or use another Covered Person's card, We may recall the card and terminate Your Coverage immediately upon written notice.
    b. You represent that all information contained in applications, questionnaires, forms, or statements submitted to Us is true, correct, and complete. Except as provided in the "Incontestability" subsection later in this section, if You furnish information or engage in any activity that, in either case, constitutes a fraud or material misrepresentation in enrollment or the use of services or facilities, then Your Coverage may be terminated immediately upon written notice. Covered Persons so terminated will be responsible for all services provided to the Covered Person hereunder that are related to such information or activity.

    With regard to Nos. 1(a) and 1(b) above, We will provide any Covered Person whose Coverage is being terminated "for cause" with 31 days' written notice prior to such termination.

2. **Termination for Loss of Eligibility**. Subject to the continuation Coverage privileges set forth below, the Coverage of any Covered Person who ceases to be eligible will terminate at the end of the day upon which eligibility ceased unless otherwise agreed upon by Us and Your Employer or Group. In the event of Your death, Coverage will terminate for Covered Persons of the Subscriber on the last day of the period for which Premium payments have been made by or on Your behalf, subject to the continuation of Coverage rights described in the applicable subsection "Continuation of Coverage Rights under COBRA" (if Your Group is subject to COBRA) or "Continuation of Coverage if Group Not Eligible for COBRA". We will provide 31 days' written notice of such termination to You.
3. **Termination for Failure to Pay Premiums**. Only Covered Persons for whom the stipulated Premium payment is received by Us will be entitled to Covered Services, and then only for the period(s) for which such payment is received. If payment is not made in full by the Employer or Group on or prior to the Premium due date, as specified in the Group Enrollment Agreement and related contracts, a grace period shall be granted to the Employer or Group for payment of any and every Premium due, except the first Premium. Coverage will remain in force during the grace period, unless the Employer or Group has given Us written notice of discontinuance in

accordance with the terms of the applicable Group Enrollment Agreement and related contracts in advance of the discontinuance. The grace period will begin on the Premium due date and continue for 31 calendar days. If the delayed but required Premium payment is not received before the end of the grace period, then Your Coverage may be terminated at the end of the grace period. If the Premium is not paid, then the Employer or Group may be held liable for the payment of a prorated Premium for the time that the Coverage was in force during the grace period. We will provide the Employer/Group with at least 15 days' written notice prior to terminating Coverage due to failure to pay Premiums.

4. **Termination of the Group Enrollment Agreement**. The insurance Coverage arising from the Group Enrollment Agreement between Us and the Employer/Group may be terminated by Us or the Employer/Group for any reason permissible under that Agreement. In addition, We may terminate the Employer's or Group's Coverage for nonpayment of Premiums or for fraud or material misrepresentation in the application for Coverage. In any such event, Coverage will terminate for all Covered Persons as of the effective date of termination of the Employer/Group Plan, subject to the notice requirements. All rights to Benefits will cease as of the effective date of termination.

5. **Reinstatement.** Once Your Coverage is terminated, re-application is necessary before new Coverage can begin. Note that if your Coverage is terminated for cause under Paragraph D.1 of this Section, you are not eligible for reinstatement.

E. Continuation of Coverage Rights Under Cobra

This section only applies if Your Employer or Group must offer COBRA continuation Coverage. Most Employers and Groups (generally those with 20 or more Employees) must give a notice of COBRA continuation rights to their Employees within 90 days after the Employees become enrolled under the employers' health care Plans. In most cases, Your Plan administrator will provide You with that notice.

This subsection contains important information about Your right to COBRA continuation Coverage. COBRA is a temporary extension of Coverage under the Employer's or Group's health care Plan. This subsection generally explains: COBRA continuation Coverage; when it may become available to You and Your family (if Your family members are enrolled); and what You need to do to protect Your right and their right to receive it.

The right to COBRA continuation Coverage was created by federal law, the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA). COBRA continuation Coverage can become available when You would otherwise lose your group health care Coverage. It can also become available to other Covered Persons of Your family covered under the Plan when they would otherwise lose group health care Coverage. This subsection gives only a summary of Your COBRA continuation Coverage rights. For more information about Your rights and obligations under the Plan and federal law, contact Your Plan administrator. Ask to review the Plan's summary plan description or get a copy of the Plan document.

The Plan administrator is often Your group administrator. You may call Our customer service representatives and ask for information if You are unsure: who your group administrator is; or how he or she may be contacted. Our representatives' telephone numbers

are **434/947-4463** or toll-free at **800/400-7247**.

COBRA Continuation Coverage. COBRA continuation Coverage is a continuation of group health care Coverage when Coverage would otherwise end because of a life event known as a "qualifying event." Specific qualifying events are dot-pointed later in this subsection. After a qualifying event, COBRA continuation Coverage must be offered to each "qualified beneficiary." A qualified beneficiary is someone who will lose Coverage under the Plan because of the qualifying event. Depending on the type of qualifying event, Employees, spouses of Employees, and Plan Participant Children of Employees may be qualified beneficiaries. Under the Plan, qualified beneficiaries who elect COBRA continuation Coverage must pay the entire cost of their Coverage (plus the administration fee allowed by law). Coverage will end if the qualified beneficiary fails to pay required Premiums on time. The initial Premium for COBRA continuation Coverage must be paid within 45 days of its due date. Each Premium, after the first, must be paid within 31 days of its due date.

If You are an Employee, You will become a qualified beneficiary if You lose Your Coverage under Your group health care Plan because one of the following qualifying events occurs:

- Your hours of employment are reduced; or
- Your employment ends for any reason other than Your gross misconduct.

If You are the legal spouse of an Employee, You will become a qualified beneficiary if You lose Your Coverage under the group health care Plan because any of the following qualifying events occurs:

- Your spouse dies;
- Your spouse's hours of employment are reduced;
- Your spouse's employment ends for any reason other than his or her gross misconduct;
- Your spouse becomes entitled to Medicare Benefits (Part A, Part B, or both); or
- You become divorced or legally separated from Your spouse.

Your Plan Participant Children will become qualified beneficiaries if they lose Coverage under the group health care Plan because any of these qualifying events occur:

- The parent-Employee dies;
- The parent-Employee's hours of employment are reduced;
- The parent-Employee's employment ends for any reason other than his or her gross misconduct;
- The parent-Employee becomes entitled to Medicare Benefits (Part A, Part B, or both);
- The parents become divorced or legally separated; or
- The Child stops being eligible for Coverage under the Plan as a "Plan Participant Child."

Sometimes, filing a bankruptcy proceeding under Title 11 of the US Code can be a qualifying event which may trigger the right to COBRA coverage. A retired Employee will become a qualified beneficiary with respect to the bankruptcy if: the bankruptcy proceeding is filed

with respect to the employer sponsoring the group health care Plan; and that bankruptcy results in loss of Coverage by the retired Employee covered under the Plan. If bankruptcy results in the loss of Coverage under the group health care Plan, the following will also be qualified beneficiaries: the retired Employee's spouse; surviving spouse; and Plan Participant Children.

COBRA Notice Requirements. **You must notify Your Plan administrator**, **and Your Plan administrator must notify Us**, **in accordance with COBRA requirements**, **if a qualifying event occurs**. We will offer COBRA continuation Coverage to qualified beneficiaries only after the Plan administrator has notified Us in writing that a qualifying event has occurred. When the qualifying event is: the end of employment or reduction of hours of employment; death of the Employee; or if the Plan provides retiree health care Coverage, the commencement of a proceeding in bankruptcy with respect to the employer; or the Employee becoming entitled to Medicare Benefits (Part A, Part B, or both), You must notify Your Plan administrator within 30 days of the qualifying event. The Plan administrator must then notify Us.

For the other qualifying events (divorce or legal separation of the Employee and spouse or a Participant Child's losing eligibility for Coverage as a Participant Child), You must notify the Plan administrator. The Plan requires You to notify the Plan administrator within 60 days after one of these qualifying events occurs. You must send this notice to the Plan administrator. The Plan administrator must then notify Us.

Once We and the Plan administrator receive notice that a qualifying event has occurred, COBRA continuation Coverage will be offered to each qualified beneficiary. Each qualified beneficiary has a right to elect COBRA continuation Coverage even if other qualified beneficiaries may not elect Coverage. Covered Employees may elect COBRA continuation Coverage on their spouses' behalf if their spouses were covered under the group health Plan when the spouses' Coverage ended. Parents may elect COBRA continuation Coverage on their Children's behalf if the Children were covered under the group health care Plan when the Children's Coverage ended. Coverage will begin on the date of the qualifying event for each qualified beneficiary: (1) who elects COBRA continuation Coverage; and (2) for whom the required Premium is paid on time.

Length of COBRA Continuation Coverage. COBRA continuation Coverage is a temporary continuation of group health care Coverage. COBRA continuation Coverage lasts for up to a total of 36 months when the qualifying event is: the death of the Employee; the Employee's becoming entitled to Medicare Benefits (Part A, Part B, or both); Your divorce or legal separation; or a Plan Participant Child's losing eligibility as a Plan Participant Child.

COBRA continuation Coverage lasts for up to 36 months after the date of Medicare entitlement when the qualifying event is: the end of employment or reduction of the Employee's hours of employment; and the Employee became entitled to Medicare Benefits less than 18 months before the qualifying event. For example, if a covered Employee becomes entitled to Medicare 8 months before the date of employment termination, COBRA continuation Coverage for his spouse and Children can last up to 36 months after the date of Medicare entitlement. This is equal to 28 months after the date of the qualifying event (36 months minus 8 months). Otherwise, when the qualifying event is the end of employment or reduction of the Employee's hours of employment, COBRA continuation of Coverage

generally lasts for only up to a total of 18 months. There are two ways in which this 18-month period of COBRA continuation Coverage can be extended:

1. **Disability extension of 18-month period of COBRA continuation Coverage**. You and Your entire family may be entitled to receive up to an additional 11 months of COBRA continuation Coverage, for a total maximum of 29 months if: the US Social Security Administration determines You or anyone in Your family covered under the group health care Plan is disabled; and You notify Your Plan administrator in a timely fashion. The disability must have started at some time before the 60th day of COBRA continuation Coverage. Also, it must last at least until the end of the 18-month period of COBRA continuation Coverage. You must ensure the Plan administrator receives a copy of the Social Security Administration's determination within 60 days of the date of the determination and before the end of the 18-month period of COBRA continuation Coverage. This notice must be sent to your Plan administrator. The Plan administrator must then notify Us.

2. **Second qualifying event extension of 18-month period of COBRA continuation Coverage**. If Your family experiences another qualifying event while receiving 18 months of COBRA continuation Coverage, Your spouse and Plan Participant Children covered under the group health care Plan can get up to 18 months of COBRA continuation Coverage, for a maximum of 36 months; but, You must notify Your Plan administrator in a timely fashion. This extension may be available to the Employee's spouse and any Dependent Children receiving COBRA continuation Coverage if: the Employee dies; becomes entitled to Medicare Benefits (under Part A, Part B, or both); or gets divorced or legally separated; or if the Plan Participant Child stops being eligible as a Plan Participant Child under the group health Benefit Plan. This extension is only available if the second event would have caused the spouse or Plan Participant Child to lose Coverage under the group health care Plan had the first qualifying event not occurred. In all of these cases, You must make sure that the Plan administrator is notified of the second qualifying event within 60 days of that event. This notice must be sent to Your Plan administrator. The Plan administrator must then notify Us.

COBRA continuation Coverage will be terminated before the end of any maximum period if: (1) any required Premium is not paid in full and on time; (2) a qualified beneficiary becomes covered, after electing COBRA continuation Coverage, under another group health Plan that does not impose any pre-existing condition limitation for the qualified beneficiary's pre-existing condition; (3) a covered Employee becomes entitled to Medicare Benefits (Part A, Part B, or both) after electing COBRA continuation Coverage; or (4) the employer ceases to provide any group health care Plan for its Employees. COBRA continuation Coverage may also be terminated for any reason that the Plan or Piedmont would terminate the Coverage of a Covered Person or beneficiary not receiving COBRA continuation Coverage (e.g. fraud or material misrepresentation).

Questions about COBRA. You should contact Us at the numbers provided elsewhere in this EOC if: We are responsible for administering your COBRA continuation Coverage; or You are uncertain who administers Your COBRA Coverage. If Your Employer/Group is responsible for administering COBRA, You should contact Your Plan administrator directly. You may also contact the nearest Regional or District Office of the U. S. Department of Labor's Employee Benefits Security Administration (EBSA) for general information about COBRA. Addresses and phone numbers of Regional and District EBSA Offices should be available through EBSA's website at **www.dol.gov/ebsa** or in the telephone directory.

Keep your Plan informed of address changes. In order to protect Your rights or Your family's rights, please keep Us and any other person or entity responsible for administering COBRA continuation Coverage informed of any changes in the addresses of Covered Persons. Also, please keep a copy for your records of any notices You send to Your Plan administrator.

F. Continuation of Coverage Rights if Group Not Eligible for Cobra

This section only applies if Your Employer or Group is not eligible for federal COBRA continuation Coverage. Typically, not eligible for COBRA continuation Coverage are: employers with fewer than 20 Employees during the preceding Benefit Year; church groups; and non-employer groups (i.e. non-employer associations).

Notice of Continuation Options

You must notify Your Plan administrator (most often Your group administrator) immediately of Your loss of eligibility under this EOC or the Group Enrollment Agreement and related contracts.

Twelve-Month Continuation under State Law

If Your eligibility for coverage terminates under the group contract, You shall have the opportunity to continue coverage under the existing group contract for a period of at least 12 months immediately following the date of termination of Your eligibility for coverage under the group contract. Continuation coverage shall not be applicable if the group contract holder is required by federal law to provide for continuation of coverage under its group health plan pursuant to COBRA. Coverage shall be provided without additional evidence of insurability subject to the following requirements:

1. The application and payment for the continued coverage is made to the group contract holder within 31 days after issuance of the written notice required as stated above, but in no event beyond the 60-day period following the date of the termination of the person's eligibility;
2. Each Premium for the continued coverage is timely paid to the group contract holder on a monthly basis during the 12-month period; and
3. The Premium for continuing the group coverage shall be at the health care plan's current rate applicable to similarly situated individuals under the group contract plus any applicable administrative fee not to exceed 2.0% of the current rate.

A continuation of coverage shall not be required to be made available when:

1. You are covered by or are eligible for benefits under Medicare;
2. You are covered by substantially the same level of benefits under any policy, contract, or plan for individuals in a group;
3. You have not been continuously covered during the three-month period immediately preceding Your termination of coverage;
4. You were terminated by Us 1) for failure to pay the premium required by the contract, 2) because the policyholder has performed an act or practice that constitutes fraud or made an intentional misrepresentation of material fact in connection with the coverage; or coverage was rescinded; or

5. You were terminated from a plan administered by the Department of Medical Assistance Services.

The group contract holder shall provide You or any other person covered under the group contract written notice of the procedures and timeframes for obtaining continuation of coverage under the group contract. The notice shall be provided within 14 days of the group contract holder's knowledge of Your or any other covered person's loss of eligibility under the group contract.

G. Coordination of Benefits

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 health insurance plans and other prepaid health 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 allowed 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.

Primary Coverage and Secondary Coverage

When a Covered Person is also enrolled in another 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 Covered Person is enrolled as: (1) the named Subscriber under one Coverage; (2) a Dependent under another, then generally the one that covers him or her as the named Subscriber will be primary.
- If a Subscriber is the named Subscriber under both Coverages, generally the one that covers him or her for the longer period of time will be primary.
- If the Subscriber 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 Covered Person 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' 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.

When We provide secondary Coverage, We first calculate the amount that would have been payable had We been primary. In no event will Our payment as secondary Coverage exceed that amount. We will coordinate Benefits so the combination of the primary Plan's payment and Our payment does not exceed Our Allowable Charge. When the primary Coverage provides Benefits in the form of services rather than payment, a reasonable cash value of the services will be assigned and then considered to be the Benefit payment.

Overpayment of Benefits

If We overpay Benefits because of COB, We have the right to recover the excess from:

- The person or entity that was overpaid; or
- Any health insurance company.

Right to Receive and Release Information

By accepting Coverage under this EOC, You should:

- Provide Us with information about other Coverage and promptly notify Us of any Coverage changes;
- Promptly respond to any requests for information from Us;
- Grant Us the right to obtain information as needed from others to coordinate Benefits;
- Promptly return any payments made on Your behalf by Piedmont if We later discover or determine the other Coverage should have been primary.

The following charts set forth a graphical presentation of the Coordination of Benefits procedures and determinations as set forth in this EOC:

Which Plan pays First? Order of Benefit Determination Rules

When a Participant is covered by 2 group Plans, and	Then	Primary	Secondary
If one Plan does not contain a COB provision	The Plan without COB provision is	X	
	The Plan with COB provision is		X
The Participant is the Subscriber under one Plan and the Dependent under the other	The Plan covering the Participant as the Subscriber is	X	
	The Plan covering the person as a Dependent is		X
The Participant is a Subscriber in two active group Plans	The Plan that has been in effect longer is	X	
	The Plan that has been in effect the shorter amount of time is		X
The Participant is an active Employee on one Plan and enrolled as a COBRA Subscriber in another	The Plan which the Subscriber is an active Employee is	X	
	The COBRA Plan is		X

The Participant is covered as a Dependent Child under both Plans	The Plan of the parent whose birthday occurs earlier in the Benefit Year (known as the birthday rule) is The Plan of the parent whose birthday is later in the Benefit Year is	X	 X
The Participant is covered as a Dependent Child and under both Plans of divorced parents, and responsibility for health care Coverage is specified in a court decree	The Plan of the parent primarily responsible for health Coverage under the court decree is The Plan of the other parent is	X	 X
The Participant is covered as a Dependent Child under both Plans of divorced parents and responsibility for health care Coverage is not specified in a court decree but one parent has custody	The custodial parent or spouse of custodial parent's Plan is The non-custodial parent's Plan is	X	 X
The Participant is covered as a Dependent Child under both Plans of divorced parents and responsibility for health care Coverage is not specified in a court decree but the parents share joint custody	The Plan of the parent whose birthday occurs earlier in the Benefit Year is The Plan of the parent whose birthday is later in the Benefit Year is NOTE: If the parents have the same birthday (MM/DD), the Plan that has been in effect longer is primary	X	 X

Coordination of Benefits with Medicare for Participants under 65 with a Disability

When a Participant is covered by Medicare and a group Plan	Then	Piedmont is Primary	Medicare is Primary
Is a disabled Participant who is allowed to maintain group enrollment an active Employee? If yes, then	If the employer employs 100 Employees or more If the employer employs fewer than 100 Employees	X	 X
Is the Participant a disabled spouse or Dependent Child of an active full-time Subscriber? If yes, then	If the employer employs 100 Employees or more If the employer employs fewer than 100 Employees	X	 X
Is the Participant disabled and the Subscriber not actively employed by the employer / group? If yes, then			X

Coordination of Benefits with Medicare for Participants Age 65 and Over

When a Participant is covered by Medicare and a group Plan	Then	Piedmont is Primary	Medicare is Primary

If the Participant is age 65 or over, and the Subscriber or the Subscriber's spouse is actively working for the employer group	If the employer group has less than 20 Employees If the employer group has 20 or more Employees	 X	X
If the Participant is age 65 or over and becomes qualified for Medicare Coverage due to ESRD after already being enrolled in Medicare due to age	If Medicare had been secondary to the group Plan before ESRD entitlement, then for the first 30 months following ESRD entitlement If Medicare had been primary to the group Plan before ESRD entitlement	X	 X
If the Participant is age 65 or over and is either the Subscriber or his /her spouse, and is retired from the employer group (not actively working)			X

H. Duplicate Coverage

Workers' Compensation and Other Insurance. Our Benefits do not duplicate those You may be eligible for under: workers' compensation; similar employer's liability or occupational disease laws.

Medicare. Any benefits covered under both this Plan and Medicare will be covered according to Medicare Secondary Payer legislation, regulations, and Centers for Medicare & Medicaid Services guidelines, subject to federal court decisions. Federal law controls whenever there is a conflict among state law, this EOC's terms, and federal law. Benefits are only coordinated with Medicare when the Covered person is enrolled in Medicare, with the exception of those with End Stage Renal Disease (ESRD) that are not required to enroll in Medicare.

Cooperation. You must complete and submit such consents, releases, applications, assignments, and other documents as may be requested by Us to obtain or assure reimbursement: under Medicare; workers' compensation or similar statutes; or any other public or private group insurance Coverage for which you are e.

I. Relationship of Contracting Parties

In-Network Providers maintain the Physician-patient relationship with You. In-Network Providers are solely responsible for all medical services. The relationship between Us and In-Network Providers of Covered Services is an independent contractor relationship. In-Network Providers of Covered Services are not employees or agents of Piedmont. Neither Piedmont nor any Employee of Piedmont is an Employee or agent of any In-Network Provider. For the purposes of this EOC, no employer, Subscriber or Provider is the agent or representative of Piedmont and none will be liable for any acts or omissions of: Piedmont; its agents; Piedmont Employees; nor any other person or organization with which We have made or hereafter will make arrangements for the provision of Covered Services.

Your In-Network Provider's agreement for providing Covered Services may include

financial incentives or risk sharing relationships related to the provision of services or referrals to other Providers, including In-Network Providers, Out-of-Network Providers, and disease management programs. If You have questions regarding such incentives or risk sharing relationships, please contact Your Provider or Us.

J. Medical Information

We may request from any Provider of Covered Services information necessary in connection with the administration of this EOC, subject to all applicable confidentiality requirements. Information from Your medical records and information from Physicians, surgeons, or Hospitals incidental to the Doctor-patient or Hospital-patient relationship will be kept confidential. This information may not be disclosed without Your consent except as permitted by any applicable state and federal law.

K. Policies and Procedures

We may adopt policies, procedures, rules, and interpretations to promote orderly and efficient administration of Coverage under this EOC.

L. Modifications

Alterations to the Group Agreement and its attachments may be made, in accordance with the terms of the Group Agreement between the Plan and group. This may be done without the Subscriber's consent or concurrence.

M. Notices

1. **From Piedmont to You**. A notice sent to You by Piedmont is considered "given" when received by the Subscriber's Employer or Group at the address listed in Our records. If sent directly to You, the notice is considered "given" when mailed to the Subscriber's last known address as shown in Our enrollment records. "Notices" include any information, which We may send You, including ID cards.

2. **From You or Your Employer to Piedmont**. Notice by You or the Subscriber's Employer or Group to Piedmont is considered "given" when it is received by Us. We will not be able to act on this notice unless Your name and identification number are included in the notice.

N. Group Enrollment Agreement with Employer; Entire Contract

Piedmont and the Subscriber's Employer or Group have entered into a Group Enrollment Agreement for the provision of Benefits described in this EOC. Under this Group Enrollment Agreement, the Subscriber's Employer or Group will contribute on Your behalf a portion of the Premiums required. That Agreement, this EOC, the Enrollment Application filled out by You, the Enrollment Application filled out by Your Employer/Group, and any amendments or exhibits to any of those documents constitute the entire contract between the parties to both the Group Enrollment Agreement and this EOC. We will provide the Subscriber's Employer or Group with at least 60 days' notice of any Benefit reductions to take effect under this contract of insurance. Under Virginia law, the Subscriber's Employer or Group is

required to provide at least 30 days' notice to the Subscriber of such Benefit reductions. In the event of any inconsistency between this EOC and the Group Enrollment Agreement, the terms of the Group Enrollment Agreement will control. You may direct specific questions related to the Group Enrollment Agreement between Your Employer or Group and Us to: (1) the Subscriber's Employer or Group; and/or (2) the Plan administrator.

O. Claim Forms

We must receive written notice of the occurrence or commencement of any loss covered under this EOC within 20 days after the date expenses are incurred. If You presented Your ID card to an In-Network Provider at the time of service, you are not required to notify Us of proof of loss. You must provide Us with written notice of a claim within 20 days or a soon as reasonably possible if: You did not present Your ID card; or if You received services from an Out-of-Network Provider. Within fifteen (15) days of receipt of written notice of a claim, We will provide You with the Benefit claim form for filing proof of loss. If You do not receive these forms, We will accept Your written description of the loss as proof of loss.

Filing Proof of Loss

In-Network Providers will file most claims for You. You may have to file claims for: out-of-Service-Area services; services rendered by Providers who are not In-Network Providers; and some prescription drug claims. You must provide Us with: written proof of loss covering the occurrence, character; and extent of the loss for which the claim is made within 90 days after the date of the loss or as soon as reasonably possible. Except in the absence of legal capacity of the claimant, in no event will proof of loss be furnished later than one year from the time proof of loss is otherwise required. You may obtain claim forms from Our customer service. Claims should be sent to the following address:

Piedmont Community Healthcare HMO, Inc.
P. O. Box 21406
Eagan, MN 55121

Payment of Claims

We will reimburse a Provider up to the Allowable Charge minus any Copayment, Deductible or Coinsurance for a Medically Necessary Covered Service paid for You only if a completed claim (including receipt) has been received within 90 days of the date You received this service. Failure to furnish such proof within 90 days of the date You received this service will not invalidate or reduce any claim if it was not reasonably possible to furnish the proof within that time and the proof is furnished as soon as reasonably possible. However, in no event, except in the absence of legal capacity of the claimant, will such proof be furnished later than one year from the time proof is otherwise required (i.e., within 1 year plus 90 days).

All In-Network Providers are required to file claims directly with Us. If You receive a bill or statement, contact the Provider to make sure the Provider has Your correct insurance information so the Provider can file directly with Us on Your behalf. All Benefits payable under the EOC, will be payable within thirty (30) days after receipt of proof of loss.

P. Claims Review

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

We will review a:

- Post-service claim within 15 days of receipt; and a
- Pre-service claim within 15 days of receipt.

A "post-service claim" is any claim under this EOC for a Benefit for which the Covered Person does not need approval before receiving the Benefit. Most claims under Your Group health Plan are post-service claims.

A "pre-service claim" is any claim under a Group health Plan for a Benefit for which the Covered Person must receive approval (prior authorization) before receiving the Benefit.

We may extend the time to review a claim for an additional 15 days if We: (1) decide that an extension is necessary for reasons beyond Our control; (2) notify You of the reason for the extension in writing before the initial review period ends; and (3) tell You when We expect to make Our final decision. If the extension is because We 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. Our time to review a claim is "tolled" or stops between the date We send the extension notice and the date We receive the requested information.

2. Expedited Decisions for Urgent Care Claims or Requests:

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 or urgent request for medical care or treatment for a Benefit for which the application of post-service or pre-service time frames or Our normal prior authorization standards:

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

We will notify the claimant of a Benefit determination (approval or denial) with respect to an Urgent Care Claim as soon as possible, considering the medical needs, but not later than 72 hours after We receive the claim or request. If the claimant fails to provide enough information to determine whether, or to what extent, Benefits are Covered or payable under the Plan or this EOC, We will notify the claimant within 24 hours of receipt of the claim or request that additional information is required to make a decision.

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

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

Q. Claims and Eligibility Appeals

1. Internal Appeals:

You will have 180 days from receipt of Our notice of an Adverse Benefit Determination to file an internal appeal with Us. For the purposes of an internal appeal, "Adverse Benefit Determination" means:

- Our determination that the request for a Benefit does not meet Our requirements for: Medical Necessity, appropriateness, health care setting, level of care or effectiveness, or We determine the service is Experimental/Investigational and, in any of these circumstances, the request is denied, reduced or terminated, or payment for the requested Benefit is not provided or made, in whole or in part;
- The denial, reduction, termination or failure to provide or make payment, in whole or in part, for a Benefit is based on Our determination that You are not eligible to participate in the health Benefit Plan;
- Any review determination that: denies, reduces or terminates or fails to provide or make payment, in whole or in part, for a Benefit;
- A rescission of Coverage determination if the cancellation or discontinuance of Coverage has retroactive effect (see below for more information about a "rescission of Coverage"); or
- Any decision to deny individual Coverage in an initial eligibility determination.

"Rescission of Coverage" does not include:

(a) A cancellation or discontinuance of Your Coverage if the cancellation or discontinuance of Coverage has only a prospective effect, or the cancellation or discontinuance of Coverage is effective retroactively because of a failure to pay on time the required Premiums or other contributions toward the cost of Your Coverage; or

(b) A cancellation or discontinuance of Your Coverage when You or Your Dependents are covered under continuation Coverage provisions such as COBRA, for which You pay no Premiums for the continuation Coverage after termination of employment, and the cancellation or discontinuance of Coverage is effective retroactively back to the date of termination of Your employment because of a delay in administrative recordkeeping.

The appeal should be in writing and include: Your name; Piedmont ID number; the reason for the appeal; the resolution You are requesting; and supporting information regarding the

medical Providers involved and services received or requested. To ensure proper handling, an appeal must be filed with Our Appeals Coordinator at appeals@pchp.net or this address:

Piedmont Community Healthcare HMO, Inc.
Attn: Appeals Coordinator
2316 Atherholt Road
Lynchburg, Virginia 24501

If You need assistance with an internal appeal, You may contact the Office of Managed Care Ombudsman at the Virginia Bureau of Insurance. Contact information for the Managed Care Ombudsman's office is in this EOC's "Complaints and Assistance" Section below.

Except as otherwise provided in this "Claims and Eligibility Appeals" paragraph, We will notify You of Our final Benefit determination within a reasonable period of time appropriate for the medical circumstances, but not later than 30 days after receipt of the appeal.

You may submit written comments, documents, records, and other information relating to the claim, even though the information had not been considered when the initial decision was made. Upon request, We will identify the health care professional whom We consulted, whether or not We relied on his or her advice in reaching Our adverse decision. You may request, and We will provide to You free of charge, reasonable access to and copies of: all documents, records, and other information relevant to Your claim for Benefits.

Prior to issuing a final Adverse Benefit Determination, We will provide to You free of charge with any new information that We relied on or generated for the appeal sufficiently far in advance of Our final determination so that You may respond, if You choose to do so.

We will conduct the appeal without deferring to the original adverse decision. The individual who conducts the appeal will not be the person who made the initial decision or that person's subordinate. We will consult a health care professional who has appropriate training and experience in the field of medicine involved if medical judgment is required. The individual who decides the appeal will not have been involved in the previous Adverse Benefits Determination with respect to the claim. The health care professional whom We consult for the appeal will not be the person whom We consulted in making the initial decision or that person's subordinate.

2. **Expedited Internal Appeals**

If the appeal is for an Urgent Care Claim or one eligible for expedited review (as explained below), then it may be made by telephone call to Our Appeals Coordinator. You may contact the Appeals Coordinator by calling **800-400-7247**. You may submit all information necessary for an appeal of an Urgent Care claim or one eligible for expedited review by: telephone, facsimile (at the number provided on the Cover Page), or similar expedited method.

If Your internal appeal involves a concurrent review decision, for example, a continuing stay in an Inpatient setting, then We will provide continued Coverage pending the outcome of Your appeal up to the limits of Your Coverage under this EOC. Any reduction or termination of a course of treatment We have approved in advance (other than by health Benefit Plan amendment or termination) to be provided over a period of time or number of treatments is

considered to be an Adverse Benefit Determination. We will notify You of the Adverse Benefit Determination in time for You or Your authorized representative to file an internal appeal with Us and receive a decision before the Covered Benefit is reduced or terminated.

In such a case, We will notify You as soon as possible, but not later than 24 hours after Our receipt of the appeal, of the specific information needed to complete the appeal claim. We will give You a reasonable time to provide the additional necessary information, considering the circumstances, but not less than 48 hours to respond. All necessary additional information, including the Benefit determination on an Urgent Care Claim Appeal, may be transmitted by: telephone (at the number provided); facsimile (at the number provided on the Cover Page); or the most expeditious method available. We will then notify You of the Benefit determination for the/an Urgent Care Claim Appeal not later than 48 hours after the earlier of: (1) Our receipt of the specified additional information, or (2) the end of the period that We have afforded You to provide the additional information.

We will respond to an appeal of an Urgent Care Claim within 72 hours after We receive the appeal unless You do not provide sufficient information for Us to determine whether, and to what extent, Benefits are covered or payable under the Plan.

Virginia law provides for the expedited review of certain Adverse Benefits Determinations. Expedited review is available when the time frames for the regular appeals process: (1) would subject a cancer patient to pain; or (2) delay the rendering of health care services in a manner detrimental to a patient's health. These decisions must be resolved within 72 hours after receipt of the appeal:

- A final adverse decision for a prescription to alleviate cancer pain; and
- By telephone call, which is initiated by the treating health care Provider, when he or she believes Our adverse decision warrants an immediate appeal.

An expedited appeal may be further appealed through the regular appeal process unless: (1) all material information and documentation were reasonably available to the treating health care Provider and to Us at the time of the expedited review; and (2) the professional Provider reviewing the claim under expedited review was a peer of the treating Provider, was board-certified or board-eligible, and specialized in a discipline pertinent to the issue being reviewed.

3. **External Appeals**:

You may also have the right to an external review of an Adverse Benefit Determination or the denial of any appeal. The Virginia Bureau of Insurance administers the external review program. We will provide You with copies of the Bureau's external utilization review request forms with its notice of a final adverse decision for a claim to which the program would apply. When requesting an external appeal, You will be required to authorize the release of any medical records required for review in order to reach a decision on the external appeal.

The Bureau's external review program is available for a specific set of adverse determinations. First, You or Your authorized representative must have exhausted the health Plan's internal appeal process (set forth above), with the exception of Adverse Benefit Determinations related to cancer. Second, to be eligible for external review, the adverse determination must be for an admission, the availability of care, continued stay or other

health care service that: (1) We have determined does not meet Our criteria for Medical Necessity, appropriateness, health care setting, level of care or effectiveness, or the service is an Experimental/Investigational service; and (2) as a result, the requested service or payment is denied, reduced or terminated by Us.

The Virginia Bureau of Insurance will consider the appeal process for the claim exhausted. You may request an external review directly from the Bureau if You or Your authorized representative have not received a response from Us to the appeal within 30 days following the date on which it was filed with Us, assuming You have not requested or agreed to a delay. For an expedited appeal, You or Your authorized representative may file a request for an external appeal with the Virginia Bureau of Insurance at the same time You file the appeal with Us.

You must file Your request for external review with the Virginia Bureau of Insurance within 120 days after the receipt of Our denial of payment or denial of a request for Coverage of a health care service or treatment. You may also file a request for an expedited external review with the Bureau of Insurance. We will make a preliminary determination as to whether the Adverse Benefits Determination is eligible for an external appeal. We will advise You and the Bureau of Insurance of Our determination. You may appeal an adverse determination directly to the Virginia Bureau of Insurance.

Contact information of the Bureau's external appeals program is below:

State Corporation Commission
Bureau of Insurance – External Review
P.O. Box 1157
Richmond, Virginia 23218
Telephone: 877/310-6560
Fax: 804/371-9915
E-mail: externalreview@scc.virginia.gov

The decision reached by the Bureau of Insurance as a result of this external review process is binding upon Piedmont. It is also binding on the Covered Person except to the extent that the Covered Person has other remedies available under applicable federal or state law. You or Your authorized representative may not file a subsequent request for an external review involving the same adverse determination or final adverse determination for which You or Your representative have already received an external review decision by the Bureau of Insurance.

R. Authorized Representative

You may authorize a representative to act on Your behalf in pursuing a claims review or claims appeal. We may require that You identify Your authorized representative in writing in advance. We will communicate directly with Your authorized representative, rather than You, for matters involving the claim or appeal.

Your authorized representative may include (without limitation): (1) a person to whom You have given express written consent to represent You; (2) a person who is authorized by law to provide a substituted consent for You; (3) Your family member or treating health care professional if You are unable to provide consent; (4) a health care professional if Your

group health Benefit Plan requires that a request for a Benefit under the Plan be initiated by the health care professional; or (5) in the case of an internal appeal for an Urgent Care Claim, a health care professional with knowledge of Your medical condition.

S. Complaints and Assistance

You may file a complaint with Us at any time if dissatisfied with the availability, delivery, or quality of health care services, or any other matter. Your authorized representative may file the complaint on Your behalf. The complaint may be in writing, or given to Us verbally, and must include: Your name; Your Piedmont ID number; the reason for the complaint; and the resolution You seek. If the complaint involves a medical Provider, it should identify the Provider and the services received or requested. If You need assistance preparing a written or verbal complaint, Our customer service staff will assist You. Our customer service telephone number is **800-400-7247**.

To ensure proper handling, a complaint must be filed with Our Grievance Coordinator at the following address:

Piedmont Community Healthcare HMO, Inc.
Attn: Grievance Coordinator
2316 Atherholt Road
Lynchburg, Virginia 24501

We will respond to all complaints within 30 days of the date of receipt. We will resolve all complaints no later than 60 days after the date of receipt. We will respond more quickly to matters involving clinical urgency if the complaint is identified as such and any information We request is received more quickly.

The Virginia Bureau of Insurance has established an "Office of Managed Care Ombudsman" to assist Virginia consumers in understanding and exercising their rights under their managed care programs. If You have any questions about an appeal or grievance concerning the health care services that You have been provided that have not been satisfactorily addressed by Your plan, You may contact the Office of Managed Care Ombudsman for assistance. You may contact this office in any of the following ways:

Mail:	**Office of Managed Care Ombudsman**	
	Virginia Bureau of Insurance	
	P.O. Box 1157	
	Richmond, VA 23218	
Telephone:	**Toll-free:**	**877-310-6560**
	Richmond Area:	**804-371-9032**
Fax:	**804-371-9944**	
E-mail:	**Ombudsman@scc.virginia.gov**	
Web Page:	**www.scc.virginia.gov**	

The Virginia Department of Health has also established an “Office of Licensure and Certification” to assist Virginia consumers with complaints about the quality of their care by managed care organizations. If You wish assistance from the Office of Licensure and Certification, You may contact this Office in any of the following ways:

Mail:	**Office of Licensure and Certification**	
	Virginia Department of Health	
	9960 Mayland Drive, Suite 401	
	Henrico, Virginia 23233-1463	
Telephone:	**Toll-free:**	**800-955-1819**
	Richmond Area:	**804-367-2106**
Fax:	**804-527-4503**	
E-mail:	**mchip@vdh.virginia.gov**	

T. Assignment of Benefits and Payments

The Covered Services available under this EOC are personal to You. You may not assign Your right to receive Covered Services. Except for payments assigned to oral surgeons and dentists who provide Covered Services to You, You may not assign Your right to receive payment for Covered Services. Prior payments to anyone, whether or not there has been an assignment of payment, will not constitute a waiver of, or otherwise restrict, Our right to direct future payments to You or any other individual or facility.

U. Limitations on Damages

In the event You or Your representative sue Piedmont or any director, officer, or employee of Piedmont acting in his/her capacity as a director, officer, or employee for a determination of what Coverage, if any, exists under this EOC, Your damages will be limited to: Our Allowable Charge(s) for Covered Services minus any Deductible, Coinsurance and/or Copayment for those Services. The damages will not exceed the amount of any claim not properly paid as of the time the lawsuit is filed. This EOC does not provide for punitive damages or damages for emotional distress or mental anguish; provided, however, this provision is not intended, and will not be construed, to affect in any manner any recovery by You or Your representative of any non-contractual damages to which You or Your representative may otherwise be entitled.

V. Piedmont's Continuing Rights

On occasion, We may not insist on Your strict performance of all terms of this EOC. Our failure to always apply terms or conditions against You, however, does not mean We waive or give up any future rights We may have under this EOC.

W. Incontestability

The validity of the Coverage provided by this EOC and other documents comprising Your health Plan will not be contested, except for nonpayment of Premiums, after the Coverage has been in effect for 2 years. No statement relating to insurability made by any person insured under the EOC and related documents will be used in contesting the validity of the insurance with respect to which such statement was made after the insurance has been in force prior to the contest for a period of 2 years during the lifetime of the person about whom the statement was made, and unless the statement is contained in a written instrument signed by the person.

X. Use of Personal Information

- Personal information may be collected from persons other than the individual proposed for Coverage.
- This information, as well as other personal or privileged information subsequently collected by Us, in certain circumstances, may be disclosed to third parties without authorization.
- Each Covered Person has a right to see and correct all personal information, which is collected about him or her.

A more complete notice of Our information practices is available upon request.

Y. Entire Contract

The entire contract between Us and the Employer/Group consists of: the Group Enrollment Agreement and its amendments; this Evidence of Coverage and its attachments, amendments (including mutually agreed-upon renewal terms); the Schedule of Benefits; Subscriber's Enrollment/Change Form; and the Employer's/Group's application. A copy of the Group application is attached to the Group Enrollment Agreement when issued to the Employer or Group. All statements made by the Employer/Group or by the Covered Persons are deemed to be representations and not warranties. No written statement made by any Covered Person will be used in any contest unless a copy of the statement is furnished to: the Covered Person; or his/her beneficiary or personal representative.

Z. Provider Non-Discrimination

Providers operating within their scope of practice, license or certification cannot be discriminated against.

AA. Non-Discouragement/Non-Discriminatory Benefit Design

We do not offer Benefit designs that will have the effect of discouraging the enrollment of individuals with significant health needs in its Plans. We will not discriminate on the basis of health status, race, color, creed, national origin, ancestry, marital status, lawful occupation, disability, age, sex, gender identity, or sexual orientation.

Covered Person's Rights and Responsibilities

Successful relationships take a strong commitment from all sides, with each side recognizing the rights and responsibilities of the other. Your health care is no different. It takes strong teamwork between You, Your health care professionals, and Us for Coverage You can count on. Below is a statement of rights and responsibilities that guide Our relationship with you. Please read them, and should You have any questions, please give Us a call.

Piedmont is committed to:

- Recognizing and respecting You as a Covered Person.
- Encouraging Your open discussions with Your health care professionals and Providers.
- Providing information to help You become an informed health care consumer.
- Providing access to health Benefits and Our Network Providers.
- Sharing Our expectations of You as a Covered Person.

You have the right to:

- Participate with Your health care professionals and Providers in making decisions about your health care.
- Receive the Benefits for which You have Coverage.
- Be treated with respect and dignity.
- Preserve the privacy of Your personal health information, consistent with state and federal laws, and Our policies.
- Receive information about Our organization and services, Our Network of health care professionals and Providers, and Your rights and responsibilities.
- Candidly discuss with Your Physicians and Providers appropriate and Medically Necessary care for Your condition, regardless of cost or Benefit Coverage.
- Make recommendations regarding the rights and responsibilities of any Covered Person as set forth in this EOC.
- Voice complaints or appeals about: Our organization, any Benefit or Coverage decisions We (or Our designated administrators) make, Your Coverage, or care provided.
- Refuse treatment for any condition, illness, or disease without jeopardizing future treatment, and be informed by Your Physician(s) of the medical consequences.
- Participate in matters of the organization's policy and operations.
- **For assistance at any time, contact Your local insurance department: by phone in Richmond (804) 371-9032, toll-free from outside Richmond (877) 310-6560, or in writing: Virginia Bureau of Insurance, 1300 East Main Street, P.O. Box 1157, Richmond, VA 23218.**

You have the responsibility to:

- Treat all health care professionals and staff with courtesy and respect.
- Keep scheduled appointments with Your Doctor, and call the Doctor's office if You have a delay or cancellation.
- Read and understand to the best of Your ability all materials concerning Your health

Benefits or ask for help if You need it.

- Understand Your health problems and participate, along with Your health care professionals and Providers, in developing mutually agreed upon treatment goals to the degree possible.
- Supply, to the extent possible, information that We and/or Your health care professionals and Providers need to provide care.
- Follow the plans and instructions for care that You have agreed on with Your health care professional and Provider.
- Tell Your health care professional and Provider if You do not understand Your treatment plan or what is expected of You.
- Follow all health Benefit Plan guidelines, provisions, policies, and procedures.
- Let Us know if You have any changes to Your: name; address; or family members covered under Your EOC.
- Provide Us with accurate and complete information needed to administer Your health Benefit Plan, including other health Benefit coverage and other insurance Benefits You may have in addition to Your Coverage with Us.