Piedmont Large Group Health Care Coverage Plan

2021 - Virginia Expanded PPO

PPOLGGROUP_NTN(01/21)

PIEDMONT COMMUNITY HEALTHCARE INC.
2316 Atherholt Road • Lynchburg, VA • 24501

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Section I: Responsibilities

Welcome to Piedmont Community Healthcare, Inc. (Piedmont). Thank you for allowing us to provide your health Benefits. This is your Piedmont Certificate of Coverage (COC) and is considered part of the Group Enrollment Agreement between Piedmont and your Employer/Group. This large group Major Medical COC is offered and underwritten by Piedmont.

A. YOUR RESPONSIBILITIES

You assume certain responsibilities by partnering with Piedmont to protect your health. It is important that you understand these responsibilities:

Know Your In-Network Physician. You should establish a personal and continuous relationship with your selected In-Network Physician. Maintaining this ongoing relationship is an essential part of health care.

Use In-Network Physicians. To receive the highest level of Benefits under your Coverage with Piedmont, you must use In-Network Physicians for all your health care needs. Although not required, Piedmont encourages you to designate and utilize a Primary Care Physician.

Choice of Treating Provider. Piedmont's agreements with In-Network Providers should not be understood as a guarantee or warranty of the professional services of such providers. The choice of In-Network Physician, In-Network Provider, or any other provider and the decision to receive or to decline to receive health care services is the sole responsibility of the Participant.

Changes in Coverage. Any change in employment, residence, or number of Participants affects Coverage. Please make sure that Piedmont is notified as soon as possible, but no more than 31 days after any of the following changes occur:

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

Failure to provide proper notice of changes in Coverage may affect your Coverage. Piedmont is not responsible for lapses in Coverage due to your failure or your employer's failure to provide proper notice of a change in Coverage.

Your Identification Card (ID Card). Piedmont will issue all Plan Participants an ID card. You must present your identification card whenever you receive Covered Services. Identification cards are not transferable. Unauthorized use of the identification card by any person

can result in termination of enrollment in Piedmont. You will be obligated to pay for the unauthorized Covered Services obtained. The identification card serves only to identify the covered Subscriber and confers no right to Covered Services or Benefits. To be entitled to Covered Services or Benefits, an identification cardholder must, in fact, be a Participant on whose behalf all applicable Premiums have actually been paid. Participants must carry their Piedmont identification cards with them at all times to assure prompt receipt of Covered Services. If a card is lost or stolen, please notify Piedmont immediately. Identification cards remain the property of Piedmont and must be returned upon termination of your Coverage with Piedmont or upon request by Piedmont.

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

- Be on time for appointments.
- Notify your In-Network Physician or any other In-Network Provider promptly if an appointment must be canceled.
- Follow the instructions and guidelines given by your In-Network Physician(s).
- Know prescribed medications, the reasons for taking them, and the procedures for taking them.
- Learn to differentiate between true Emergency situations and Urgent Care needs and how to handle them.
- Make the lifestyle changes recommended by your In-Network Physician or Piedmont.
- Pay Copayments, Coinsurance, and/or Deductibles at the time the Covered Service is rendered.
- Transfer previous medical records to your In-Network Physician.
- Make sure that Piedmont is notified of any changes in name, address, phone number, or Participant eligibility.
- Utilize Grievance and Appeal Procedures discussed further in this Certificate of Coverage to resolve concerns and complaints.
- Obtain Covered Services through In-Network Physicians and other In-Network Providers.
- Obtain Preauthorization before treatment is received for services that require it.
- Obtain a formal Authorized referral from Piedmont before treatment is received from Out-of-Network Providers in the event care from Out-of-Network Providers is necessary in order to receive In-Network Benefits. Failure to obtain the Authorized referral 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.
- Provide Piedmont with requested information, including medical records, physician statements regarding care and treatment, and any information regarding your physical condition.
- Provide Piedmont with the necessary information so Coordination of Benefits may take place. Your failure to do so may result in the denial of your claims.

All statements made by a Subscriber shall be considered representations and not warranties. No statement shall be the basis for voiding Coverage or denying a claim after the Certificate

of Coverage has been in force for two years from its effective date, unless the statement was material to the risk and contained in a written application.

B. PIEDMONT'S RESPONSIBILITIES

Piedmont will provide health care Benefits according to this Certificate of Coverage and agrees to:

- Provide each Participant with a Piedmont identification card.
- Provide all Benefits described in this Certificate of Coverage subject to its terms, conditions, limitations, and exclusions.
- Keep you informed regarding changes in procedures, Benefits, and In-Network Providers. Piedmont does not guarantee the continued availability of a particular In-Network Provider.
- Keep all medical records confidential in accordance with the terms of federal and state privacy protection laws.
- Provide courteous, prompt resolution of your questions, concerns, or complaints.
- Allow continuation of your group Coverage without a break in Coverage or loss of eligibility as provided for herein.
- Assist you in getting an appointment with In-Network Physicians when requested.
- Make Network arrangements such that your In-Network Physician (or another physician with whom your In-Network Physician has made arrangements) is available 24 hours per day, seven days per week in order to refer or direct you for prompt medical care in cases where there is an immediate, urgent need or Emergency.
- Have Piedmont's or its designee's personnel available for Preauthorization of treatment at all times when Preauthorization is required. Piedmont requires In-Network Providers (or Participants if they are acting on their own behalf) to make Preauthorization arrangements during regular business hours. Piedmont's Preauthorization is not required for Emergencies or Urgent Care situations after hours.
- Offer you the right to make recommendations regarding your rights and responsibilities.

Special Limitations - Rights of Plan Participants and obligations of Piedmont are subject to the following special limitations:

To the extent that a natural disaster, war, riot, civil insurrection, epidemic or any other emergency or similar event not within the control of Piedmont results in the facilities, personnel, or financial resources of Piedmont being unavailable to provide or arrange for the provision of Covered Services, Piedmont shall make a good faith effort to provide or arrange for the provision of such health services taking into account the covered Hospital and medical services insofar as practical, and according to its best judgment. Piedmont and In-Network Providers shall 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, you can always contact your agent or Piedmont directly at:

Piedmont Community HealthCare
Customer Service Department
2316 Atherholt Road
Lynchburg, Virginia 24501
Locally: (434) 947-4463
Toll free: (800) 400-7247
FAX: (434) 947-3670
WEB PAGE: 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 7-1-1 for assistance. This is a free service.

NON-DISCRIMINATION AND LANGUAGE ASSISTANCE

Discrimination is Against the Law

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

Piedmont shall provide coverage under the health benefit plan without discrimination on the basis of gender identity or status as a transgender individual, including coverage of medically necessary transition-related care, and shall treat covered individuals consistent with their gender identity. "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. "Medically necessary transition-related care" means any medical treatment prescribed by a licensed physician for treatment of gender dysphoria and includes (i) outpatient psychotherapy and mental health services for gender dysphoria and associated co-morbid psychiatric diagnoses; (ii) continuous hormone replacement therapy; (iii) outpatient laboratory testing to monitor continuous hormone therapy; and (iv) gender reassignment surgeries.

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 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 Piedmont's Customer Service at 1-800-400-7247 (TTY: 711).

If you believe that Piedmont has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance with our Compliance Officer by mail or phone:

Compliance Officer
Piedmont Community Health Plan
2316 Atherholt Road
Lynchburg, VA 24501
434-947-4463 (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 اذكر 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).

বাংলা (Bengali)

লক্ষ্য করুনঃ যদি আপনি বাংলা, কথা বলতে পারেন, তাহলে নিঃখরচায় ভাষা সহায়তা পরিষেবা উপলব্ধ আছে। ফোন করুন ১-800-400-7247 (TTY: 711)।

Ɓàsɔ́ɔ̀-wùɖù-po-nyɔ̀ (Bassa)

Dè ɖɛ nià kɛ dyéɖé gbo: Ɔ jǔ ké m̀ [Ɓàsɔ́ɔ̀-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).

اُردُو (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

हिंदी (Hindi)

ध्यान दें: यदि आप हिंदी बोलते हैं तो आपके लिए मुफ्त में भाषा सहायता सेवाएं उपलब्ध हैं। 1-800-400-7247 (TTY: 711) पर कॉल करें।

فارسی (Persian/Farsi)

توجه: اگر به زبان فارسی گفتگو می کنید، تسهیلات 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
(804) 371-9741
(800) 552-7945 (toll free)
1-877-310-6560 (national toll free)

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, or by calling them at **(800) 955-1819**.

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 familiarize yourself with our grievance procedure and make use of it before taking any other action.

Piedmont will issue to your Employer/Group a Group Enrollment Agreement. Piedmont will also issue to your Employer/Group, for delivery to each person insured, a Certificate of Coverage. This Certificate of Coverage along with the 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 Certificate of Coverage is not a complete description of your policy. This document summarizes certain applicable provisions from the group policy between your employer and Piedmont. By being a Certificate of Coverage holder, you are agreeing to abide by the applicable terms and conditions of the group policy and this Certificate of Coverage.

Together, the Group Policy and its amendments; this Certificate of Coverage and its attachments, amendments and/or riders (including mutually agreed-upon renewal terms); the Schedule of Benefits, Enrollment/Change Form; and the employer's/group's application constitute the entire contractual Policy between you and Piedmont.

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

D. OUT-OF-NETWORK OPTION

In order to fully understand your Benefits, it is important for you to read and understand this Certificate of Coverage. This PPO plan allows you to choose whether to receive Benefits from providers who participate in our Network (In-Network Providers) or to go outside of that Network (Out-of-Network Providers) to receive care at a reduced level of Coverage (Out-of-Plan Benefits). This Certificate of Coverage describes the Benefits for which you and your covered Participants are eligible.

E. REGULATORY AGENCIES

As a Managed Care Health Insurance Plan 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 II: How to Use Your Benefits

A. COVERED PROVIDERS

This is a PPO (Preferred Provider Organization) Plan. This plan provides the highest level of Benefits, called “In-Plan” Benefits, when you obtain Covered Services from In-Network Providers.

If you choose to receive Covered Services from Out-of-Network providers, these services will be subject to a reduced level of Benefits (which may result in no Benefits for some services). These reduced Benefits are called "Out-of-Plan" Benefits. Coverage for both "In-Plan" and "Out-of-Plan" Benefits is described on the Schedule of Benefits that is a part of this Certificate of Coverage.

Referrals are not needed for an office visit to an In-Network Specialist Provider, including mental/behavioral health Providers.

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

If you require services that are not available from In-Network Providers, these may still be covered under your In-Plan Benefits by obtaining an authorization prior to services. To obtain a Preauthorization, contact the plan providing documentation that Covered Services are required and not available through In-Network providers. Piedmont will review this documentation with you and your In-Network Provider as necessary to allow Covered Services to be provided by referral to Out-of-Network Providers as required.

If you have an ongoing special condition as determined by Piedmont that causes you to see an Out-of-Plan Specialist Physician often, you may receive a standing referral. Piedmont or your PCP will refer you to another Out-of-Network Specialist Physician for treatment of the ongoing special condition.

<u>Care for Special Condition</u>

“Special condition” means a condition or disease that is (i) life-threatening, degenerative, or disabling and (ii) 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.

Out-of-Plan cost sharing for In-Plan settings

In most cases, when using any In-Network setting or facility, Covered Services provided by an Out-of-Network ancillary Provider are covered under In-Plan Benefits. If an occasion comes up where this does not apply, Piedmont will count cost sharing paid by the enrollee for the Covered Service by the Out-of-Network ancillary provider at the In-Network setting or facility towards the In-Plan annual Out-of-Pocket maximum.

Piedmont provides a list of participating In-Network Providers and their locations free of charge. You may call Piedmont Customer Service to see if a Provider participates in your Plan's Networks. A list may be viewed on Piedmont's website at www.pchp.net.

B. CONTINUITY/TRANSITION OF CARE

The Continuity/Transition of Care Program provides a process that allows continued care for members when:

- Their Primary Care Physician (PCP) or other provider is terminated from provider networks included in the member's plan
- They are a new member of Piedmont and their treating provider is not a participating provider within provider networks included in the member's plan
- Continuity of care is at risk for reasons over which the member has no control.

You may request Continuity/Transition of Care using the Continuity/Transition of Care Request Form:

- If you are in an active treatment for an acute medical condition or a serious chronic condition. An acute medical condition is a medical condition that involves a sudden onset of symptoms due to an illness, injury or other medical problem that requires prompt medical attention and that has a limited duration. A serious chronic condition is a medical condition due to a disease, illness, or other medical problem that is serious in nature and that persists without full cure or worsens over time or one that requires ongoing treatment to maintain remission or prevent deterioration. 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 you are in an active course of treatment for any behavioral health condition;
- If you are pregnant, regardless of trimester;
- If you have a terminal illness;
- If you have 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 you have 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 enrollee.

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

1. Covered Services from your In-Network Primary Care Physician for a period of 90 days from the date of the Primary Care Physician's notice of termination to Piedmont as an In-Network Physician as long as the Physician remains in the Service Area and is open to see patients.

2. Covered Services from In-Network Providers other than your Primary Care Physician for a period of 90 days from the date of the In-Network Provider's notice of termination as an In-Network Provider, but only if you

    a. Were in an active course of treatment from the In-Network Provider prior to the notice of termination, and
    b. Request the ability to continue receiving Covered Services from this In-Network Provider for the 90-day period following the date of the In-Network Provider's notice of termination as an In-Network Provider.

3. For a Participant who has entered the second trimester of her pregnancy at the time of her In-Network Provider's notice of termination as an In-Network Provider may continue to receive Covered Services from her In-Network Provider. This continuation of maternity Coverage shall include, at the Participant's option, Covered Services for postpartum care directly related to the delivery.

4. A terminally ill Participant (as defined by Section 1861 (dd) (3) (A) of the United States Social Security Act), who had been determined to be terminally ill at the time of his/her In-Network Provider's notice of termination as an In-Network Provider, may continue, at his/her option, to receive Covered Services directly related to treatment of the terminal illness from this provider for the remainder of his/her life.

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) Piedmont terminates your In-Network Provider (including your Primary Care Physician) from the Network "for cause"; or (b) if you cease to be a Plan Participant. Piedmont will pay the provider for Covered Services you receive pursuant to this subsection in accordance with Piedmont's agreement with the provider in effect immediately before the termination of the provider as an In-Network Provider.

C. ACCESS TO PARTICIPATING PROVIDERS

You will receive the highest level of Benefits when Covered Services are received from In-Network Providers, Settings, and Facilities, except in the case of Emergencies. You will be eligible for a lower level of Benefits or no Benefits under this Certificate of Coverage if you receive services from an Out-of-Network Provider, Setting, or Facility except as described in Section B. above.

A Participant may select as his or her primary care provider any qualified In-Network Physician who is available to accept the Participant.

A Participant may select as his or her enrolled Child's primary care provider any In-Network Physician who specializes in pediatrics if the physician is available to accept the Child as a patient.

An office visit to any In-Network Physician does not require a referral to, a Preauthorization by, or notification to Piedmont. An In-Network Physician may perform the following procedures or diagnostic exams in his/her office without a Preauthorization:

1. Routine laboratory services referred to an In-Network Provider or in the Physician's office, except for genetic testing which would require a Preauthorization.
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.

You are not required to receive a referral or Preauthorization from your Primary Care Provider before receiving obstetrical or gynecological care from an In-Network Provider who specializes in obstetrics or gynecological care including obstetrical and gynecological items and services that are Covered Benefits.

These are general guidelines. Please contact Piedmont to verify Preauthorization requirements for specific services and procedures.

D. SERVICES REQUIRING PREAUTHORIZATION

Certain Covered Services will require Preauthorization by Piedmont, except in an Emergency or Urgent Care situation after hours. Your In-Network Physician will work with you and Piedmont to assist in these Preauthorization arrangements and the responsibility for obtaining the required Preauthorization 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 Preauthorization 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.

Piedmont shall not require prior authorization for the interhospital transfer of (i) a newborn infant experiencing a life-threatening emergency condition or (ii) the hospitalized mother of such newborn infant to accompany the infant.

Examples of Services which require Preauthorization include, but are not limited to, the following:

1. Services to all Providers who are not In-Network Providers in order to obtain In-Network Benefits. Failure to obtain the Authorization will result in a reduced level of benefits called Out-of-Network Benefits;
2. Transplant services;
3. Outpatient substance use disorder services/treatment;
4. Non-Emergent ambulance or air ambulance transport services.
5. Clinical trials;
6. 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. Contact Piedmont Customer Service or view Piedmont's website for further information;
7. Certain medications, including but not limited to:
    - Botulinum toxin;
    - Chemotherapy;
    - Infusion therapy, including ambulatory infusion center setting;
    - Injections, including but not limited to intravitreal injections and viscosupplementation;
8. Inpatient Hospital (except for routine vaginal/C-section deliveries at In-Network Hospitals);
9. Partial Hospitalization;
10. Acute rehabilitation;
11. Skilled nursing facility;
12. Long-term acute care Hospital;
13. Substance abuse treatment;
14. Magnetic resonance imaging (MRI) (except breast MRI);
15. Magnetic resonance angiography (MRA);
16. Magnetic resonance cholangiopancreatography (MRCP);
17. Positron emission tomography (PET) scans;
18. Bone scans;
19. Certain Outpatient surgeries, including those performed in the Outpatient Hospital or ambulatory surgery center setting and oral surgery;
20. Ablation procedures (no Preauthorization needed for cardiac ablation procedures), and radiofrequency ablation, including those performed in-office;
21. Endoscopic retrograde cholangio-pancreatography (ERCP);
22. Sclerotherapy;
23. Wireless capsule endoscopy;
24. All tertiary care services, including transplant services;
25. Applied behavioral analysis (ABA) services for autism spectrum disorder; and
26. Home infusion services.

You or your Provider must submit documentation, including a treatment plan when requested, to Piedmont for services requiring Preauthorization. Piedmont will establish that the appropriate level of criteria have been met and, if so, provide a Preauthorization to the Provider from whom you plan to receive services. Piedmont will determine through the Preauthorization assessment what level of benefits (In-Network or Out-of-Network) will be applied to the services if the Preauthorization is approved.

An approved Preauthorization is certification by Piedmont of Medical Necessity and not a guarantee of payment. For Benefits to be Covered Services, on the date You get service:

1. You must be eligible for Benefits;
2. Premium must be paid for the time period that services are given;
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. You must not have exceeded any applicable limits under Your Policy.

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

Emergency Services provided to the Participant 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 Preauthorization determination, even if the Emergency Services are provided by an Out-of-Network Provider; and
(3) If the Emergency Services are provided by an Out-of-Network Provider, 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.

If such services are provided out-of-network, Piedmont shall pay the Out-of-Network Provider in accordance with provisions under the section "Balance Billing for Certain Services Prohibited" 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.

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.

E. PREAUTHORIZATION FOR SERVICES FROM OUT-OF-NETWORK PROVIDERS

If your In-Network Physician feels that you need to see a physician or other medical professional who is not an In-Network Provider and you believe these services may be eligible for In-Plan Benefits, then your physician must submit a referral request for Preauthorization, in-

cluding medical information to Piedmont prior to your receiving services. Retroactive requests for consideration at the In-Plan Benefit level will not be considered. Covered services from Out-of-Network Providers must be Authorized by Piedmont. Piedmont has the right to determine where the service can be provided for Coverage when an In-Network Provider cannot render the service.

F. PREAUTHORIZATION FOR TRANSPLANT PROCEDURES

Transplantation of internal organs will require additional information prior to Preauthorization by Piedmont. Piedmont will request a predetermination letter from the treating physician that provides a brief clinical summary and specifies the need for the procedure. Covered transplant procedures received without Piedmont's Preauthorization or from providers not Authorized by Piedmont will be subject to out-of-plan Benefits.

G. PREAUTHORIZATION FOR COSMETIC SURGERY PROCEDURES

Some surgical procedures may be considered cosmetic and may require additional information prior to Preauthorization. Piedmont will request a predetermination letter providing a brief clinical summary and specifying the need for the procedure. Any procedure determined to be cosmetic is not eligible as a Covered Service under this Certificate of Coverage. A list of procedures normally considered cosmetic procedures includes, but is not limited to, those listed below:

1. Blepharoplasty/Ptosis.
2. Breast reduction surgery, except reconstructive breast surgery as defined in this policy.
3. Otoplasty.
4. Replacement of breast implants.
5. Rhinoplasty.
6. Rhytidectomy.
7. Scar revision, except reconstructive surgery when such service is incidental to or follows surgery resulting from trauma, infection, or other diseases of the involved part.
8. Sclerotherapy for varicose veins; this treatment is covered when services are Medically Necessary.
9. Surgical treatment of hemangiomas.

H. PREAUTHORIZATION FOR MENTAL HEALTH AND SUBSTANCE USE DISORDER SERVICES

Inpatient and Outpatient mental health and substance use disorder services are available. As required for other medical and surgical facility Benefits, a Preauthorization from Piedmont is required for any Inpatient or Outpatient mental health and substance use disorder facility services. A Preauthorization is also required for any Inpatient or Outpatient services and office visits from Out-of-Network Providers. Mental health and substance use disorder services received without Piedmont’s Preauthorization when required or from Out-of-Network Providers not Authorized by Piedmont, will be covered as Out-of-Plan Benefits.

I. CASE MANAGEMENT

The case management program is comprehensive in its approach. Case management personnel, working in the community in a cooperative manner with local physicians, will become involved with management of a Participant's care in both the Inpatient setting and the Outpatient setting. Case management will be instituted for all patients with complex diagnoses, frequent readmissions, and diagnoses identified by Piedmont as amenable to case management coordination.

J. UTILIZATION MANAGEMENT PROGRAM

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

1. Evaluation of requests for Preauthorization 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 program evaluates the appropriateness and/or Medical Necessity of healthcare Services to determine what is payable under this Certificate of Coverage. 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 an approved Preauthorization by Piedmont before you receive them. If our requirements for Preauthorization are not followed, Piedmont may not pay for these services. Typically, In-Network Providers know which services require Preauthorization and will request Preauthorization when needed. Your Primary Care Physician and other In-Network Providers have been given detailed information about our Preauthorization procedures and they are responsible for meeting these requirements requesting and obtaining the needed Preauthorization. Since the Preauthorization is the responsibility of our In-Network Providers, any reduction or denial of benefits and Covered Services due to not obtaining a Preauthorization shall not affect the Participant.

Most Out-of-Network providers will try to assist in requesting Preauthorizations, however, if you require treatment at an Out-of-Network provider, you are responsible for assuring all required Preauthorizations 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. Piedmont does 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 III: What You Pay for Benefits

All services or supplies that you receive are subject to the terms, conditions, definitions, limitations, and exclusions described elsewhere in this Certificate of Coverage and in the Group Enrollment Agreement between Piedmont and your Employer/Group. Piedmont will only pay for Medically Necessary Covered Services. Additionally, Piedmont will only pay the charges incurred by you when you are actually eligible for the Covered Services received (for example, Premium has been paid by you or on your behalf).

To the extent permitted by federal law and regulation, when calculating an enrollee's overall contribution to any Out-of-Pocket maximum or any cost-sharing requirement under this Plan, Piedmont shall include any amounts paid by the enrollee or paid on behalf of the enrollee by another person, toward the enrollee's Out-of-Pocket maximum or Copayment, Coinsurance or Deductible.

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 Calendar Year, a Participant 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 Participants of a Family Unit have incurred the dollar amount shown in the Schedule of Benefits toward their Calendar Year Deductibles, the Deductibles of all Participants of that Family Unit will be considered satisfied for that Calendar Year. No individual family member will pay more than the "per person" amount shown in the Schedule of Benefits. Any amounts of Deductible paid in excess of the Family Unit Limit in a calendar year will be promptly reimbursed to the paying Plan Participant.

B. COPAYMENT/COINSURANCE AMOUNTS

For Benefits with only Copayment responsibilities, Participants will pay a specific Copayment amount and the remainder will be covered in full up to the Allowable Charge.

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

For plans with Deductibles, the Coinsurance applies after the applicable Deductible has been satisfied if the service is subject to the Deductible. When seeing an Out-of-Network Provider, Participants are responsible for billed charges in excess of the Allowable Charge. Amounts above the Allowable Charge do not apply toward the maximum out-of-pocket.

For some 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, Benefits will be covered 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 Calendar Year, Benefits will be paid for those Covered Services a Participant receives that are in excess of the Deductible. Payment will be made based on the amounts shown in the Schedule of Benefits. No Benefits will be paid in excess of the limits listed in this Certificate of Coverage or the Schedule of Benefits that is made a part hereof.

D. OUT-OF-POCKET MAXIMUM

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

Piedmont shall maintain records showing the amount of cost shares paid by a Family Unit of Plan Participants during the Calendar Year. When a Family Unit reaches the Out-of-Pocket Maximum, Allowable Charges incurred by a Participant of that Family Unit will be payable by Piedmont at 100% (except those for charges excluded from the Out-of-Pocket Maximum) for the remainder of that Calendar Year. Piedmont shall provide written notice to a Subscriber within 30 days after the Out-of-Pocket Maximum is reached for cost shares and shall thereafter not charge any further cost shares to that Family Unit of Plan Participants for the remainder of the Calendar Year. Any excess cost shares received after such notice shall be promptly refunded.

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

- Any amounts payable by the Participant for Pediatric Dental;
- Non-Covered Services as described in this Certificate of Coverage;
- Charges in excess of any Benefit limitations; and
- Amounts above the Allowable Charge.

If your Schedule of Benefits has a separate Out-of-Pocket Maximum for Medical Benefits and Prescription Drug Benefits, any amounts payable by the Participant for Prescription Drugs will be applied to the Prescription Drug Out-of-Pocket Maximum.

Once you have met your maximum Out-of-Pocket Maximum for the Calendar Year, you will still have cost obligations for the items listed above.

NOTE: The Out-of-Pocket maximums for In-Plan and Out-of-Plan Benefits accumulate separately.

E. ALLOWABLE CHARGE

Allowable Charge means the amount determined by Piedmont as payable for a specified Covered Service or the provider's charge for that service, whichever is less. It is the maxi-

mum portion of a billed charge a health carrier will pay, including any applicable cost-sharing requirements, for a covered service or item rendered by a participating provider or by a nonparticipating provider. Piedmont will not pay more than its Allowable Charge for any Covered Service. You will only have to pay your Copayment, Deductible, and/or Coinsurance and will not be balance billed by In-Network Providers for amounts above the Allowable Charge. When seeing an Out-of-Network Provider due to a Piedmont Authorized referral, Participants 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 FOR CERTAIN SERVICES PROHIBITED

No Out-of-Network Provider providing services in the State of Virginia shall balance bill an enrollee for:

- Emergency Services provided to a Participant; or
- Nonemergency services provided to an enrollee at an In-Network Facility if the nonemergency services involve Surgical or Ancillary Services provided by an Out-of-Network provider.

A Participant that receives services described above satisfies his obligation to pay for the services if he pays the In-Network Cost-Sharing Requirement specified in the participant's or applicable group health plan contract. The Participant's obligation shall be determined using Piedmont's median In-Network contracted rate for the same or similar service in the same or similar geographical area. Piedmont shall provide an explanation of benefits to the Participant and the Out-of-Network Provider that reflects the Cost-Sharing Requirement determined under this subsection. The obligation of a Participant in a health benefit plan that uses no median In-Network contracted rate for the services provided shall be determined as provided by the Commission who may adopt rules and regulations governing an arbitration process.

Piedmont and the Out-of-Network Provider shall ensure that the Participant incurs no greater cost than the amount determined under the subsection above and shall not Balance Bill or otherwise attempt to collect from the Participant any amount greater than such amount. Additional amounts owed to health care providers through good faith negotiations or arbitration shall be the sole responsibility of Piedmont unless Piedmont is 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 shall preclude a provider from collecting a past due balance on a cost-sharing requirement with interest.

Piedmont shall 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 shall apply any cost-sharing amount paid by a Participant for such services toward the In-Network Maximum Out-of-Pocket payment obligation.

If the Participant pays the Out-of-Network Provider an amount that exceeds the amount determined above, the provider shall refund the excess amount to the Participant within 30 business days of receipt. The provider shall pay the Participant 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 shall be a commercially reasonable amount, based on payments for the same or similar services provided in a similar geographic area. Within 30 calendar days of receipt of a clean claim from an Out-of-Network provider, Piedmont shall offer to pay the provider a commercially reasonable amount. If the Out-of-Network Provider disputes the Piedmont's payment, the provider shall notify Piedmont no later than 30 calendar days after receipt of payment or payment notification from Piedmont. If the Out-of-Network Provider disputes Piedmont's initial offer, Piedmont and provider shall have 30 calendar days from the initial offer to negotiate in good faith. If Piedmont and 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 shall be resolved through an arbitration process regulated by the Commission.

Piedmont shall make payments for services described in the two bullet points above directly to the provider.

Piedmont shall make available through electronic and other methods of communication generally used by a provider to verify enrollee eligibility and benefits information regarding whether a Participant's health plan is subject to the requirements of this section.

Section IV: Covered Benefits

Piedmont covers only those services that are Medically Necessary. Just because the service is prescribed by a provider does not mean the service is Medically Necessary. Piedmont shall make all determinations that are required for the administration of the Certificate of Coverage including determinations regarding Medical Necessity and Covered Services. Medical Necessity is to be determined in accordance with generally accepted standards of medical care as determined by Piedmont. Participants have a right to appeal any adverse claims determination made by Piedmont. The appeals process is described in Section VII of this Certificate of Coverage.

Covered Services are covered at the In-Plan level only when provided by an In-Network Provider or when appropriate Preauthorization has been obtained as described in Section II of this Certificate of Coverage. Out-of-plan Benefits are described in Section VI of this Certificate of Coverage.

A. ALLERGY TREATMENT

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

B. AMBULANCE SERVICES

Medically Necessary ambulance services are Covered Services if these services are authorized in advance by Piedmont. Coverage only includes one-way transportation for services to or from the nearest Hospital or skilled care facility where necessary treatment can be provided. In an Emergency, Preauthorization in advance of receiving services is not required and services are available 24 hours a day, 7 days a week. Air ambulance services are also Covered Services when preauthorized by Piedmont or without Preauthorization in cases of Medical Necessity requiring resuscitation or Emergency relief or where human life is endangered. In cases of Medical Necessity, only those air ambulance services required to take such Participant to the geographically closest Hospital capable of treating that Participant's Medically Necessary condition will be covered. Reimbursement shall be made directly to the provider, when Piedmont is presented with an assignment of Benefits by the person providing such services.

C. CHEMOTHERAPY

Chemotherapy, the treatment of disease by chemical or biological antineoplastic agents, is covered. 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 shall not be greater than cost-sharing for intravenously or by injection administered drugs.

D. CLINICAL TRIALS FOR LIFE-THREATENING DISEASES/CONDITIONS

This Certificate of Coverage includes Coverage of routine patient costs of qualified individuals associated with approved clinical trials for life-threatening diseases or conditions. Piedmont 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. Piedmont will not discriminate against the individual on the basis of the individual's participation in the approved clinical trial. Routine patient costs do not include the cost of the investigational item, device or service; the cost of items and services provided solely to satisfy data collection and analysis needs and that are not used in direct clinical management; the cost for a service that is clearly inconsistent with widely accepted and established standards of care for a particular diagnosis.

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 (i) a federally funded or approved trial, (ii) conducted under an investigational new drug application reviewed by the U.S. Food and Drug Administration, or (iii) 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 life-threatening diseases or conditions is available only if:

a. There is no clearly superior non-Investigative treatment alternative;
b. The available clinical or pre-clinical data provides a reasonable expectation that the life threatening disease treatment will be at least as effective as the non-Investigative alternative; and
c. You and your Physician who furnishes Covered Services to you conclude that your participation in the clinical trial would be appropriate under the terms and conditions contained in your Piedmont Coverage.
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 United States National Institutes of Health-approved peer review program operating within the group - includes the NCI Clinical Cooperative Group and the NCI Community Clinical Oncology Program) or an NCI center);

i. The United States Food and Drug Administration 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 United States Department of Health and Human Services that defines the relationship of the institution to the Department of Health and Human Services 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).

Piedmont's payment for Covered Services that you receive during participation in clinical trials for treatment studies on life threatening diseases will be determined in the same manner as Piedmont determines 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 to you for the purposes of a clinical trial. Covered Services do not include (i) the costs of non-health care services that you may be required to receive as a result of the treatment being provided for the purposes of a clinical trial, (ii) the costs associated with managing the research associated with the clinical trial, or (iii) the costs of the investigational drug or device.

E. DIABETES CARE MANAGEMENT

Piedmont covers 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 and syringes 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.

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.

In order to receive In-Plan Benefits, equipment and supplies for diabetes must be obtained from the designated In-Network Providers for this health service. Equipment that has been lost or damaged due to your neglect or abuse will not be repaired or replaced.

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

F. 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, QTC 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 by you. 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. Diagnostic sleep testing and treatment are covered.

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
- QTC Bone Densitometry
- Diagnostic CT Colonography
- Single Photon Emission Computed Tomography (SPECT) Scans

G. DIALYSIS

Piedmont covers dialysis treatment, which is the treatment of severe kidney failure or chronic poor functioning of the kidneys. This includes hemodialysis and peritoneal dialysis. Home dialysis equipment and supplies are covered Benefits. In addition, dialysis treatments are covered in an Outpatient facility or doctor's office.

H. DOCTOR VISITS AND SERVICES

Piedmont covers visits to a doctor's office (including second surgical opinions), including office visits to a Primary Care Physician, a Specialist Physician, nurse practitioner, physician assistant and any other Provider(s) as defined in this Certificate of Coverage, or your doctor's visits to your home, visits to an Urgent Care center, Hospital Outpatient department or Emergency room, visits to Retail Health Clinics (walk-ins), 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 precertification, or Doctor to Doctor discussions. Physician (Doctor) includes Primary Care Physician (PCP), Specialist Physician, nurse practitioner, physician assistant and any other Provider(s) as defined in this COC.

I. DURABLE MEDICAL EQUIPMENT AND SUPPLIES

Rental of Medically Necessary Durable Medical Equipment (or purchase if such purchase would be less than rental cost as determined by Piedmont) is a Covered Service. In order to receive In-Plan Benefits, Durable Medical Equipment must be obtained from designated In-Network Providers. Covered Durable Medical Equipment, including the cost of fitting, adjustment, and repair, is listed below:

a. Hospital beds;
b. Bedside commode, shower chair, and tub rails;
c. Canes, crutches, walkers, slings, splints, cervical collars, and traction apparatus;
d. Wheelchairs and Medically Necessary wheelchair accessories and supplies;
e. Oxygen and oxygen equipment, including C-pap) and Bi-pap;
f. Ostomy supplies, including bags, flanges, and belts;*
g. Indwelling catheters, straight catheters, and catheter bags;*
h. Respirators;
i. Jobst stockings or equivalent when prescribed by a vascular surgeon prior to or following vascular surgery;

j. The first pair of contact lenses or eyeglasses following approved cataract surgery without implant or for the treatment of accidental injury;
k. Prosthetic devices and components, 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;
l. Two bras or camisoles per year (two total) following mastectomy;
m. Nebulizers;
n. One wig following chemotherapy
o. Negative pressure wound therapy or "wound vac";
p. Orthotics, other than foot orthotics;
q. Phototherapy lights; and
r. 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.

Piedmont covers maintenance and necessary repairs of Durable Medical Equipment except when damage is due to neglect. Piedmont 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 unit and TMJ appliances.

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

Piedmont will consider providing Coverage for the replacement (rather than repair) of Durable Medical Equipment under the following conditions:

1. Non repairable as deemed by the manufacturer.
2. When cost of repairs exceed replacement costs.
3. When device is no longer functional as deemed by manufacturer or Durable Medical Equipment provider.
4. Not for reason of warranty expiration.

J. 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 environment, and shall 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.

K. EMERGENCY AND URGENT CARE SERVICES

When you require resuscitation, Emergency treatment, or your life is endangered, Piedmont does not require a Preauthorization before you call: (1) an Emergency 911 system; or (2) other state, county or municipal Emergency medical system. Piedmont covers 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 stabilize a patient with an emergency medical condition.

Emergency services, including professional and facility services, provided to the Participant 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 Preauthorization by Piedmont, even if the Emergency services are provided by an Out-of-Network Provider; and
(3) If the Emergency services are provided by an Out-of-Network Provider, 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 for Certain Services Prohibited" 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.

Cost-Sharing for Emergency Services

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. Services received in an emergency room setting that are not for a true emergency will be applied to the Out-of-Plan level of cost sharing equal to other services received Out-of-Plan, except for the initial screening and stabilization. The initial screening and stabilization services will be applied to the In-Plan level of cost sharing for emergency services.

Piedmont will pay the greater of the following amounts for Emergency services received from an Out-of-Network Provider:

(1) The amount set forth in your certificate or Schedule of Benefits.
(2) (a) The amount negotiated with In-Network Providers for the Emergency service provided, less any Copayment or Coinsurance amounts imposed in your Certificate of Coverage or Schedule of Benefits. (b) If there is more than one amount negotiated with In-Network Providers for the Emergency service, the amount paid will be the median of these negotiated amounts, less any Copayment or Coinsurance amounts imposed in your Certificate of Coverage or Schedule of Benefits.

(3) The Usual and Customary amount for the Emergency service calculated using the same method that Piedmont generally uses to determine payments for services provided by an Out-of-Network Provider (the Allowable Charge), less any Co-payment or Coinsurance amounts imposed in your Certificate of Coverage or Schedule of Benefits.
(4) The amount that would be paid under Medicare (Part A or Part B of Title XVIII of the Social Security Act, 42 U.S.C. 1395 et seq.) for the Emergency service, less any Copayment or Coinsurance amounts imposed in your Certificate of Coverage or Schedule of Benefits.

The other cost-sharing provisions in your Certificate of Coverage and Schedule of Benefits for Covered Benefits received from Out-of-Network Providers continue to apply to Emergency services received from Out-of-Network Providers. Examples of these other cost-sharing provisions include Deductibles and Out-of-Pocket Limits. Any Deductible or Out-of-Pocket Maximum that applies generally to services received from Out-of-Network Providers also applies to Emergency services received from Out-of-Network Providers. Out-of-Network Providers (including facilities) may balance bill for amounts in excess of the maximum allowed amount. This means you may be responsible for the difference between the covered amount and the amount charged by the provider, in addition to any copay, coinsurance or deductible.

1. **Emergency and Urgent Care Services Within the Service Area**

a. Medical Care is available through In-Network Physicians 7 days a week, 24 hours a day. If you need medical care, you should call your In-Network Physician immediately for instructions on how to receive care.
b. If the Emergency requires immediate action, you should be taken to the nearest appropriate Hospital or skilled medical facility.
c. Piedmont covers services rendered by providers other than In-Network Providers when the condition treated is an Emergency as defined in this Certificate of Coverage.
d. Emergency services provided within Piedmont's Service Area will include Covered Services from Out-of-Network Providers.

2. **Emergency and Urgent Care Services Outside the Service Area**

a. Piedmont covers Urgent Care and Emergency services outside the Service Area 24 hours a day, 7 days a week, if you sustain an injury or become ill while temporarily away from the Service Area. Accordingly, Benefits for these services are limited to care which is 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 you are temporarily outside the Service Area, you should obtain care at the nearest Hospital or

skilled medical facility. You or your representative is responsible for notifying Piedmont within 24 hours, on the next working day, or as soon as you are physically/mentally capable of doing so.

c. Benefits for continuing or follow-up treatment must be pre-arranged by Piedmont and provided in the Service Area by In-Network Providers in order to be Covered as In-Network Benefits. This is subject to all provisions of this Certificate of Coverage.

3. **Notification**

In the event of an Emergency requiring Hospitalization, or for which Outpatient Emergency services are necessary, you or your representative must notify Piedmont within 24 hours after care is commenced, on the next working day, or as soon as you are physically/mentally capable of doing so. This applies to services received inside or outside the Service Area.

L. HEARING SERVICES

Piedmont covers infant hearing examinations for covered newborn children when performed by a Provider in the manner provided for herein, including screenings for congenital cytomegalovirus for newborns who fail the newborn hearing screens. Piedmont's Coverage is for infant hearing screenings and all necessary audiological examinations provided pursuant to applicable law or regulation of the Commonwealth of Virginia using any technology approved by the United States Food and Drug Administration, and 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 terms and conditions hereof, 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 are not covered.

M. HEMOPHILIA

Treatment of **hemophilia** and **other congenital bleeding disorders** are Covered Services. The Benefits include Coverage for expenses incurred in connection with the treatment of routine bleeding episodes, including Coverage for the purchase of blood products and blood infusion equipment required for home treatment 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 Plan Participants or family members are trained to provide infusion therapy at home in order 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.

N. HOME HEALTH CARE

1. **Home Health Services.** Home health services covers treatment provided in your 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, including visits from a therapist; medical/social services; diagnostic services; nutritional guidance; Durable Medical Equipment; training of the patient and/or family/caregiver; habilitative and short-term rehabilitative therapy services (subject to the limitations set forth herein, and except for manipulation therapy which is not covered 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 your condition generally confines you to your home except for brief absences. Homemaker services, food and home-delivered meals, custodial care (including Outpatient custodial care), respite care, and/or other non-medical services are not Covered Services. **Maximum of 100 visits per Calendar Year**. Physical, speech, and occupational therapy services provided as part of home care are not subject to separate visits limits for therapy services.

2. **House Calls.** House calls determined to be Medically Necessary by your Physician and Piedmont are Covered Services.

3. **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.

O. HOSPICE SERVICES

Hospice services are Covered Services if and when:

- A Provider that Piedmont recognizes as a qualified Provider to furnish these services provides these services. Hospice Services means a coordinated program of home and Inpatient care provided directly or under the direction of a licensed hospice under Article 7 of Chapter 5 of Title 32.1 of the Code of Virginia. 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 Participant has a terminal illness (i. e. For the purposes of this subsection, “terminal illness” means a condition that has been diagnosed as terminal by a licensed physician and whose life expectancy is six months or less);

- The Participant elects to receive Palliative Care rather than curative care (i. e. the Participant elects treatment directed at controlling pain, relieving other symptoms, and focusing on the special needs of the Participant as he/she experiences the stress of the dying process rather than treatment aimed at investigation and intervention for the purpose of cure or prolongation of life); and
- Piedmont authorizes 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 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.

P. HOSPITAL SERVICES

Covered Services include the Hospital and doctors' services when you are treated on an Outpatient basis, or when you are Inpatient because of illness, injury, or pregnancy. This includes Inpatient rehabilitative/habilitative services and devices when Medically Necessary. Covered Services also include anesthesia services in an Inpatient setting as well as services rendered by an anesthesiologist. Piedmont also covers Medically Necessary Outpatient services at an ambulatory surgery center or an Outpatient Hospital facility, including the facility fee, anesthesia, and blood and blood products and its administration.

Piedmont covers surgery charges when treatment is received at an Inpatient, Outpatient or ambulatory surgery facility, or doctor's office. Medically necessary care in a semi-private room or intensive or special care unit is covered. This includes your bed, meals, special diets, and general nursing services, drugs, injectable drugs, blood, oxygen and nuclear medicine. A private room charge will be covered if you need a private room because you have a highly contagious condition or are at greater risk of contracting an infectious disease because of your medical condition. Otherwise, your Inpatient Benefits would cover the Hospital's

charges for a semi-private room. If you choose to occupy a private room, you will be responsible for paying the daily difference between the semi-private and private room rates in addition to your copayment and coinsurance (if any).

1. Inpatient services and supplies furnished by a Hospital are Covered Services and require Preauthorization. Piedmont reserves the right to determine whether the continuation of any Hospital admission is Medically Necessary. Special rules apply in Emergencies and for transplant services. Piedmont shall not require preauthorization for the interhospital transfer of (i) a newborn infant experiencing a life-threatening emergency condition or (ii) the hospitalized mother of such newborn infant to accompany the infant.

2. The room and board and nursing care furnished by a skilled nursing facility are Covered Services if and when:

    a. The Participant is confined as a bed patient in the facility;
    b. The attending Physician completes a treatment plan that describes the type of care that is needed; and
    c. Piedmont authorizes the services provided.

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

3. For certain conditions, the law mandates a minimum Inpatient length of stay. Piedmont will provide the following Benefits to you for Inpatient services received:

    a. Benefits are provided for a minimum Inpatient stay of 48 hours for a Participant receiving a covered radical or modified radical mastectomy. Benefits are also covered for a minimum Inpatient stay of 24 hours for a Participant receiving a covered total mastectomy or a partial mastectomy with lymph node dissection for the treatment of breast cancer unless the Participant's Physician, consulting with the Participant, determines a shorter Inpatient stay is appropriate.
    b. Benefits are provided for a minimum Inpatient stay of 48 hours for a Participant receiving a covered vaginal hysterectomy. Benefits are also covered for a minimum Inpatient stay of 23 hours for a Participant receiving a covered laparoscopy-assisted vaginal hysterectomy unless the Participant's Physician, consulting with the Participant, determines that a shorter Inpatient stay is appropriate.
    c. Benefits are provided for a minimum Inpatient stay of 48 hours (vaginal delivery) or 96 hours (caesarean section delivery) for a Participant receiving these Covered Services unless the Participant's Physician, consulting with the Participant, determines that a shorter Inpatient stay is appropriate.

Q. INDIVIDUAL CASE MANAGEMENT

In addition to the Covered Services specified in this Certificate of Coverage, Piedmont may elect to offer Benefits for services pursuant to a Piedmont-approved alternative treatment

plan for a Participant whose condition would otherwise require continued long-term Inpatient care. Piedmont shall provide these alternative Benefits at its discretion and only when and for so long as it determines (in consultation with the Participant's In-Network Physician) that the alternative services are Medically Necessary and cost-effective, and that the total Benefits paid for such services do not exceed the maximum Benefits to which the Participant would otherwise be entitled under this Certificate of Coverage in the absence of alternative Benefits. If Piedmont elects to provide alternative Benefits for a Participant in one instance, that election will not obligate Piedmont to provide the same or similar Benefits for any Participant in any other instance, nor shall it be construed as a waiver of Piedmont's right to administer this Certificate of Coverage in strict accordance with its express terms.

R. INFUSION SERVICES

Covered Services include infusion of therapeutic agents, medication and nutrients; infusion of enteral nutrition into the gastrointestinal tract; and infusion of prescription medications. Benefits for infusion services are provided in an Inpatient, Outpatient, and home setting. These services include Coverage of all medications administered intravenously and/or parenterally.

S. 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.

T. MATERNITY CARE

1. **Pregnancy and Childbirth.** Pregnancy testing, maternity care, maternity-related checkups, and pre-natal and post-natal care for a Participant (including covered Dependents) are Covered Services. Coverage is included for victims of rape or incest. Services related to surrogacy if the Participant is not the surrogate are not Covered Services. Elective abortions are not Covered Services; this limitation shall not apply to an abortion performed (i) 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 (ii) 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 free-standing birthing centers;
   - 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, 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, and urinary tract or other infection. In addition, folic acid supplements and expanded tobacco intervention and counseling for pregnant users are covered.
- 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, which are 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;
- Injectables; x-ray; and laboratory services;
- Piedmont shall not require preauthorization for the interhospital transfer of (i) a newborn infant experiencing a life-threatening emergency condition or (ii) 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 with regard to 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 less than 48 hours following a vaginal delivery, or 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 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 the "Standards

for Obstetrical-Gynecological Services" prepared by the American College of Obstetricians and Gynecologists. This Coverage shall 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.

Coverage for obstetrical services as an Inpatient in a general Hospital or obstetrical services by a Physician shall provide such benefits with durational limits, Deductibles, Coinsurance factors, and Copayments that are no less favorable than for physical illness generally.

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. Formulary drugs for impotence or to enhance arousal, libido or sexual response are Covered Services.

3. **Infertility Services.** Piedmont covers 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.

U. MEDICAL AND SURGICAL SUPPLIES AND MEDICATIONS

Medical and Surgical supplies, including Medically Necessary supplies, are Covered Services if they are prescribed by a covered provider in an inpatient, outpatient hospital facility, or outpatient surgical facility setting. Examples include:

- Hypodermic needles and syringes;
- Oxygen and equipment (respirators) for its administration;
- Prescription medications provided by your 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 to you by a pharmacy. Please see the Section on PRESCRIPTION DRUG SERVICES for more information.

V. MENTAL/BEHAVIORAL HEALTH AND SUBSTANCE USE DISORDER SERVICES

Piedmont will provide mental/behavioral health and substance use disorder services equal to the Coverage for medical and surgical Benefits. As required for other medical and surgical facility Benefits, Piedmont requires a Preauthorization for any Inpatient or Outpatient mental/behavioral health and substance use disorder facility services. We also require a Preauthorization for any Inpatient or Outpatient services, and office visits from Out-of-Network Providers. Coverage includes inpatient services for substance use disorder and eating disorders 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. 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 psychotherapy, group psychotherapy, psychological testing, counseling with family members to assist with the patient's diagnosis and treatment, behavioral health treatment, and convulsive therapy treatment, including professional services, in an Inpatient facility setting.

Mental/behavioral health or substance use disorder Outpatient care Coverage includes: diagnosis and treatment of psychiatric conditions, including individual psychotherapy, group psychotherapy, and psychological testing, including professional services and physician charges, in an Outpatient facility or office visit setting.

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 shall 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.

Visits to your physician to make sure that medication you are taking for a mental/behavioral health or substance use disorder problem is working and the dosage is right for you are Covered Services in an Outpatient facility or office setting.

Piedmont covers diagnosis and treatment of **Autism Spectrum Disorder** in Plan Participants of any age, to include 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. Also, 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, including

- Autistic Disorder,
- Asperger's Syndrome,
- Rett Syndrome,
- Childhood Disintegrative Disorder, or
- Pervasive Developmental Disorder – Not Otherwise Specified, as defined in the most recent edition 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. Autism spectrum disorder treatment shall be identified in a treatment plan. This includes the following care prescribed or ordered for a Plan Participant diagnosed with autism spectrum disorder by a licensed physician or a licensed psychologist who determines the care to be Medically Necessary: (i) behavioral health treatment, (ii) pharmacy care, (iii) psychiatric care, (iv) psychological care, (v) therapeutic care, and (vi) applied behavior analysis when provided or supervised by a board certified behavior analyst who is licensed by the Board of Medicine. The prescribing practitioner shall be independent of the Provider of applied behavior analysis.

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

W. NEW TECHNOLOGY

Piedmont regularly evaluates new and existing technologies for inclusion as a Covered Service. Confirmation that the appropriate regulatory body has assessed any new or existing technology to be covered in cases where that assessment is required by law must occur prior to approval. New and existing technologies to be considered Covered Services must, based on clinical evidence reported by Peer Reviewed Medical Literature, demonstrate a marked improvement in health outcomes, health risks, and health Benefits when compared with established procedures and products.

X. ORAL SURGERY; DENTAL SERVICES

No dental services are Covered Services under this Certificate of Coverage. 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 Piedmont determines 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:

1. Medically necessary dental services resulting from an accidental dental injury, regardless of the date of such injury, are Covered Services. Treatment must begin within 12 months of the injury, or as soon after that as possible to be a Covered

Service. Preauthorization from Piedmont 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.

4. Dental services and dental appliances furnished to a newborn or any covered Participant 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 tumors and biopsies, as well as incision and drainage of infection of soft tissue not including odontogenic cysts or abscesses.

6. Orthognathic surgery 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 are not covered. 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 Covered Services.

8. Maxillary or mandibular frenectomy when not related to a dental procedure is a Covered Service.

9. Alveolectomy when related to a Covered tooth extraction is a Covered Service.

10. Surgical services on the hard or soft tissue in the mouth when the main purpose is not to treat or help the teeth and their supporting structures are Covered Services.

11. Piedmont covers Medically Necessary **general anesthesia, Hospitalization, or Outpatient facility charges** by a facility licensed to provide Outpatient surgical procedures for dental care provided to a Participant who is:

    a. determined by a licensed dentist, in consultation with the Participant's 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 five, or severely disabled, or has a medical condition and requires admission to a Hospital or Outpatient surgery facility and general anesthesia for dental care.

Preauthorization is required to the same extent it is 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 in this Certificate of Coverage, the underlying dental care provided incident to this anesthesia, Hospitalization, or Outpatient surgery, is not covered. For the purposes of determining whether general anesthesia, the Hospital admission, or the Outpatient surgery is Medically Necessary under this section, Piedmont will consider whether the Participant'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.

Y. 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 your prescription drug Benefit. This includes 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, Piedmont will cover up to a 31-day or 100 unit supply, whichever is less, for the applicable Copayment, Deductible and/or Coinsurance amount. Additional Copayments, Deductible and/or Coinsurance amount and Preauthorization are required for quantities that exceed the unit supply limits. Piedmont's program requires "mandatory" generic substitution if the FDA has determined the generic to be equivalent to the brand product. Generic drugs will be dispensed except when a Physician requires brand name drugs. In this case, You will still have to pay the difference between the brand name drug and the generic drug, in addition to your appropriate Copayment, Deductible and/or Coinsurance amount. If the Physician does not require a brand name drug, you may request a brand name drug and pay the difference between the brand name drug and the generic drug, in addition to your appropriate Copayment, Deductible and/or Coinsurance amount.

Medication Synchronization - Piedmont shall permit and apply a prorated daily cost-sharing rate to prescriptions that are dispensed by a network pharmacy for a partial supply if the prescribing provider or the pharmacist determines the fill or refill to be in the best interest of the enrollee and the enrollee requests or agrees to a partial supply for the purpose of synchronizing the enrollee's medications. Piedmont shall allow a pharmacy to override any denial codes indicating that a prescription is being refilled too soon for the purposes of synchronizing the enrollee's medications. Dispensing fees for partially filled or refilled prescriptions

shall be paid in full for each prescription dispensed, regardless of any prorated copay or fee paid for synchronization services.

Your prescription drug Benefits cover prescriptions obtained from a pharmacist and includes injections administered at authorized pharmacies. Simply choose a pharmacy that participates in the pharmacy Network and show your ID card to receive Benefits. You also have 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 - Your prescription drug Coverage is limited to only those drugs listed on our formulary. Most prescription drugs are listed on this formulary; however, certain prescription drugs with clinically equivalent alternatives may be excluded. Piedmont's 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. 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 Piedmont's Customer Service Department at 800-400-7247 (or local at 434-947-4463) and at www.pchp.net.
We will provide to each affected Plan Participant 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. Piedmont and our PBM have established guidelines in place that make sure certain drugs are prescribed correctly.

Piedmont 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 Piedmont or its PBM through the use of a step therapy protocol, the Plan Participant and prescribing provider shall have access to a clear, readily accessible, and convenient process to request a step therapy exception. Piedmont will use its 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 shall 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 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, Piedmont and its PBM shall authorize coverage for the prescription drug prescribed by the Participant’s treating provider, provided that the prescription drug is covered under Piedmont’s formulary. Piedmont or its PBM shall respond to a step therapy exception request within 72 hours of receipt, including hours on weekends, that the request is approved, denied, or requires supplementation. In cases where exigent circumstances exist, we shall respond within 24 hours of receipt, including hours on weekends, that the request is approved, denied, or requires supplementation. A Plan Participant may appeal any step therapy exception request denial through Piedmont’s existing appeal procedures located later in this Certificate.

Exception Request for Prescription Drugs Not Included on the Formulary

Piedmont has a process in place for a Plan Participant, a designated representative, the prescribing Physician or other prescriber to request and gain access to clinically appropriate drugs not otherwise covered on Piedmont’s formulary. A Formulary Exception request may be submitted to allow a Plan Participant to obtain coverage for a drug by phone or fax.

An Exceptions 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. Exceptions 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 You have 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 Plan's appeal process described later in the Certificate of Coverage.

Piedmont 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 your 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.

A Plan Participant, 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 you are suffering from a health condition that may seriously jeopardize your life, health, or ability to regain maximum function, or if you are 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 your request. If we approve your request, coverage of the drug will be provided for the duration of the exigency. If we deny your 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 the Plan denies 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 Member, 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, the Plan 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 Member's covered benefits. For expedited exception requests Coverage of the non-formulary drug will be provided for the duration of the exigency and without additional cost-sharing beyond that provided for formulary prescription drugs in the Member's covered benefits.

There are two additional exceptions to the formulary requirement that will also be acted upon within one (1) business day of receipt of the request:

- You may obtain Coverage without additional cost sharing beyond that which is required of formulary prescription drugs for a non-formulary drug if we determine, after consultation with the prescribing physician, that the formulary drugs are inappropriate therapy for your condition.
- You may obtain Coverage without additional cost sharing beyond that which is required of formulary prescription drugs for a non-formulary drug if:

- You have been taking or using the non-formulary prescription drug for at least six months prior to its exclusion from the formulary; and
- The prescribing physician determines that either the formulary drugs are inappropriate therapy for your condition, or that changing drug therapy presents a significant health risk.

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

"Preferred Drugs" are brand name drugs (including specialty drugs and therapeutic biological products) listed on the formulary as 2nd tier 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" are brand name drugs (including specialty drugs and therapeutic biological products) listed on the formulary as 3rd tier 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" 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 as 4th tier drugs. 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.

Piedmont classifies medically necessary formula and enteral nutrition products as medicine and includes 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. "Medically necessary formula and enteral nutrition products" means any liquid or solid formulation of formula and enteral nutrition products for covered individuals requiring treatment for an inherited metabolic disorder and for which the covered individual'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 individual 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 individual'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.

This coverage shall:

1. Apply to the partial or exclusive feeding of a covered individual by means of oral intake or enteral feeding by tube;
2. Include coverage for any medical equipment, supplies, and services that are required to administer the covered formula or enteral nutrition products;
3. Apply only when the formula and enteral nutrition products are (i) 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 (ii) used under medical supervision, which may include a home setting; and
4. Not apply to nutritional supplements taken electively.

Piedmont covers medical food supplements prescribed by a Doctor and Medically Necessary for nutrition infusion in the home and special medical formulas which are a source of nutrition for covered Participants with inborn errors of amino acid or organic acid metabolism, metabolic abnormality or severe protein or soy allergies.

Piedmont also covers prescription drugs and devices approved by the Food and Drug Administration (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.

Coverage will be provided for otherwise covered **prescribed pain relieving agents** approved by the United States Food and Drug Administration 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 is in excess of the recommended dosage of the pain-relieving agent. The pain-relieving agent must be prescribed in accordance with federal and state law.

If you receive prescription drugs from your doctor, they will be covered as other medical services or supplies. If you receive prescription drugs from the Hospital, they will be covered as a Hospital service.

Piedmont does not provide Coverage for any of the following:

a. Any legend drug prescribed prior to your joining Piedmont, as determined by Piedmont. However, you may get a new prescription after enrolling with Piedmont and receive Coverage for conditions not excluded under this Certificate of Coverage;
b. Over the counter drugs, unless recommended by the U.S. Preventive Services Task Force and prescribed by a physician;
c. Any prescription drug whose primary purpose is nutritional, dietary or weight loss, including anorexiants; however, we do cover drugs for weight loss based on BMI;
d. Drugs prescribed primarily for a cosmetic purpose, including Retin-A when used for any purpose other than treatment for severe acne and minoxidil when used to treat baldness;

e. Drugs and medications for conditions excluded under this Certificate of Coverage;
f. Injectable prescription drugs that are supplied by a Provider other than a pharmacy that is not an In-Network Provider;
g. Drugs and medications that are experimental, investigational or not approved by the U.S. Food and Drug Administration (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);
h. DESI drugs (i.e. drugs which are of questionable therapeutic value as designated by the FDA's Federal Drug Efficacy Study);
i. Any refill dispensed after one year from the date of the original prescription order;
j. Medicine covered by workers' compensation, Occupational Disease Law, state or government agencies;
k. Certain drugs that have limited clinical value and which have clinically-appropriate, lower-cost alternatives (e.g., brand name drugs that are combinations of existing generic or over-the-counter drugs, new formulations of existing drugs);
l. Any other drug not on Piedmont's formulary deemed not Medically Necessary by Piedmont;
m. Infertility drugs.

Benefits are provided for prescriptions filled at a pharmacy that is not an In-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. Otherwise, prescriptions filled at a pharmacy that is not an In-Network Provider will be reimbursed to you up to the amount that would have been paid to an In-Network Provider pharmacy (less your Copayment, Deductible and/or Coinsurance).

Maintenance Medications

Maintenance medications are those you take routinely to treat or control a chronic illness such as heart disease, high blood pressure, or diabetes. In addition to the pharmacy, you may also purchase maintenance medications through your mail order Benefit. This allows you to receive a 90-day or 300-unit supply, whichever is less, of a maintenance medication prescription through the mail for the applicable Copayment, Deductible and/or Coinsurance amount. Additional Copayments, Deductibles and/or Coinsurance amounts and Preauthorization are required for quantities that exceed the unit supply limits. You must have used 75% of your prescription before ordering refills.

To receive your maintenance medication by mail:

- Ask your doctor to prescribe a 90-day supply of your maintenance medication plus refills. If you need the medicine immediately, ask your doctor 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 your written prescription, which is required for your first order of each different prescription medication.
- Mail your form, written prescription, and payment to cover the amount of your Co-payment, Deductible and/or Coinsurance amount.
- You can order refills by mail, telephone, or online. Contact information is listed on the mail order form.

NOTE: Piedmont also has special arrangements with certain participating pharmacies that allow you to fill your 90-day or 300-unit maintenance medication prescription on location. This means you do not have to mail your written prescription. Simply visit one of the participating 90-day pharmacy locations to fill your prescription. These are listed in your Network directory and on our website at www.pchp.net.

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

Piedmont does not prescribe drugs or seek to improperly influence physicians and other providers who do. From time-to-time, Piedmont may receive payments from prescription drug manufacturers based on the volume of a particular drug or series of drugs that physicians and other providers have prescribed for use by Piedmont's Participants collectively. Piedmont uses these payments to reduce its administrative expenses. Piedmont does not credit the payments against an individual's, group's or provider's past, present, or future claims costs. Piedmont will take these payments into account when Piedmont determines future cost trend factors for Premiums or rates.

Z. PREVENTIVE CARE SERVICES

Piedmont covers 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 you receive them from an In-Network Physician in Piedmont's Network or other In-Network Provider. Out of Network services will be subject to Out-of-Plan cost-sharing provisions as set forth herein.

"Preventive services" means:

(i) 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;

(ii) 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;

(iii) 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
(iv) 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.

The following preventive health services are provided when performed by a Physician: well-baby care from birth, health assessments, including annual physical exams, for adults and children, smoking and tobacco cessation counseling, and immunizations in accordance with the chart below.

When performed by a Physician for Plan Participants up to age 19, the following are provided: (1) an annual vision screening (assessment of visual activity through use of the 55 Snellen chart and the detection of color blindness); and (2) an annual hearing screening (assessment of monaural threshold and the ability to locate the source of pure tones through use of a pure tone, air-only audiometer).

An annual gynecological examination, which consists of a breast exam, pelvic exam, and Pap smear, is covered for Participants when it is performed by a Physician.

Piedmont shall provide coverage for any items or services under the most current recommendations and guidelines within the scope of preventive services as required by the PPACA as in effect on January 1, 2019. These services are not subject to cost-sharing provisions (such as a Deductible, Copayment amount or Coinsurance percentage) when you receive them as In-Network or In-Plan from an In-Network Physician or other In-Network Provider (Out-of-Network services will be subject to Out-of-Plan cost-sharing provisions):

(1) Evidenced-based items or services that have in effect a rating of "A" or "B" in the current recommendations of the United States Preventive Services Task Force, except that the current recommendations of the United States Preventive Service Task Force regarding breast cancer screening, mammography, and prevention of breast cancer shall be considered the most current other than those issued in or around November 2009 are not considered to be current;
(2) Immunizations that have in effect a recommendation from the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention with respect to the individual involved;
(3) With respect to infants, children, and adolescents, evidence-informed preventive care and screenings provided for in the comprehensive guidelines supported by the Health Resources and Services Administration; and

(4) With respect to women, such additional evidence-informed preventive care and screenings, not described in paragraph (1) above, as provided for in comprehensive guidelines supported by the Health Resources and Services Administration.
(5) All routine and necessary immunizations for newborn children from birth to age 36 months:
    (a) Diphtheria;
    (b) Pertussis;
    (c) Tetanus;
    (d) Polio;
    (e) Hepatitis B;
    (f) Measles;
    (g) Mumps;
    (h) Rubella; and
    (i) Other immunizations prescribed by the Commissioner of Health.
(6) One PSA test in a 12-month period and digital rectal examination for 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.
(7) One screening mammogram for Participants between the ages of 35 to 39; a screening mammogram each year for Participants age 40 and over.
(8) Colorectal cancer screening. 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 occult blood test;
    b. flexible sigmoidoscopy or colonoscopy;
    c. radiologic imaging in appropriate circumstances.
(9) Preventive nutritional counseling and smoking/tobacco cessation counseling.
(10) 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 that 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;
(11) 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;
(12) 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;
(13) 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;

(14) 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;

(15) Contraception Methods and Counseling (Females only) - All Food and Drug Administration approved contraceptive methods, sterilization procedures, and patient education and counseling for all women with reproductive capacity are covered at 100% as a preventive care service. The frequency is as prescribed. Piedmont 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 copay. 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. Piedmont's 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;

(16) 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. Frequency is in conjunction with each birth. Piedmont's standard medical management and Network restrictions apply; and

(17) 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.

The Secretary of the U. S. Department of Health and Human Services (the "Secretary") will update this list on a periodic basis, and Piedmont will update its Coverage within the timeframe provided for in this paragraph. For list of the Secretary's current recommendations and guidelines, please visit:

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.healthcare.gov/law/information-for-you/women.html

You may also contact Piedmont at 434-947-4463 or toll free at 1-800-400-7247 for more information.

Piedmont will provide Coverage for the preventive care services described in subparagraphs (1) through (4) above for plan years that begin on or after September 23, 2010 or, as later changes are made, for plan years that begin on or after the date that is one year from the date that the recommendation or guideline is issued.

Piedmont will provide Coverage for the preventive care services described in subparagraphs (10) through (17) above for plan years that begin on or after August 1, 2012 or, as later changes are made, for plan years that begin on or after the date that is one year from the date that the recommendation or guideline is issued.

Piedmont will use reasonable medical management techniques for Coverage of preventive care items and services to determine the frequency, timing, method, treatment or setting of services to the extent that they are not specified in the relevant recommendation or guideline.

If the preventive care service described in subparagraphs (1) through (17) above:

(a) Is billed separately from an office visit, cost sharing requirements may be imposed on the office visit;
(b) Is not billed separately from the office visit and the primary purpose of the office visit is delivery of the preventive care service, cost sharing requirements may not be imposed on the office visit; or
(c) Is not billed separately from an office visit and the primary purpose of the office visit is not delivery of the preventive care services, cost-sharing requirements may be imposed on the office visit.

Cost sharing requirements for treatment not described in subparagraphs (1) through (17) above may be imposed even if that treatment results from an item or service that is described in those subparagraphs.

Piedmont follows the guidelines as 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.

The chart below summarizes specific types of Preventive Covered Services by age of the Covered Plan Participant:

AGE OF COVERED PERSON	COVERED SERVICES
0 to 12 months	6 checkups, including all routine and necessary immunizations recommended by the Virginia Commissioner of Health. Coverage includes, but is not limited to, immunizations for diphtheria, tetanus, pertussis (DTP), polio, measles, mumps, rubella (MMR), Rotavirus, hemophilus vaccine (HIB), hepatitis B, varicella virus (chicken pox) vaccine, pneumococcal conjugate vaccine.
13 to 24 months	3 checkups, including all routine and necessary immunizations recommended by the Virginia Commissioner of Health. Cover-

AGE OF COVERED PERSON	COVERED SERVICES
	age includes, but is not limited to, immunizations for diphtheria, tetanus, pertussis (DTP), polio, measles, mumps, rubella (MMR), hemophilus vaccine (HIB), hepatitis A, hepatitis B, varicella virus (chicken pox) vaccine, pneumococcal conjugate vaccine, and tuberculin test.
2 to 19 years	1 checkup/physical exam, including all routine and necessary immunizations recommended by the Virginia Commissioner of Health up to age 36 months. After that, one checkup/physical exam, including all routine and necessary immunizations, every 12 months up to age 19. Annual pap smear for females beginning at age 13. Human papillomavirus vaccine (HPV) after age 9, and meningococcal vaccine.
20 to 39 years	1 physical exam every 12 months, including pap and physician breast exam for women (gynecological care may be provided annually also). Tetanus-diphtheria booster every 10 years; hepatitis A & B vaccine, pneumococcal vaccines, influenza vaccine if needed. Human papillomavirus vaccine (HPV) and meningococcal vaccine. Fasting serum glucose and cholesterol checked every two to five years. Hematocrit and urinalysis to be checked with gynecological exam. A baseline screening mammogram between the ages of 35 and 39 for females.
40 to 49 years	1 physical exam every 12 months, including pap and physician breast exam for women. Digital prostate exams to be done with male exam. Tetanus-diphtheria booster every 10 years; hepatitis A & B vaccines, pneumococcal vaccines, meningococcal vaccine, influenza vaccine if needed. Fasting serum glucose and cholesterol checked every two to five years. Hematocrit and urinalysis to be checked with gynecological exam. Screening mammography once each year beginning at age

AGE OF COVERED PERSON	COVERED SERVICES
	40. Flexible sigmoidoscopy as recommended by physician. Screening colonoscopy beginning at age 45 for African Americans.
50 years and older	1 physical exam every 12 months, including pap and physician breast exam for women, digital prostate exams for men. Tetanus-diphtheria booster every 10 years; hepatitis A & B vaccines, pneumococcal vaccines, zoster (shingles) vaccine, influenza vaccine if needed. Hematocrit and urinalysis to be checked with gynecological exam. Fasting serum glucose and cholesterol checked every two to five years. Annual screening mammography for females. Annual occult blood test. One baseline EKG. Annual PSA. Screening colonoscopy or flexible sigmoidoscopy as recommended by physician.

Flexible sigmoidoscopy, PSA tests, pap smears, and mammograms may be covered at an earlier age or more frequently if recommended by a Physician due to the Participant being at greater risk for cancer. Coverage for pap smears includes FDA-approved gynecologic cytology screening technologies.

Mammograms performed in a Hospital Outpatient facility are typically diagnostic mammograms. These diagnostic mammograms are covered as an Outpatient facility Benefit. Screening mammograms that are provided in any type of facility or office are Covered Services without cost-sharing that are available as described in the "Age of the Covered Person" provisions that precede this paragraph.

Piedmont does not provide Coverage for a preventive or prophylactic mastectomy. For the purposes of this subsection, the term "preventive or prophylactic mastectomy" means removal of a breast for a Participant who (a) has not been diagnosed with breast cancer or another life-threatening condition that necessitates the removal, or (b) is not at high risk of developing breast cancer or another life-threatening condition if the breast is not removed. Piedmont determines "high risk" in accordance with generally accepted standards of medical practice.

AA. 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 Calendar Year**.

BB. RADIATION THERAPY

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

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 shall be construed to mandate the Coverage of proton radiation therapy under the Plan.

CC. RECONSTRUCTIVE SURGERY

Covered Services for reconstructive surgery are to correct: functional impairment; newborn congenital defects and birth abnormalities; 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), 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; 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 Plan Participant. Reconstructive breast surgery done at the same time as a mastectomy or following a mastectomy to reestablish symmetry between two breasts is also covered. 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

DD. REHABILITATIVE AND HABILITATIVE SERVICES

Habilitative services include Coverage for health care services that help a person keep, learn, or improve skills and functioning for daily living. 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, loss additionally due to congenital anomaly or prior medical treatment.

Piedmont covers 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 your condition and provided by a licensed therapist:

1. 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.
2. Chemotherapy, the treatment of disease by chemical or biological antineoplastic agents, is covered.

3. Physical therapy is covered. This is treatment by physical means to relieve pain, teach, keep, improve or restore function, and prevent disability after illness, injury, or loss of limb, including treatment of lymphedema.
4. Occupational therapy is covered. This is the 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, and bathing.

With regard to Nos. 3 and 4 above, Coverage for Physical/Occupational therapy is limited to 30 visits per Calendar Year for rehabilitative and habilitative services combined.

5. Radiation therapy, including rental or cost of radioactive materials, which is for the treatment of disease by x-ray, radium, cobalt, or high energy particle sources is covered.
6. Respiratory therapy, which is the introduction of dry or moist gases into the lungs to treat illness or injury, is covered.
7. Speech therapy, i.e., treatment for the correction of a speech impairment, or services necessary to keep, improve or teach speech, which results from disease, surgery, injury, congenital anatomical anomaly, or prior medical treatment, is covered. **This is limited to 30 visits per Calendar Year combined for rehabilitative and habilitative services.**

EE. SERVICES OF OUT-OF-NETWORK PROVIDERS

No Out-of-Network Provider operating in the State of Virginia shall balance bill a Plan Participant for (i) emergency services provided to the Plan Participant or (ii) nonemergency services provided to a Plan Participant at an In-Network facility if the nonemergency services involve surgical or ancillary services provided by an Out-of-Network provider. Piedmont shall make payments for these services directly to the Provider.

In other cases if you receive Covered Services from an Out-of-Network Provider, Piedmont reserves the right to pay its allowable charge less amounts you must pay under this Certificate of Coverage, for these Covered Services directly to you, the Out-of-Network Provider, or any other person responsible for paying the Out-of-Network Provider's charge subject to applicable Virginia laws that require direct payment (for example, to dentists and oral surgeons who submit valid assignments of Benefits). You will be responsible for any difference between the billed amount by the Out-of-Network Provider and Piedmont's payment. It is

your responsibility to apply any plan payment you receive to the claim from the Out-of-Network Provider. You are responsible for the difference of the billed amount and maximum allowed amount for Out-of-Network (Out-of-Plan) services, except as provided in Section III, Subsection F - Balance Billing for Certain Services Prohibited. Non-Emergency or non-Urgent Care services when you are traveling outside the United States are not Covered Services.

FF. SKILLED NURSING FACILITY

Coverage for skilled nursing facility stays requires a Preauthorization. Your doctor must submit a plan of treatment that describes the type of care you need. The following items and services will be provided to you as an Inpatient in a skilled nursing bed of a skilled nursing facility:

- Room and board in semi-private accommodations;
- Rehabilitative services; and
- Drugs, biologicals, and supplies furnished for use in the skilled nursing facility and other medically necessary services and supplies.

Piedmont covers a private room is covered if you need a private room because you: (1) have a highly contagious condition; or (2) are at greater risk of contracting an infectious disease because of your medical condition. Otherwise, your Inpatient Benefits would cover the skilled nursing facility's charges for a semi-private room. If you choose to occupy a private room, you will be responsible for paying: (1) the daily difference between the semi-private and private room rates; and (2) your 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.

GG. SPINAL MANIPULATION AND OTHER MANUAL MEDICAL INTERVENTIONS

Piedmont covers: (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 calendar year**.

HH. SURGERY

Piedmont covers 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 and congenital abnormalities in newborn children;
- 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.

II. TELEMEDICINE SERVICES

Telemedicine services as it pertains to the delivery of health care services, means the use of electronic technology or media, including interactive audio or video, for the purpose of diagnosing or treating a patient, providing remote patient monitoring services, or 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 Preauthorization. Technical fees or costs for the provision of telemedicine services are not covered.

JJ. TRANSPLANTS

Piedmont covers Medically Necessary human organ, tissue, and bone marrow/stem cell transplants and transfusions when provided as part of physician office services, Inpatient facility services, and Outpatient facility services. This includes autologous bone marrow transplants for breast cancer. Piedmont shall provide Benefits for medically necessary human organ and tissue transplant services only when Piedmont has preauthorized the services. Benefits include Coverage for necessary acquisition procedures, harvest and storage, and include medically necessary preparatory myeloablative therapy, reduced intensity preparatory chemotherapy, radiation therapy, or a combination of these therapies.

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 the Benefits of the health plan. Specific limited

transportation/lodging costs and donor costs are also covered. When a living donor who is not a Plan Participant provides a human organ or tissue transplant to a Plan Participant, 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. Reimbursement for reasonable and necessary transportation and lodging costs for the donor are covered when the recipient and donor are both covered by this Plan. No Benefits are provided a Plan Participant who is donating the organ to someone who is not a Plan Participant.

Certain organ or tissue transplants are considered Experimental/Investigative or not Medically Necessary and therefore not covered. All organ transplants are subject to Preauthorization for medical necessity according to Piedmont guidelines.

Relating to coverage for anatomical gift and organ, eye or tissue transplant, Piedmont shall not:

1. Deny coverage to a covered person solely on the basis of the person's disability;
2. Deny a person eligibility or continued eligibility to enroll in or to renew coverage under the plan for the purpose of avoiding the nondiscrimination requirement;
3. 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;
4. 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.

All organ transplants, except those listed below, are not covered unless the particular circumstances of your case warrant an exception by Piedmont, at its sole discretion, (subject to all appeals available to you).

Covered Transplants:

- Allogenic stem cell for certain genetic diseases and acquired anemias, multiple myeloma
- Autologous stem cell for multiple myeloma, amyloidis, germ cell tumors
- Cornea
- Heart
- Heart-Lung
- Kidney
- Kidney-Pancreas
- Liver
- Single Lung, Double Lung, Lobar

Autologous bone marrow transplants for breast cancer are covered only when the procedure is performed in accordance with protocols approved by the institutional review board of any

United States medical teaching college. These include, but are not limited to, National Cancer Institute protocols that have been: (1) favorably reviewed; and (2) used by hematologists or oncologists who are experienced in high dose chemotherapy and autologous bone marrow transplants or stem cell transplants. This procedure is covered despite the exclusion of Experimental/Investigative services.

KK. VISION SERVICES

Piedmont covers prescription glasses or contact lenses required as a result of surgery or for treatment of accidental 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. if related to the surgery or injury.

Piedmont covers 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 sclera lenses prescribed in connection with keratoconus
    c) Sclera lenses prescribed to retain moisture when normal tearing is not possible or inadequate; or
    d) Corneal or sclera lenses are required to reduce a corneal irregularity other than astigmatism.

Routine vision services, except as provided herein for children up to age 19, are not covered unless additional Coverage (Vision Rider) is purchased by the employer.

Section V: What is Not Covered (Exclusions)

Piedmont does not cover any service or supply: (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. The following services are specifically excluded from Coverage under this Certificate of Coverage:

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 riot, or civil disobedience.

4. **Acupuncture.**

5. **Administrative Services:** provider's 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 such clerical charges, with the exception of covered telemedicine services.

6. **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.

7. **After Hours or Holidays Charges:** Additional charges beyond the Maximum Allowed Amount for basic and primary services for services requested after normal Provider service hours or on holidays.

8. **Allergy Tests/Treatment;** the following services, supplies or care are not covered:

   - IgE RAST tests unless intradermal tests are contraindicated.
   - Allergy tests for non-specific or non-allergy related symptoms such as fatigue and weight gain.
   - Specific non-standard allergy services and supplies, including but not limited to, skin titration (Rinkle method), cytotoxicity testing (Bryan's Test), treatment of non-specific candida sensitivity, and urine autoinjections.

- Antigen leukocyte cellular antibody test (ALCAT); or
- Cytotoxic test; or
- HEMOCODE Food Tolerance System; or
- IgG food sensitivity test; or
- Immuno Blood Print test; or
- Leukocyte histamine release test (LHRT).

9. **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), hypnotherapy, acupuncture; sleep therapy; behavior training; recreational therapy (dance, arts, crafts, aquatic, gambling and nature therapy); hair analysis; naturopathy, thermography, orthomolecular therapy, contact reflex analysis, bioenergial synchronization technique (BEST), iridology – study of the iris, auditory integration therapy (AIT), colonic irrigation, magnetic innervation therapy, electromagnetic therapy, holistic medicine; homeopathy; aroma therapy; Reiki therapy, massage, and massage therapy; herbal, vitamin, or dietary products or therapies.

10. **Ambulance:** Usage is not covered when another type of transportation can be used without endangering the Member's health. Any ambulance usage for the convenience of the Member, 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.

11. **Applied Behavioral Analysis,** except as provided in this Certificate for diagnosis and treatment of autism spectrum disorder in Plan Participants of any age.

12. **Artificial/Mechanical Devices - Heart Condition:** Related to artificial and/or mechanical hearts or ventricular and/or atrial assist devices related to a heart condition or for subsequent services and supplies for a heart condition as long as any of the above devices remain in place. This exclusion includes services for implantation, removal and complications. This exclusion does not apply to ventricular assist devices used as a bridge to transplantation, or as a permanent alternative to heart transplantation, or the total artificial heart if the request meets Our Medical Policy criteria.

13. **Breast reductions** unless related to surgical interventions following a mastectomy.

14. **Charges** which are in excess of any Benefit limitations (e.g. number of days, etc.) and amounts above the allowable charge for a service.

15. **Charges Not Supported by Medical Records:** Charges for services not described in Your medical records.

16. **Clinical Trials:** We do not provide benefits for procedures, equipment, services, supplies or charges for the following (this does not exclude any services mandated by §38.2-3418.8 of the Code of Virginia):

- The Investigational item, device, or service;
- Items and services that are given only to satisfy data collection and analysis needs and that are not used in the direct clinical management of the patient;
- 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.

17. **Cochlear implants** and all related services.

18. Supplies and devices that are for **comfort or convenience** only (such as radio, television, telephone, and guest meals) and private rooms, unless a private room is Medically Necessary and approved by Piedmont during Inpatient Hospitalization or Inpatient stay at a skilled nursing facility.

19. **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.

20. Non-prescription and Over-the-counter **contraception** methods and devices.

21. Reconstructive or **cosmetic surgery or procedures**, unless previously approved as Medically Necessary by Piedmont. Complications of previous cosmetic surgery or procedures or that result from such surgeries or procedures. Cosmetic surgeries and procedures are performed mainly to improve or alter a person's appearance including: body piercing; tattooing; or removal of tattoos. However, a cosmetic surgery does not include the following types of reconstructive surgery that are covered: (1) a surgery or procedure to correct deformity caused by: disease; trauma; or a previous therapeutic process; (2) surgeries or procedures to correct 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. The patient's mental state is not considered when deciding if a surgery is cosmetic.

22. **Counseling Services:** Counseling Services and treatment related to religious counseling, marital/relationship counseling, vocational or employment counseling, and sex therapy.

23. **Court Ordered Testing:** Court ordered testing or care unless Medically Necessary.

24. **Custodial care**, including Inpatient or Outpatient custodial care, nursing home care, respite care, rest cures, domiciliary or convalescent care along with all related services except for hospice care.

25. **Dental** services including, but are not limited to:

- Treatment of natural teeth due to diseases;
- Dental care, treatment, supplies or dental x-rays (Coverage is provided for medically necessary dental services resulting from an accidental injury as described in Section IV, paragraph W. Oral Surgery; Dental Services);
- 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 appliances for temporomandibular joint pain dysfunction;
- Periodontal care, prosthodontal care or orthodontic care (except 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.

26. **Donor** searches for organ or tissue transplants, including compatibility testing of potential donors who are not immediate, blood related family members (parent, Child, sibling).

27. **Durable Medical Equipment (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.

28. **Educational, Vocational, or Self-Training Services** or supplies, classes, programs, and support groups including, but not limited to, prenatal courses, marital counseling, self-help training and other non-medical self-care and those dealing with lifestyle changes, except as otherwise specifically covered or when received as part of a covered wellness visit or screening.

29. Services for injuries or diseases related in any way to **employment**, when:

- You receive payment from the employer on account of the disease or injury;
- The employer is required by federal, state, or local laws or regulations to provide 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 have failed to comply with procedures set out by the employer to receive these Benefits. It also applies if the employer (or the 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.

30. **Examinations** required specifically for: insurance; employment; school; sports; camp; licensing; adoption; marriage; those ordered by a third party; immunizations required for travel and work; and Court-ordered examinations or care; or relating to research screenings.

31. **Experimental/Investigative** medical or surgical procedures and drugs, as determined by Piedmont in its discretion (subject to all appeals available to you), except as provided under: (1) the Prescription Drug Services subsection; (2) and under "clinical trial for treatment studies on cancer" paragraphs of the Covered Benefits section. Services which do not meet each of the following criteria will be excluded from Coverage as Experimental/Investigative:

A. Any supply or drug used must have received final approval to market by the U.S. Food and Drug Administration (FDA) for the particular indication or application in question. Moreover, quantities of any drug or medication used must be within recommended maximum daily dose or duration established by the FDA or any of the standard reference compendia defined below. This excepts those drugs used: (1) in the treatment of cancer pain; and (2) prescribed in compliance with established statutes pertaining to patients with intractable cancer pain. 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 Drug & Biologics Compendium;
  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 by unbiased experts for: scientific accuracy; validity; and reliability. 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. (1) 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.

Despite the above two exceptions, this criterion will not be satisfied if the FDA has determined that use of the drug is not recommended for the treatment of the specific indication for which it is prescribed.

B. There must be enough information in the peer-reviewed medical and scientific literature to let Piedmont 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.

E. The services supplied must be approved by the Centers for Medicare and Medicaid Services for Coverage by Medicare.

32. **Eye Exercises**, such as orthoptics and vision training/vision therapy.

33. **Eyeglasses and Contact Lenses for Adults**, except after a covered eye surgery or accidental eye injury.

34. **Eye surgery**, including services for radial keratotomy and other surgical procedures to correct refractive defects; LASIK procedures.

35. The following **Family Planning Services** 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.

36. **Foot care** (palliative or cosmetic), including but not limited to:

- 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; Tarsakgua; Metatarsalgia; Hyperkeratoses; chronic foot strain; or 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 an illness affecting the lower limbs;
- Routine foot care, such as removal of corns or calluses and the trimming of toe-nails, except for treatment of patients with diabetes or vascular disease.

37. **Free Care,** including services the covered Participant 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. Also care for military service-connected disabilities and conditions for which you are legally entitled to health services and for which facilities are reasonably accessible to you.

38. **General**: Your coverage does not include benefits for the following Services or treatment:

- Inpatient stays for environmental changes;
- Cognitive rehabilitation therapy;
- Education therapy;
- Long term behavioral health care;
- Conduct disorders;
- Vocational or recreational activities;
- Coma stimulation therapy;
- Services for sexual deviation or dysfunction;
- Treatment for social maladjustment without signs of a psychiatric disorder;
- Remedial or special education services;
- Marriage or relationship counseling;
- Employment counseling;
- Treatment of intellectual and learning disabilities (except for attention deficit hyperactivity disorder -ADHD and autism)
- Psychiatric evaluation or therapy when related to judicial or administrative proceedings or orders, when employer requested, or when required for school;
- Educational testing or psychological testing, unless part of a treatment program for Covered Services; or
- More than one hour of psychotherapy in a 24 hour time period. Group therapy with one therapist with more than eight patients.

39. **Gene Therapy:** Gene therapy, as well as any Drugs, procedures, health care services related to it that introduce or is related to the introduction of genetic material into a person intended to replace or correct faulty or missing genetic material.

40. Except as provided by federal law, the cost of care for conditions that federal, state or local law requires be treated in a public facility or services or supplies provided or arranged by a **governmental facility** for which no charge would be made if you had no health Benefits insurance.
    - Care for military service-connected disabilities and conditions for which you are legally entitled to health services and for which facilities are reasonably accessible to you.
    - Costs of health care services covered under the Medicare program.

41. **Group speech therapy.**

42. **Gynecomastia,** services for surgical treatments for cosmetic purposes, unless determined to be Medically Necessary by Piedmont.

43. **Hair loss care and treatment,** 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.

44. **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.

45. **Hearing** care except as provided herein for Participants up to age 19. Hearing aids or the examination to prescribe or fit hearing aids.

46. **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.

47. **Hyperhydrosis:** For treatment of hyperhydrosis (excessive sweating).

48. **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 this policy.

49. **Infertility** surgical or medical treatment is not covered. This includes: services; office visits; lab and diagnostic tests; and procedures to promote conception once a diagnosis of infertility has been established. 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. These excluded Services include, but are not limited to:

    - Artificial insemination or in vitro fertilization 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;

- Reversals of voluntarily induced sterilization and complications incidental to such procedures; or
- Paternity testing.

50. **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.

51. **Long-Term/Custodial Nursing Home care.**

52. Services and supplies deemed **not Medically Necessary.**

53. **Medical equipment, appliances, devices and supplies** that have both a therapeutic and non-therapeutic use. These include: elastic or leather braces or supports; corsets; batteries and battery chargers; exercise equipment; air conditioners, dehumidifiers, humidifiers, and purifiers; special bed linens, mattress or mattress covers; other special supplies, appliances, and equipment such as office chairs, sun or heat lamps, whirlpool baths, and heating pads; rental or purchase of 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; home improvement items, including but not limited to, escalators, elevators, ramps, stair glides or emergency alert equipment; and expenses incurred at a health spa, gym or similar facility. An office visit for the purpose of fitting for a noncovered device or supply is not covered.

54. **Medicare Benefits:** (1) for benefits which are payable for the Member enrolled in Medicare under Medicare Parts A, B and/or D, or for the Member eligible for Medicare due to age, for benefits which would have been payable if the Member had applied for Medicare Part B, except as specified elsewhere in this EOC, or as otherwise prohibited by federal law. If a Member eligible for Medicare due to age, has not enrolled in Medicare Part B, We will calculate benefits as if the Member had enrolled; (2) for services or supplies provided pursuant to a private contract between the Member and a Provider, for which reimbursement under the Medicare program is prohibited as specified in Section 1802 (42 U.S.C. 1395a) of Title XVII of the Social Security Act.

55. **Methadone maintenance** at any level of care.

56. Charges for **Missed** or **Cancelled Appointments**

57. Services for which you have **no financial responsibility**. Except as otherwise required by state or federal law, Piedmont will not pay for, or reimburse, the cost of any Covered Service for which the Participant is not financially liable. Examples include charges for complimentary health screenings, charges for Covered Services provided by an immediate family Participant, and charges incurred as a donor or surrogate 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 Certificate of Coverage, in which case that subsection applies).

58. Medical **Nutritional Therapy** (Obesity); **nutrition counseling**, except when provided as part of diabetes education or when received as part of a covered wellness service visit or screening; **nutritional and/or dietary supplements**, except as 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.

59. **Organ transplants and tissue transplants** are not covered, except as described in the Covered Benefits section of this Certificate of Coverage.

60. **Outdoor Treatment Programs and/or Wilderness Programs/Camps**, except psychotherapy provided by a licensed mental health and substance use disorder provider during the course of these programs, which is covered.

61. **Over-the-counter convenience and hygienic items.**

62. **Paternity testing:** Your coverage does not include benefits for paternity testing.

63. **Penile implants** and related services.

64. **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 except as otherwise stated;
- Purchase or rental of supplies for common household use, such as water purifiers;
- Allergenic pillows, cervical neck pillows, special mattresses, or waterbeds;
- Sports helmets.

65. **Physician Stand-by Charges:** For stand-by charges of a Physician.

66. **Physician/Other Practitioners' Charges:** Physician/Other Practitioners' Charges including:

- Physician or other practitioners' charges for consulting with Members by telephone, facsimile machine, electronic mail systems or other consultation or medical management service not involving direct (face-to-face) care with the Member. 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 Your care.
- Charges that are not documented in Provider records.
- Charges from an outside laboratory or shop for services in connection with an order involving devices (e.g., prosthetics, orthotics) which are manufactured by that laboratory or shop, but which are designed to be fitted and adjusted by the attending physician.
- 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.

67. **Prescription Drugs:** Your 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 Piedmont.
- Non-formulary drugs, except in certain circumstances described in Coverage documents.
- Compound Drugs, unless there is at least one ingredient that you need a prescription for, and the Drug is not essentially a copy of a commercially available drug product.
- Drugs given to You or prescribed in a way that is against approved medical and professional standards of practice.
- Charges for delivery of Prescription Drugs.
- Drugs You take at the time and place where You are given them 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 Members 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.
- Hypodermic syringes except when given for use with insulin and other covered self- injectable Drugs and medicine.
- Any Drug mainly used for weight loss except those Drugs that are covered based on BMI.
- Drugs used for cosmetic purposes.
- Prescription Drugs used to treat infertility.
- Charges for services not described in Your 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 You can buy over the counter and those You 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/stepchild, brother/stepbrother, sister/stepsister, parent/stepparent, in-law, or self.

68. **Private duty nursing** in an Inpatient setting.

69. **Prophylactic mastectomy**, which means removal of a breast for a Plan Participant who: (a) has not been diagnosed with breast cancer or another life-threatening condition that necessitates the removal; or (b) is not at high risk of developing breast cancer or another life-threatening condition if the breast is not removed. Piedmont determines "high risk" in accordance with generally accepted standards of medical practice.

70. **Prosthetics for Sports or Cosmetic Purposes**, including wigs and scalp hair prosthetics, except for wigs needed after cancer treatment.

71. Non-covered **Providers**, including massage therapists, physical therapist technicians, and athletic trainers.

72. **Recreation therapy**, including, but not limited to, sleep, dance, arts, crafts, aquatic, gambling, and nature therapy.

73. **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, half-way 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, even if psychotherapy is included; however, psychotherapy provided by a licensed mental health and substance use disorder provider during the course of these programs is covered.

74. **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 You receive 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.

75. **Services or supplies** if they are:

- Ordered by a doctor whose services are not covered;
- Not prescribed, performed, or directed by a provider licensed to do so;
- Received before the effective date or after a covered Participant's Coverage ends;
- Travel, whether or not recommended by a physician;
- Rendered by a provider that is a Member of the covered person's immediate family;
- Services for which a charge is not usually made;
- Received or rendered outside of the United States, except for Emergencies or Urgent Care; or
- Any types of health services, supplies, or treatments not specifically provided herein. The term "services" as used in this Exclusions section includes supplies or medical items.

76. Procedures, services, and supplies to treat **sexual dysfunction** (male or female sexual problems). This includes medical and mental health services. However, formulary

prescription drugs for impotence or to enhance arousal, libido or sexual response are Covered Services.

77. **Shock Wave Treatment:** Extracorporeal Shock Wave Treatment for plantar fasciitis and other musculoskeletal conditions.

78. **Skilled nursing facility stays** are not covered when the skilled nursing facility is used mainly for care of the aged, custodial or domiciliary care; mainly for a place for rest, educational, or similar services; a private room is not covered unless Medically Necessary.

79. Oral surgery that is dental in origin; Reversal of voluntary sterilization; radial keratotomy, keratoplasty, Lasik and other **surgical procedures** to correct refractive defects.

80. Services related to **surrogacy** if the Plan Participant is not the surrogate.

81. Non-interactive **telemedicine services**, such as audio-only telephone conversations; electronic mail message or fax transmissions.

82. **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
- Sensory integration therapy (SIT)

83. **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, 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 are not Covered Services.

84. **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).
- Return visits for the donor for a treatment of a condition found during the evaluation.

85. Treatment of **varicose veins or telangiectatic dermal veins (spider veins)** when services are rendered for cosmetic purposes.

86. Routine **vision**, except as provided herein for children up to age 19. Surgical and other services/supplies to correct near-sightedness and/or far-sightedness, including radial keratotomy (RK) and Lasik refractive surgery. Annual routine vision examinations are covered when additional Coverage (Vision Rider) is purchased by the employer. The following vision services are not covered:
    - Eyeglass lenses, frames, or contact lenses, unless listed as covered in this booklet, including special lens coatings and non-prescription lenses.
    - Safety glasses and accompanying frames.
    - Sunglasses and accompanying frames.
    - Vision orthoptic training.

87. Services for **weight loss** or weight control and related services (except Drugs covered based on BMI), including but not limited to gastric bypass surgery or services for complications resulting from gastric bypass surgery, unless additional Coverage to cover Morbid Obesity (Morbid Obesity Rider) is purchased by the employer.

88. **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.

Section VI: Out-of-Plan Benefits

You have the option to receive services from In-Network or Out-of-Network Providers. When you choose to receive services from an Out-of-Network Provider you are considered "Out-of-Plan" or Out-of-Network. You have access to almost all of the same Covered Services as provided in this Certificate of Coverage; however you may have different Copayment, Deductible and/or Coinsurance amounts or Benefit maximums listed on your Schedule of Benefits for Out-of-Plan services that will apply. If you receive certain services without the proper Preauthorization, you are considered Out-of-Plan. These are listed in the "How to Use Your Benefits" Section of this Certificate of Coverage.

When you receive care or treatment from an Out-of-Network Provider you may be responsible for all claims filing and Preauthorization if this provider does not agree to do so on your behalf. In addition you may be balance billed by Out-of-Network Providers as described below.

Balance Billing

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

Balance billing is when the Out-of-Network Provider bills you for the amounts over and above Piedmont's Allowable Charge. You are responsible for amounts above the Allowable Charge in addition to any Copayment, Deductible and/or Coinsurance amounts. Balance billed amounts do not count towards the out-of-pocket maximum. **Please refer to Section III, Paragraph F. Balance Billing For Certain Services Prohibited** to see the exceptions to Balance Billing.

Preauthorization

If you are being treated by an Out-of-Network Provider and you need services that require Preauthorization, then either you or your physician must contact Piedmont's Medical Management staff at (434) 947-4463 or toll free at 1-800-400-7247.

Traveling

Participants who are traveling outside the Service Area are covered for routine services at the out-of-plan level. If you have a non-urgent or non-emergent medical need while traveling, please contact Piedmont for specific Preauthorization and Coverage information.

Coverage for Emergencies or urgent care outside the service area or outside the country is covered at the in-plan level. When doing so, present your identification card to the medical provider and ask that they file the charges directly with Piedmont. In some cases you may be asked to pay for Emergency or acute illness care. If this occurs, simply submit an itemized statement to Piedmont or complete a medical claim form and attach all receipts for reimbursement.

Section VII: Eligibility and Other Terms and Conditions

A. ELIGIBILITY

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

Spouse. A Subscriber may enroll his/her legal spouse as a Plan Participant during the Subscriber's Open Enrollment Period or within 30 days of the date of the Subscriber's marriage. To be eligible to enroll as a spouse, a person must: (1) meet all eligibility requirements of the Subscriber's employer/group; and (2) be the Subscriber's legal spouse. A person is not eligible for Coverage as a Participant'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 the Subscriber's sole Domestic Partner and has been for 12 months or more; he or she is mentally competent; he or she is not related to the Subscriber 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 with the Subscriber.

For purposes of this Plan, a Domestic Partner shall 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 shall be treated the same as any other child.

Any federal or state law that applies to a Member who is a spouse or child under this Plan shall also apply to a Domestic Partner or Domestic Partner's child who is a Member 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) the Subscriber's biological, legally adopted, or foster Child; or (2) the biological, legally adopted, or foster Child of the Subscriber's legal spouse if such spouse is also a covered Participant under the Certificate of Coverage. 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 below, there is no requirement that the Child: be financially dependent on an

individual covered under the Certificate of Coverage; share a residence with an individual covered under the Certificate of Coverage; 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 Certificate of Coverage is age 26.

Except as provided below with respect to the "Subscriber's Newborn Child," a spouse or Child not added to the Subscriber's Coverage at the time of open enrollment: (1) may not be added to the Subscriber's Coverage until the employer's next open enrollment; or (2) in the case of newly eligible Plan Participants other than the Subscriber, not added to the Subscriber's Coverage within 30 days of the initial date of eligibility.

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

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

The Subscriber's biological newborn Child's Coverage will be identical to Coverage provided to the Subscriber; except that, regardless of whether the Coverage would otherwise be provided under the terms and conditions of this Certificate of Coverage, 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 Certificate of Coverage; 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, Coinsurance, or other cost-sharing, and policy or contract maximum provisions, provided that the provisions are no more restrictive for these services than for any injury or sickness covered under the Certificate of Coverage.

If payment of a specific Premium is required to provide Coverage for the eligible Child, you must notify Piedmont 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 in order to have the Coverage continue beyond the initial 31-day period. If the Subscriber's newborn Child's mother expects to receive Benefits from another carrier, but the Subscriber wishes his newborn Child's claims paid under this Certificate of Coverage, we request that you notify us in advance of the Child's birth. This is so Piedmont may ensure the Child's claims are correctly paid when Piedmont receives 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 the Subscriber's employer or group plan provides for "Child" Coverage, then when a Child has been placed with a Subscriber 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 Coverage must be submitted within 30 days from the date of eligibility, along with proof that adoption is pending. If a newborn infant is placed for adoption with a Subscriber within 31 days of birth, Piedmont shall consider this Child a newborn Child of the Subscriber to the same extent as if that Child had been a Subscriber's newborn biological Child.

Legal Guardianship of a Child. If the Subscriber's employer or group plan provides for "Child" Coverage, the Subscriber may enroll a Child or a Child of the Subscriber's legal spouse when the Subscriber is the legal guardian of the Child. The Child for whom the Subscriber is the Child's legal guardian will be added to the Subscriber's policy only during the Subscriber's group's Open Enrollment Period, or within 30 days of the Subscriber's assuming legal guardianship for the Child.

Handicapped Child. A Child unable to support himself or herself because of an intellectual disability or physical handicap; and who was enrolled under the contract or Certificate of Coverage before attaining the Limiting Age, will not have his/her Coverage terminated when reaching the Limiting Age if: (1) a qualified Physician furnishes proof of such handicap; and (2) the Subscriber provides proof of dependency within 31 days of the Child's reaching the Limiting Age. Piedmont may require subsequent proof, but not more frequently than annually after the two-year period following the Child's 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; (2) remains unmarried; and (3) remains dependent on the Subscriber or the Subscriber's enrolled legal spouse.

Termination of a Child's Coverage. Unless terminated earlier for other reasons specified in the Certificate of Coverage (e.g., employer or group cancels its employer or group contract for Coverage), Coverage for an enrolled Child terminates on the last day of the month in which he/she reaches the Limiting Age. It is the Subscriber's responsibility to send a notice of termination to his/her employer and to Piedmont when a Child is no longer eligible. 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, a Subscriber may enroll any eligible Participants by: completing a Piedmont enrollment application; or a change form to be sent to Piedmont by the employer or group. Piedmont covers 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 Participant 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. A special enrollment period is allowed 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, death of a spouse.
- Participant status change: birth, adoption, custody, or placement of a foster child.
- Employment status change: loss or gain of other Coverage due to employment.
- Address change that changes Benefits eligibility: Subscriber moving in or out of the Service Area.
- 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 Premium 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 the Subscriber's 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 the Subscriber's employer or group. Upon receipt, your employer will qualify the QMCSO and forward it to Piedmont. If the order is qualified, you may cover your Participant Child, who is the subject of the order, under Piedmont's plan. If you are not already enrolled with Piedmont, you must purchase the Coverage before your Participant 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 Participant Child who is 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 am on the effective date.

Subject to the payment of applicable Premiums and Piedmont's receipt of a completed enrollment application from or on behalf of each eligible person to be enrolled in Piedmont, Coverage for the Subscriber and enrolled Participants will begin on the date agreed upon by Piedmont and the employer or group.

1. 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 Piedmont in the Group Enrollment Agreement.
2. The effective date of Coverage of a Subscriber's newborn Child is described in Eligibility subsection above.
3. Coverage of newly acquired Participants who enroll in the plan with Piedmont will become effective on the date of the qualifying event following application, subject to the: enrollment limitations; eligibility requirements; and payment of Premium referenced above.

D. TERMINATION OF COVERAGE

The entire Group Enrollment Agreement, the Coverage of an individual Subscriber, or the family Coverage for Dependent Participants of the individual Subscriber that is enrolled, may only be rescinded or voided if: (1) the individual Subscriber or Participant (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 Participant (or a person seeking Coverage on behalf of the individual) makes an intentional misrepresentation of material fact to the plan in an application, form, or statement.

For the purposes of this Certificate of Coverage, a "rescission" is a cancellation or discontinuance of Coverage that has retroactive effect. For example, a cancellation that treats this Certificate of Coverage and the Coverage as void from the time of the Subscriber's or 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 make contributions toward the cost of Coverage in the manner required by the Group Enrollment Agreement or Certificate of Coverage.

Participants affected by a rescission of Coverage will be provided at least 30-days' advance written notice of the proposed rescission of Coverage before Coverage under the Plan may be rescinded, regardless of whether the rescission applies to the entire group or only to an individual within the group. Rescission is permitted only for an act, practice or omission that constitutes fraud or an intentional misrepresentation of a material fact. Piedmont 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 Piedmont'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.

Piedmont will not terminate a Participant's Coverage on the basis of the status of the Participant's health or because the Participant has exercised his or her rights under the grievance or appeal systems described later in this Certificate of Coverage by registering a complaint against Piedmont or an appeal of Piedmont's determination on Benefits.

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

1. **Termination for Cause.** If the Subscriber's Coverage is terminated for cause, the Coverage for all Participants enrolled in the plan through that Subscriber is terminated as well. The employer or group must determine eligibility for other insurance Coverage if Piedmont's 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 identification card by any other person or use another Participant's card, Piedmont 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 Piedmont 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. Participants so terminated shall be responsible to pay for all services provided to the Participant hereunder that are related to such information or activity.

   With regard to Nos. 1(a) and 1(b) above, Piedmont shall provide any Participant 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 Participant who ceases to be eligible will terminate at the end of the day upon which eligibility ceased unless otherwise agreed upon by Piedmont and the Subscriber's employer. In the event of the Subscriber's death, Coverage will terminate for covered Participants of the Subscriber on the last day of the period for which payments have been made by or on behalf of the Subscriber,

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". Piedmont will provide 31 days' written notice of such termination to the Subscriber.

3. **Termination for Failure to Pay Premium.** Only Participants for whom the stipulated Premium payment is actually received by Piedmont shall be entitled to Covered Services and then only for the period for which such payment is received. If payment is not made in full by the employer on or prior to the Premium due date, as specified in the Policy, a grace period shall be granted to the employer or group for payment of any Premium due except the first Premium. Coverage will remain in force during the grace period, unless the employer has given Piedmont written notice of discontinuance in accordance with the terms of the Policy and in advance of the date of discontinuance. The grace period shall begin on the Premium due date and continue for 31 calendar days. If payment is not made before the end of the grace period, your Coverage may be terminated at the end of the grace period. If the Premium is not paid, the employer or group may be held liable for the payment of a prorata Premium for the time that the Coverage was in force during the grace period. Piedmont shall provide employer/group with at least 15 days' written notice prior to terminating Coverage due to failure to pay Premiums.

4. **Termination of the Policy.** The Policy between Piedmont and the employer or group may be terminated by the employer/group or by Piedmont for any reason permissible under the policy. In addition, Piedmont may terminate the employer's or group's Coverage for nonpayment of Premium or for fraud or material misrepresentation in the application for Coverage. In any such event, Coverage shall terminate for all Subscribers and Participants as of the effective date of termination of the Policy. All rights to Benefits shall 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 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 group health care plan. **This subsection generally explains COBRA continuation Coverage, when it may become available to you and your family (if your family is 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 to you when you would otherwise lose your group health care Coverage. It can also become available to other Participants of your family who are 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, you should contact your plan administrator. Ask to review the plan's summary plan description or to get a copy of the plan document.

The plan administrator is often your group administrator. If you are unsure who your group administrator is or how he or she may be contacted, you may call Piedmont's customer service representatives and ask for that information. 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 person who is a "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 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 the 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 on 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 either 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 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 Participant children will become qualified beneficiaries if they lose their Coverage under the group health care plan because any of the following qualifying events occurs:

- 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 "Participant Child."

Sometimes, filing a bankruptcy proceeding under Title 11 of the United States Code can be a qualifying event. 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 a retired Employee covered under the plan, the retired Employee will become a qualified beneficiary with respect to the bankruptcy. The retired Employee's spouse, surviving spouse, and Participant children will also be qualified beneficiaries if bankruptcy results in the loss of their Coverage under the group health care plan.

COBRA Notice Requirements. You must notify your plan administrator, and your plan administrator must notify Piedmont, in accordance with COBRA requirements, if a qualifying event occurs. Piedmont will offer COBRA continuation Coverage to qualified beneficiaries only after the plan administrator has notified Piedmont 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; if the plan provides retiree health care Coverage, the commencement of a proceeding in bankruptcy with respect to the employer; or the Employee's 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 Piedmont.

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 Piedmont.

Once the plan administrator and Piedmont 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 though if the 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. For each qualified beneficiary who elects COBRA continuation Coverage and for whom the required Premium is paid on time, the Coverage will begin on the date of the qualifying event.

Length of COBRA Continuation Coverage. COBRA continuation Coverage is a temporary continuation of group health care Coverage. 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 Participant Child's losing eligibility as a Participant Child, COBRA continuation Coverage lasts for up to a total of 36 months.

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, COBRA continuation Coverage lasts for up to 36 months after the date of Medicare entitlement. For example, if a covered Employee becomes entitled to Medicare 8 months before the date on which his employment terminates, COBRA continuation Coverage for his spouse and children can last up to 36 months after the date of Medicare entitlement, which 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.** If the U. S. Social Security Administration determines that 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, 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. The disability must have started at some time before the 60th day of COBRA continuation Coverage and must last at least until the end of the 18-month period of COBRA continuation Coverage. You must ensure that 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 Piedmont.

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 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, if you 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 Participant Child stops being eligible as a Participant Child under the group health Benefit plan. This extension is only available if the second event would have caused the spouse or 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 Piedmont.

COBRA continuation Coverage will be terminated before the end of any maximum period if: (1) any required Premium is not paid in full 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 participant or beneficiary who is not receiving COBRA continuation Coverage (such as fraud or material misrepresentation).

Questions about COBRA. If Piedmont is responsible for administering your COBRA continuation Coverage or you are uncertain who administers your COBRA Coverage, you should contact Piedmont at the numbers provided elsewhere in this Certificate of Coverage. If your group is responsible for administering COBRA, you should contact your group 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, you should keep Piedmont and any other person or entity responsible for administering COBRA continuation Coverage informed of any changes in the addresses of family Participants. You should also keep a copy, for your records, of any notices you send to your plan administrator.

F. CONTINUATION COVERAGE IF GROUP NOT ELIGIBLE FOR COBRA

This section only applies if your group is not eligible for federal COBRA continuation Coverage. Typically, employers with fewer than 20 Employees during the preceding calendar year, church groups, and non-employer groups (i.e. non-employer associations) are not eligible for COBRA continuation Coverage.

Notice requirements. You must notify your plan administrator (most often your group administrator) immediately of your loss of eligibility under the group policy. The group is then responsible for providing you a notice of your options for continuing Coverage within 14 days.

You may continue your Coverage under your group's contract for a period of 12 months immediately following the date that you are no longer eligible for Coverage under the group's contract. Coverage will be provided without additional evidence of insurability. In order to continue Coverage, you must submit a completed application form to Piedmont within 60 days following the date of termination of your group Coverage. The Benefits will be the same as your group's Benefits. You must make Premium payments for your Coverage at the rate that the group is paying. This means that, if the group's Coverage or Premiums change during your 12-month continuation period, your Coverage and rate will also change. Premiums may be paid monthly.

Continuation Coverage is not available when:

1. You are covered for Benefits under Medicare;
2. You are covered by or eligible for substantially the same level of Hospital, medical and surgical Benefits under state or federal law;
3. You are covered by substantially the same level of Benefits under any policy, contract, or plan for individuals in a group;
4. You have not been continuously covered under the group's contract during the three month period immediately preceding your termination of Coverage; or
5. You were terminated from the Group Health Plan for:
    (a) failing to pay the amounts due under the contract, including failure to pay the Premiums that the contract or the Certificate of Coverage requires;
    (b) fraud or material misrepresentation in enrollment or in the use of services or facilities; or
    (c) material violation of the terms of 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 group health plans, including but not limited to:

- Group health insurance plans, health maintenance organization, and other prepaid Cover age;
- Labor management trustee plans, union welfare plans, employer welfare plans, employer organization plans, or Employee Benefit organization plans; and
- Coverage under any tax-supported or government program to the extent permitted by law.

When the COB provision applies, the health 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 Participant 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 in this section. Highlights of these rules are described below:

- If the other Coverage does not have COB rules substantially similar to Piedmont's, the other Coverage will be primary.
- If a Participant is enrolled as the named insured under one Coverage and as a Dependent under another, generally the one that covers him or her as the named insured will be primary.
- If a Participant is the named insured under both Coverages, generally the one that covers him or her for the longer period of time will be primary.
- If the Participant is enrolled as a Dependent Child under both Coverages (for example, when both parents cover their Child), typically the Coverage of the parent whose birth day falls earliest in the calendar year will be the primary.
- Special rules apply when a Participant is enrolled as a Dependent Child under two coverages and the Child's parents are separated or divorced. Generally, the Coverage of the parent or stepparent with custody will be primary. However, if there is a court order that requires one parent to provide for medical expenses for the Child, that parent's Coverage

will be primary. If there is a court order that states that 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 calendar year will be primary.

When Piedmont provides secondary Coverage, we first calculate the amount that would have been payable had Piedmont been primary. In no event will Piedmont's payment as secondary Coverage exceed that amount. We coordinate Benefits so that the combination of the primary plan's payment and Piedmont's payment does not exceed Piedmont's 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 Piedmont overpays Benefits because of COB, we have the right to recover the excess from:
- Any person to, or for whom such payments were made,
- Any insurance company, or
- Any other organization.

Right to Receive and Release Information

By accepting Coverage under this Certificate of Coverage 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;
- Give us the right to obtain information as needed from other to coordinate Benefits;
- Return any excess amounts to us if we make a payment and later find that 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 Certificate of Coverage:

Which Plan pays First? Order of Benefit Determination Rules

When a Member 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 Member is the subscriber under one plan and the Dependent under the other	The plan covering the Member as the subscriber is	X	
	The plan covering the person as a Dependent is		X
The Member is a subscriber in two active group plans	The plan that has been in effect longer is	X	
			X

	The plan that has been in effect the shorter amount of time is		
The Member is an active Employee on one plan and enrolled as a COBRA subscriber	The plan which the subscriber is an active Employee is The COBRA plan is	X	 X
The Member is covered as a Dependent Child under both plans	The plan of the parent whose birthday occurs earlier in the calendar year (known as the birthday rule) is The plan of the parent whose birthday is later in the calendar year is	X	 X
The Member is covered as a Dependent Child and 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 Member is covered as a Dependent Child and Coverage is specified in a court decree	The custodial parent or spouse of custodial parent's plan is The non-custodial parent's plan is	X	 X
The Member is covered as a Dependent Child and the parents share joint custody	The plan of the parent whose birthday occurs earlier in the calendar year is The plan of the parent whose birthday is later in the calendar 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 Members under 65 with a Disability

When a Member is covered by Medicare and a group plan	Then	Piedmont is Primary	Medicare is Primary
Is a Member who is qualified for Medicare Coverage due solely to End Stage Renal Disease (ESRD)	During the 30-month Medicare entitlement period Upon completion of the 30-month Medicare entitlement period	X	 X
Is a disabled Member who is allowed to maintain group enrollment as an active Employee	If the employer employs 100 Employees or more If the employer employs fewer than 100 Employees	X	 X
Is the disabled spouse or Dependent Child of an active full-time Subscriber	If the employer employs 100 Employees or more	X	

	If the employer employs fewer than 100 Employees		X
Is a person who becomes qualified for Medicare Coverage due to ESRD after already being enrolled in Medicare due to disability	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
Disabled and Subscriber not actively employed by the employer group			X

Coordination of Benefits with Medicare for Members under 65 and Over

When a Member is covered by Medicare and a group plan	Then	Piedmont is Primary	Medicare is Primary
The Member is age 65 or over, and is the Subscriber or the Subscriber's spouse, and the Subscriber 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 a person who 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
The Member is age 65 or over, is the Subscriber or the Subscriber's spouse and the Subscriber is retired from the employer group (not actively working)			X

H. DUPLICATE COVERAGE

Workers' Compensation and Other Insurance. Piedmont's Benefits do not duplicate those for which you may be eligible under workers' compensation or similar employer's liability or occupational disease laws or any motor vehicle no-fault law.

Medicare. Except as otherwise provided by applicable federal law, Piedmont's Benefits for Participants eligible for Medicare payments do not duplicate any Benefit for which these Participants are eligible under the Medicare Act, including Part B of the Medicare Act. If you do not elect Part B Coverage for which you are eligible, the payment to be made by Piedmont may be made as if you had elected Part B Coverage.

Cooperation. You must complete and submit to Piedmont such consents, releases, applications, assignments, and other documents as may be requested by Piedmont in order 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 eligible. If you are eligible for but fail to enroll in Medicare, including Part B, your Coverage (and, if you are the Subscriber, the Coverage of any of your Participants) may be terminated as indicated in the "Termination of Coverage" subsection above.

I. RELATIONSHIP OF CONTRACTING PARTIES

In-Network Providers maintain the physician-patient relationship with you and are solely responsible for all medical services. The relationship between Piedmont 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 and neither Piedmont nor any Employee of Piedmont is an Employee or agent of any In-Network Provider. For the purposes of this Certificate of Coverage, no employer or Participant is the agent or representative of Piedmont and neither shall be liable for any acts or omissions of Piedmont, its agents or Employees, or any other person or organization with which Piedmont has made or hereafter shall 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

Piedmont may request (from any provider of Covered Services to you), information necessary in connection with the administration of this Certificate of Coverage but 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 shall be kept confidential and, except as permitted by any applicable state and federal law, may not be disclosed without your consent.

K. POLICIES AND PROCEDURES

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

L. MODIFICATIONS

Subject to, and as permitted by applicable law, with 60 days advance notice before the effective date of any material modification, any: provision; term; Benefit; or condition of Coverage of this Certificate of Coverage may be amended, revised, or deleted by Piedmont. This may be done without the Participant's consent or concurrence. Alterations to the Group Enrollment Agreement and its attachments may be made, in accordance with the terms of the Group Enrollment 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 at the address listed in Piedmont's records or, if sent directly to you, the notice is considered "given" when mailed to the Subscriber's last known address as shown in Piedmont's enrollment records. Notices include any information, which Piedmont may send you, including identification cards.

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

N. POLICY WITH EMPLOYER; ENTIRE CONTRACT

Piedmont and the Subscriber's employer or group have entered into a Policy for the provision of the Benefits described in this Certificate of Coverage. Under this Policy the Subscriber's employer or group will contribute on your behalf a portion of the Premiums required. The Policy, this Certificate of Coverage, and any amendments to either constitute the entire contract between the parties to the Policy. Piedmont will provide the Subscriber's employer or group with at least 60 days notice of any Benefit reductions to take effect under this Policy. 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 Certificate of Coverage and the Policy, the terms of the Policy will control. You may direct specific questions related to the Policy between Piedmont and the Subscriber's employer or group to: (1) the Subscriber’s employer or group; and/or (2) the plan administrator.

O. CLAIM FORMS

Piedmont must receive written notice of the occurrence or commencement of any loss covered under this Group Policy within twenty (20) days after the date expenses are incurred. If you presented your identification card to an In-Network Provider, you are not required to notify us of proof of loss. If you did not present your identification card or if you received services from an Out-of-Network Provider, you must provide us with written notice of a claim within twenty (20) days or a soon as reasonably possible. Within fifteen (15) days of receipt of written notice of a claim, Piedmont 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-area services, services rendered by providers who are not In-Network Providers, and some prescription drug claims. You must provide Piedmont with written proof of loss covering the occurrence, character, and extent of the loss for which the claim is made within ninety (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 shall proof of loss be furnished later than one year

from the time proof of loss is otherwise required. You may obtain claim forms from Piedmont's Customer Service. Claims should be sent to Piedmont at the following address:

Piedmont Community HealthCare, Inc.
Post Office Box 14408
Cincinnati, Ohio 45250-0408

Payment of Claims

Piedmont 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 by Piedmont within 90 days of the date you received this service.

All In-Network Providers are required to file claims directly with Piedmont. 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 Piedmont on your behalf. All Benefits payable under the policy other than Benefits for loss of time shall be payable within sixty (60) days after receipt of proof of loss.

Benefits for loss of life of the Participant shall be payable to the beneficiary designated by the Participant. A beneficiary may be the family member specified by the policy.

Physical Examinations and Autopsy

Piedmont has the right to examine the Participant for whom a claim is made when and as often as it may reasonably require during the pendency of claim under the policy and to make an autopsy where it is not prohibited by law.

P. CLAIMS REVIEW

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

We will review a:

- Post-service claim within: 30 days after we receive it; and
- Pre-service claim within: 15 days after we receive it.

A "post-service claim" is any claim under a group health plan for a Benefit for which the Participant 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 Participant must receive approval (Preauthorization) 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 decision. If the extension is because we did not receive necessary information, the extension notice will describe the information. You will have 45 days after you receive the 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 Preauthorization standards:

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

Piedmont will notify the claimant of a Benefit determination (whether adverse or not) with respect to an Urgent Care claim as soon as possible, taking into account the medical exigencies, but not later than 72 hours after Piedmont receives the claim or request. If the claimant fails to provide sufficient information to determine whether, or to what extent, Benefits are covered or payable under the plan or this Certificate of Coverage, 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, we will treat the claim as an Urgent Care claim.

Piedmont may extend the time to review an Urgent Care claim if it: (1) does not receive information that it needs to determine whether the claim is covered; and (2) tells you what information Piedmont needs to complete its claims review. We will provide this notice within 24 hours after we receive your 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 Piedmont's notice of an adverse Benefits determination to file an internal appeal with Piedmont. For the purposes of an internal appeal, "adverse Benefits determination" means:

- Piedmont's 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 Piedmont's determination 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 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.

If your internal appeal involves a continuing stay in an Inpatient setting, for example, we will provide continued Coverage pending the outcome of your appeal up to the limits of your policy. Any reduction or termination of a course of treatment that 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 Benefits determination.

Piedmont will notify you of the adverse Benefits 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. If your request to extend the course of treatment beyond the period of time or number of treatments, which we have approved in advance, is an urgent care appeal, we will decide the appeal as soon as possible, taking into account the medical exigencies. For these urgent care appeals, you and your treating health care professional will be notified of our determination within 72 hours after we receive the internal appeal.

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 Piedmont's Appeals Coordinator at the following address:

Piedmont Community HealthCare, 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 the "Complaints and Assistance" section of this Certificate of Coverage.

Except as otherwise provided in this "Claims and Eligibility Appeals" paragraph, Piedmont 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. If your health plan provides for a second level of internal appeal, we will respond to the initial appeal within a maximum of 15 days from the date of receipt of your appeal and within 15 days from the date of receipt of the second level of appeal.

If the appeal is for an urgent care claim or one eligible for expedited review (as explained below), 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, or similar expedited method. We will respond to an appeal for 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 health care plan. In this 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 claim.

We will give you a reasonable time to provide the information, taking into account the circumstances, but not less than 48 hours. All necessary information, including the Benefit determination on an urgent care appeal, may be transmitted by telephone, facsimile or the most expeditious method available. We will then notify you of the Benefit determination for an urgent care appeal not later than 48 hours after the earlier of (1) our receipt of the specified information or (2) the end of the period that we have afforded you to provide the addition information.

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 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. 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.

In addition to the above, 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 is related to treatment of cancer; or (2) delay the rendering of health care services in a manner that would be detrimental to a patient's health or would seriously jeopardize the life and health of the covered person or would jeopardize the covered person's ability to regain maximum function. These decisions must be resolved within 24 hours after receipt of the appeal and all information necessary for our re-consideration:

- 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 Piedmont's 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 Piedmont 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.

2. External Appeals:

You may also have the right to an external review of an adverse Benefit determination by Piedmont or the denial of any appeal by Piedmont. The Virginia Bureau of Insurance administers the external review program. Piedmont 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 that are 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 your health plan's internal appeal process (set forth above), with the exception of adverse benefit determinations related to treatment of a 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) Piedmont has determined does not meet its criteria for Medical Necessity, appropriateness, health care setting, level of care or effectiveness, or the service is Experimental/Investigational; and (2) as a result, the requested service or payment is denied, reduced or terminated by Piedmont.

The Bureau of Insurance will consider the appeal process for your claim exhausted. You may request an external review directly from the Bureau if you or your authorized representative has not received a response from Piedmont to the appeal within 30 days following the date on which it was filed with Piedmont, 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 Piedmont.

You must file your request for external review with the Virginia Bureau of Insurance within 120 days after the receipt of Piedmont's 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. Piedmont will make a preliminary determination as to whether the adverse 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 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 Participant except to the extent that the Participant 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 has 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 for us in writing in advance. We will deal 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 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 urgent care claim, a health care professional with knowledge of your medical condition.

S. COMPLAINTS AND ASSISTANCE

You may file a complaint with Piedmont at any time if you are 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, Piedmont's 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 Piedmont's Grievance Coordinator at the following address:

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

We will respond to all complaints within 30 days of the date of receipt. Piedmont 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 the Managed Care Ombudsman" to assist Virginia consumers in understanding and exercising their rights under their managed care programs. If you have any question about an appeal or complaint involving a service that Piedmont has provided or that Piedmont has not satisfactorily addressed, you may contact the Office of the Managed Care Ombudsman for assistance. You may contact this office in any of the following ways:

Mail:	**Office of the Managed Care Ombudsman** **Virginia Bureau of Insurance** **P.O. Box 1157** **Richmond, VA 23218**	
Telephone:	**Toll-free:** **Richmond Area:**	**877-310-6560** **804-371-9032**
e-mail:	**ombudsman@scc.virginia.gov**	
Web page:	**http://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

1. The Covered Services available under your Certificate of Coverage are personal. You may not assign your right to receive Covered Services.

2. 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, shall not constitute a waiver of, or otherwise restrict, Piedmont's right to direct future payments to you or any other individual or facility.

U. TIME LIMIT ON LEGAL ACTION

No legal action may be brought to recover on the policy within 60 days after proof of loss has been filed in accordance with the policy requirements, and no such action shall be brought after the expiration of three years from the time the proof of loss was required to be filed.

V. LIMITATION ON DAMAGES

In the event you or your representative sues 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 Certificate of Coverage, your damages shall be limited to: Piedmont's 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 Certificate of Coverage does not provide for punitive damages or damages for emotional distress or mental anguish; provided, however, this provision is not intended, and shall 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.

W. PIEDMONT'S CONTINUING RIGHTS

On occasion, Piedmont may not insist on your strict performance of all terms of this Certificate of Coverage. Failure to apply terms or conditions does not mean Piedmont waives or gives up any future rights it may have under this Certificate of Coverage.

X. INCONTESTABILITY

The validity of the policy shall not be contested, except for nonpayment of Premiums, after the policy has been in effect for two years. No statement relating to insurability made by any person insured under the policy shall 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 two 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.

Y. 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 Piedmont, in certain circumstances, may be disclosed to third parties without authorization.
- Each Participant has a right to see and correct all personal information, which is collected about him or her.

A more complete notice of Piedmont's information practices is available upon request.

Z. ENTIRE CONTRACT

The entire contract between Piedmont and the employer / group consists of: the Group Enrollment Agreement and its amendments; this Certificate of Coverage and its attachments, amendments and/or riders (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 Participants are deemed to be representations and not warranties. No written statement made by any Participant shall be used in any contest unless a copy of the statement is furnished to: the Participant; or to his beneficiary or personal representative.

AA. PROVIDER NONDISCRIMINATION

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

BB. NONDISCRIMINATORY BENEFIT DESIGN

Piedmont does not offer Benefit designs that will have the effect of discouraging the enrollment of individuals with significant health needs in its plans. Nor does Piedmont 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.

CC. MISSTATEMENT OF AGE

An equitable adjustment of Premiums, Benefits or both shall be made if the age of the person insured has been misstated.

DD. CONSIDERATION OF MEDICAID ELIGIBILITY PROHIBITED

The Plan shall not, in determining the eligibility of an individual for Coverage, consider the eligibility of such individual for medical assistance ("Medicaid") from this Commonwealth or from any other state.

The Plan shall not, in determining Benefits payable to, or on behalf of an individual covered under the Plan, take into account the eligibility of such individual for medical assistance ("Medicaid") from this Commonwealth or from any other state.

PLAN PARTICIPANT 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 team work between you, your health care professionals, and Piedmont for Coverage you can count on. Below is a statement of rights and responsibilities that guide Piedmont's relationship with you. Please read through them, and should you have any questions, please give Piedmont a call.

Piedmont is committed to:

- Recognizing and respecting you as a Plan Participant.
- 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 In-Network Providers.
- Sharing our expectations of you as a Plan Participant.

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 Plan Participants as set forth in this Certificate of Coverage.
- Voice complaints or appeal 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:

- Choose an In-Network Provider for services to receive the highest level of Benefits, called "In-Plan" Benefits.
- 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 Piedmont know if you have any changes to your name, address, or family members covered under your policy.
- 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.

Section VIII: 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 or Allowed Amount means the amount determined by Piedmont as payable for a specified Covered Service or the provider's charge for that service, whichever is less. It is the maximum portion of a billed charge a health carrier will pay, including any applicable cost-sharing requirements, for a covered service or item rendered by a participating provider or by a nonparticipating provider. Piedmont will never pay more than its Allowable Charge for any Covered Service.

Authorized Service(s) means a Covered Service you get from an Out-of-Network Provider that we have specifically agreed in advance to cover at the In-Network level. You will have to pay any In-Network Deductible, Coinsurance, and/or Copayment(s) that apply, and may also have to pay the difference between the Maximum Allowed Amount and the Out-of-Network Provider's charge.

Balance Bill means a bill sent to an enrollee by an out-of-network provider for health care services provided to the enrollee after the provider's billed amount is not fully reimbursed by the carrier, exclusive of applicable cost-sharing requirements.

Benefit(s) or Covered Benefit(s) means the payouts to Providers that Piedmont is contractually obligated to make pursuant to your Coverage.

Calendar Year means the period from January 1st through December 31st or the lesser part of that period during which the Participant is enrolled under this Certificate of Coverage.

Certificate of Coverage or COC means this document, the Schedule of Benefits, and any Amendment or related document issued in conjunction with this document, setting out the Coverage and other rights to which you are entitled.

Child 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 certificate. 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 specifically noted in the "Eligibility" section of the Certificate of Coverage, there is no requirement that the Child be financially dependent on an individual covered under the contract or certificate, the Child share a residence with an individual covered under the contract or certificate, the Child meet student status requirements, the Child be unmarried, the Child not be employed, or any combination of these factors. The "Limiting Age" of a Child otherwise eligible for Coverage under the contract or certificate is age 26.

Coinsurance means a fixed percentage of the Allowable Charge that you must pay out-of-pocket for a Covered Service in order to receive that service.

Coordination of Benefits is the process of determining which of two or more insurance policies will have the primary responsibility of processing/paying a claim and the extent to which the other policies will contribute.

Copayment means the amount you must pay out-of-pocket for a Covered Service in order to receive that service.

Cost-Sharing Requirement means an enrollee's deductible, copayment amount, or coinsurance rate.

Coverage or Covered Services means those Medically Necessary Primary Care, Specialty Care, Inpatient, Outpatient and Hospital and medical services which Plan Participants are entitled to receive and that are: (i) listed as covered in this Certificate of Coverage; (ii) performed, prescribed, or directed by an In-Network Physician or by an Out-of-Network Provider; and (iii) subject to the terms, conditions, definitions, limitations, and exclusions described in the Certificate of Coverage, the group enrollment agreement and related documents.

Deductible(s) means the amount that a Participant is required to pay out-of-pocket for a Covered Service or Covered Services before Piedmont begins to pay the costs associated with the service(s).

Dependent means any Plan Participant of the Subscriber's family: who meets all of the eligibility requirements of this Certificate of Coverage; who is enrolled hereunder; and for whom the payment of a Premium required under the Certificate of Coverage and the Group Enrollment Agreement has actually been received by Piedmont.

Durable Medical Equipment (DME) means medical equipment that is:

- Ordered, prescribed, or provided by a Physician for outpatient use primarily in a home setting;
- Primarily and customarily used to serve a medical purpose;
- Not useful to a person in the absence of illness or injury;
- Reusable and can stand repeated use; and
- Not consumable or disposable except as needed for the effective use of Covered DME.

Emergency medical condition **or Emergencies** means, regardless of the final diagnosis rendered to a covered person, those services rendered by In-Network Providers or Out-of-Network Providers after the sudden onset of a medical condition that: (a) manifests itself by acute symptoms of sufficient severity, including severe pain, and (b) that the absence of immediate medical attention could reasonably be expected by a prudent layperson who possesses an average knowledge of health and medicine to result in: (i) serious jeopardy to the

mental or physical health of the individual; (ii) danger of serious impairment of the individual's bodily functions; (iii) serious dysfunction of any bodily organ or part; or (iv) in the case of a pregnant woman, serious jeopardy to the health of the fetus. Emergencies include: heart attacks; hemorrhaging; poisonings; loss of consciousness; convulsions; and other acute conditions as Piedmont shall determine. (Plan Participant always has the right to appeal any such determination by Piedmont).

Emergency services means those health care services that are rendered by affiliated or non-affiliated providers after the sudden onset of a medical condition that manifests itself by symptoms of sufficient severity, including severe pain, that the absence of immediate medical attention could reasonably be expected by a prudent layperson who possesses an average knowledge of health and medicine to result in (i) serious jeopardy to the mental or physical health of the individual, (ii) danger of serious impairment of the individual's bodily functions, (iii) serious dysfunction of any of the individual's bodily organs, or (iv) in the case of a pregnant woman, serious jeopardy to the health of the fetus.

Emergency services shall include Covered Services from Out-of-Network Providers. Emergency services means with respect to an Emergency medical condition: (1) a medical screening examination within the capability of the Emergency department of a Hospital or other skilled medical facility, including ancillary services routinely available to the Emergency department to evaluate the condition; and (2) within the capabilities of the staff/facilities available at the Hospital or skilled medical facility.

> **Stabilize,** with respect to Emergency services, means to provide treatment that assures that no material deterioration of the Emergency medical condition is likely to result from or occur during the transfer of the individual from a Hospital or other skilled medical facility, or with respect to a pregnant woman, that the woman has delivered, including the placenta.

Employee shall 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. These services are being further defined by the Secretary of the U. S. Department of Health and Human Services pursuant to authority conferred by the Affordable Care Act, and Piedmont expects to conform this definition to those changes.

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

Experimental/Investigative means any service or supply which is determined to be experimental or investigative in Piedmont's sole discretion (subject to all appeals available to you).

Piedmont will apply the following criteria in exercising its discretion. A service or supply will be Experimental/Investigative if Piedmont determines that any one of the criteria is not satisfied:

A) Any supply or drug used must have received final approval to market by the U.S. 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 Piedmont 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 is the covered Subscriber and the Subscriber's family members that are Plan Participants of that Subscriber covered as Dependents.

Group Enrollment Agreement means the policy of insurance Coverage between Piedmont and Subscriber's Employer or Group, of which this Certificate of Coverage is a part.

Hospital shall mean 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 and which has entered into a Participation Agreement with Piedmont (or Affiliate) to provide Covered Services to Plan Participants.

In-Network Physician means a duly licensed Doctor of Medicine or Osteopathy who has contracted with Piedmont or Piedmont's subcontractor(s) to provide medical services to Participants.

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 Piedmont, its designee, contractor, or subcontractor(s) to provide Covered Services to Participants and be reimbursed by Piedmont at a contracted rate as payment in full for the health care services, including applicable cost-sharing requirements. A list of In-Network Providers is made available to each Subscriber upon enrollment and is available upon request from Piedmont and viewable online at **www.pchp.net**. Piedmont shall revise the list as Piedmont deems necessary or at such other time as applicable law requires.

Inpatient means a Participant who has been admitted to a Hospital or skilled nursing facility, is confined to a bed there, and receives meals and other care in that facility.

Limiting Age means the age after which a Participant Dependent Child is no longer eligible for Coverage under this Certificate of Coverage. The Limiting Age for Dependent Children is age 26.

Medical Director means a duly licensed physician or his designee who has been assigned by Piedmont to perform the functions required of him or her under this Certificate of Coverage.

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

Network shall refer to any Primary Care Physicians Specialist Physicians, mental/behavioral health professionals, Hospitals, facilities, and ancillary service providers as set forth in the applicable Provider Directory supplied by Piedmont.

Open Enrollment Period refers to the period of time during which eligible Subscribers who have not previously enrolled in the Plan may apply to newly enroll for Coverage or otherwise change Plans.

Out-of-Network or Nonparticipating Provider is a Provider that does not have an agreement or contract with Piedmont, or Piedmont's contractor(s) or subcontractor(s) to provide Covered Services to Participants.

Out-of-Pocket Maximum or Maximum Out-of-Pocket (MOOP) means the maximum amount an enrollee is required to pay in the form of 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 Participant who is receiving care but who has not been admitted to a Hospital, skilled medical facility, or skilled nursing facility.

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 or a Doctor of Osteopathy. 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, chiropodist, clinical nurse specialist, audiologist, speech pathologist, certified nurse midwife or other nurse practitioner, marriage and family therapist or licensed acupuncturist. Physician includes Primary Care Physician (PCP), Specialist Physician, nurse practitioner, physician assistant and any other Provider(s) as defined in this Certificate of Coverage.

Piedmont means Piedmont Community Healthcare, Inc.

Plan shall mean the Employer's/Group's Coverage insured by Piedmont and evidenced by the: (1) Group Enrollment Agreement; (2) COC; (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 COC; (2) are validly enrolled hereunder; and (3) for whom the payment of the Premium required under the Group Enrollment Agreement and this COC 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 Piedmont and the Subscriber's employer, including this Certificate of Coverage.

Preauthorization means an evaluation process that assesses the Medical Necessity and appropriateness of a request for care or treatment and determines that the treatment is being provided at the appropriate level of care.

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

Preventive Services means:

(i) 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;

(ii) 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;

(iii) 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

(iv) 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 whom you select to provide primary health care and to coordinate the other Covered Services that you may require. PCPs include internists, family/general practitioners, pediatricians, and geriatricians. All Participants should have a Primary Care Physician. Each Participant may choose any available Primary Care Physician in accordance with the terms and conditions of this Certificate of Coverage.

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) shall mean any professional organization, association or entity which furnishes or causes to be furnished Primary or Specialty care services, Hospital services or ancillary medical services in connection therewith or any form thereof.

Service Area means the geographic area within which most Covered Services are available. Information about Piedmont's service area is provided as part of your enrollment materials, may be updated from time to time, and is available from Piedmont on request. The Service Area for this Certificate of Coverage includes the cities of Lynchburg, Bedford, Danville,

Harrisonburg, Staunton, and Waynesboro; and the counties of Amelia, Amherst, Appomattox, Augusta, Bedford, Buckingham, Campbell, Charlotte, Cumberland, Halifax, Lunenburg, Mecklenburg, Nelson, Nottoway, Pittsylvania, Prince Edward, and Rockingham; all in the Commonwealth of Virginia.

Specialist Physician means a medical professional other than a Primary Care Physician (family, general, internal medicine and pediatric physicians) providing specialty medical services to Plan Participants. This includes professionals providing Urgent Care and chiropractic services.

Subscriber means the eligible Employee: (1) as defined in the Policy; (2) who has elected Coverage for himself/herself and his or her family members who are Plan Participants (if any); (3) who meet the eligibility requirements of this Certificate of Coverage and enroll hereunder; and (4) for whom the Premium required by the Policy shall have been paid to and received by Piedmont.

Surgical or Ancillary Services means professional services, including surgery, anesthesiology, pathology, radiology, or hospitalist services and laboratory services.

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, and minor cuts. An Urgent Care situation is distinguished from an Emergency medical condition, and it may be handled through Your Primary Care Physician if available, or through an Urgent Care center.

Usual and Customary means the amount paid 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, Inc. (Piedmont). These words always refer to Piedmont even though the first letters of the words may not be capitalized.

You, your, yourself refers to a Participant. These words always refer to a Plan Participant even though the first letters of the words may not be capitalized.