LARGE GROUP

2023 PPO Certificate of Coverage

PIEDMONT COMMUNITY HEALTHCARE, INC.
2316 Atherholt Rd., Lynchburg, VA 24501

Cover Page

IMPORTANT INFORMATION REGARDING YOUR INSURANCE.

THIS IS THE CERTIFICATE OF COVERAGE FOR LARGE GROUP MAJOR MEDICAL INSURANCE

RENEWABILITY

We automatically renew Your Coverage annually under this Certificate of Coverage (COC), at Our option, as long as these three provisions are met:

1. Premiums are paid in accordance with this COC's terms and the Group Enrollment Agreement of Your Employer/Group;
2. The Subscriber under this COC lives, works or resides in the Service Area; and
3. There are no fraudulent or material misrepresentations on the application or under the terms of this Coverage.

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

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

THIS CERTIFICATE OF COVERAGE IS NOT A MEDICARE SUPPLEMENT INSURANCE POLICY

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

Piedmont Community HealthCare, Inc.
Customer Service Department
2316 Atherholt Road
Lynchburg, Virginia 24501
Locally: (434) 947-4463
Toll free: (800) 400-7247
Fax: (434) 947-3670
Website: www.pchp.net

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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 Us and Your Employer/Group. This large group Major Medical COC is offered and underwritten by Us.

A. Your Responsibilities

You assume certain responsibilities by partnering with Us 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, We encourage You to designate and utilize a PCP.

Choose Your Treating Providers. Our agreements with Our 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 Your sole responsibility.

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

1. Change in marital status;
2. Covered Person loses eligibility for enrollment (e.g. marriage, exceeding the Limiting Age, divorce, etc.);
3. New Covered Person becomes eligible (e.g. newborns);
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; or
8. Availability of other health Coverage.

Failure to provide proper notice of changes in Coverage may affect Your Coverage. We are not responsible for 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). We will issue each Covered Person an ID card. You must present Your ID card whenever You receive Covered Services. ID cards are not transferable. Unauthorized use of the ID by any person can result in termination of enrollment by Us. You will be obligated to pay for the unauthorized Covered Services obtained. The ID card serves only to identify You and confers no right to Covered Services or Benefits. To be

entitled to Covered Services or Benefits, an ID cardholder must, in fact, be a Covered Person on whose behalf all applicable Premiums have actually been paid. Covered Persons must always carry their Piedmont ID card with them to assure prompt receipt of Covered Services. If a card is lost or stolen, please notify Us immediately. ID cards remain the property of Piedmont and must be returned to Piedmont or destroyed upon termination of Your Coverage.

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 the 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 We are notified of any changes in name, address, phone number, or Covered Person's eligibility.
- Utilize grievance and appeal procedures discussed further in this COC to resolve concerns and complaints.
- Obtain Covered Services through In-Network Physicians and other In-Network Providers.
- Obtain Preauthorization before treatment is received for Covered Services that require it.
- Obtain a formal Authorized referral from Us before treatment is received from Out-of-Network Providers if care from Out-of-Network Providers is necessary. 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 Us with requested information, including medical records, Physician statements regarding care and treatment, and any information regarding Your or the Covered Person's physical condition.
- Provide Us 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 COC 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

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

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

Special Limitations - Rights of the Covered Person 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 Our control results in Our facilities, personnel, or financial resources being unavailable to provide or arrange for the provision of Covered Services, We will make a good faith effort to provide or arrange for the provision of Covered Services as practical, and according to Our best judgment. Piedmont and the In-Network Providers will incur no liability or obligation for delay, or failure to provide or arrange for health services if such failure or delay is caused by such an event.

C. Important Information Regarding Your Insurance

In the event You need to contact someone about Your Coverage, You can always contact Your agent or Piedmont directly at:

Piedmont Community HealthCare, Inc.
Customer Service Department
2316 Atherholt Road
Lynchburg, Virginia 24501

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

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

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

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

- We provide 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)
- We provide free language services to people whose primary language is not English, such as:
    - Qualified interpreters
    - Information written in other languages

If You need these services, contact Our customer service at 1-800-400-7247 (TTY: 711).

If You believe that We have failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, You can file a grievance with Our 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 nìà 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. Ɖá 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۔1-800-400-7247 (TTY: 711)

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

Igbo asusu (Ibo)

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

Русский (Russian)

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

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

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

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

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

We will issue to Your Employer/Group a Group Enrollment Agreement and for delivery to each person insured, a COC. This COC 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 COC is not a complete description of Your Policy. This document summarizes certain applicable provisions from the group Policy between Your employer and Us. By being a COC holder, You are agreeing to abide by the applicable terms and conditions of the group Policy and this COC.

Together, the Group Policy and its amendments; this COC 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 Us.

No oral statement of any person, including Our employees, will modify or otherwise affect the Benefits, limitations, and Exclusions of the COC, convey or void any Coverage, increase or reduce any Benefits under this COC, 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 COC. 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. This COC describes the Benefits for which You and Your Covered Persons 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 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). Coverage for both In-Network and Out-of-Network Benefits is described on the Schedule of Benefits that is a part of this COC.

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 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. We 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 Us that causes You to see an Out-of-Network Specialist Physician often, You may receive a standing referral. We or your PCP will refer You to another Out-of-Network Specialist Physician for treatment of the ongoing special condition.

Care for Special Condition

"Special condition" means a condition or disease that is:

1. life-threatening, degenerative, or disabling; and
2. requires specialized medical care over a prolonged period of time.

The standing referral will allow the Out-of-Network Specialist Physician to treat the Covered Person 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 the Covered Person has been diagnosed with cancer, he/she 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 the PCP and any oncologist providing care 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 the cancer treatment.

Out-of-Network cost sharing

When using any In-Network Providers, Covered Services provided by an Out-of-Network ancillary Provider are covered. We will count cost sharing paid by the enrollee for the Covered Service by the Out-of-Network ancillary Provider at the In-Network Provider towards the In-Network annual Out-of-Pocket Maximum.

We provide a list of participating In-Network Providers and their locations free of charge. You may call Our customer service to see if a Provider participates in Your Plan's Networks. A list may be viewed on Our website at www.pchp.net.

B. Continuity/Transition of Care

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

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

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

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

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

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

2. Covered Services from In-Network Providers other than the PCP 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 the Covered Person

   a. Is in an active course of treatment from the In-Network Provider prior to the notice of termination, and
   b. Requests 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 Covered Person 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 will include, at the Participant's option, Covered Services for postpartum care directly related to the delivery.

4. A terminally ill Covered Person (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) We terminate the In-Network Provider (including the PCP) from the Network "for cause"; or (b) if You cease to be an eligible Subscriber. We will pay the Provider for Covered Services received pursuant to this subsection in accordance with Our 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 COC if You receive services from an Out-of-Network Provider, Setting, or Facility except as described in Section B. above.

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

A Covered Person 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 Us. 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 PCP 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 Us to verify Preauthorization requirements for specific services and procedures.

D. Services Requiring Preauthorization

Certain Covered Services will require Preauthorization by Us, except in an Emergency or Urgent Care situation after hours. The In-Network Physician will work with You or the Covered Person and Us to handle these Preauthorization arrangements. 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.

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

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

1. 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. Non-Emergent ambulance or air ambulance transport services;
4. Clinical trials;
5. 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 Our customer service or view Our website for further information;
6. 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;
7. Inpatient Hospital (except for routine vaginal/C-section deliveries at In-Network Hospitals);
8. Partial Hospitalization;
9. Acute rehabilitation;
10. Skilled nursing Facility;
11. Long-term acute care Hospital;
12. Inpatient detox, residential treatment, partial hospital and intensive Outpatient for substance abuse;
13. Magnetic resonance imaging (MRI) (except breast MRI);
14. Magnetic resonance angiography (MRA);
15. Magnetic resonance cholangiopancreatography (MRCP);
16. Positron emission tomography (PET) scans;
17. Bone scans;
18. Certain Outpatient surgeries, including those performed in the Outpatient Hospital or ambulatory surgery center setting and oral surgery;
19. Ablation procedures (no Preauthorization needed for cardiac ablation procedures), and radiofrequency ablation, including those performed in-office;
20. Endoscopic retrograde cholangio-pancreatography (ERCP);
21. Sclerotherapy;
22. Wireless capsule endoscopy;
23. All tertiary care services, including transplant services;
24. Applied behavioral analysis (ABA) services for autism spectrum disorder; and
25. Home infusion services.

You or the Provider must submit documentation, including a treatment plan when requested, for Covered Services requiring Preauthorization. We will establish that the appropriate level of criteria have been met and, if so, provide a Preauthorization to the Provider from whom the Covered Person plans to receive Covered Services. We 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 Our certification of Medical Necessity and not a guarantee of payment. For Benefits to be Covered Services, on the date the Covered Person gets service:

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

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

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

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

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

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

E. Preauthorization For Services From Out-of-Network Providers

If the In-Network Physician feels that the Covered Person needs to see a Physician or other medical professional who is not an In-Network Provider and the Covered Person believes these services may be eligible for In-Network Benefits, then the Physician must submit a referral request for Preauthorization, including medical information to Us prior to Your receiving services. Retroactive requests for consideration at the In-Network Benefit level will not be considered. Covered Services from Out-of-Network Providers must be Authorized by Us. We have the right to determine where the Covered Service can be provided when an In-Network Provider cannot provide the Covered Service.

F. Preauthorization For Transplant Procedures

Transplantation of internal organs will require additional information prior to Preauthorization by Us. We 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 Our Preauthorization or from Providers not Authorized by Us will be subject to Out-of-Network Benefits.

G. Preauthorization For Cosmetic Surgery Procedures

Some surgical procedures may be considered cosmetic and may require additional information prior to Preauthorization. We 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 COC. 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 Us 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 Our Preauthorization when required or from Out-of-Network Providers not Authorized by Us, will be covered as Out-of-Network 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 Covered Person'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 Us 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 COC. The goal of the UM program is to ensure the most medically appropriate services are rendered to patients in the most appropriate clinical setting.

Some services require Our approved Preauthorization before they are received. If Our requirements for Preauthorization are not followed, We may not pay for these services. Typically, In-Network Providers know which services require Preauthorization and will request Preauthorization when needed. The PCP 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 You.

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

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

Section III: What You Pay for Benefits

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

To the extent permitted by federal law and regulation, except for HSA qualified plans, when calculating a Covered Person's overall contribution to any Out-of-Pocket Maximum or any Cost-Sharing Requirement under this Plan, We will include any amounts paid by the Covered Person or on their behalf by another person.

A. Deductible (When Applicable)

1. **Deductible Amount.** This is an amount of charges for Covered Services for which no Benefits will be paid. Before Benefits can be paid in a Benefit Year, You must meet the Deductible shown in the Schedule of Benefits. Covered Services that are subject to a Copayment rather than Coinsurance will not be subject to the Deductible.

2. **Family Unit Limit.** When all of the Covered Persons of a Family Unit have incurred the dollar amount shown in the Schedule of Benefits toward their Family Benefit Year Deductibles, the Deductibles for the Family Unit will be considered satisfied for that Benefit Year. No individual family member will pay more than the "per person" amount shown in the Schedule of Benefits. Any amounts of Deductible paid more than the Family Unit Limit in a Benefit Year will be promptly reimbursed to You.

B. Copayment/Coinsurance Amounts

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

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

For insurance plans with Deductibles, the Coinsurance applies after the applicable Deductible has been satisfied if the Covered Service is subject to the Deductible. When seeing an Out-of-Network Provider, the Covered Person will be responsible for billed charges more than the Allowable Charge. Amounts above the Allowable Charge do not apply toward the Maximum Out-of-Pocket.

For some insurance Plans, the Copayment, Deductible, and Coinsurance may all apply to Benefits, however, the Copayment and Coinsurance will not apply to the same Benefit. In these instances, 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 Benefit Year, Benefits will be paid for those Covered Services a Covered Person receives once the Deductible is met. Payment will be made based on the amounts shown in the Schedule of Benefits. Benefits will not be paid more than the limits listed in this COC or the Schedule of Benefits.

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 Covered Person will be payable at 100% (except for those charges excluded from the Out-of-Pocket Maximum) for the remainder of that Benefit Year.

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

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

- Any amounts payable by the Participant for Pediatric Dental;
- Non-Covered Services as described in this COC;
- Charges more than 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 Out-of-Pocket Maximum for the Benefit Year, You will still have cost obligations for the items listed above.

NOTE: The Out-of-Pocket Maximums for In-Network and Out-of-Network Benefits accumulate separately.

E. Allowable Charge

You will only have to pay your Copayment, Deductible, and/or Coinsurance and will not be Balance Billed by In-Network Providers for amounts above the Allowable Charge. When seeing an Out-of-Network Provider due to a Piedmont Authorized referral, Covered Persons

are responsible for billed charges in excess of the Allowable Charge. Amounts above the Allowable Charge do not apply toward the Out-of-Pocket Maximum.

F. Balance Billing Prohibited for Certain Services

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

- Emergency Services provided to a Covered Person; or
- Nonemergency services provided to a Covered Person at an In-Network Facility if the nonemergency services involve surgical or ancillary Services provided by an Out-of-Network Provider.

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

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

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

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

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

days and either party chooses to pursue further action to resolve the dispute, the dispute will be resolved through an arbitration process regulated by the Commission.

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

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

In addition, the Federal No Surprises Act states that Balance Billing is prohibited for Out-of-Network emergency air ambulance services.

Section IV: What is Covered

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

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

A. Allergy Treatment

Allergy testing, diagnosis, and Medically Necessary treatment (including allergy shots) are Covered Services, including 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 Us. 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, including fixed wing or rotary wing, are also Covered Services when preauthorized by Us 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 Covered Person to the geographically closest Hospital capable of treating that the Covered Person's Medically Necessary condition will be covered. Reimbursement will be made directly to the Provider, when We are presented with an assignment of Benefits by the person providing such services.

In addition, the Federal No Surprises Act states that Balance Billing is prohibited for Out-of-Network emergency air ambulance 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 will not be greater than cost-sharing for intravenously or by injection administered drugs.

D. Clinical Trials for Life-Threatening Diseases/Conditions

This COC includes Coverage of routine patient costs of qualified individuals associated with approved clinical trials for life-threatening diseases or conditions. We will not deny a qualified individual participation in an approved clinical trial, deny or limit, or impose additional conditions on the Coverage of routine patient costs for items or services furnished in connection with participation in the approved clinical trial. We will not discriminate against the individual based on the individual's participation in the approved clinical trial. Routine patient costs do not include the cost of 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 (1) a federally funded or approved trial, (2) conducted under an Investigational new drug application reviewed by the U.S. Food and Drug Administration, or (3) a drug trial that is exempt from having an Investigational new drug application. "Life threatening condition" means any disease or condition from which the likelihood of death is probable unless the course of disease or condition is interrupted. In all cases, Coverage for any clinical trial for 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;
c. You and the Physician who furnishes Covered Services to You conclude that participation in the clinical trial would be appropriate under the terms and conditions contained in Your Piedmont Coverage; and
d. The Facility and personnel providing the treatment are capable of doing so by virtue of their experience, training, and expertise.

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

a. The National Institutes of Health (NIH). (Includes the National Cancer Institute ("NCI");
b. The Centers for Disease Control and Prevention;
c. The Agency for Health Care Research and Quality;
d. The Centers for Medicare and Medicaid Services;
e. Cooperative group or center of any of the entities described in (a) through (d) or the Department of Defense or the Department of Veterans Affairs;
f. A qualified non-governmental research entity identified in the guidelines issued by the National Institutes of Health for center support grants;
g. The Department of Veterans Affairs, the Department of Defense, or the Department of Energy as long as the study or investigation has been reviewed and approved through a system of peer review that the Secretary determines 1) to be comparable to the system of peer review of studies and investigations

used by the National Institutes of Health, and 2) assures unbiased review of the highest scientific standards by qualified individuals who have no interest in the outcome of the review;

h. An NCI cooperative group (i.e. a formal Network of facilities that collaborates on research projects and has an established US National Institutes of Health-approved peer review program operating within the group such as: the NCI Clinical Cooperative Group and the NCI Community Clinical Oncology Program) or an NCI center);

i. The FDA in the form of an investigational new drug application; or

j. An institutional review board of an institution in the Commonwealth of Virginia that has a multiple project assurance contract (i.e. a contract between an institution and the 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).

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

E. Diabetes Care Management

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

- Medically Necessary insulin pumps;
- Home blood glucose monitors, lancets, blood glucose test strips, syringes, and hypodermic needles when purchased from a pharmacy; and
- Outpatient self-management training and education performed in-person; including medical nutrition therapy, when provided by a certified, licensed, or registered health care professional.

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-Network 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 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 scans, PET/CT Fusion scans, CT scans, SPECT scans, QCT Bone Densitometry, diagnostic CT Colonography, nuclear cardiology, BRCA and fetal screenings, and non-preventive diagnostic colonoscopy and diagnostic mammography performed in an Inpatient or Outpatient Facility are covered under the Inpatient or Outpatient Facility Benefit. Preventive screening mammography and screening colonoscopy services may be covered without requirement of further payment. Diagnostic tests include lab and pathology services as well as the professional services for test interpretation, x-ray reading, lab interpretation and scan reading. Diagnostic tests are covered in both an Inpatient and Outpatient setting. Diagnostic sleep testing and treatment are covered (see Durable Medical Equipment and Supplies within Section IV: What is Covered for specifics).

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

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

Advanced Imaging Services include but are not limited to:

- CT Scans;
- CTA Scans;
- Magnetic Resonance Imaging (MRI);
- Magnetic Resonance Angiography (MRA);
- Magnetic Resonance Spectroscopy (MRS);
- Nuclear Cardiology;
- PET Scans;

- PET/CT Fusion Scan;
- QCT Bone Densitometry;
- Diagnostic CT Colonography;
- Single Photon Emission Computed Tomography (SPECT) Scans.

Diagnostic and surgical treatment involving any bone or joint of the head, neck, face, or jaw is covered like any other bone or joint of the skeletal system. The treatment must be Medically Necessary and be required because of a medical condition or injury that prevents normal function of the joint or bone and is deemed Medically Necessary to attain functional capacity of the affected part. Coverage includes Outpatient surgical or Inpatient settings.

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

G. Dialysis

We cover dialysis treatment, which is the treatment of severe kidney failure or chronic poor functioning of the kidneys. This includes:
- hemodialysis;
- peritoneal dialysis.

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

H. Doctor Visits and Services

We cover visits to a Doctor's office (including second surgical opinions), including:
- office visits to a PCP, a Specialist Physician, NP, PA and any other Provider(s) as defined in this COC;
- visits for direct access obstetrical or gynecological services by any covered female of age thirteen or older to a participating obstetrician-gynecologist authorized to provide services under the policy, contract, or plan and selected by such female;
- Doctor's visits to the Covered Person's 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 payment questions;
- asking for referrals to Doctors outside the online care panel;
- Benefit precertification; or
- Doctor to Doctor discussions.

Physician (Doctor) includes Primary Care Physician (PCP), Specialist Physician, NP, PA 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 Us) is a Covered Service. In order to receive In-Network 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:

- Hospital beds;
- Bedside commode, shower chair, and tub rails;
- Canes, crutches, walkers, slings, splints, cervical collars, and traction apparatus;
- Wheelchairs and Medically Necessary wheelchair accessories and supplies;
- Oxygen and oxygen equipment, including C-pap) and Bi-pap;
- Ostomy supplies, including bags, flanges, and belts;*
- Indwelling catheters, straight catheters, and catheter bags;*
- Respirators;
- Jobst stockings or equivalent when prescribed by a vascular surgeon prior to or following vascular surgery;
- The first pair of contact lenses or eyeglasses following approved cataract surgery without implant or for the treatment of accidental injury;
- Prosthetic Devices and components (including Medically Necessary Prosthetic Devices), orthopedic braces, leg braces including attached or built-up shoes attached to a leg brace, molded or therapeutic shoes for diabetics with peripheral vascular disease; arm braces, back braces, neck braces, head halters, catheters and related supplies and splints;
- Two bras or camisoles per year (two total) following mastectomy;
- Nebulizers;
- One wig following chemotherapy;
- Negative pressure wound therapy or “wound vac”;
- Orthotics, other than foot orthotics;
- Phototherapy lights; and
- Lymphedema sleeves.

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

We cover maintenance and necessary repairs of Durable Medical Equipment except when damage is due to neglect. We will not replace lost Durable Medical Equipment. Any Durable Medical Equipment not listed above is not a Covered Service. This includes but is not limited to TENS unit and TMJ appliances.

Prosthetic Device means an artificial device to replace, in whole or in part, a limb. Medically Necessary Prosthetic Device includes any myoelectric, biomechanical, or microprocessor-controlled prosthetic device that peer-reviewed medical literature has determined to be medically appropriate on the basis of the clinical assessment of the enrollee's rehabilitation potential. Limb means an arm, a hand, a leg, a foot, or any portion of an arm, a hand, a leg, or a foot. Component means the materials and equipment needed to ensure the comfort and functioning of a Prosthetic Device

Coverage is provided for Medically Necessary Prosthetic Devices and their repair, fitting, adjustment, replacement, and Components. This coverage does not include:

- The cost of repair and replacement due to enrollee neglect, misuse, or abuse; or
- Prosthetic Devices designed primarily for an athletic purpose.

We will consider replacement of Durable Medical Equipment if:

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

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/her environment, and will include services that enhance functional ability without effecting a cure. No therapy visit maximum applies to occupational, physical or speech therapy services received under this Benefit.

K. Emergency and Urgent Care Services

When the Covered Person requires resuscitation, Emergency treatment, or the Covered Person's life is endangered, We do not require prior authorization before the Covered Person

calls: (1) an Emergency 911 system; or (2) other state, county or municipal emergency medical system. We cover emergency room professional and Facility services including diagnostic x-ray, lab services, medical supplies, and advanced diagnostic imaging, such as MRIs and CAT scans, to evaluate and Stabilize a patient with an Emergency Medical Condition.

Emergency Services, including professional and Facility services, provided to a Covered Person in the emergency department of a Hospital or other skilled medical Facility are Covered Benefits:

1. Without regard to the final diagnosis rendered to the Covered Person or whether the Provider furnishing the Emergency Services is an In-Network Provider with respect to the services;
2. Without the need for Our Preauthorization, 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 Prohibited for Certain Services" less any Cost-Sharing Requirement. Any such Cost-Sharing Requirement shall not exceed the Cost-Sharing Requirement that would apply if such services were provided In-Network.

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. The initial screening and stabilization services will be applied to the In-Network level of cost sharing for Emergency Services.

We 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 COC 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 COC or Schedule of Benefits.
3. The Usual and Customary amount for the Emergency Service calculated using the same method that We generally use to determine payments for services provided by an Out-of-Network Provider (the Allowable Charge), less any Copayment or Coinsurance amounts imposed in your COC 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 COC or Schedule of Benefits.

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

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

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

a. We cover Urgent Care and Emergency Services outside the Service Area 24 hours a day, 7 days a week, if the Covered Person sustains an injury or becomes ill while temporarily away from the Service Area. Accordingly, Benefits for these services are limited to care 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 a Covered Person is temporarily outside the Service Area, please obtain care at the nearest Hospital or skilled medical Facility. The Covered Person or his/her representative is responsible for notifying Us within 24 hours, on the next working day, or as soon as he/she is physically/mentally capable of doing so.
c. Benefits for continuing or follow-up treatment must be pre-arranged by Us in order to be covered as In-Network Benefits. This is subject to all provisions of this COC.

3. **Notification for Emergency Services**

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

L. Hearing Services

We cover infant hearing examinations for covered newborn Children when performed by a Provider, including screenings for congenital cytomegalovirus for newborns who fail the newborn hearing screens. Coverage is for infant hearing screenings and all necessary audiological examinations provided pursuant to applicable law or regulation of the Commonwealth of Virginia using any technology approved by the 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 COC's terms and conditions, this coverage includes any follow-up audiological examinations as recommended by a Physician or audiologist and performed by a licensed audiologist to confirm the existence or absence of hearing loss. All other hearing services and supplies are not covered.

M. Hemophilia

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

- Coverage for the purchase of blood 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 the Covered Person 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

- **Home Health Services.** Home health services covers treatment provided in the Covered Person's home on a part-time or intermittent basis if provided by a licensed health care professional, including nurse, therapist, or home health aide.
  This includes:
  - intermittent skilled nursing care by an R.N. or L.P.N.;

- home health aide services when receiving skilled nursing or therapy services;
- physical, occupational, and speech therapy;
- medical/social services;
- diagnostic services;
- nutritional guidance;
- Durable Medical Equipment;
- training of the patient and/or Family/caregiver;
- habilitative and short-term rehabilitative services (subject to the limitations set forth in this COC and does not include manipulation therapy when given in the home);
- home infusion therapy as described in this section under Paragraph **R. Infusion Therapy**;
- medical supplies; and
- other Medically Necessary services and supplies.

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

The following are not Covered Services:

- Homemaker services;
- Food and home-delivered meals;
- Custodial care (including Outpatient custodial care);
- Respite care; and/or
- Other non-medical services.

- **Home Health Limits: Maximum of 100 visits per Benefit Year**. Physical, speech, and occupational therapy services provided as part of home care are not subject to separate visit limits for therapy services.

- **House Calls.** House calls determined to be Medically Necessary by the Physician and Us are Covered Services.

- **Remote Patient Monitoring Services using Telemedicine.** Remote Patient Monitoring Services using Telemedicine are Covered Services and means the delivery of home health services using telecommunications technology to enhance the delivery of home health care, including monitoring of clinical patient data such as weight, blood pressure, pulse, pulse oximetry, blood glucose, and other condition-specific data; medication adherence monitoring; and interactive video conferencing with or without digital image upload.

O. Hospice Services

Hospice services are Covered Services when:

- A Provider that We determine is a licensed hospice provides these services. "Hospice Services" means a coordinated program of home and Inpatient care provided directly or under the direction of a licensed hospice. This includes palliative and supportive physical, psychological, psychosocial, and other health services to individuals with a terminal illness utilizing a medically directed interdisciplinary team;
- The Covered Person has a terminal illness (For the purposes of this Subsection, "terminal illness" means a condition diagnosed as terminal by a licensed Physician and whose life expectancy is six months or less);
- The Covered Person elects to receive Palliative Care rather than curative care. This means that the Covered Person elects treatment directed at controlling pain, relieving other symptoms, and focusing on special needs related to the stress of the dying process rather than treatment aimed at investigation and intervention for the purpose of cure or prolongation of life; and
- We authorize the services provided.

Covered Hospice Services include:

- Skilled nursing care, including IV therapy services;
- Drugs and other Outpatient prescription medications for palliative care and pain management;
- Services of a medical social worker;
- Services of a home health aide or homemaker and in-home Hospice;
- Short-term Inpatient 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 the Covered Person is treated on an Outpatient basis, or when he/she is an Inpatient because of illness, injury, or

pregnancy. This includes Inpatient rehabilitative/habilitative services and devices when Medically Necessary. Covered Services include anesthesia services in an Inpatient setting as well as services rendered by an anesthesiologist.

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

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

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

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

- Inpatient services and supplies furnished by a Hospital are Covered Services and require Preauthorization. We reserve the right to determine whether the continuation of any Hospital admission is Medically Necessary. Special rules apply in Emergencies and for transplant services. We will not require Preauthorization for the interhospital transfer of (1) a newborn infant experiencing a life-threatening emergency condition or (2) the hospitalized mother of such newborn infant to accompany the infant.

- The room and board and nursing care furnished by a skilled nursing Facility are Covered Services when:

    - The Covered Person is confined as a bed patient in the Facility;
    - The attending Physician completes a treatment plan that describes the type of care that is needed; and
    - We authorize the services provided.

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

- For certain conditions, the law mandates a minimum Inpatient length of stay. We will provide the following Benefits for Inpatient services received:

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

Q. Individual Case Management

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

- at Our discretion;
- only when and for so long as We determine (in consultation with the In-Network Physician) that the alternative services are Medically Necessary and cost-effective; and
- the total Benefits paid for such services do not exceed the maximum Benefits to which the Covered Person would otherwise be entitled under this COC in the absence of alternative Benefits.

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

R. Infusion Services

Covered Services include:

- infusion of therapeutic agents, medication and nutrients;

- infusion of special medical formulas as the primary source of nutrition for a Covered Person with inborn errors of amino acid or organic acid metabolism, metabolic abnormality or severe protein or soy allergies;
- 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.** Covered Services are:
   - Pregnancy testing;
   - maternity care;
   - maternity-related checkups;
   - breast pumps (limit of one pump per pregnancy); and
   - pre-natal and post-natal care for a Covered Person (including covered Dependents).

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

Maternity care includes the following services:

- Hospital services, including use of delivery room;
- Physician services, including operations and special procedures such as Caesarean section;
- Home setting covered with nurse midwives; also includes delivery at 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 Anemia, gestational diabetes, Hepatitis B, Rh incompatibility, and urinary tract or other infection.
- folic acid supplements for pregnant Covered Persons;
- expanded tobacco intervention and counseling for pregnant users;
- Inpatient and Outpatient dental, oral surgical, and orthodontic services that are Medically Necessary for the treatment of medically diagnosed cleft lip, cleft palate, or ectodermal dysplasia;
- Fetal screenings, 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;
- We will not require Preauthorization for the interhospital transfer of (1) a newborn infant experiencing a life-threatening emergency condition or (2) the hospitalized mother of such newborn infant to accompany the infant.
- **There is no cost-sharing for required Preventive Services.**

The Newborns' and Mothers' Health Protection Act was signed into federal law on September 26, 1996. It provides important protections for mothers and their newborn Children 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: (1) less than 48 hours following a vaginal delivery; or (2) less than 96 hours following a cesarean section. However, federal law generally does not prohibit the mother's or newborn's attending Physician, after consulting with the

mother, from discharging the mother or her newborn earlier than 48 hours (or 96 hours as applicable).

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

Coverage for obstetrical services as an Inpatient in a general Hospital or obstetrical services by a Physician will 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.** We cover services to diagnose and treat conditions resulting in infertility. All other infertility services including treatment to promote conception by artificial means and medications are not Covered Services.

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 the Physician; and
- Prescription medications infused through IV therapy in the Physician's office or Outpatient Facility.

Certain medical supplies may be covered under the prescription drug Benefit when purchased or supplied by a pharmacy. Please see the Section on PRESCRIPTION DRUG SERVICES for more information.

V. Mental/Behavioral Health and Substance Use Disorder Services

We will provide mental/behavioral health and substance use disorder services equal to the Coverage for medical and surgical Benefits. As required for other medical and surgical Facility Benefits, We require Preauthorization for any Inpatient or Outpatient mental/behavioral health and substance use disorder Facility services. We also require 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 and group psychotherapy;
- psychological testing;
- counseling with family members to assist with the patient's diagnosis and treatment;
- behavioral health and convulsive therapy treatment;
- detoxification; and
- professional services in a Facility.

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

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

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

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

Diagnosis and treatment of **Autism Spectrum Disorder** of any age is a Covered Service, including applied behavior analysis (ABA) services. Applied behavior analysis means the design, implementation, and evaluation of environmental modifications, using behavioral

stimuli and consequences, to produce socially significant improvement in human behavior, including the use of direct observation, measurement, and functional analysis of the relationship between environment and behavior. Physical, speech, and occupational therapy services for the treatment of Autism Spectrum Disorder are not subject to separate visit limits for therapy services.

- Autism Spectrum Disorder means any pervasive developmental disorder, at the time of diagnosis of the disorder or autism spectrum disorder, as defined in the most recent edition or the most recent edition Diagnostic and Statistical Manual of Mental Disorders of the American Psychiatric Association.

Autism Spectrum Disorder diagnosis means Medically Necessary assessments, evaluations, or tests to diagnose whether an individual has an Autism Spectrum Disorder. Medically Necessary means in accordance with the generally accepted standards of mental disorder or condition care and clinically appropriate in terms of type, frequency, site, and duration, based upon evidence and reasonably expected to do any of the following:

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

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

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

W. New Technology

We regularly evaluate 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. To be considered Covered Services, new and existing technologies must demonstrate a marked improvement in health outcomes, health risks, and health benefits when compared

with established procedures and products based on clinical evidence reported by Peer Reviewed Medical Literature.

X. Oral Surgery; Dental Services

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

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

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

1. Medically Necessary dental services resulting from an accidental dental injury, regardless of the date of such injury, are Covered Services. Treatment must begin within 12 months of the injury, or as soon after that as possible to be a Covered Service. Our Preauthorization 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 Person when required to treat medically diagnosed cleft lip, cleft palate, or ectodermal dysplasia are Covered Services.

5. Dental services to prepare the mouth for medical services and treatments such as radiation therapy to treat cancer and prepare for transplants are Covered Services, including dental x-rays, extractions, and anesthesia. Also covered is treatment of non-dental lesions, such as removal of 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 Services. Bone or joint treatment involving a bone or joint of the head, neck, face, or jaw is covered like any other bone or joint of the skeletal system. The treatment must be Medically Necessary and be required because of a medical condition or injury that prevents normal function of the joint or bone. Coverage includes Outpatient surgical or Inpatient settings.

7. All oral Surgical Services for extractions of impacted wisdom teeth are Covered Services.

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

9. Alveolectomy when related to 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. We cover Medically Necessary general anesthesia, Hospitalization or Outpatient Facility charges by a Facility licensed to provide Outpatient surgical procedures for dental care provided to any Covered Person who is:

    a. determined by a licensed dentist, in consultation with the treating Physician, to require general anesthesia and admission to a Hospital or Outpatient surgery Facility to provide dental care effectively and safely; and
    b. under the age of 5, or severely disabled, or has a medical condition and requires admission to a Hospital or Outpatient surgery Facility and general anesthesia for dental care.

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 COC, the underlying dental care provided incidental to anesthesia, Hospitalization, or Outpatient surgery, is not covered. For the purposes of determining whether: (1) general anesthesia; (2) the Hospital admission; or (3) the Outpatient surgery is Medically Necessary under this section, We will consider whether the Covered Person's age, physical condition or mental condition requires the utilization of general anesthesia and the admission to a Hospital or Outpatient surgery Facility to provide the underlying dental care safely.

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 the 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, We 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. Our 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, the Covered Person will still have to pay the difference between the brand name drug and the generic drug, in addition to the appropriate Copayment, Deductible and/or Coinsurance amount. If the Physician does not require a brand name drug, the Covered Person may request a brand name drug and pay the difference between the brand name drug and the generic drug, in addition to the appropriate Copayment, Deductible and/or Coinsurance amount.

Medication Synchronization: We will permit and apply a prorated daily cost-sharing rate to prescriptions that are dispensed by a Network pharmacy for a partial supply if the Covered Person requests or agrees to a partial supply to synchronize their medication, and the prescribing Provider or the pharmacist determines the fill or refill to be in their best interest. We will allow a pharmacy to override any denial codes indicating that a prescription is being refilled too soon for the purposes of synchronizing the medications. Dispensing fees for partially filled or refilled prescriptions will be paid in full for each prescription dispensed, regardless of any prorated Copayment or fee paid for synchronization services.

The Prescription Drug Benefits cover prescriptions obtained from a pharmacist and includes injections administered at authorized pharmacies. 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: The 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. Our formulary is reviewed at least annually by a pharmacy & therapeutics committee of Our Pharmacy Benefit Manager (PBM) as required by state and federal laws and regulations. We may add or delete Prescription Drugs from the formulary from time to time. A description of the formulary is available upon request by calling Our customer service department at 800-400-7247 (or local at 434-947-4463) and at https://pchp.net/index.php/group-coverage-members/commercial-prescription-drugs.html.

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

Step Therapy Protocols and Step Therapy Exceptions:

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

We and Our PBM ensure that Our step therapy protocols:

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

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

When coverage of a Prescription Drug for the treatment of any medical condition is restricted for use by Us or Our PBM through the use of a step therapy protocol, the Covered Person and prescribing Provider will have access to a clear, readily accessible, and convenient process to request a step therapy exception. We will use Our existing medical exceptions request process and form shown below for Prescription Drugs not included on the formulary as the process for requesting a step therapy exception.
A step therapy exception request will be granted if the prescribing Provider's submitted justification and supporting clinical documentation, if needed, are determined to support the prescribing Provider's statement that:

1. The required prescription drug is contraindicated;
2. The required drug would be ineffective based on the known clinical characteristics of the patient and the known characteristics of the Prescription Drug regimen;

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

Upon the granting of a step therapy exception, We and Our PBM will authorize coverage for the Prescription Drug prescribed by the Covered Person's treating Provider, provided that the Prescription Drug is covered under Our formulary. We or Our PBM will respond to a step therapy exception request within 72 hours of receipt, including hours on weekends, to notify the Covered Person that the request is approved, denied, or requires supplementation. In cases where exigent circumstances exist, We will respond within 24 hours of receipt, including hours on weekends, that the request is approved, denied, or requires supplementation. The Covered Person may appeal any step therapy exception request denial through Our existing appeal procedures located later in this Certificate.

Exception Request for Prescription Drugs Not Included on the Formulary:

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

An Exception Request Form is available online at https://pchp.net/index.php/group-coverage-members/commercial-member-forms.html. Forms may be faxed to CVS/Caremark at 1-855-245-2134. Exception requests may also be communicated by phone to CVS/Caremark at 1-855-582-2022. Please note that this exception process form applies to drugs not included on the formulary as well as for step therapy exception requests. If a Covered Person has been denied Coverage for a drug included on the formulary, You have the right to a full and fair appeal of Our decision and should follow the appeal process described later in the COC.

We will act on this standard formulary 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. If We approve the coverage of the drug, coverage of the drug will be provided for the duration of the prescription, including refills. If We deny coverage of the drug, We have a process in place to allow the request to be reviewed by an independent review organization as described under "External Exception Request Review" in this Section.

Any Covered Person, a designated representative, the prescribing Physician or other prescriber may also submit a request for a Prescription Drug that is not on the formulary based on exigent circumstances. Exigent circumstances exist if he/she is suffering from a health condition that may seriously jeopardize life, health, or ability to regain maximum function, or if he/she is undergoing a current course of treatment using a drug not on the formulary. We will make a coverage decision within 24 hours of receipt of the request. If We approve the request, coverage of the drug will be provided for the duration of the exigency. If We deny

the request, We have a process in place to allow the request to be reviewed by an independent review organization as described under "External Exception Request Review" in this Section.

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

There are two exceptions to the formulary requirement:

1. Coverage may be obtained without additional cost-sharing beyond that which is required of formulary Prescription Drugs for a non-formulary drug if We determine, after consultation with the prescribing Physician, that the formulary drugs are inappropriate therapy for the condition.
2. Coverage may be obtained without additional cost-sharing beyond that which is required of formulary Prescription Drugs for a non-formulary drug if:

    - The Covered Person has been taking or using the non-formulary Prescription Drug for at least six months prior to its Exclusion from the formulary; and
    - The prescribing Physician determines that either the formulary drugs are inappropriate therapy for the condition, or that changing drug therapy presents a significant health risk.

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

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

This coverage shall:

- o Apply to the partial or exclusive feeding of a Covered Person by means of oral intake or enteral feeding by tube;
- o Include coverage for any medical equipment, supplies, and services that are required to administer the covered formula or enteral nutrition products;
- o Apply only when the formula and enteral nutrition products are
  - o 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
  - o used under medical supervision, which may include a home setting; and
  - o Not apply to nutritional supplements taken electively.

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

We also cover Prescription Drugs and devices approved by the 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.

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

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

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

We do not provide Coverage for any of the following:

1. Any legend drug prescribed prior to Your joining this Plan. However, You may get a new prescription after enrolling with Piedmont and receive Coverage for conditions not excluded under this COC;

2. Over the counter drugs, unless recommended by the U.S. Preventive Services Task Force and prescribed by a Physician;
3. Any prescription drug whose primary purpose is nutritional, dietary or weight loss, including anorexiants;
4. Drugs prescribed primarily for a cosmetic purpose, including: (1) Retin-A, when used for any purpose other than treatment for severe acne; and (2) minoxidil, when used to treat baldness;
5. Drugs and medications for conditions excluded under this COC;
6. Injectable Prescription Drugs that are supplied by a Provider other than a pharmacy that is not an In-Network Provider;
7. Drugs and medications that are: (1) Experimental; (2) Investigational; or (3) not approved by the FDA for the purpose prescribed (except that Benefits for drugs that have been approved by the FDA for use in the treatment of cancer will not be denied on the basis that the drug has not been approved by the FDA for treatment of the specific type of cancer for which the drug has been prescribed, provided that the drug has been recognized as safe and effective for treatment of that specific type of cancer in the American Hospital Formulary Service Drug Information, the National Comprehensive Cancer Network's Drug & Biologics Compendium, or the Elsevier Gold Standard's Clinical Pharmacology);
8. DESI drugs (i.e. drugs which are of questionable therapeutic value as designated by the FDA's Federal Drug Efficacy Study);
9. Any refill dispensed after one year from the date of the original prescription order;
10. Medicine covered by workers' compensation, Occupational Disease Law, state or government agencies;
11. 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);
12. Any other drug not on Our formulary deemed not Medically Necessary by Us; and
13. Infertility drugs.

Benefits are provided for outpatient prescription drugs, including specialty drugs, 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 and rates, including copayment, 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 taken routinely to treat or control a chronic illness such as heart disease, high blood pressure, or diabetes. In addition to the pharmacy, maintenance medications may be purchased through the mail order Benefit. This allows receipt of a 90-day or 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. 75% of the prescription must be used before ordering refills.

To receive maintenance medication by mail:

- Ask the Doctor to prescribe a 90-day supply of the maintenance medication plus refills. If the medicine is needed immediately, ask the 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 the written prescription. This is required for the first order of each different prescription medication.
- Mail the form, written prescription, and payment to cover the amount of the Copayment, Deductible and/or Coinsurance amount.
- Refills can be ordered by mail, telephone, or online. Contact information is listed on the mail order form.

NOTE: We also have special arrangements with certain participating pharmacies that allow a 90-day or 300-unit maintenance medication prescription on location. This means the written prescription does not need to be mailed. Simply visit one of the participating 90-day pharmacy locations to fill the prescription. These are listed in Your Network directory and on Our website at www.pchp.net.

Specialty Drugs must be purchased from the Pharmacy Benefit Manager's Specialty Pharmacy, unless another Pharmacy or its intermediary has sent previous notification to plan or PBM of its agreement to accept reimbursement for its services at rates applicable to the PBM's Specialty Pharmacy.

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

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

Z. Preventive Care Services

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

1. Evidenced-based items or services that have in effect a rating of "A" or "B" in the current recommendations of the US Preventive Services Task Force, except that the current recommendations of the US 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 Covered Persons age 50 and over, and persons age 40 and over who are at high risk for prostate cancer. PSA testing means the analysis of a blood sample to determine the level of prostate specific antigen.
7. One screening mammogram for Covered Persons between the ages of 35 to 39; a screening mammogram each year for Covered Persons age 40 and over.
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 ap-

propriate, 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 FDA 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. We will cover pharmacy prescription generic oral contraceptives and those brands which do not have generic equivalents at 100% as a preventive care service through Our Network retail pharmacies or mail order. Brand contraceptives with a generic equivalent will be covered subject to the appropriate Plan Prescription Drug Copayment. Over-the-counter contraceptives are not covered. Medical/surgical type contraceptives/sterilizations (office/Facility based medical and surgical) will be covered at 100% as a preventive care service. Our standard medical management, Network, and formulary restrictions apply. Coverage is also provided for up to a 12-month supply of FDA-approved, self-administered hormonal contraceptives, when dispensed or furnished at one time for a Covered Person by a Provider or pharmacy, or at a location licensed or otherwise authorized to dispense drugs or supplies;
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. Our 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 We 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 Us at 434-947-4463 or toll free at 1-800-400-7247 for more information.

We 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.

We 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.

We 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:

1. Is billed separately from an office visit, Cost-Sharing Requirements may be imposed on the office visit;
2. Is not billed separately from the office visit and the primary purpose of the office visit is delivery of the preventive care service, Cost-Sharing Requirements may not be imposed on the office visit; or
3. Is not billed separately from an office visit and the primary purpose of the office visit is not delivery of the preventive care services, 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 described in those subparagraphs.

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

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

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. Coverage 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

AGE OF COVERED PERSON	COVERED SERVICES
	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 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 Covered Person 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.

We do 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 Covered Person 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. We determine "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 Benefit 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 will be construed to mandate the Coverage of proton radiation therapy under the Plan.

CC. Reconstructive Surgery

Covered Services for reconstructive surgery are to correct: congenital abnormalities that cause functional impairment; newborn congenital defects and birth abnormalities; significant deformities caused by congenital or developmental abnormalities, disease, trauma, or previous therapeutic process to create a more normal appearance (other than for orthognathic surgery), and reconstructive breast surgery following a mastectomy. Coverage includes:

- Inpatient and Outpatient dental, oral surgical, and orthodontic services that are Medically Necessary for the treatment of medically diagnosed cleft lip, cleft palate or ectodermal dysplasia;
- reconstruction of the breast on which the mastectomy has been performed;

- reconstructive breast surgery done at the same time as a mastectomy or following a mastectomy to reestablish symmetry between two breasts
- surgery and reconstruction of the unaffected breast to produce a symmetrical appearance; and
- prostheses and physical complications of all stages of mastectomy, including lymphedemas;

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

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, due to congenital anomaly or prior medical treatment.

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

- Cardiac rehabilitative/habilitative therapy is covered. This is the process of restoring, maintaining, teaching, or improving the physiological, psychological, social and vocational capabilities of patients with heart disease. Benefits are available for medical evaluation, training, supervised exercise, and psychosocial support to care for the Covered Person after a cardiac event (heart problem). Benefits do not include home programs (other than home health care services), on-going conditioning, or maintenance care.
- Chemotherapy, the treatment of disease by chemical or biological antineoplastic agents, is covered.
- Physical therapy is covered. This is treatment provided by a licensed therapist by physical means to relieve pain, teach, keep, improve or restore function or health, and prevent disability after illness, injury, or loss of limb, including hydrotherapy, heat, physical agents, bio-mechanical and neuro-physiological principles and devices, as well as treatment of lymphedema. Rehabilitative physical therapy services must involve setting goals attainable in a reasonable period of time.
- Occupational therapy is covered. This is treatment to teach, keep, improve or restore a physically disabled person's ability to perform activities such as: walking; eating; drinking; dressing; toileting; transferring from wheelchair to bed; bathing; and job related activities. Rehabilitative occupational therapy services must involve setting goals attainable in a reasonable period of time.

Regarding bulleted item numbers 3 and 4 above, rehabilitative physical and occupational therapy is limited to 30 visits per Benefit Year combined and habilitative physical and occupational therapy is limited to 30 visits per Benefit Year combined.

- 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.
- Respiratory therapy, which is the introduction of dry or moist gases into the lungs to treat illness or injury, is covered.
- Speech therapy is covered. This includes treatment for the correction of a speech impairment, or services necessary to keep, improve or teach speech, which results from disease, surgery, injury, congenital anatomical anomaly, or prior medical treatment.
    - **Rehabilitative speech therapy is limited to 30 visits per Benefit Year, and habilitative speech therapy is limited to 30 visits per Benefit Year.**

EE. Preauthorized Services of Out-of-Network Providers

No Out-of-Network Provider shall Balance Bill a Covered Person for (1) Emergency Services provided to the Covered Person or (2) nonemergency services provided to a Covered Person at an In-Network Facility if the nonemergency services involve Surgical or Ancillary Services provided by an Out-of-Network provider. We will make payments for these services directly to the Provider.

In the event a Covered Person receives Covered Services from an Out-of-Network Provider that have been preauthorized, We reserve the right to pay the Allowable Charge less amounts You must pay under this COC, for these Covered Services

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

This is subject to applicable Virginia laws that require direct payment (e.g., dentists and oral surgeons who submit valid assignments of Benefits). You are responsible for any difference between the billed amount by the Out-of-Network Provider and Our payment. It is Your responsibility to apply any 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 services, except as provided in Section III, Subsection F - Balance Billing Prohibited for Certain Services. 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 stays at a skilled nursing Facility requires a Preauthorization. The Covered Person’s Doctor must submit a plan of treatment that describes the type of care needed. The following items and services will be provided as an Inpatient in a skilled nursing bed of a skilled nursing Facility:

- Room and board in semi-private accommodations;

- Rehabilitative services; and
- Drugs, biologicals, and supplies furnished for use in the skilled nursing Facility and other Medically Necessary services and supplies.

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

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

GG. Spinal Manipulation and Other Manual Medical Interventions

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

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

HH. Surgery

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

- Accepted operative and cutting procedures;
- Surgeries and procedures to correct congenital abnormalities that cause functional impairment 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: (1) interactive audio; (2) interactive video; or (3) other electronic technology or media used, including interactive audio or video, for the purpose of diagnosing or treating a patient, providing remote patient monitoring services, consultation, or treatment a patient consulting with other health care Providers regarding a patient's diagnosis, prescription of certain medications, or other treatment.

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

Remote patient monitoring services means the delivery of home health services using telecommunications technology to enhance the delivery of home health care, including monitoring of clinical patient data such as weight, blood pressure, pulse, pulse oximetry, blood glucose, and other condition-specific data; medication adherence monitoring; and interactive video conferencing with or without digital image upload.

Telemedicine services are Covered Benefits that do not require Preauthorization. Technical fees or costs for the provision of telemedicine services are not covered.

JJ. Transplants

We cover 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. We will provide Benefits for Medically Necessary human organ and tissue transplant services only when We have Preauthorized the services. We will also cover complications from the donor procedure for up to six weeks from the date of procurement. Benefits include coverage for necessary acquisition procedures, 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 Covered Person provides a human organ or tissue transplant to a Covered Person, the donor may receive Benefits of the health plan limited to those not available to the donor from any other source. This includes, but is not limited to, other health insurance, grants, foundations, or other government programs. 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 any Covered Person who is donating the organ to someone who is not a Covered Person.

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 Our guidelines.

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

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

All organ transplants, except those listed below, are not covered unless the particular circumstances of Your case warrant an exception by Us, 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

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

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

(1) Prescribed to replace the human lens lost due to surgery or injury;
(2) “Pinhole” glasses are prescribed after surgery for a detached retina; or
(3) Lenses are prescribed instead of surgery due to;
    a) Contact lenses used for treatment of infantile glaucoma

b) Corneal or 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)

We do 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 COC:

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, except for 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; Bio-Energetical 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 Covered Person's health. Any ambulance usage for the convenience of the Covered Person, Family or Physician is not a Covered Service. Non-Covered Services for Ambulance include but are not limited to, trips to a Physician's office or clinic, or to a morgue or funeral home.
    Coverage is not available for air ambulance transport from a Hospital capable of treating the patient because the patient and/or the patient's Family prefer a specific Hospital or Physician. Air ambulance services are not covered for transport to a Hospital that is not an acute care Hospital, such as a nursing Facility, Physician's office, or Your home.

11. **Applied Behavioral Analysis,** except as provided in this Certificate for diagnosis and treatment of Autism Spectrum Disorder in Plan Participants of any age, or if determined to be Medically Necessary.

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 if 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** more than 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 the Covered Person's 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.
    - Covered Services for clinical trials can be found under Section IV, D. Clinical Trials for Life-Threatening Diseases/Conditions.

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 Preauthorized by Us 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 Us. Complications of previous cosmetic surgery or procedures or that result from such surgeries or procedures. Cosmetic surgeries and procedures are performed to improve or alter a Covered 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, relationship counseling for unmarried couples unless the services provided are

related to a mental health or substance use disorder diagnosis, 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 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, prosthodontic 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, except as otherwise specifically covered or when received as part of a covered wellness visit or screening. Covered Services include, but are not limited to:
    - prenatal courses;
    - marital counseling; and

- self-help training and other non-medical self-care and those dealing with life-style changes.

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

- You receive payment from the employer because of the disease or injury;
- The employer provides Benefits to You; or
- You could have received Benefits for the injury or disease if You had complied with applicable laws and regulations.

This Exclusion applies whether or not You have waived Your rights to payment for the services available or did not comply with procedures set out by the employer to receive these Benefits. It also applies if the employer (or 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;
- Ordered by a third party;
- Immunizations required for travel and work;
- Ordered by a court, including court-ordered 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 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 Us judge the safety and efficacy.

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

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

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; Laser-Assisted In Situ Keratomileusis (LASIK) procedures.

35. **Family Planning Services:** The following are excluded:

- Assisted reproductive technologies (ART) and related diagnostic tests and drugs, including artificial insemination, in vitro fertilization, zygote intrafallopian transfer (ZIFT), or gamete intrafallopian transfer (GIFT), or any other types of artificial or surgical means of conception including any drugs administered in connection with these procedures;
- Drugs used to treat infertility;
- Surrogate pregnancy expenses when the person is not covered under this plan;
- Reversals of voluntarily induced sterilization and complications incidental to such procedures; or
- Paternity testing.

36. **Foot care** (palliative or cosmetic), including:

- cleaning and preventive foot care when there is no illness or injury to the foot;
- surgical treatment of flat foot conditions;
- subluxations of the foot;
- treatment of bunions only covered when associated with capsular or bone surgery;
- fallen arches;
- weak feet;
- Tarsalgia;
- Metatarsalgia;
- Hyperkeratoses;
- chronic foot strain;
- symptomatic complaints of the feet;
- foot orthotics, including support devices, arch supports, foot inserts, orthopedic or corrective shoes not part of leg brace and fitting, castings, and other services related to devices of the feet, unless used for an illness affecting the lower limbs; and
- routine foot care, such as removal of corns or calluses and the trimming of toenails, except for when these services are Medically Necessary.

37. **Free Care,** including services the Covered Person would not have to pay for if not covered by this plan, such as government programs, services received in jail or prison, services from free clinics, and Workers' Compensation Benefits. Care for military service-connected disabilities and conditions for which the Covered Person is legally entitled to health services and for which Facilities are reasonably accessible.

38. **General**: Coverage does not include benefits for the following services or treatment:

- Inpatient stays for environmental changes;
- Cognitive rehabilitation therapy;
- Education therapy;
- Vocational or recreational activities;
- Coma stimulation therapy;

- Treatment for social maladjustment without signs of a psychiatric disorder;
- Remedial or special education services;
- 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 Us.

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. **Hyperhidrosis:** For treatment of hyperhidrosis (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 Transcutaneous Electrical Nerve Stimulation (TENS) units;
    - orthotic shoe inserts;
    - personal hygiene, comfort, and convenience items including but not limited to grab/tub bars, tub benches, telephone, television, guest meals and accommodations, take home medications, and supplies;
    - 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 fitting for a noncovered device or supply is not covered.

54. **Medicare Benefits:** (1) for benefits which are payable for the Covered Person enrolled in Medicare under Medicare Parts A, B and/or D, or for the Covered Person eligible for Medicare due to age, for benefits which would have been payable if the Covered Person had applied for Medicare Part B, except as specified elsewhere in this COC, or as otherwise prohibited by federal law. If a Covered Person eligible for Medicare due to age, has not enrolled in Medicare Part B, We will calculate benefits as if the Covered Person had enrolled; (2) for services or supplies provided pursuant to a private contract between the Covered Person 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 there is **no financial responsibility**. We will not pay for, or reimburse, the cost of any Covered Service for which the Covered Person is not financially liable. Examples include:
    - charges for complimentary health screenings;
    - charges for Covered Services provided by an immediate family member; and
    - charges incurred as a donor for which another individual or entity has assumed financial responsibility (except when assumed by a "Plan," as defined in the "Coordination of Benefits" Subsection of this COC, in which case that Subsection applies).

58. Medical **Nutritional Therapy** (Obesity) and **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 COC.

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 the Covered Person by telephone, facsimile machine, electronic mail systems or other consultation or medical management service not involving direct (face-to-face) care with the patient. This does not include In-Network telemedicine services with interactive virtual visits.
- Surcharges for furnishing and/or receiving medical records and reports.
- Charges for doing research with Providers not directly responsible for the Covered Person's care.
- Charges that are not documented in Provider records.
- 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:** The Prescription Drug Benefits do not cover the following:

- Administration Charges for the administration of any drug except for covered immunizations as approved by Us or the Pharmacy Benefits Manger (PBM).
- Prescription drugs prescribed by a Provider that does not have the necessary qualifications, registrations and/or certifications as determined by Us.
- Non-formulary drugs, except in certain circumstances described in coverage documents.
- Compound drugs are not covered unless there is at least one ingredient that the Covered Person needs a prescription for, and the drug is not essentially a copy of a commercially available drug product.
- Drugs given to the Covered Person or prescribed in a way that is against approved medical and professional standards of practice.
- Charges for delivery of Prescription Drugs.
- Drugs taken at the time and place where they are given or where the prescription order is issued. This includes samples given by a Doctor. This Exclusion does not apply to drugs used with a diagnostic service, drugs given during chemotherapy as described in the "Chemotherapy" Section, or drugs covered under the "Medical and Surgical Supplies and Medications" Benefit – they are Covered Services.
- Drugs that do not need a prescription by federal law (including drugs that need a prescription by State law, but not by federal law), except for injectable insulin. This Exclusion does not apply to over-the-counter drugs that We must cover under federal law when recommended by the U.S. Preventive Services Task Force and prescribed by a Physician.
- Drugs which are over any quantity or age limits set by the Plan.
- Drugs in amounts over the quantity prescribed, or for any refill given more than one year after the date of the original prescription order.
- Items Covered as Durable Medical Equipment (DME) - Therapeutic DME, devices and supplies except peak flow meters, spacers, and blood glucose monitors.
- Refills of lost or stolen drugs.
- Prescription drugs dispensed by any mail service program other than Our PBM's Home Delivery Mail Service, unless We must cover them by law.
- Drugs not approved by the FDA.
- Off label use, unless We must cover the use by law or if We, or the PBM, approve it.
- Drugs for Onychomycosis (toenail fungus) except when We allow it to treat individuals who are immuno-compromised or diabetic.
- Drugs, devices and products, or legend drugs with over the counter equivalents and any drugs, devices or products that are therapeutically comparable to an over the counter drug, device, or product. This includes prescription legend drugs when any version or strength becomes available over the counter.
- Hypodermic syringes except when given for use with insulin and other covered self-injectable drugs and medicine.
- Any drug mainly used for weight loss.
- Drugs used for cosmetic purposes.
- Prescription drugs used to treat infertility.
- Charges for services not described in the Covered Person's medical records.
- Services We conclude are not Medically Necessary. This includes services that do not meet Our medical policy, clinical coverage, or Benefit policy guidelines.
- Nutritional and/or dietary supplements, except as described in this COC or that We must cover by law. This Exclusion includes, but is not limited to, nutritional

formulas and dietary supplements that the Covered Person can buy over the counter and those the Covered Person can get without a written prescription or from a licensed pharmacist.

- Services prescribed, ordered, referred by or received from a member of Your immediate family, including Your spouse, domestic partner, Child, brother/stepbrother, sister/stepsister, parent/stepparent, in-law, or self.
- Certain drugs that have limited clinical value and which have clinically-appropriate, lower cost alternatives (e.g., brand name or generic drugs that are combinations of existing generic or over-the-counter drugs, new formulations of existing drugs). Piedmont's PBM shall determine which drugs meet the criteria for exclusion.

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

69. **Prophylactic mastectomy**, which means removal of a breast for a Covered Person 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. We determine "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 and physical therapist technicians.

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, halfway house, or school because the individual's own home arrangements are not available or are unsuitable, and consist chiefly of room and board, even if therapy is included.
    - Care provided or billed by a hotel, health resort, convalescent home, rest home, nursing home or other extended care Facility home for the aged, infirmary, school infirmary, institution providing education in special environments, supervised living or halfway house, or any similar Facility or institution.

- Services or care provided or billed by a school, custodial care center for the developmentally disabled, or outward-bound programs; 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 the Covered Person receives active 24-hour skilled professional nursing care, daily Physician visits, daily assessments, and structured therapeutic services. A residential treatment center must qualify as a substance use disorder center providing a continuous, structured, 24 hour a day program of drug or alcohol treatment and rehabilitation including 24 hour a day nursing care.

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 Person'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 in this Policy. 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, 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 Covered Person 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; or
    - sensory integration therapy (SIT).

83. **Temporomandibular Joint (TMJ) Disorder Device**, appliances for TMJ pain dysfunction that reposition the teeth, fillings, or prosthetics. Covered Services do not include fixed or removable appliance that involve movement or repositioning of the teeth, repair of teeth (fillings), or prosthetics (crown, bridges, dentures); oral hygiene instructions; repair or replacement of lost/broken appliances; 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.

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); and
    - 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, 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-Network 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-Network. You have access to almost all of the same Covered Services as provided in this COC; however You may have different Copayment, Deductible and/or Coinsurance amounts or Benefit maximums listed on Your Schedule of Benefits for Out-of-Network services that will apply. If You receive certain services without the proper Preauthorization, You are considered Out-of-Network. These are listed in the "How to Use Your Benefits" Section of this COC.

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

Our payment for Covered Services is based on an Allowable Charge. When Covered Services are received from an In-Network Provider who has agreed to Our negotiated rate, Covered Persons 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-Network Covered Services, the Benefit payable is based on an Allowable Charge that We have 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 Our 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 Prohibited for Certain Services** 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 Our Medical Management staff at (434) 947-4463 or toll free at 1-800-400-7247.

Traveling

Covered Persons who are traveling outside the Service Area are covered for routine services at the Out-of-Network level. If You have a non-urgent or non-emergent medical need while traveling, please contact Us 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-Network level. When doing so, present your identification card to the medical Provider and ask that they file the charges directly with Us. In some cases You may be asked to pay for Emergency or acute illness care. If this occurs, simply submit an itemized statement to Us 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, You must: (1) be entitled to participate in Your 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 Us (including any applicable Waiting Period), as evidenced in the Group Enrollment Agreement and other related documents. Any applicable Waiting Period shall not exceed 90 days.

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

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

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

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

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

Child. To be eligible for coverage, a "Child" must be either: (1) Your biological, legally adopted, or foster Child; or (2) the biological, legally adopted, or foster Child of Your legal spouse if such spouse is also a Covered Person under the COC. Child includes a son, daughter, step-Child, adopted Child, including a Child placed for adoption, foster Child, or any other Child eligible for coverage under the health Benefit plan. Except as noted below, there is no requirement that the Child: be financially dependent on an individual covered under the COC; share a residence with an individual covered under the COC; 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 COC is age 26.

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

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

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

Your biological newborn Child’s coverage will be identical to Coverage provided to You; except that, regardless of whether the Coverage would otherwise be provided under the terms and conditions of this COC, 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 COC; 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 the provisions are no more restrictive for these services than for any injury or sickness covered under the COC.

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

Subscriber’s Adopted Child. If Your employer or group plan provides for “Child” Coverage, then when a Child has been placed with You for the purpose of legal adoption, that Child is eligible for “Child” Coverage from the date of such adoptive or parental placement. However, an application for 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 You within 31 days of birth, We will consider this Child a newborn Child of Yours to the same extent as if that Child had been Your newborn biological Child.

Legal Guardianship of a Child. If Your employer or group plan provides for "Child" Coverage, You may enroll a Child or a Child of Your legal spouse when You are the legal guardian of the Child. The Child for whom You are the Child's legal guardian will be added to Your Policy only during Your group's Open Enrollment Period, or within 30 days of Your 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 has enrolled under the contract or COC 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) You provide proof of dependency within 31 days of the Child's reaching the Limiting Age. We may require subsequent proof, but not more frequently than annually after the two-year period following the Child'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 You or Your enrolled legal spouse.

Termination of a Child's Coverage. Unless terminated earlier for other reasons specified in the COC (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 calendar year in which he/she reaches the Limiting Age. Coverage will terminate retroactively as of the date the Child was no longer eligible.

B. Enrollment

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

Special Enrollment Periods are allowed due to certain losses of other qualifying Coverage and changes in family status. 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.
- Covered Person 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 Your employer or group to comply with a qualified medical Child support order ("QMCSO"). A QMCSO is an order, judgment, or decree by which an Employee is required to include a Dependent Child under his or her group health care Coverage. A QMCSO can also enforce a state medical Child support law under section 1908 of the federal Social Security Act.

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

If a QMCSO issued in a divorce or legal separation proceeding requires You to provide health care Coverage to a Child 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 a.m. on the effective date.

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

- The Coverage of persons who enroll during the employer's or group's Open Enrollment Period is effective as agreed upon by the employer or group and Us in the Group Enrollment Agreement.
- The effective date of Coverage of a Subscriber's newborn Child is described in the Eligibility subsection above.
- Coverage of newly acquired Covered Persons who enroll in the plan with Piedmont will become effective on the date of 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 Covered Persons of the individual Subscriber that is enrolled, may only be rescinded or voided if: (1) the individual Subscriber or Covered Person (or a person seeking Coverage on behalf of the individual) performs an act, practice, or omission that constitutes fraud; or (2) the individual Subscriber or Covered Person (or a person seeking Coverage on behalf of the individual) makes an intentional misrepresentation of material fact to the plan in an application, form, or statement.

For purposes of this COC, a "rescission" is a cancellation or discontinuance of Coverage that has retroactive effect. For example, a cancellation that treats this COC and the Coverage as void from the time of Your 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 COC.

Covered Persons affected by a rescission of Coverage will be provided at least 30-days' advance written notice of the proposed rescission of coverage before overage 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. We will not rescind a Policy in the case of inadvertent misstatements of fact. Such notice shall at a minimum contain:

- Clear identification of the alleged fraudulent act, practice, or omission or the intentional misrepresentation of material fact;
- An explanation as to why the act, practice, or omission was fraudulent or was an intentional misrepresentation of a material fact;
- 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;

- A description of Piedmont's internal appeal process for rescissions, including any time limits applicable to those procedures; and
- The date when the advance notice ends and the date back to which the coverage will be rescinded.

We will not terminate a Covered Person's Coverage on the basis of the status of their health or because they have exercised his or her rights under the grievance or appeal systems described later in this COC by registering a complaint against Us or an appeal of Our determination of Benefits.

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

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

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

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

2. **Termination for Loss of Eligibility.** Subject to the continuation Coverage privileges set forth below, the Coverage of any Covered Person who ceases to be eligible will terminate at the end of the day upon which eligibility ceased unless otherwise agreed upon by Us and Your employer. In the event of Your death, Coverage will terminate for Covered Persons of the Subscriber on the last day of the period for which Premium payments have been made by or on Your behalf, subject to the continuation of Coverage rights described in the applicable subsection "Continuation of Coverage Rights under COBRA" (if Your group is subject to COBRA) or "Continuation of Coverage if Group Not Eligible for COBRA". We will provide 31 days' written notice of such termination to You.

3. **Termination for Failure to Pay Premium.** Only Covered Persons for whom the stipulated Premium payment is received by Us will be entitled to Covered Services and then only for the period 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 Us written notice of discontinuance in accordance with the terms of the Policy and in advance of the date of discontinuance. The grace period will 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 prorated Premium for the time that the Coverage was in force during the grace period. We will provide the employer/group with at least 15 days' written notice prior to terminating Coverage due to failure to pay Premiums.

4. **Termination of the Policy.** The Policy between Us and the employer/group may be terminated by Us or the employer/group for any reason permissible under the Policy. In addition, We 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 will terminate for all Covered Persons as of the effective date of termination of the Policy. All rights to Benefits will cease as of the effective date of termination.

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

E. Continuation of Coverage Rights Under COBRA

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

This subsection contains important information about Your right to COBRA continuation Coverage. COBRA is a temporary extension of Coverage under the employer's 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 when You would otherwise lose Your group health care Coverage. It can also become available to other Covered Persons 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, contact Your plan administrator. Ask to review the plan's summary plan description or get a copy of the plan document.

The plan administrator is often Your group administrator. If You are unsure who Your group administrator is or how he or she may be contacted, You may call Our 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 "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 of its due date.

If You are an Employee, You will become a qualified beneficiary if You lose Your Coverage under Your group health care plan because 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 these qualifying events occur:

- The parent-Employee dies;
- The parent-Employee's hours of employment are reduced;
- The parent-Employee's employment ends for any reason other than his or her gross misconduct;

- The parent-Employee becomes entitled to Medicare Benefits (Part A, Part B, or both);
- The parents become divorced or legally separated; or
- The Child stops being eligible for Coverage under the plan as a "Participant Child."

Sometimes, filing a bankruptcy proceeding under Title 11 of the US 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 Us, in accordance with COBRA requirements, if a qualifying event occurs. We will offer COBRA continuation Coverage to qualified beneficiaries only after the plan administrator has notified Us in writing that a qualifying event has occurred. When the qualifying event is the end of employment or reduction of hours of employment; death of the Employee; if the plan provides retiree health care Coverage, the commencement of a proceeding in bankruptcy with respect to the employer; or the Employee becoming entitled to Medicare Benefits (Part A, Part B, or both), You must notify Your plan administrator within 30 days of the qualifying event. The plan administrator must then notify Us.

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

Once We and the plan administrator receive notice that a qualifying event has occurred, COBRA continuation Coverage will be offered to each qualified beneficiary. Each qualified beneficiary has a right to elect COBRA continuation Coverage even if other qualified beneficiaries may not elect Coverage. Covered Employees may elect COBRA continuation Coverage on their spouses' behalf if their spouses were covered under the group health plan when the spouses' Coverage ended. Parents may elect COBRA continuation Coverage on their Children's behalf if the Children were covered under the group health care plan when the Children's Coverage ended. 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 Us.

2. **Second qualifying event extension of 18-month period of COBRA continuation Coverage.** If Your family experiences another qualifying event while receiving 18 months of COBRA continuation Coverage, Your spouse and 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 Us.

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 Covered Person or beneficiary who is not receiving COBRA continuation Coverage (e.g, fraud or material misrepresentation).

Questions about COBRA. If We are responsible for administering Your COBRA continuation Coverage or You are uncertain who administers Your COBRA Coverage, You should contact Us at the numbers provided elsewhere in this COC. 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, please keep Us and any other person or entity responsible for administering COBRA continuation Coverage informed of any changes in the addresses of Covered Persons. Also, please keep a copy for Your records of any notices You send to Your plan administrator.

F. Continuation 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 Benefit Year, church groups, and non-employer groups (i.e. non-employer associations) are not eligible for COBRA continuation Coverage.

Notice of Continuation Options

You must notify Your plan administrator (most often Your group administrator) immediately of Your loss of eligibility under the group Policy.

The group policyholder shall provide each employee or other person losing coverage under such policy written notice of a twelve-month continuation opportunity. Such notice shall be provided within 14 days of the policyholder's knowledge of your loss of eligibility under the policy. If the group policyholder does not provide the required notice, please contact Us directly within 60 days from the date you lose eligibility for coverage to discuss your continuation options.

Twelve-Month Continuation under State Law

If your employer's group health plan is not subject to the requirements of the COBRA law, twelve-month continuation coverage, as defined by State law, applies.

If you or a Dependent loses eligibility for your group's coverage, you may be able to continue your present group coverage under the policy for a period of 12 months beginning immediately following the date of the termination of the person's eligibility, without evidence of insurability. The following rules apply:

- the person must have been enrolled and continuously insured under the group policy during the entire three-month period immediately preceding termination of eligibility;
- the person must not be eligible for Medicare or Medicaid benefits prior to the loss of eligibility for group coverage;
- the person must apply for coverage with the group policyholder and pay the first month's premium within 31 days after issuance of the written notice described in the Notice of Continuation Options section above, but in no event beyond the 60 day period following the date of the termination of the person's eligibility;
- premium for such extended coverage is timely paid to the group policyholder on a monthly basis during the twelve-month period; and
- the premium for continuing the group coverage shall be at the insurer's current rate applicable to the group policy plus any applicable administrative fee not to exceed two percent of the current rate.

Twelve-month continuation under state law shall not be available to an employee whose eligibility for coverage under the group plan ceased because the employee was discharged from employment by the group for gross misconduct. Gross misconduct means any conduct connected with the employee's work that would constitute misconduct under state law, including deliberately and willfully engaging in conduct evincing a complete disregard for the employer's workplace standards and policies.

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 coverage;
- Labor management trustee Plans, union welfare plans, employer welfare plans, employer organization plans, or Employee Benefit organization plans; and
- Coverage under any tax-supported or government program to the extent allowed by law.

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

Primary Coverage and Secondary Coverage

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

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

- If a Covered Person is enrolled as the named Subscriber under one Coverage and as a Dependent under another, generally the one that covers him or her as the named Subscriber will be primary.

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

- If the Subscriber is enrolled as a Dependent Child under both Coverages (e.g., when both parents cover their Child), typically the Coverage of the parent whose birthday falls earliest in the Benefit Year will be the primary.

- Special rules apply when a Subscriber 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 a court order 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 Benefit Year will be primary.

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

Overpayment of Benefits

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

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

Right to Receive and Release Information

By accepting Coverage under this COC 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 payments made on Your behalf by Us if We 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 COC:

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	
	The plan that has been in effect the shorter amount of time is		X
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	X	
	The COBRA plan is		X
The Member is covered as a Dependent Child under both plans	The plan of the parent whose birthday occurs earlier in the Benefit Year (known as the birthday rule) is	X	
	The plan of the parent whose birthday is later in the Benefit Year is		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	X	
	The plan of the other parent is		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	X	
	The non-custodial parent's plan is		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 Benefit Year is	X	
	The plan of the parent whose birthday is later in the Benefit Year is NOTE: If the parents have the same birthday (MM/DD), the plan that has been in effect longer is primary		X

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	X	
	Upon completion of the 30-month Medicare entitlement period		X
Is a disabled Member who is allowed to maintain group enrollment as an active Employee	If the employer employs 100 Employees or more	X	
	If the employer employs fewer than 100 Employees		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	X	
	If Medicare had been primary to the group plan before ESRD entitlement		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		X
	If the employer group has 20 or more Employees	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	X	
	If Medicare had been primary to the group plan before ESRD entitlement		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. Our 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, Our Benefits for Covered Persons eligible for Medicare payments do not duplicate any Benefit for which these Covered Persons 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 Us may be made as if You had elected Part B Coverage.

Cooperation. You must complete and submit such consents, releases, applications, assignments, and other documents as may be requested by Us 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 Us and In-Network Providers of Covered Services is an independent contractor relationship. In-Network Providers of Covered Services are not Employees or agents of Piedmont and neither Piedmont nor any Employee of Piedmont is an Employee or agent of any In-Network Provider. For the purposes of this COC, no employer or Subscriber is the agent or representative of Piedmont and neither will be liable for any acts or omissions of Piedmont, its agents or Employees, or any other person or organization with which We have made or hereafter will make arrangements for the provision of Covered Services.

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

J. Medical Information

We may request from any Provider of Covered Services information necessary in connection with the administration of this COC 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 will 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

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

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 COC may be amended, revised, or deleted by Us. This may be done without the Subscriber'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 Our records or, if sent directly to You, the notice is considered "given" when mailed to the Subscriber's last known address as shown in Our enrollment records. Notices include any information, which We may send You, including ID cards.

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

N. 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 COC. Under this Policy the Subscriber's employer or group will contribute on Your behalf a portion of the Premiums required. The Policy, this COC, and any amendments to either constitute the entire contract between the parties to the Policy. We 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 COC and the Policy, the terms of the Policy will control. You may direct specific questions related to the Policy between Us and the Subscriber's employer or group to: (1) the Subscriber's employer or group; and/or (2) the plan administrator.

O. Claim Forms

We must receive written notice of the occurrence or commencement of any loss covered under this Group Policy within twenty (20) days after the date expenses are incurred. If You presented Your ID card to an In-Network Provider, You are not required to notify us of proof

of loss. If You did not present Your ID 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, We will provide You with the Benefit claim form for filing proof of loss. If You do not receive these forms, we will accept Your written description of the loss as proof of loss.

Filing Proof of Loss

In-Network Providers will file most claims for You. You may have to file claims for out-of-area services, services rendered by Providers who are not In-Network Providers, and some prescription drug claims. You must provide Us with written proof of loss covering the occurrence, character, and extent of the loss for which the claim is made within 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 will proof of loss be furnished later than one year from the time proof of loss is otherwise required. You may obtain claim forms from Our customer service. Claims should be sent to the following address:

Piedmont Community HealthCare, Inc.
PO Box 21406
Eagan, MN 55121

Payment of Claims

All In-Network Providers are required to file claims directly with Us. If You receive a bill or statement, contact the Provider to make sure the Provider has Your correct insurance information so the Provider can file directly with Us on Your behalf. All Benefits payable under the Policy other than Benefits for loss of time will 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 Covered Person. A beneficiary may be the family member specified by the Policy.

Physical Examinations and Autopsy

We have the right to examine the Covered Person 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 15 days of receipt; and
- Pre-service claim within 15 days of receipt.

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

A “pre-service claim” is any claim under a group health plan for a Benefit for which the Covered Person must receive approval (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 patient’s life, health, or ability to regain maximum function; or
- would, in the opinion of a Physician who is knowledgeable about the patient’s medical condition, subject the patient to severe pain that cannot be adequately managed without the Benefit.

We will notify the claimant of a Benefit determination (approval or denial) with respect to an Urgent Care claim as soon as possible, considering the medical needs, but not later than 72 hours after We receive the claim or request. If the claimant fails to provide enough information to determine whether, or to what extent, Benefits are Covered or payable under the plan or this COC, 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.

We may extend the time to review an Urgent Care claim if: (1) We do not receive information that We need to determine whether the claim is covered; and (2) We tell You what information We need to complete Our claims review. We will provide this notice within 24 hours after We receive 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 Our notice of an adverse Benefits determination to file an internal appeal with Us. For the purposes of an internal appeal, "adverse Benefits determination" means:

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

"Rescission of Coverage" does not include:

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

We 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 Ur-

gent Care appeal, We will decide the appeal as soon as possible, considering 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 Our Appeals Coordinator at appeals@pchp.net or 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 COC.

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

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

2. External Appeals:

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

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

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

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

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

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

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

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

R. Authorized Representative

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

Your authorized representative may include (without limitation): (1) a person to whom You have given express written consent to represent You; (2) a person who is authorized by law

to provide a substituted consent for You; (3) Your family member or treating health care professional if You are unable to provide consent; (4) a health care professional if Your 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 Us 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, Our customer service staff will assist You. Our customer service telephone number is **800-400-7247**.

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

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

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

The Virginia Bureau of Insurance has established an "Office of the Managed Care Ombudsman" to assist Virginia consumers in understanding and exercising their rights under their managed care programs. If You have any questions about an appeal or grievance concerning the health care services that You have been provided that have not been satisfactorily addressed by Your plan, You may contact the Office of 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: 877-310-6560**
Richmond Area: 804-371-9032

e-mail: **ombudsman@scc.virginia.gov**

Web page: **www.scc.virginia.gov**

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

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

T. Assignment of Benefits and Payments

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

U. 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 will 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 COC, Your damages will be limited to: Our Allowable Charge(s) for Covered Services minus any Deductible, Coinsurance and/or Copayment for those services. The damages will not exceed the amount of any claim not properly paid as of the time the lawsuit is filed. This COC does not provide for punitive damages or damages for emotional distress or mental anguish; provided, however, this provision is not intended, and will not be construed, to affect in any manner any recovery by You or Your representative of any non-contractual damages to which You or Your representative may otherwise be entitled.

W. Piedmont's Continuing Rights

On occasion, We may not insist on Your strict performance of all terms of this COC. Failure to apply terms or conditions does not mean We waive or give up any future rights We may have under this COC.

X. Incontestability

The validity of the Policy will 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 will be used in contesting the validity of the insurance with respect to which such statement was made after the insurance has been in force prior to the contest for a period of 2 years during the lifetime of the person about whom the statement was made, and unless the statement is contained in a written instrument signed by the person.

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

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

Z. Entire Contract

The entire contract between Us and the employer/group consists of: the Group Enrollment Agreement and its amendments; this COC 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 Covered Persons are deemed to be representations and not warranties. No written statement made by any Covered Person will be used in any contest unless a copy of the statement is furnished to: the Covered Person; or his/her beneficiary or personal representative.

AA. Provider Nondiscrimination

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

BB. Nondiscriminatory Benefit Design

We do not offer Benefit designs that will have the effect of discouraging the enrollment of individuals with significant health needs in its plans. We will not discriminate on the basis of

health status, race, color, creed, national origin, ancestry, marital status, lawful occupation, disability, age, sex, gender identity, or sexual orientation.

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.

Covered Person's Rights and Responsibilities

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

Piedmont is committed to:

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

You have the right to:

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

You have the responsibility to:

- Choose an In-Network Provider for services to receive the highest level of 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 Us 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 means the amount determined by Us as payable for a Covered Service or the Provider's charge for that service, whichever is less. We will never pay more than the Allowable Charge for any Covered Service.

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

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

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

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

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 or Children means the Subscriber's Child (biological or adopted) and/or the Child (biological or adopted) of the Subscriber's spouse if the Subscriber's spouse is also covered under the contract or 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 COC, 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 a Covered Person 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 a Covered Person 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.

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

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

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

Dependent(s) means the Subscriber’s Child, spouse, or Domestic Partner who meets all of the eligibility requirements of this COC; is enrolled hereunder; and for whom the payment of a Premium required under the COC and the Group Enrollment Agreement has actually been received by Us.

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: (1) serious jeopardy to the mental or physical health of the individual; (2) danger of serious impairment of the individual's bodily functions; (3) serious dysfunction of any bodily organ or part; or (4) in the case of a pregnant woman, serious jeopardy to the health of the fetus.

Emergency Services means those health care services that are rendered by affiliated or nonaffiliated Providers after the sudden onset of an Emergency Medical Condition. Emergency Services will include Covered Services from Out-of-Network Providers. Emergency Services 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.

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

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

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 Our sole discretion (subject to all appeals available to You). We will apply the following criteria in exercising its discretion. A service or supply will be Experimental/Investigative if We 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 Us judge the safety and efficacy.

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

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

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

Family Unit refers to the Subscriber and the Subscriber's Dependents.

Group Enrollment Agreement means the Policy of insurance Coverage between Us and the Subscriber's Employer or Group, of which this COC is a part.

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

In-Network Physician means a Physician who has independently contracted with Us, Our designee or Our subcontractor(s) to provide medical services to Covered Persons.

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

Inpatient means a Covered Person 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 Subscriber's Dependent Child is no longer eligible for Coverage under this COC. The Limiting Age for Dependent Children is age 26.

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

Medically Necessary services or Medical Necessity refers to those Covered Services that We determine are:
(1) consistent with the diagnosis and treatment of the Covered Person's condition;
(2) are appropriate 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.

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

Physician (Doctor) means a person who is certified or licensed under the laws of the state to provide medical services within the scope of such certification or licensure, such as a Doctor of Medicine 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, athletic trainer (provided that such service is performed in an office setting), or licensed acupuncturist. Physician includes Primary Care Physician (PCP), Specialist Physician, nurse practitioner (NP), physician assistant (PA) and any other Provider(s) as defined in this COC.

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 COC.

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.

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

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

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

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

- **Specialty Drugs (Tier 4)** are higher cost, injected, infused, oral or inhaled medications (including therapeutic biological products) that are used to treat chronic or complex illnesses or conditions and are on the formulary at the two highest tiers. Preferred Specialty Drugs are the lower cost brand name drugs in the Specialty Drugs therapeutic category. Non-preferred Specialty Drugs are classified as higher cost drugs in the Specialty Drugs therapeutic category. Specialty Drugs may have special handling, storage and shipping requirements, such as temperature control. Specialty Drugs may require nursing services or special programs to encourage patient compliance. The specialty pharmacy will fill both retail and mail order prescriptions, although the ability to provide a 90-day supply of a specialty drug may be limited by the storage requirements of that particular drug.

Preventive Services means:

(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, but is not required to choose, any available Primary Care Physician in accordance with the terms and conditions of this COC.

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. **Limb** means an arm, a hand, a leg, a foot, or any portion of an arm, a hand, a leg, or a foot. **Medically Necessary Prosthetic Device** includes any myoelectric, biomechanical, or microprocessor-controlled prosthetic device that peer-reviewed medical literature has determined to be medically appropriate on the basis of the clinical assessment of the enrollee's rehabilitation potential.

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.

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

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

Service Area means the geographic area within which 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 COC includes the cities of Bristol, Buena Vista, Charlottesville, Danville, Galax, Harrisonburg, Lexington, Lynchburg, Martinsville, Newport News, Norton, Radford, Roanoke, Salem, Staunton, Suffolk, Waynesboro and Williamsburg; and the counties of Accomack, Albemarle, Amelia, Amherst, Appomattox, Augusta, Bedford, Bland, Botetourt, Buchanan, Buckingham, Campbell, Carroll, Charlotte, Craig, Culpeper, Cumberland, Dickenson, Floyd, Fluvanna, Franklin, Giles, Gloucester, Grayson, Greene, Halifax, Henry, Isle of Wight, James City, Lee, Lunenburg, Madison, Mathews, Mecklenburg, Montgomery, Nelson, Northampton, Nottoway, Orange, Patrick, Pittsylvania, Prince Edward, Pulaski, Rappahannock, Roanoke, Rockbridge, Rockingham, Russell, Scott, Smyth, Surry, Tazewell, Washington, Wise, Wythe, and York; all in the Commonwealth of Virginia.

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.

Stabilize means with respect to an emergency medical condition, to provide such medical treatment as may be necessary to assure, within reasonable medical probability, that no material deterioration of the condition is likely to result from or occur during the transfer of the

individual from a facility, or, with respect to a pregnant woman, that the woman has delivered, including the placenta.

Subscriber means the eligible Employee: (1) as defined in the 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 COC 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.

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

Urgent Care means care for a health problem usually marked by rapid onset of persistent or unusual discomfort associated with an illness or injury. These problems may include high fever, vomiting, sprains, 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.