PIEDMONT
COMMUNITY HEALTH PLAN

Group Benefits Administrator Guide

2316 Atherholt Road, Lynchburg, Virginia 24501
1-800-400-PCHP | 434-947-4463
PCHP.net

July 2020

Welcome!

Thank you for choosing Piedmont Community Health Plan for your company's health insurance coverage – you've made a great choice. Investing in your employees' health care will pay off today – and tomorrow.

The information needed to administer your Piedmont group plan is summarized here.

There's also a **Contact Us** section in this guide should you have any questions.

You'll need to understand the provisions of your plan, particularly the need to submit timely and accurate data. All of this is described in this guide.

The specific terms of your plan are in your plan documents. They include:

- Group Policy
- Schedule of Benefits
- Evidence/Certificate of Coverage
- Group Agreement

At Piedmont, we're working hard to simplify health insurance decision making and administration.

Let us know what we can do to make your job easier.

And, again, welcome.

Contents

This guide serves as a supplement to Piedmont's legally authorized policies, procedures, and plan documents. In the event of conflicting information, information here is superseded by official company policies, procedures, and plan documents.

Customer Service – at your service

Do you have a question or a problem with your group plan? We're here to help!

Contact Us

You, your employees, and their families can call Customer Service with questions about:

- Benefits
- General policies and procedures
- Member ID cards
- Name and address changes
- Provider and pharmacy networks
- COBRA
- Enrollment and eligibility
- Authorizations

Piedmont Customer Service

Monday - Friday, 8:30 a.m. - 5:00 p.m.
434-947-4463 or 1-800-400-7247

CVS Caremark Member Services

1-800-966-5772

Register at Caremark.com or call Piedmont Customer Service at 1-800-400-7247.

Forms

All forms needed to administer your plan are available here - Employer Forms - or at PCHP.net, Group Coverage, Employers, Employer Forms. You may also request these forms by calling Customer Service at 434-947-4463.

Enrollment & Eligibility

The eligibility requirements necessary to enroll for coverage are described in the Evidence/Certificate of Coverage and your Group Application. Please refer to these documents for specific eligibility requirements.

Open Enrollment

The open enrollment period is the period your group has selected to allow eligible employees to enroll in the health plan.

Upon meeting eligibility requirements as described in the Evidence/Certificate of Coverage or Group Application, any prospective employee may apply for enrollment by completing, signing, and submitting the appropriate Enrollment/Change Form during the open enrollment period.

Coverage becomes effective on the renewal date agreed upon, in writing, by Piedmont and your group. A signed Enrollment/Change Form is required from prospective members for coverage to become effective. Please submit Enrollment/Change forms with your Group Application. Alternatively, a spreadsheet including the same information may be submitted.

New Hires

New employees and their eligible dependents are first eligible for coverage at the end of the waiting period indicated on your Group Application. Any employee who is hired or becomes eligible for coverage subsequent to the open enrollment period may apply for coverage by completing an Enrollment/Change Form.

Piedmont will be able to offer coverage or authorize payment for services only after a completed Enrollment/Change Form has been received within 31 days of eligibility.

Current employees who have satisfied the waiting period but decline coverage during your group's open enrollment must wait until your group's next open enrollment period to enroll.

After the Enrollment/Change Form is received by Piedmont, coverage becomes effective per the terms requested on the Group Application.

NOTE: Exceptions to this policy may be made if the employee experiences a qualifying event or is entitled to a special enrollment period. Please refer to the Qualifying Events and Special Enrollment Periods section of your Evidence/Certificate of Coverage.

Dependents

Dependents are eligible to remain on a policy if they meet the age requirements specified in the Evidence/Certificate of Coverage. Dependents who do not meet eligibility requirements will be removed from the policy. If a dependent is removed from the policy, the group benefits administrator and the dependent will be notified in writing. Please refer to your Evidence/Certificate of Coverage to confirm specific age limitations.

Disabled Dependents

Disabled dependents are eligible to remain on a policy provided the dependent meets eligibility criteria. Medical documentation of the disabling condition is required when the dependent reaches age 26 and may be requested periodically thereafter.

Coordination of Benefits

If the member's spouse and/or dependents are covered by Piedmont and another group health plan, both plans will be coordinated so that up to, but no more than, the plan's maximum benefit of the eligible expenses will be paid. Information regarding other insurance carriers must be completed by the employee on the Enrollment/Change Form. Information regarding any changes or additions of a group health plan should be provided to Piedmont immediately by contacting Customer Service.

Adding/Deleting Dependents

If the employee does not complete a form to enroll his or her eligible family members for coverage within 31 days from the day they first become eligible or within the period stipulated in your Group Application, Evidence of Coverage or Certificate of Coverage, they will not be eligible to enroll in Piedmont until the group's next open enrollment period. Exceptions to this policy may be made if the employee experiences a qualifying event or is entitled to a special enrollment period as described in the following section.

Qualifying Events & Special Enrollment Periods

Members may enroll dependents at any time if any of the following events occur:

- Birth of a child
- Adoption of a child or placement for adoption*
- A Qualified Medical Child Support Order (QMCSO)*
- Marriage*
- Termination of spouse's employment, or a change in employee's, or employee's spouse's employment status from full-time to part-time status
- A significant change in health insurance premium or medical benefits available to the employee's spouse through his or her employment*
- Dependent's involuntary loss of other health coverage.

* *Supporting documentation of these events is required and must be submitted with an Enrollment/Change Form.*

Piedmont requires employees to complete a new Enrollment/Change Form to report changes that affect their coverage (this may be in addition to any forms required by the group).

Any Enrollment/Change Forms required must be received by Piedmont within 31 days of the qualifying event. Coverage will be retroactive to the date of the change. For marriage, an employee's spouse will be added on the date of marriage. Any eligible dependents that are not enrolled during this time will not be eligible for enrollment until the next open enrollment period. Please refer to your Evidence/Certificate of Coverage for further details.

Member ID Cards

After your group's Enrollment/Change Forms have been processed by Piedmont, your employees will receive their new member identification (ID) cards.

For members to receive ID cards promptly, it is important that Piedmont receives Enrollment/Change Forms that are filled out accurately and legibly. When the Enrollment/Change Forms are complete, members will usually receive their ID card within 10 working days after Piedmont has processed the request.

The ID card lists the employee's member number, the group number, and co-payments or coinsurance for selected benefits.

The ID card should be reviewed for accuracy. If any information on the card is incorrect or if additional cards are needed, please have the member contact Customer Service at 434-947-4463 or 1-800-400-7247.

If the member needs their card immediately, they can print a temporary card from the Piedmont website. It is important that the member present their ID card prior to receiving medical care. If a member misuses the ID card, coverage for that employee and covered dependents may be terminated.

Health Insurance Portability & Accountability Act of 1996 (HIPAA)

Health Insurance Portability and Accountability Act of 1996 (HIPAA) requires that employer groups and carriers provide proof of coverage to employees and their dependents whose coverage under the plan has terminated. Since some health plans have exclusion periods for pre-existing conditions, the member can show other carriers the proof of coverage in order to have this exclusion period credited or waived, depending on the length of their previous coverage.

Upon request, Piedmont issues proof of coverage in the form of a certificate to each terminating member which includes the effective date and termination date for that member. Certificates are usually sent directly to the employee's home address.

Employee Status Change

Certain changes to an employee's status may affect their health care coverage. Some of the more common situations are listed below.

Termination of Coverage

Terminated employees may only be covered through the period selected on your Group Application. Coverage for terminated employees ends at the end of that period. When an employee terminates employment or no longer meets Piedmont's eligibility requirements, an Enrollment/Change Form must be completed and submitted within thirty-one (31) days of the termination. If the Enrollment/Change Form is not received within that timeframe, Piedmont will not reimburse premiums paid for an employee who has been terminated from the plan for more than two (2) calendar months. However, if there are outstanding claims after the requested termination date, the group may not be eligible for premium reimbursement.

When dependents cease to meet eligibility requirements as described in the Evidence/Certificate of Coverage, the group should submit an Enrollment/Change Form to terminate the coverage effective when the dependent ceases to be eligible.

If Piedmont determines that a dependent is ineligible, coverage will terminate for that dependent. The member will be notified of any terminations.

Summary for Change of Status

When a change to an employee's status occurs, members are required to complete an Enrollment/Change Form. The following information must be included:

1. Type of change (new enrollment, termination, change, or a COBRA election)
2. Effective date of change (change will become effective on the date mutually agreed upon by Piedmont and the group)
3. Plan option affected by change
4. Dependent information section (if adding dependents)
5. When adding a dependent, indicate the reason. Documentation may be required.
6. When removing a dependent, include the name of the dependent and reason for the termination. Supporting documentation is not required.
7. When terminating a member, include the last date of employment and the reason for the termination. Employee signature is not required.
8. All Enrollment/Change Forms must be signed and dated by the authorized group representative.
9. Whenever an employee is adding or dropping dependents from an existing policy or is a new employee, the Enrollment/Change Form must be signed and dated by the employee before Piedmont can process the form.

Consolidated Omnibus Budget Reconciliation Act (COBRA)

Piedmont will fulfill their role in the Group's obligation to offer employees or dependents a temporary extension of benefits as required under the Consolidated Omnibus Budget Reconciliation Act (COBRA). However, at Piedmont, our policy is that groups exempt from offering continued coverage through COBRA, such as employer groups with less than 20 employees, are not permitted to do so. Please note that unless the group contracts with Piedmont to administer their COBRA, it is the responsibility of the group to issue COBRA notification.

Terminating employees or employees who no longer meet the eligibility requirements for Piedmont coverage should inform their employer of their decision to elect COBRA no later than 60 days after the date of notification of COBRA eligibility or the date of the qualifying event, whichever is later. If employees and/or their dependents decide to elect COBRA, Piedmont must receive notice within 31 days after that initial 60-day period.

If only a dependent elects COBRA, Piedmont must receive a new Enrollment/Change Form signed by the dependent (or parent/guardian if dependent is under age 18) within 31 days after the initial 60-day period.

Small Group Employers (less than 20 employees) may elect a 90-day continuation option. The group's benefits and rates remain in effect for these members during the 90-day period.

Premiums must be received on a regular basis from the group for an employee on COBRA. Late receipt of premium may result in the termination of the policy. COBRA will be terminated upon member's entitlement to Medicare. Please be aware that if the Group terminates coverage with Piedmont, employees covered under COBRA will be terminated as well.

NOTE: COBRA rules and information are subject to change as per any new U.S. Government directives or legislation.

Billing & Premium Statements

Piedmont will provide the Group with a comprehensive statement of the account status each month. The statement consists of the Group Statement, Employee Enrollment, and Retroactive Adjustments. Billing usually occurs around the 15th of the month prior to the coverage period. Payment is due on the 1st day of the month of the coverage period.

Group Statement

The Group Statement is a summary of the account status. Please note that payments or changes received after the statement date may not be reflected on the Group's Premium Statement.

Employee Enrollment

The Employee Enrollment Statement is a detailed roster of the Group's employees who are active during the current month, according to Piedmont records. Any necessary changes should be recorded on the Enrollment/Change Form and forwarded to Piedmont.

Termination of Coverage

When an employee terminates employment or no longer meets Piedmont's eligibility requirements, an Enrollment/Change Form must be completed and submitted within thirty-one (31) days of the termination. If the Enrollment/Change Form is not received within that timeframe, Piedmont will not reimburse premiums paid for an employee who has been terminated from the plan for more than two (2) calendar months. However, if there are outstanding claims after the requested termination date, the group may not be eligible for premium reimbursement.

Payment Responsibility

The Group has agreed to pay, on behalf of each employee and his or her dependents, the amounts specified as premiums. All premium statements are mailed around the 15th of the month prior to the due date and all amounts are due on the first of the month of the coverage period. A 31-day grace period exists. The Group policy may be cancelled if payment is not received by the end of the 31-day grace period. Notice of termination of the group medical coverage for nonpayment of premiums will be provided to the group at least 15 days prior to termination. Upon the Group's receipt of the termination notice, the Group is required by Virginia law to notify employees within 15 days. The member will be held responsible for full payment of all services performed.

Please remit payment to:

Piedmont Community Health Plan
2316 Atherholt Road
Lynchburg, Virginia 24501

Claims & Reimbursements

Automatic Network Filing

Participating network physicians, hospitals and other providers are required to file claims directly with Piedmont when a member shows them an ID card. However, a member may occasionally receive a bill or be required to file a claim for services rendered by nonparticipating providers.

In some instances, a participating provider may generate a statement to inform the member of his or her account status. A participating provider may also send a statement to inform the member that a claim has been filed, to request insurance information, or to indicate that a claim has been paid.

When a Member Files a Claim

If a member visits a nonparticipating provider, (for example, in an emergency out-of-the service area), he or she may be asked to pay for covered services rendered at the time or may be billed directly for services received. In these instances, the member should forward a copy of the claim or itemized bill along with a Benefit Claim Form to:

Piedmont Community Health Plan
P.O. Box 14408
Cincinnati, Ohio 45250

Researching Physician, Provider, or Hospital Bills

Any bill or statement a member receives should be reviewed carefully. If the member does not understand the purpose of the bill or statement, they should contact the provider's office. Members may also log in to the member portal here - PCHP Member Portal – or go to PCHP.net, Group Coverage, Members, Login, and follow instructions to log in and/or create an account. From there, members can access Claim and Eligibility Information and view the status of claims. Customer Service can also assist by researching the payment status of a claim. Call 434-947-4463.

If you are asked by the member to investigate a claim or coverage issue on his or her behalf, you should direct them to the website or to Customer Service. If a member is unable or unwilling to follow this procedure, a signed Authorization Statement must be submitted to Piedmont before information can be released to you. The Authorization Statement allows Piedmont to release certain confidential information to you at the specific written request of the member.

Appeal and Grievance Processes

If a member is unable to resolve a claim or other problem related to benefits or coverage, they should file an appeal. If a member is dissatisfied with the availability, delivery, or quality of health care services provided, they should file a grievance. Please refer to the Certificate of Coverage for a complete description of the appeal and grievance processes. Members should submit their written requests describing their concerns and desired outcomes to:

Piedmont Community Health Plan
2316 Atherholt Drive
Lynchburg, Virginia 24501
Attention: Appeal/Grievance

Appeals and grievances may also be submitted by calling 800-400-7247.

Appeals are reviewed and the member is notified in a timely manner according to the type of appeal submitted.

Piedmont offers the following types of appeals:

- pre-service
- post-service
- expedited

In addition to an internal appeal review, an external appeal review may also be available after an adverse benefit determination is reached by Piedmont.

Grievances are investigated and the member is notified of findings within 30 days of receipt.

Members should contact Piedmont's Customer Service if assistance is needed during the appeal/grievance process.

Payment Policy for Nonparticipating Providers

Claims for preapproved care (care authorized by Piedmont) will be covered at the in-network level.

In many instances, when a member sees a nonparticipating provider for preapproved care, Piedmont will reimburse the claim directly to the employee on the policy and the employee is responsible for paying the provider. The amount of the payment will be the same as if the provider were paid directly by Piedmont. This policy applies to claims from any nonparticipating physician or professional provider. Piedmont will continue to make payments to nonparticipating hospitals for covered services.

Piedmont will continue to accept claim forms directly from any provider. The employee receives an Explanation of Benefits which shows provider name, date of service, services provided, and amount of payment for each service.

To find in-network providers, click here, Provider Search, or go to **PCHP.net** and select **Provider Search**.

Explanation of Benefits

The Explanation of Benefits (EOB) provides information concerning members' claims payments. The EOB is not an invoice; it is intended to explain how we have processed a claim submitted under the member's policy. It also indicates what portion of a claim, if any, a member may owe a provider.

Members should read their EOBs carefully. If they have any questions, or if a service has been denied or processed incorrectly, members should contact Customer Service as soon as possible. To appeal the denial of a claim, Piedmont must receive a request for appeal within 180 days of the date of the EOB notice.

The following information is included on the standard Piedmont Explanation of Benefits (EOB) statement which is mailed to the member following receipt of service(s):

- **Service Provided:** A short description of the service(s) provided.
- **Dates of Service:** Date or date-range of services provided.
- **Billed:** Total amount billed for each code submitted.
- **Provider Discount:** Adjustment the provider must make based on their contract and participation with Piedmont.
- **Allowed:** Piedmont's maximum benefit allowable for the service(s) provided.
- **Non-Covered:** Charges for services that are not covered by the plan(s) selected.
- **Other Insurance:** The amount paid by the member's primary insurance carrier.
- **Benefit Payable:** The amount paid on a claim as per the selected Piedmont plan(s).
- **Deductible Applied:** Plan deductible must be met before any benefits are payable by Piedmont.
- **Co-pay:** Amount of applicable employee co-pay.
- **Co-Ins:** Amount of applicable employee co-insurance.
- **Member Portion:** Total amount the member is required to pay the provider for the service(s) provided.
- **Codes:** This is any set of numbers (codes) used to define the terms and medical concepts of medical diagnostic codes, or medical procedure codes.

Key Points About Coverage

Plan Documents

The Certificate of Coverage is a detailed explanation of the covered services, exclusions, limitations and procedures required for obtaining coverage for care. Every employee receives a copy of the Certificate of Coverage, Schedule of Benefits, and any amendments at initial enrollment. If benefit changes occur, it is important for each employee to thoroughly read his/her documentation.

Medical Emergencies

A medical emergency is the sudden onset of a medical condition, such as unusually severe symptoms. Immediate medical attention should be sought if the condition could result in serious jeopardy to the mental or physical health of the member, danger of serious impairment of the member's bodily functions, serious dysfunction of any of the member's bodily organs, or in the case of a pregnant woman, serious jeopardy to the health of the fetus.

Piedmont acknowledges, supports, and pays for prudent emergency care. Members are covered for emergency care, as described below, anytime and anywhere in the world. Preauthorization is not required for a medical emergency. However, follow-up care for emergencies must be coordinated by the member's PCP (if applicable) and appropriate authorization must be obtained prior to treatment.

If the services of a specialist are required, the member should make every effort to be treated by a participating specialty physician. Should a member seek emergency room services or require inpatient care, Piedmont should be notified within 24 hours of admission or the next business day after a weekend or holiday to ensure proper claims processing. Please refer to the Certificate of Coverage for a more detailed description of emergency procedures.

Examples of a medical emergency are:

- Convulsions
- Loss of consciousness
- Obvious broken bones
- Prolonged or repeated seizures
- Serious burns
- Severe or unusual bleeding
- Sudden onset of severe pain
- Suspected poisoning
- Trouble breathing
- Vaginal bleeding during pregnancy

Out-of-Area Coverage

All members are covered for emergency care or urgent care when traveling outside the service area. Emergency services will be covered if the member is out of the service area or if the patient is a covered dependent who resides outside the service area.

All members are covered at the in-network level for true medical emergencies when traveling outside of the service area. Once stabilized, if additional care is needed, Piedmont may arrange for care to be provided within the service area.

Out-of-area urgent care is defined as the initial treatment of an unexpected acute illness or injury for which a member cannot reasonably return to the service area for treatment. Examples of urgent care include suspected fractures, and cuts requiring stitches.

If an emergency or urgent care situation occurs when a member is temporarily outside of the service area, they should obtain care at the nearest medical facility. The member or their representative is responsible for notifying Piedmont within 24 hours of admission or on the next business day after a weekend or holiday. Failure to do so may result in reduced benefits or no benefits.

Benefits for continuing or follow-up treatment must be pre-arranged by Piedmont and provided in the service area by Piedmont providers and are subject to all provisions of the Evidence/Certificate of Coverage.

Dependents of PPO, HMO-POS Plan Members

Dependents of PPO and HMO-POS plan members may receive in-plan benefits if they reside and receive services outside the Piedmont Service Area. The Piedmont Out-of-Area Registration Form can be obtained here - PCHP.net - or by calling Piedmont Customer Service at 434-947-4463 or 800-400-PCHP.

Dependents of HMO Plan Members

Dependents of HMO plan members who reside outside of the Piedmont Service Area are covered *only* in the event of an emergency. Dependents of HMO plan members are responsible for all applicable medical expenses incurred outside the Piedmont Service Area except in cases of emergency. (See previous section for details of emergency care.)

NOTE: COBRA participants who reside outside the service area are not eligible for special network arrangements.

Questions & Answers

Enrollment & Eligibility

Q: *Where can I find enrollment and eligibility forms?*

A: Click here - Employer Forms – or go to PCHP.net and select Group Coverage, Employers, Employer Forms.

Q: *When can a new/existing employee enroll?*

A: New employees may enroll effective the day they satisfy the waiting period established by the employer in the Group Application. If they do not enroll at this time, they must wait until the group's open enrollment period unless they experience a qualifying event (e.g., birth of a child, marriage, adoption, spouse's loss of coverage, etc.). Piedmont must receive an Enrollment/Change Form within 31 days of a member's date of eligibility, and coverage is retroactive to that date.

Q: *How do I add/drop a dependent on an existing employee's policy?*

A: Dependents may be added by completing an Enrollment/Change Form and submitting it to Piedmont within 31 days of open enrollment, the qualifying event or special enrollment situation. Coverage is retroactive to the date of open enrollment or the qualifying event. Dependents may also be dropped by completing an Enrollment/Change Form and submitting it to Piedmont. Coverage is usually active through the end of the month.

Q: *What can a member do if they need services but have not received an ID card?*

A: Members may contact Customer Service at 434-947-4463. Coverage can usually be verified by the physician's office, hospital or pharmacy. They can also register and print a temporary ID card on the Piedmont website. Click here - PCHP Member Portal – or go to PCHP.net and select Group Coverage, Members, Login, and follow instructions to log in and/or create an account.

Q: *If we offer more than one plan option, when can a member switch from one to another?*

A: Members may switch from one plan option to another during open enrollment.

Q: *How do I enroll/terminate an employee?*

A: To enroll an employee, submit a completed Enrollment/Change Form to Piedmont within 31 days of the employee's date of eligibility. Coverage will be retroactive to the date of eligibility for a qualifying event or special enrollment situation. An Enrollment/Change Form should be submitted to terminate coverage for an existing employee.

Q: *When can coverage for an existing employee be terminated?*

A: Terminated employees may be covered until the end of the coverage period as established by the employer on the Group Application. Employees may also voluntarily drop coverage at any time during the month if the Group allows this option.

Billing & Premium Statements

Q: *I sent Piedmont enrollment changes. Why are they not showing on my bill?*

A: If the change does not appear on the bill it may be that the change was submitted too late to be processed prior to the current billing cycle. If the change does not show on the next month's statement, contact Customer Service at 434-947-4463 for assistance.

Q: *When are bills mailed?*

A: Usually by the 15th of the month prior to the coverage period.

Q: *Do I pay the total amount due on my bill?*

A: The total amount due should be paid. Any retro adjustments not reflected on the current bill will be reflected on future statements.

Q: *Can payments be automatically drafted?*

A: No, not currently.

Q: *Why will Piedmont cancel the Group's policy by the stated deadline?*

A: The Group's policy is a prepaid plan. Payment is due on the first day of the month of the coverage period. Payment must be received by the end of the 31-day grace period. The policy may be cancelled after the grace period. You will be provided with a termination notice at least 15 days in advance of any impending termination for nonpayment of premiums.

Health Coverage

Q: *Where and at what times may a member call for specific plan information?*

A: Members may contact Customer Service at 434-947-4463, 8:30 a.m. to 5:00 p.m., Monday - Friday.

Q: *How does a member change an address, request a card, or obtain other information?*

A: Members may contact Customer Service at 434-947-4463; click here - Member Portal - and follow the prompts; or go to PCHP.net and select Group Coverage, Members, Login, and follow instructions to log in and/or create an account.

Q: *How does a member obtain authorization for certain inpatient admissions, outpatient services or nonparticipating provider services?*

A: Members may contact Piedmont Medical Management to obtain authorizations. Authorization status can be confirmed through the Member Portal here - Member Portal - or go to PCHP.net, select Group Coverage, Members, Login, and follow instructions to log in and/or create an account; or call Customer Service at 434-947-4463.

Q: *How do I obtain medical assistance after hours?*

A: In a medical emergency, members should go to the nearest emergency room. The member or their representative must notify Piedmont within 24 hours or on the next business day by calling 434-947-4463. Members may also call our 24x7x365 Nurse Advice Line at 844-447-8470.

Piedmont Website

Q: *What information is available on the website?*

A: The Piedmont website offers many features. Members can search for providers by name, specialty, and location. Upon registering, members can also quickly perform several tasks, including checking status of claims and authorizations, accessing eligibility information, and printing a temporary ID card.

Q: *Can members check claims status online?*

A: Yes, once members login they can check the status of their claims and authorizations, request a new ID card, or request information from Piedmont.

Q: *Is there a listing of prescription drugs on the website?*

A: Yes. The Piedmont website features our prescription drug formularies. Members and non-members may view all prescription drugs covered by Piedmont.

***Please visit our website at PCHP.net*.**