Piedmont Individual Health Care Coverage Plan

2019

Piedmont Choice POS

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

CHOICEPOSIND(01/19).HIX

Piedmont Community Healthcare HMO, Inc.

EVIDENCE OF COVERAGE
AMENDMENT

As of the effective date of the Evidence of Coverage, this amendment becomes part of your Evidence of Coverage. It is issued in exchange for payment to Piedmont on your behalf.

Paragraph A. "ELIGIBILITY" of SECTION VII under "Persons Not Eligible For Coverage" is hereby amended and reads as follows:

Persons Not Eligible For Coverage. The following persons are not eligible for Coverage:

- A person eligible for Coverage in any social welfare programs, such as entitled to or enrolled in Medicare Parts A/B and/or D. (NOTE: Eligibility for Medicaid does not make a person ineligible for Coverage under the Plan)
- Eligibility to age 26 does not extend to a spouse of a child receiving dependent Coverage.
- Eligibility to age 26 does not extend to a child of a child receiving dependent Coverage unless the Subscriber or spouse has legal custody of the grandchild.

PIEDMONT COMMUNITY HEALTHCARE HMO, INC.

IMPORTANT INFORMATION REGARDING YOUR INSURANCE.

THIS IS A POLICY FOR HEALTH MAINTENANCE ORGANIZATION (HMO) INSURANCE – POINT OF SERVICE PLAN

RENEWABILITY

Piedmont Community HealthCare HMO, Inc. (Piedmont) automatically renews your Coverage annually under this Policy, at the option of the insured, as long as these four provisions are met:

1) **Premiums are paid in accordance with the terms of this Policy;**
2) **The Insured lives, works or resides in the Service Area;**
3) **There are no fraudulent or material misrepresentations on the application or under the terms of this Coverage; and**
4) **Eligibility criteria, as determined by the Exchange, continues to be met as a Qualified Individual.**

RIGHT TO RETURN POLICY WITHIN TEN DAYS

If for any reason you are not satisfied with the Coverage set forth in this Policy, you may return this Policy to Piedmont within 10 days of receiving it. Thereafter, we will promptly refund Premiums you paid. It will be as if we never issued you Coverage.

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

We issued this Policy in reliance on the information entered in your application, a copy of which is attached hereto. If you know of any misstatement in your application, you should advise Piedmont immediately regarding the incorrect or omitted information; otherwise, your Policy may not be a valid contract.

THIS POLICY 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 the company. If you need to contact someone about your Coverage, you can contact your agent or Piedmont directly at:

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

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

GEOGRAPHICAL SERVICE AREA

The Service Area for this Policy includes: the cities of Lynchburg, Bedford, and Danville; and the counties of Amherst, Appomattox, Bedford, Buckingham, Campbell, Charlotte, Cumberland, Halifax, Lunenburg, Mecklenburg, Nelson, Nottoway, Pittsylvania, and Prince Edward; all in the Commonwealth of Virginia.

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SECTION I: DEFINITIONS

Allowable Charge means the amount determined by Piedmont as payable for a specified Covered Service or the Providers charge for that service, whichever is less. Piedmont will never pay more than its Allowable Charge for any Covered Service.

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

Benefit Year means the period from January 1st through December 31st or the lesser part of that period during which the Insured has Coverage under this Policy.

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

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

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

Coverage or Covered Services means those Medically Necessary Primary Care, Specialty Care, Inpatient, Outpatient, Hospital and other medical services which Insureds are entitled to receive and that are: (i) listed as covered in this Policy; (ii) performed, prescribed, or directed by a Piedmont Provider or by a non-Piedmont Provider if preauthorized by Piedmont; and (iii) subject to the terms, conditions, definitions, limitations, and exclusions described in this Policy and related documents.

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

Dependent means any member of the Insured's family: who meets all of the eligibility requirements of this Policy and for whom the payment of a Premium required under the Policy has actually been received by Piedmont.

Emergency medical condition or **Emergencies** means a sudden onset of a medical condition that: (a) manifests itself by acute symptoms of sufficient severity, including severe pain; and (b) the absence of immediate medical attention of which could reasonably be expected by a prudent layperson who possesses an average knowledge of health and medicine to result in: (i) serious jeopardy to the mental or physical health of the individual; (ii) danger of serious impairment of the individual's bodily functions; (iii) serious dysfunction of any bodily organ

or part; or (iv) in the case of a pregnant woman, serious jeopardy to the health of the fetus. Emergencies include: heart attacks; hemorrhaging; poisonings; loss of consciousness; convulsions; and other acute conditions as Piedmont shall determine (Plan Participant always has the right to appeal any such determination by Piedmont).

Emergency services means those health care services that are rendered by affiliated or nonaffiliated providers after the sudden onset of a medical condition that manifests itself by symptoms of sufficient severity, including severe pain, that the absence of immediate medical attention could reasonably be expected by a prudent layperson who possesses an average knowledge of health and medicine to result in (i) serious jeopardy to the mental or physical health of the individual, (ii) danger of serious impairment of the individual's bodily functions, (iii) serious dysfunction of any of the individual's bodily organs, or (iv) in the case of a pregnant woman, serious jeopardy to the health of the fetus. Emergency services shall include Covered health care Services from non-Piedmont Providers within Piedmont's Service Area only when delay in receiving services from a Piedmont Provider could reasonably be expected to cause the Plan Participant's condition to worsen if left unattended.

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

Essential Health Benefits means: ambulatory patient services; Emergency services; Hospitalization; maternity and newborn care; mental health and substance abuse 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. The Secretary of the US Department of Health and Human Services (HHS) pursuant to authority conferred by the Affordable Care Act, and Piedmont expects to conform this definition to those changes.

Experimental/Investigational means any service or supply which is determined to be experimental or investigational in Piedmont's sole discretion (subject to all appeals available to you). Piedmont will apply the following criteria in exercising its discretion. A service or supply will be Experimental/Investigational if Piedmont determines that any one of the following criteria is not satisfied:

A) Any supply or drug used must have received final approval to market by the United States (US) Food and Drug Administration (FDA) for the particular indication or application in question. Moreover, quantities of any drug or medication used, except those drugs used in the treatment of cancer pain and prescribed in compliance with established statutes pertaining to patients with intractable cancer pain, must be within recommended maximum daily dose or duration established by the FDA or any of the standard reference compendia defined below. There are two exceptions which apply when a drug has received final approval to market by the FDA, but not for the particular indication or application in question.

    1) This criterion will be satisfied if the use of the drug is recognized for treatment of the indication or application in any of the following resources:

- The following three standard reference compendia defined below:
  a) American Hospital Formulary Service Drug Information;
  b) National Comprehensive Cancer Network's Drugs & Biologics Compendium; or
  c) Elsevier Gold Standard's Clinical Pharmacology.

- In substantially accepted peer-reviewed medical literature. Peer-reviewed medical literature means a scientific study published only after having been critically reviewed for scientific accuracy, validity, and reliability by unbiased independent experts. This study must appear in a journal that has been determined by the International Committee of Medical Journal Editors to have met the Uniform Requirements for Manuscripts submitted to biomedical journals. Peer-reviewed medical literature does not include publications or supplements to publications that are sponsored to a significant extent by a pharmaceutical manufacturing company or health carrier; or

2) In the case where the drug is being used for the treatment of a specific type of cancer, this criterion will be satisfied if the use of the drug is recognized as safe and effective for treatment of the specific type of cancer in any of the standard reference compendia.

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.

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

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

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

Family Unit is the covered Insured and the Insured's family members that are covered Dependents of that Insured.

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

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

Insured(s) means the insured individual, and his / her legal spouse and eligible Child who: (1) meet all the eligibility requirements provided for in this Policy; and (2) for whom the

payment of the Premium required under this Policy has actually been received by Piedmont.

Limiting Age means the age after which an Insured Dependent Child is no longer eligible for Coverage under this Policy. The Limiting Age for Dependent Children is age 26.

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

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

Network shall refer to the Insured's Primary Care Physician (PCP) and the Hospital and Specialty physicians affiliated with the PCP, as set forth in the applicable Provider Directory supplied by Piedmont.

Open Enrollment Period (OEP) refers to the period of time each year during which a Qualified Individual may apply to newly enroll for Coverage or otherwise change Coverage in an individual market Qualified Health Plan through the Marketplace. The Marketplace OEP is now November 1st through December 15th of each year for enrollment with an effective date beginning January 1st of the following year.

Out-of-Pocket Limit means the amount above which the Allowable Charges that an Insured incurs will be payable at 100% (except for those charges excluded from the Out-of-Pocket Limit) for the remainder of that Benefit Year.

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

Physician (Doctor) means a person who is certified or licensed under the laws of the state to provide medical services within the scope of such certification or licensure, such as a Doctor of Medicine or a Doctor of Osteopathy. Any other health care provider or allied practitioner who is mandated by state law and who acts within the scope of their license will be considered on the same basis as a Physician. Physician includes Primary Care Physician (PCP), Specialist Physician, nurse practitioner, physician assistant and any other Provider(s) as defined in this Policy.

Participant means any Insured or Dependent of an Insured.

Piedmont means Piedmont Community HealthCare HMO, Inc.

Piedmont Physician means a duly licensed doctor of medicine or osteopathy who has independently contracted with Piedmont to provide medical services to Insureds.

Piedmont Provider means: a medical group; Piedmont Physician; Hospital; skilled medical

facility; skilled nursing facility; pharmacy; or any other duly licensed institution or health professional that has contracted with Piedmont or its designee to provide Covered Services to Insureds. A list of Piedmont Providers is made available to each Insured upon issuance of the Policy and is available upon request from Piedmont and viewable online at **www.pchp.net**. Piedmont shall revise the list of Piedmont Providers as Piedmont deems necessary or at such other time as applicable law requires.

Policy means this document, the Schedule of Benefits, the Insured's application, and any amendment or related document issued in conjunction with this document, setting out the Coverage and other rights to which you are entitled.

Premium(s) shall mean the monthly payment due from the Insured to Piedmont as specified in the Policy and related documents as a condition precedent for Insureds to receive Coverage.

Primary Care Physician or **PCP** means the Piedmont Physician you select to provide primary health care and to coordinate the other Covered Services you may require. All Insureds are required to have a Primary Care Physician. Each Insured may choose any available Primary Care Physician in accordance with the terms and conditions of this Policy.

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.

Qualified Health Plan (QHP) is a health plan that has in effect a certification issued or recognized by each Marketplace (Exchange) through which such health plan is offered.

Qualified Individual (QI) is, with respect to the Federal Marketplace, an individual who has been determined eligible to enroll through the Marketplace in a QHP in the individual market.

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

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

Urgent Care means care for a health problem usually marked by rapid onset of persistent or unusual discomfort associated with an illness or injury. These problems may include: high fever; vomiting; sprains; or 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 HMO, Inc. These words always refer to Piedmont even though the first letters of the words may not be capitalized.

You, Your, Yourself refers to an Insured. These words always refer to an Insured even though the first letters of the words are not capitalized.

SECTION II: RESPONSIBILITIES

A. YOUR RESPONSIBILITIES

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

Paying Your Monthly Premium. This Policy is issued to the Insured. Piedmont agrees to provide Covered Services to you under the terms contained in this Policy. You must pay the applicable Premium on or before the first day of the Coverage month. The Premium can be found in the Premium Explanation (Attachment A) to this Policy. An administrative fee of $35 will be charged for any check, automatic deduction, or Electronic Funds Transfer which is returned or dishonored by the financial institution as non-payable to Piedmont for any reason. Piedmont reserves the right to refuse to effectuate new coverage for you if you have unpaid past-due premiums with us for the period of time coverage was actually in force within the prior 12 months from your prospective coverage effective date. All past due premiums owed to us for coverage within the prior 12-month period must be paid in full to effectuate new coverage; this is normally no more than 31 days of Premium.

Choose a Primary Care Physician. Upon issuance of this Policy to the Insured, you and all family members that are insured Participants enrolled under your Coverage must select a Primary Care Physician. If you do not select a Primary Care Physician upon the issuance of this Policy or if the Primary Care Physician you previously selected terminates his/her relationship with Piedmont, then Piedmont may request a Primary Care Physician to provide your primary health care. Piedmont cannot guarantee the continued availability of a particular Piedmont Provider as a Primary Care Physician. If you want a different Primary Care Physician, then you may request another Primary Care Physician from among those available to insureds of Piedmont. You will receive an Identification (ID) Card listing your Primary Care Physician's name.

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

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

Your Choice of Treating Providers. Piedmont's agreements with its Network of Piedmont Providers should not be understood as a guarantee or warranty of the professional services of such Providers. The (1) choice of Primary Care Physician, Piedmont Provider, or any other provider, and/or (2) decision to receive or decline health care services from such Provider, is the sole responsibility of the Participant.

Changes in Coverage. The Premium amount due under this Policy may change because of adding a Dependent(s) or terminating Coverage of a Dependent(s). Please make sure that Piedmont is notified as soon as possible, but no more than 31 days after any of the following changes occur:

1. Change in marital status (the Insured and the Covered Dependent spouse divorce);
2. The end of the month a Covered Dependent Child reaches the Limiting Age of 26;
3. A Covered Participant begins active duty with the Armed Services;
4. Death of a Dependent; or
5. A Dependent Child is born to or adopted by the Insured.

Failure to provide proper notice of changes in Coverage may affect your Coverage. Piedmont is not responsible for any lapse in Coverage due to your failure to provide proper notice of a change in Coverage as required herein.

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

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

- Select a Primary Care Physician.
- Transfer previous medical records to your Primary Care Physician.
- Be on time for appointments.
- Notify your Primary Care Physician or any other Piedmont Provider promptly to cancel or reschedule an appointment.
- Obtain Covered Services through your Piedmont Providers for the highest level of Benefits called In-Network Benefits.
- Obtain preauthorization before treatment is received for services that require it.
- Obtain a formal referral from Piedmont before treatment is received from non-Piedmont Providers in the event care from non-Piedmont Providers is necessary, in order to receive In-Network Benefits. Failure to obtain the 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.
- Follow guidance given by your Primary Care Physician or other Piedmont Provider.
- Make the lifestyle changes recommended by your Piedmont Physician or Piedmont.

- Know prescribed medications, reasons for taking them, and procedures for taking them.
- Learn to differentiate between true Emergency situations and Urgent Care needs; and how to handle them.
- Pay Copayments, Coinsurance, and/or Deductibles at the time the Covered Service is rendered.
- Make sure to notify Piedmont of any change in name, address, phone number, or Dependent's or other Participant's eligibility.
- Utilize Grievance and Appeal Procedures discussed further in this Policy to resolve concerns and complaints.
- Provide Piedmont with (1) requested information, including medical records; (2) physician statements regarding care and treatment; and (3) any information regarding your physical condition.
- Provide Piedmont with the necessary information so Coordination of Benefits may take place.

B. PIEDMONT'S RESPONSIBILITIES

Piedmont will provide health care Benefits according to this Policy and agrees to:

- Provide each Participant with a Piedmont ID card.
- Provide all Benefits described in this Policy subject to its terms, conditions, limitations, and exclusions.
- Keep you informed regarding changes in procedures, Benefits, and Piedmont Providers. Piedmont does not guarantee the continued availability of a particular Piedmont Provider.
- Keep all medical records confidential in accordance with federal and state privacy protection laws.
- Provide courteous, prompt resolution of your questions, concerns, complaints or appeals.
- Assist you in getting an appointment with and changing Providers in Piedmont's Network when requested.
- Make Network arrangements so your Physician in Piedmont's Network (or another physician with whom your In-Network Physician has made arrangements) is available 24/7 to refer or direct you for prompt medical care where there is an immediate, urgent need or Emergency.
- Have Piedmont's or its designee's personnel available for treatment preauthorization at all times when preauthorization is required. Piedmont requires Providers (or Participants acting on their own behalf) to make preauthorization arrangements during regular business hours. Piedmont's preauthorization is not required for Emergencies anytime or Urgent Care situations after hours.
- Offer you the right to make recommendations about your rights and responsibilities.

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

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

C. IMPORTANT INFORMATION REGARDING YOUR INSURANCE

In the event you need to contact someone about your Coverage, or if you need to request a copy of the List of Participating Providers (a copy of which can always be viewed online at the web address listed below), you can always contact your agent or Piedmont directly at:

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

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

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

NON-DISCRIMINATION AND LANGUAGE ASSISTANCE

Discrimination is Against the Law

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

Piedmont:

• Provides free aids and services to people with disabilities to communicate effectively with us, such as:

- Qualified sign language interpreters
- Written information in other formats (large print, audio, accessible electronic formats, other formats)

• Provides free language services to people whose primary language is not English, such as:

- Qualified interpreters
- Information written in other languages

If you need these services, contact Piedmont's Customer Service at 1-800-400-7247 (TTY: 711).

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

Compliance Officer
Piedmont Community Health Plan
2316 Atherholt Road
Lynchburg, VA 24501
434-947-4463 (TTY: 711)

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights, electronically through the Office for Civil Rights Complaint Portal, available at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf , or by mail or phone at:

U.S. Department of Health and Human Services
200 Independence Avenue, SW
Room 509F, HHH Building
Washington, D.C. 20201
1-800-368-1019, 800-537-7697 (TDD)

Complaint forms are available at http://www.hhs.gov/ocr/office/file/index.html.

Language Assistance

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

English

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

Español (Spanish)

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

한국어 (Korean)

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

Tiếng Việt (Vietnamese)

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

Tagalog (Tagalog - Filipino)

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

العربية (Arabic)

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

(رقم هاتف الصم والبكم: -711)

繁體中文 (Chinese)

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

Français (French)

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

বাংলা (Bengali)

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

Ɓàsɔ́ɔ̀-wùɖù-po-nyɔ̀ (Bassa)

Dè ɖɛ 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. Đá 1-800-400-7247 (TTY:711)

èdè Yorùbá (Yoruba)

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

Deutsch (German)

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

اُردُو (Urdu)

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

हिंदी (Hindi)

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

فارسی (Persian/Farsi)

توجه: اگر به زبان فارسی گفتگو می کنید، تسهیلات زبانی بصورت رایگان برای شما

فراهم می باشد. با 1-800-400-7247 (TTY: 711) تماس بگیرید.

አማርኛ (Amharic)

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

Igbo asusu (Ibo)

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

Русский (Russian)

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

తెలుగు (Telugu)

శ్రద్ధ పెట్టండి: ఒకవేళ మీరు తెలుగు భాష మాట్లాడుతున్నట్లయితే, మీ కొరకు తెలుగు భాషా సహాయక సేవలు ఉచితంగా లభిస్తాయి. 1-800-400-7247 (TTY: 711) కు కాల్ చేయండి.

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

Post Office Box 1157
Richmond, Virginia 23218-1157
(804) 371-9741
(800) 552-7945 (toll free)
1-877-310-6560 (national toll free)

Complaints regarding your Coverage may also be directed to the Office of Licensure and Certification of the Virginia Department of Health located at 9960 Mayland Drive, Suite 401, Henrico, Virginia 23233-1463, or by calling them at **(800) 955-1819**.

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

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

This Policy, including the endorsements and the attached papers, if any, and our customer service department are the best resources for information about your Coverage. It is your responsibility to know and understand your Benefits.

By being an Insured holder of this Policy, you agree to abide by applicable terms and conditions of this Policy, including the endorsements and the attached papers, if any, which documents collectively constitute the entire contractual agreement between you and Piedmont for the provision of health insurance. No oral statement of any person, including Piedmont's employees, shall modify or otherwise affect the Benefits, limitations, and exclusions of the Policy, convey or void any Coverage, increase or reduce any Benefits under this Policy, or be used in support or defense of a claim under this Coverage.

A. REGULATORY AGENCIES

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

SECTION III: HOW TO USE YOUR BENEFITS

A. CHOOSE A PRIMARY CARE PHYSICIAN (PCP)

Upon each Participant's enrollment in Coverage, each Participant whose Coverage arises through this Policy must select a Primary Care Physician (PCP). Piedmont may choose a PCP if a Participant does not choose one.

A Participant may select as his or her Primary Care Physician any qualified Physician available to accept the Participant in Piedmont's Network.

A Participant may select as his or her enrolled Dependent Child's Primary Care Physician (allopathic or osteopathic) any Physician in Piedmont's Network who specializes in pediatrics if the Physician is available to accept the Child as a patient.

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

Each Participant will receive an identification (ID) card listing his/her Primary Care Physician's name. If a Participant is not satisfied with his/her Primary Care Physician, then he/she may request another Primary Care Physician from those available in Piedmont's Network. Such change is effective upon receipt of notice of the change. Piedmont will not honor a request for a retroactive change in Primary Care Physician. Piedmont does not guarantee availability of a particular Piedmont Provider.

B. COVERED PROVIDERS

This Plan is a Point of Service plan. The highest level of Benefits is available when you obtain Covered Services from Piedmont Providers. The Benefits are called "In-Network" Benefits. Referrals are never needed to visit an In-Network Specialist Physician, including behavioral health Providers. For receipt of In-Network Benefits when required Services are not available from Piedmont Providers the Plan Participant (or his or her Piedmont Physician) shall contact Piedmont and provide information that the required Covered Services needed by the Plan Participant are not available from Piedmont Providers. In that case, Piedmont will review the information with you and /or your Piedmont Physician as necessary and work with you and/or your Piedmont Physician to arrange for the Services to be provided as In-Network Benefits by referral providers outside the Service Area (or outside Piedmont's Network of Providers) with whom Piedmont has made arrangements to provide these Covered Services.

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

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

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

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

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

An office visit to a Piedmont Physician does not require an authorization or notification to Piedmont. A Piedmont Physician may perform the following procedures or diagnostic exams in his/her office without a preauthorization from Piedmont:

1. Laboratory services referred to a Piedmont Provider or in the Physician's office.
2. X-rays.
3. Prescriptions for 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.

C. SERVICES REQUIRING PREAUTHORIZATION

Certain Covered Services will require preauthorization by Piedmont, except in an Emergency or Urgent Care situation after hours (see below). Your Piedmont Physician will work with you and Piedmont to handle these preauthorization requirements. Examples of these Services include, but are not limited to, the following:

1. Referrals for Covered Services to all Providers who are not Piedmont Providers in order to obtain In-Network Benefits. Failure to obtain the referral will result in a reduced level of Benefits called Out-of-Network Benefits;
2. Transplant services;
3. Non-Emergent ambulance transport services;

4. Audiology testing;
5. Outpatient substance use disorder services/treatment;
6. Clinical trials;
7. Durable medical equipment (DME) requires preauthorization depending on the type of equipment or supply (based on CPT code). Repair and replacement of DME follows the same guidelines. Contact Piedmont Customer Service or view Piedmont's website for further information;
8. Medications:
    - Botulinum toxin;
    - Chemotherapy;
    - Infusion therapy, including ambulatory infusion center setting;
    - Injections, including but not limited to intravitreal injections and viscosupplementation.
9. Inpatient Hospital (except for routine vaginal/C-section deliveries at In-Network Hospitals;
10. Partial Hospitalization;
11. Acute rehabilitation;
12. Skilled nursing facility;
13. Long-term acute care Hospital;
14. Substance abuse treatment;
15. Magnetic resonance imaging (MRI) (except breast MRI);
16. Magnetic resonance angiography (MRA);
17. Magnetic resonance cholangiopancreatography (MRCP);
18. Positron emission tomography (PET) scans;
19. Bone scans;
20. Outpatient surgeries, including those performed in the Outpatient Hospital or ambulatory surgery center setting and oral surgery;
21. Ablation procedures (no preauthorization needed for cardiac ablation procedures), and radiofrequency ablation, including those performed in-office;
22. Endoscopic retrograde cholangio-pancreatography (ERCP);
23. Sclerotherapy;
24. Wireless capsule endoscopy;
25. All tertiary care services, including transplant services;
26. Applied behavioral analysis (ABA) services; and
27. Home infusion services.

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

D. OBSTETRICAL AND GYNECOLOGICAL CARE DOES NOT REQUIRE PREAUTHORIZATION BY PIEDMONT

A Plan Participant is not required to receive a referral or authorization from their Primary Care Physician before receiving obstetrical or gynecological care from a Piedmont Provider

specializing in obstetrics or gynecological care. Obstetrical and gynecological care the Plan Participant receives from a Piedmont Provider without the Primary Care Physician's prior authorization includes ordering related obstetrical and gynecological items and services that are Covered Benefits.

E. EMERGENCY SERVICES DO NOT REQUIRE A NETWORK PROVIDER OR PREAUTHORIZATION BY PIEDMONT

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

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

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

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

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

Cost-Sharing for Emergency services

The Copayment amounts and Coinsurance percentages for Emergency services received from a non-Piedmont Provider are the same as the Copayment amounts and Coinsurance percentages for Emergency services received from a Piedmont Provider.

Piedmont will pay the greater of the following amounts for Emergency services received by a Participant from a non-Piedmont Provider:

(1) The amount set forth in your Policy or Schedule of Benefits.

(2) (a) The amount negotiated with Piedmont Providers for the Emergency Services provided, less any Copayment or Coinsurance amounts imposed in your Policy or Schedule of Benefits. (b) If there is more than one amount negotiated with Piedmont Providers for the Emergency Services, the amount paid will be the median of these negotiated amounts, less any Copayment or Coinsurance amounts imposed in your Policy or Schedule of Benefits.

(3) The Usual and Customary amount for the Emergency Services calculated using the same method that Piedmont generally uses to determine payments for services provided by a non-Piedmont Provider (the Allowable Charge), less any Copayment or Coinsurance amounts imposed in your Policy 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 Services, less any Copayment or Coinsurance amounts imposed in your Policy or Schedule of Benefits.

The other cost-sharing provisions in your Policy and Schedule of Benefits for Covered Benefits received from non-Piedmont Providers continue to apply to Emergency Services received from non-Piedmont Providers. Examples of such cost-sharing provisions include Deductibles and Out-of-Pocket Limits. Any Deductible or Out-of-Pocket Limit that applies generally to services received from non-Piedmont Providers also applies to Emergency Services received from non-Piedmont Providers.

F. PREAUTHORIZATION FOR SERVICES FROM NON-PIEDMONT PROVIDERS

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

G. CONTINUITY OF CARE

If your Piedmont Provider leaves Piedmont's Network, you may continue to receive Covered Services from this Provider in the following cases:

1. You may receive Covered Services from your Piedmont Primary Care Physician for a period of 90 days from the date of the Primary Care Physician's termination notice to Piedmont as a Piedmont Provider as long as the physician remains in the Service Area and is open to see patients.

2. You may receive Covered Services from Piedmont Providers other than your Primary Care Physician for a period of 90 days from the date of that physician’s termination notice termination as a Piedmont Provider, but only if you:

    a. Were in an active course of treatment from the Piedmont Provider prior to the notice of termination; and

    b. Request the ability to continue receiving Covered Services from this physician for the 90-day period following the date of the physician’s termination notice as a Piedmont Provider.

3. A Participant in the second trimester of pregnancy at the time of her Piedmont Provider’s termination notice as a Piedmont Provider has the option to continue

receiving Covered Services from that Provider. This continuation of maternity Coverage may include Covered Services for postpartum care directly related to the delivery.

4. A Participant determined to be terminally ill (as defined by Section 1861 (dd) (3) (A) of the United States Social Security Act) at the time of his/her Piedmont Provider's termination notice as a Piedmont Provider has the option to continue receiving Covered Services directly related to treatment of the terminal illness from this Provider for the remainder of his/her life.

The continuity of care provided for in this Continuity of Care subsection is not available if either (a) Piedmont terminates your Piedmont Provider (including your Primary Care Physician) from the Network "for cause;" or (b) if you cease to be an eligible Participant. Piedmont will pay the Provider for Covered Services you receive under this subsection according to Piedmont's agreement with the Provider in effect immediately before the termination of the Provider as a Piedmont Provider.

H. CASE MANAGEMENT

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

I. UTILIZATION MANAGEMENT PROGRAM

The Utilization Management (UM) program evaluates the appropriateness and/or Medical Necessity of healthcare Services to determine what is payable under this Policy. 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 preauthorization by Piedmont before you receive them. If our requirements for preauthorization are not followed, Piedmont may not pay for these services. Typically, In-Network Providers know which services require preauthorization and will get one when needed. Your Primary Care Physician and other In-Network Providers have been given detailed information about our preauthorization procedures and they are responsible for meeting these requirements and obtaining the needed preauthorization. Since the preauthorization is the responsibility of our In-Network Providers, any reduction or denial of benefits due to not obtaining a preauthorization should not affect the Participant.

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

SECTION IV: WHAT YOU PAY FOR BENEFITS

All Services or supplies you receive are subject to the terms, conditions, definitions, limitations, and exclusions described elsewhere in this Policy. Piedmont will only pay for Medically Necessary Covered Services. Additionally, Piedmont will only pay the charges incurred by you when you are actually eligible for the Covered Services received (e.g., Premiums have been paid by you or on your behalf).

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, a Participant must meet the Deductible shown in the Schedule of Benefits. Covered Services that are subject to a Copayment rather than Coinsurance will not be subject to the Deductible.

2. **Family Unit Limit.** When Participants that are members of a Single-Family Unit for an Insured have collectively incurred the total dollar amount shown in the Schedule of Benefits toward their Benefit Year Deductibles, then the Deductibles of all Participants of that Family Unit will be considered satisfied for that Benefit Year. Any amounts of Deductible paid in excess of the Family Unit Limit in a Benefit year will be promptly reimbursed to the paying Insured.

B. COPAYMENT/COINSURANCE AMOUNTS

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

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

For insurance plans with Deductibles, the Coinsurance applies after the applicable Deductible has been satisfied if the Service is subject to the Deductible. When seeing a non-Piedmont Provider due to a Piedmont preauthorized referral or an Emergency, Insureds are responsible for billed charges in excess of the Allowable Charge. Amounts above the Allowable Charge do not apply toward the maximum Out-of-Pocket Limit (as defined in Section IV(D) below).

C. BENEFIT PAYMENT

Each Benefit Year, Piedmont will pay Benefits for those Covered Services a Participant receives in excess of the Deductible. Payment will be made based on the amounts shown in the Schedule of Benefits. No Benefits will be paid in excess of the limits listed in this Policy or the Schedule of Benefits that is made a part hereof.

D. OUT-OF-POCKET LIMIT

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

Piedmont shall maintain records showing the amount of Copayments paid by a Family Unit of Insureds during the Benefit Year. When a Family Unit reaches the Out-of-Pocket Limit, Allowable Charges incurred by a Participant that is a member of that Family Unit will be payable by Piedmont at 100% (except for those charges excluded from the Out-of-Pocket Limit as set forth below) for the remainder of that Benefit Year. Piedmont shall provide written notice to an Insured within 30 days after the maximum Out-of-Pocket Limit is reached for Copayments and shall thereafter not charge any further Copayments to that Family Unit of Insureds for the remainder of the Benefit Year. Any excess Copayments received after such notice shall be promptly refunded.

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

- Non-Covered Services described in this Policy;
- Charges in excess of any Benefit limitations; and
- Amounts above the Allowable Charge.

Once you have met your maximum Out-of-Pocket Limit for the Benefit Year, you will still have cost obligations for the 3 items listed above.

E. ALLOWABLE CHARGE

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

SECTION V: COVERED BENEFITS

Piedmont covers only those Medically Necessary Services. Just because the Service is prescribed by a Provider does not necessarily mean that the Service is "Medically Necessary." Piedmont shall make all determinations required for the administration of the Policy. This includes determinations about Medical Necessity and Covered Services. Medical Necessity is to be determined in accordance with generally accepted standards of medical care as determined by Piedmont. Participants have a right to appeal any adverse claims determination made by Piedmont. The appeals process is described in Section VIII of this Policy.

A. ALLERGY TREATMENT

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

B. AMBULANCE (INCLUDING AIR AMBULANCE) SERVICES

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

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

Reimbursement shall be made directly to the Provider when Piedmont is presented with an assignment of benefits by the person or entity providing such services.

C. CHEMOTHERAPY

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

D CLINICAL TRIALS FOR LIFE-THREATENING DISEASES/CONDITIONS

This Policy includes Coverage of routine patient costs of qualified individuals associated

with approved clinical trials for life-threatening diseases or conditions. "Qualified individual" means a covered person who is eligible to participate in an approved clinical trial according to the trial protocol, with respect to treatment of cancer or other life-threatening disease or condition, and the referring health care professional has concluded that the individual's participation in such trial is appropriate to treat the disease or condition, or the individual's participation is based on medical and scientific information. Piedmont will not deny a qualified individual participation in an approved clinical trial, deny or limit, or impose additional conditions on the Coverage of routine patient costs for items or services furnished in connection with participation in the approved clinical trial. Piedmont will not discriminate against the individual on the basis of the individual's participation in the approved clinical trial.

An "approved clinical trial" means a phase I, phase II, phase III, or phase IV clinical trial that is conducted in relation to the prevention, detection, or treatment of cancer or other life-threatening disease or condition, and the study or investigation is (i) a federally funded or approved trial, (ii) conducted under an investigational new drug application reviewed by the U.S. Food and Drug Administration, or (iii) a drug trial that is exempt from having an investigational new drug application. "Life threatening condition" means any disease or condition from which the likelihood of death is probable unless the course of disease or condition is interrupted.

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

a. The National Institutes of Health (NIH). (Includes the National Cancer Institute (NCI));

b. The Centers for Disease Control and Prevention;

c. The Agency for Health Care Research and Quality;

d. The Centers for Medicare and Medicaid Services;

e. Cooperative group or center of any of the entities described in (a) through (d) or the Department of Defense or the Department of Veterans Affairs;

f. A qualified non-governmental research entity identified in the guidelines issued by the National Institutes of Health for center support grants;

g. The Department of Veterans Affairs, the Department of Defense, or the Department of Energy as long as the study or investigation has been reviewed and approved through a system of peer review that the Secretary determines 1) to be comparable to the system of peer review of studies and investigations used by the National Institutes of Health, and 2) assures unbiased review of the highest scientific standards by qualified individuals who have no interest in the outcome of the review;

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

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

j. An institutional review board of an institution in the Commonwealth of Virginia that has a multiple project assurance contract (i.e., a contract between an institution and the US HHS that defines the relationship of the institution to the HHS and sets out the responsibilities of the institution and the procedures that will be used by the institution to protect human subjects) approved by the NCI's Office of Protection for Research Risks.

Piedmont's payment for Covered Services you receive during participation in clinical trials for treatment studies on life threatening diseases will be determined in the same manner as Piedmont determines payment for other Covered Services. Durational limits, dollar limits, Deductibles, Copayments, Coinsurance, and Allowable Charge limits for these services will be no less favorable than for other Covered Services. Covered Services mean Medically Necessary health care services that are incurred as a result of the treatment being provided to you for the purposes of a clinical trial. "Routine patient costs" means all items and services consistent with the coverage provided under the health benefit plan that is typically covered for a qualified individual who is not enrolled in a clinical trial. Routine patient costs do not include (i) the investigational item, device, or service itself; (ii) items or services that are provided solely to satisfy data collection and analysis needs and that are not used in the direct clinical management of the patient; (iii) a service that is clearly inconsistent with widely accepted and established standards of care for a particular diagnosis; or (iv) any item or service that is paid for, or should have been paid for, by the sponsor of the trial.

E. DIABETES CARE MANAGEMENT

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

- Medically Necessary insulin pumps;

- Home blood glucose monitors, lancets, blood glucose test strips, syringes, and hypodermic needles and syringes when purchased from a pharmacy; and

- Outpatient self-management training and education performed in-person; including medical nutritional therapy and nutrition counseling, when provided by a certified, licensed, or registered health care professional.

To receive Benefits, equipment and supplies for diabetes must be obtained from the designated Piedmont Providers for this health service. Piedmont will not repair or replace lost or damaged equipment due to your neglect or abuse. Supplies must be purchased in quantities or units equivalent to a 30-day supply.

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

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, CT scans, PET/CT Fusion scans, SPECT scans, QTC Bone Densitometry, diagnostic CT Colonography, nuclear cardiology, BRCA and fetal screenings, and non-preventive diagnostic colonoscopy and diagnostic mammography performed in an Inpatient or Outpatient facility are covered under the Inpatient or Outpatient facility Benefit. Preventive screening mammography and screening colonoscopy services may be covered without requirement of further payment by you. Diagnostic tests include lab and pathology services as well as the professional services for test interpretation, x-ray reading, lab interpretation and scan reading. Diagnostic tests are covered in both an Inpatient and Outpatient setting. Piedmont covers diagnostic sleep testing and treatment (see subsection I (e) in this section 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
- QTC 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

Piedmont covers services for acute and chronic (end-stage) renal disease, including hemodialysis, home intermittent peritoneal dialysis (IPD), home continuous cycling peritoneal dialysis (CCPD), and home continuous ambulatory peritoneal dialysis (CAPD). Home dialysis equipment and supplies are Covered Benefits. In addition, dialysis treatments are covered in an Outpatient dialysis facility or Doctor's office.

H. DOCTOR VISITS AND SERVICES

Piedmont covers visits to a Doctor's office (including second surgical opinions) or your Doctor's visits to your home, visits to an Urgent Care center for urgent but non-emergent care, Hospital Outpatient department or Emergency room, visits to Retail Health Clinics (walk-ins) for routine care and common illnesses, visits for shots needed for treatment (including allergy shots), and interactive telemedicine services, including online visits with the Doctor by a webcam, chat or voice. Piedmont covers online visits and webcam, chat, or voice in place of a physical office visit, if your Primary Care Provider makes these services available. Online visits do not include reporting normal lab or other test 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. Specialist office visits include office surgeries and second surgical opinions. Physician (Doctor) includes Primary Care Physician (PCP), Specialist Physician, nurse practitioner, physician assistant and any other Provider(s) as defined in this Policy.

I. DURABLE MEDICAL EQUIPMENT AND SUPPLIES

Rental of Medically Necessary durable medical equipment and medical devices (or purchase, if such purchase would be less than rental cost as determined by Piedmont) is a Covered Service, when meant for repeated use and is not disposable, has no other use than medical, is meant for use outside a medical facility, and is only for the use of the patient. To receive Benefits, durable medical equipment must be obtained from designated durable medical equipment and supplies Piedmont Providers for this covered health service. Covered durable medical equipment, including the cost of fitting, adjustment, and repair, is listed below:

a. Hospital-type beds;
b. Bedside commode, shower chair, and tub rails;
c. Canes, crutches, walkers, slings, splints, cervical collars, and traction

apparatus;

d. Wheelchairs and Medically Necessary wheelchair accessories and supplies;
e. Oxygen and oxygen equipment for administration, including devices and supplies for sleep treatment such as APAP, CPAP BPAP and oral devices, oxygen concentrator, ventilator;
f. Colostomy and other related ostomy supplies, including bags, flanges, and belts; *
g. Indwelling catheters, straight catheters, and catheter bags; *
h. Respirators;
i. Jobst stockings or equivalent when prescribed by a vascular surgeon prior to or following vascular surgery;
j. The first pair of contact lenses or eyeglasses following approved cataract surgery without implant or for the treatment of accidental eye injury;
k. Prosthetic devices and components, including artificial limbs and components Medically Necessary for daily living, breast prosthesis following a mastectomy, restoration prosthesis (composite facial prosthesis), cochlear implants, orthopedic braces, leg braces including attached or built-up shoes attached to a leg brace, molded or therapeutic shoes for diabetics with peripheral vascular disease; arm braces, back braces, neck braces, head halters, catheters and related supplies and splints;
l. Two bras or camisoles per year (two total) following mastectomy;
m. Nebulizers;
n. **One wig per Benefit Year following chemotherapy or cancer treatment**;
o. Negative pressure wound therapy devices or "wound VAC";
p. Orthotics (braces, boots, splints), other than foot orthotics;
q. Phototherapy lights; and
r. Lymphedema sleeves.

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

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

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

Piedmont will consider replacement of durable medical equipment replacement if:

1. Non-repairable as deemed by the manufacturer.

2. Cost of repairs exceed replacement costs.

3. No longer functional as deemed by manufacturer or durable medical equipment Provider.

4. Not for reason of warranty expiration.

J. EARLY INTERVENTION SERVICES

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

K. EMERGENCY AND URGENT CARE SERVICES

When you require resuscitation, Emergency treatment, or your life is endangered, Piedmont does not require prior authorization before you call: (1) an Emergency 911 system; or (2) other state, county or municipal Emergency medical system. Piedmont covers Emergency room professional and facility services including diagnostic x-ray, lab services, medical supplies, and advanced diagnostic imaging, such as MRIs and CAT scans, to evaluate and stabilize a patient with an emergency medical condition.

Emergency services, including professional and facility services, provided to a Participant in the Emergency department of a Hospital or other skilled medical facility are Covered Benefits:

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

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

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

Cost-Sharing for Emergency services

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

provided by a non-Piedmont provider, Participants are responsible for billed charges in excess of the Allowable Charge.

Piedmont will pay the greater of the following amounts for Emergency services received by a Participant from a non-Piedmont Provider:

(1) The amount set forth in your Policy or Schedule of Benefits.

(2) (a) The amount negotiated with Piedmont Providers for the Emergency Services provided, less any Copayment or Coinsurance amounts imposed in your Policy or Schedule of Benefits. (b) If there is more than one amount negotiated with Piedmont Providers for the Emergency Services, the amount paid will be the median of these negotiated amounts, less any Copayment or Coinsurance amounts imposed in your Policy or Schedule of Benefits.

(3) The Usual and Customary amount for the Emergency Services calculated using the same method that Piedmont generally uses to determine payments for services provided by a non-Piedmont Provider (the Allowable Charge), less any Copayment or Coinsurance amounts imposed in your Policy 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 Services, less any Copayment or Coinsurance amounts imposed in your Policy or Schedule of Benefits.

The other cost-sharing provisions in your Policy and Schedule of Benefits for Covered Benefits received from non-Piedmont Providers continue to apply to Emergency Services received from non-Piedmont Providers. Examples of such cost-sharing provisions include Deductibles and Out-of-Pocket Limits. Any Deductible or Out-of-Pocket Limit that applies generally to services received from non-Piedmont Providers also applies to Emergency Services received from non-Piedmont Providers.

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

a. Medical Care is available through Physicians in Piedmont's Network 24/7. If you need medical care, you should call your In-Network Physician immediately for instructions on how to receive care.

b. If the Emergency requires immediate action, you should be taken to the nearest appropriate Hospital or skilled medical facility.

c. Piedmont covers services rendered by Providers other than Piedmont Providers when the condition treated is an Emergency as defined in this Policy.

d. Emergency Services provided within Piedmont's Service Area will include Covered Services from non-Piedmont Providers.

2. Emergency and Urgent Care Services Outside the Service Area

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

b. If an Emergency or Urgent Care situation occurs when you are temporarily outside the Service Area, you should obtain care at the nearest Hospital or skilled medical facility. You or your representative is responsible for notifying Piedmont within 24 hours, on the next working day, or as soon as you are physically/mentally capable of doing so.

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

3. **Notification**

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

L. HEARING SERVICES

Piedmont covers infant hearing examinations for covered newborn Children when performed by a Provider as provided for herein. Piedmont's Coverage is for infant hearing screenings and all necessary audiological examinations provided pursuant to: (1) applicable law or regulation of the Commonwealth of Virginia using any technology approved by the US FDA; and (2) as recommended by the national Joint Committee in Infant Hearing in its most current position statement addressing early hearing detection and intervention programs. Subject to the terms and conditions hereof, this Coverage includes any follow-up audiological examinations as recommended by a physician or audiologist and performed by a licensed audiologist to confirm the existence or absence of hearing loss. All other hearing services and supplies, with the exception of cochlear implants, are not covered.

M. HEMOPHILIA

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

routine bleeding episodes, including Coverage for the purchase of blood, the administration of blood products and blood infusion equipment required for a home treatment program of routine bleeding episodes associated with hemophilia and other congenital bleeding disorders when the home treatment program is under the supervision of a state-approved hemophilia treatment center. For the purposes of this subsection, the following terms have the following meanings: "Blood infusion equipment" includes, but is not limited to, syringes and needles. "Blood product" includes, but is not limited to, Factor VII, Factor VIII, Factor IX, and cryoprecipitate. "Hemophilia" means a lifelong hereditary bleeding disorder usually affecting males that results in prolonged bleeding primarily into the joints and muscles. "Home treatment program" means a program where Participants or family members are trained to provide infusion therapy at home in order to achieve optimal health and cost effectiveness. "State-approved hemophilia treatment center" means a Hospital or clinic that receives federal or state Maternal and Child Health Bureau, and/or Centers for Disease Control funds to conduct comprehensive care for persons with hemophilia and other congenital bleeding disorders.

N. HOME HEALTH CARE

1. **Home Health Services.** Home health services covers treatment provided in your home on a part-time or intermittent basis if provided by a licensed health care professional. This includes intermittent skilled nursing care by an R.N. or L.P.N., home health aide services when receiving skilled nursing or therapy services, including visits from a therapist; medical/social services; diagnostic services; nutritional guidance; durable medical equipment; training of the patient and/or family/caregiver; habilitative and short-term rehabilitative therapy services (subject to the limitations set forth herein and except for manipulation therapy which is not covered when given in the home); home infusion therapy as described in this section under **Paragraph R. Infusion Therapy**; medical supplies; and other Medically Necessary services and supplies. Home health services are only covered for care and treatment of an injury or illness when Hospital or skilled nursing facility confinement would otherwise be required. These services are only covered when your condition generally confines you to your home except for brief absences. The following are not Covered Services: homemaker services; maintenance therapy; food and home-delivered meals; custodial care (including Outpatient custodial care); respite care; and/or other non-medical services.
   Maximum of 100 visits per Benefit Year. **This home health care visit limit applies to any combination of physical, occupational, speech therapy, or cardiac rehabilitation received in the home instead of any individual therapy limits**. **This home health care limit does not apply to home infusion therapy or home dialysis.** Physical, speech, and occupational therapy services provided as part of home care are not subject to separate visit limits for therapy services.

2. **House Calls.** House calls determined to be Medically Necessary by your In-Network Primary Care Physician and Piedmont are Covered Services.

O. HOSPICE SERVICES

Hospice services are Covered Services if and when:

- A Provider that Piedmont determines 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 Participant 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 Participant elects to receive palliative care rather than curative care. This means that the Participant elects treatment directed at controlling pain, relieving other symptoms, and focusing on the Participant's special needs related to the stress of the dying process. Palliative care does not include treatment aimed at investigation and intervention for the purpose of cure or prolongation of life; and

- Piedmont authorizes the services provided.

Covered Hospice Services include:

- Skilled nursing care, including IV therapy services;
- Drugs and other Outpatient prescription medications for palliative care and pain management;
- Services of a medical social worker;
- Services of a home health aide or homemaker;
- Short-term Inpatient Hospital care, including both respite care and procedures necessary for pain control and acute chronic symptom management. Respite care means non-acute Inpatient care for the covered person in order to provide the covered person's primary caregiver a temporary break from caregiving responsibilities. Respite care may be provided only on an intermittent, non-routine and occasional basis.
- Physical, speech, or occupational therapy (services provided as part of hospice care are not subject to separate visit limits for therapy services);
- Durable medical equipment;
- Routine medical supplies;
- Routine lab services;
- Counseling, including nutritional counseling with respect to the covered person's care and death; and
- Bereavement counseling for immediate family members both before and after the covered person's death.

P. HOSPITAL SERVICES

Covered Services include the Hospital and physicians' services when you are treated on an Outpatient basis, or when you are Inpatient because of illness, injury, or pregnancy. This includes Inpatient rehabilitative or habilitative services and devices when Medically

Necessary. Covered Services include anesthesia services in an Inpatient or Outpatient facility setting, as well as services rendered by an anesthesiologist, blood and blood products, medical and surgical dressings and supplies, casts, splints, diagnostic services, and therapy services. Piedmont also covers 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.

Piedmont covers surgery charges when treatment is received at an: (1) Inpatient; (2) Outpatient or ambulatory surgery facility; or (3) physician's office. Professional Inpatient services are covered including physician, surgical, and general nursing services. Piedmont covers Medically Necessary care in a semi-private room or intensive or special care unit. This includes your bed, meals, special diets, and general nursing services, drugs, injectable drugs, blood, oxygen and nuclear medicine. Piedmont covers a private room charge if you need a private room because you have a highly contagious condition or are at greater risk of contracting an infectious disease because of your medical condition. Otherwise, your Inpatient Benefits would cover the Hospital's charges for a semi-private room. If you choose to occupy a private room, you will be responsible for paying the daily difference between the semi-private and private room rates in addition to any Copayment and Coinsurance.

1. Inpatient services and supplies furnished by a Hospital are Covered Services and require preauthorization. Piedmont reserves the right to determine whether the continuation of any Hospital admission is Medically Necessary. Special rules apply in Emergencies and for transplant services as set forth herein.

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

    a. The Participant is confined as a bed patient in the facility;

    b. The attending Physician completes a treatment plan that describes the type of care that is needed; and

    c. Piedmont authorizes the services provided.

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

3. Piedmont will provide the following Benefits to you for Inpatient services received:

    a. Benefits are provided for a minimum Inpatient stay of 48 hours for a Participant receiving a covered radical or modified radical mastectomy. Benefits are also covered for a minimum Inpatient stay of 24 hours for a Participant receiving a covered total mastectomy or a partial mastectomy with lymph node dissection for the treatment of breast cancer unless the Participant's Physician, consulting with the Participant, determines a shorter Inpatient stay is appropriate.

    b. Benefits are provided for a minimum Inpatient stay of 48 hours for a Participant receiving a covered vaginal hysterectomy. Benefits are also

covered for a minimum Inpatient stay of 23 hours for a Participant receiving a covered laparoscopy-assisted vaginal hysterectomy unless the Participant's Physician, consulting with the Participant, determines that a shorter Inpatient stay is appropriate.

c. Benefits are provided for a minimum Inpatient stay of 48 hours (vaginal delivery) or 96 hours (caesarean section delivery) for a Participant receiving these Covered Services unless the Participant's Physician, consulting with the Participant, determines that a shorter Inpatient stay is appropriate.

Q. INDIVIDUAL CASE MANAGEMENT

In addition to Covered Services specified in this Policy, Piedmont may elect to offer Benefits for Services pursuant to a Piedmont-approved alternative treatment plan for a Participant whose condition would otherwise require continued long-term Inpatient care. Piedmont shall provide these alternative Benefits: (1) at its discretion; (2) only when and for so long as it determines (consulting with the Participant's Piedmont Physician) the alternative services are Medically Necessary and cost-effective; and (3) the total Benefits paid for such Services do not exceed the maximum Benefits the Participant would otherwise be entitled under this Policy and the Schedule of Benefits, absent alternative Benefits. If Piedmont elects to provide alternative Benefits for a Participant in one instance, that election will not obligate Piedmont to provide the same or similar Benefits for any Participant in any other instance. Nor, shall it be construed as a waiver of Piedmont's right to administer this Policy in strict accordance with its express terms.

R. INFUSION SERVICES

Covered Services include drug infusion therapy, blood products, and injectables that are not self-administered; Total Parenteral Nutrition (TPN), Enteral nutrition therapy, antibiotic therapy, pain care, and chemotherapy. Piedmont provides Benefits for nursing, durable medical equipment and drugs that are delivered and administered by a health care provider as part of a doctor’s visit, home care visit, or at an Outpatient facility. These Services include Coverage of all medications administered intravenously and/or parenterally.

S. LYMPHEDEMA

Treatment of **lymphedema** is a Covered Service. If prescribed by a Provider legally authorized to prescribe or provide these items for the treatment of lymphedema, the Benefits are: equipment; supplies; complex decongestive therapy; and Outpatient self-management training and education.

T. MATERNITY CARE

1. **Pregnancy and Childbirth.** Pregnancy testing, maternity care, maternity-related checkups, and pre-natal and post-natal care for a female Participant, including a covered dependent who becomes pregnant, are Covered Services. Coverage is included for victims of rape or incest. Services related to surrogacy if the Participant

is not the surrogate are not Covered Services. Elective abortions are not Covered Services; this limitation shall not apply to an abortion performed (i) when the life of the mother is endangered by a physical disorder, physical illness, or physical injury, including a life-endangering physical condition caused by or arising from the pregnancy itself, or (ii) when the pregnancy is the result of an alleged act of rape or incest. Maternity care includes the following services:

- Hospital services, including use of delivery room and care; Physician services, including operations and special procedures such as Caesarean section;
- Home setting covered with nurse midwives;
- 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**; also includes dental services and dental appliances furnished to a newborn when required to treat medically diagnosed cleft lip, cleft palate, or ectodermal dysplasia;
- Necessary care and treatment of medically diagnosed congenital defects and birth abnormalities;
- Inpatient and outpatient dental, oral surgical, and orthodontic services that are medically necessary for the treatment of medically diagnosed cleft lip, cleft palate or ectodermal dysplasia;
- Fetal screenings, i.e., tests for the genetic and/or chromosomal status of the fetus. The term also means anatomical, biochemical or biophysical tests, to better define the likelihood of genetic and/or chromosomal anomalies. Also covers screening for pregnant women for anemia, gestational diabetes, Hepatitis B, Rh incompatibility, and urinary tract or other infection. In addition, folic acid supplements and expanded tobacco intervention and counseling for pregnant users are covered;
- Medically Necessary diagnostic genetic testing and counseling; and
- Injectables; x-ray; and laboratory services.
- **There is no cost sharing for required preventive services.**

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 shall be provided incorporating any changes in these Guidelines or Standards within a maximum of 6 months of the publication of these Guidelines or Standards or any official amendment to them.

2. **Family Planning.** Voluntary Family Planning services are Covered Services. Covered Services include vasectomies and other services detailed in this Section under Z. Preventive Care Services, paragraphs (9)(a) and (9)(f). Any drug for: impotence; or to enhance arousal, libido or sexual response, is not a Covered Service.

3. **Infertility Services.** Piedmont covers services to diagnose and treat conditions resulting in infertility. All other infertility services, including treatment to promote conception by artificial means and medications, are not Covered Services.

4. **Sterilization Services.** Benefits include sterilization services and services to reverse a non-elective sterilization that resulted from an illness or injury. Reversals of elective sterilizations are not covered. Sterilizations for women are covered under the "Preventive Care Services" Benefit.

U. MEDICAL AND SURGICAL SUPPLIES AND MEDICATIONS

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

- Hypodermic needles, syringes, surgical dressings, splints, and other similar items that serve only a medical purpose; these supplies are covered in an Inpatient, Outpatient Hospital Facility, Ambulatory Surgical Center, or Office setting.
- Oxygen and equipment (respirators) for its administration;
- Prescription medications provided by your physician; and
- Prescription medications infused through IV therapy in the physician's office or Outpatient facility.

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

V. MENTAL/BEHAVIORAL HEALTH AND SUBSTANCE USE DISORDER SERVICES

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

treatment limitations. As required for other medical and surgical facility Benefits, Piedmont requires a preauthorization from Piedmont for: any Inpatient or Outpatient mental/behavioral health and substance use disorder facility services. We also require an authorization for any Inpatient or Outpatient services, and office visits from non-Piedmont Providers. Coverage includes inpatient services for substance use disorder, eating disorders and other like conditions provided in a Hospital or treatment facility, including a residential treatment facility (RTF), that is licensed to provide a continuous, structured program of treatment and rehabilitation, including 24 hour-a-day nursing care. Individualized and intensive treatment includes observation and assessment by a psychiatrist at least weekly and rehabilitation, therapy, education, and recreational or social activities. Care from a residential treatment facility (RTF) or other non-skilled, sub-acute setting will not be covered if the services are merely custodial, residential, or domiciliary in nature.

Mental/behavioral health or substance use disorder Inpatient care Coverage includes: individual psychotherapy; group psychotherapy; psychological testing; counseling with family members to assist with the patient's diagnosis and treatment; behavioral health treatment, detoxification, rehabilitation treatment, and convulsive therapy treatment, including Hospital and Inpatient professional services and charges, in any Hospital or Inpatient facility setting required by state law.

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

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

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

W. NEW TECHNOLOGY

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

X. ORAL SURGERY; DENTAL SERVICES

No dental services are Covered Services under this Policy. The only exception is the limited oral surgical procedures and dental services described in this paragraph. Services of a cosmetic nature are not Covered Services. Services that Piedmont determines are functional repairs necessary for working properly are Covered Services. This includes a surgery or procedure to correct deformity caused by disease, trauma, or a previous therapeutic process; surgeries or procedures to correct congenital abnormalities that cause functional impairment; or surgeries or procedures on newborn children to correct congenital abnormalities. The following specific procedures are Covered Services or non-Covered Services:

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

2. Dental services for an injury that results from chewing, biting, or decay are not Covered Services.

3. The cost of dental services and dental appliances are Covered Services only when required to diagnose or treat an accidental injury to the teeth. Repair of dental appliances damaged as a result of accidental injury to the jaw, mouth or face are Covered Services. Major adult dental care and adult orthodontia are covered as Medically Necessary as a result of an accidental injury.

4. Dental services and dental appliances furnished to a newborn or any covered Participant when required to treat medically diagnosed cleft lip, cleft palate, or ectodermal dysplasia are Covered Services.

5. Dental services to prepare the mouth for medical services and treatments such as radiation therapy to treat cancer and prepare for transplants are Covered Services, including dental x-rays, extractions, and anesthesia. Also covered is treatment of non-dental lesions, such as removal of tumors and biopsies, as well as incision and drainage of infection of soft tissue not including odontogenic cysts or abscesses.

6. Orthognathic surgeries required because of a medical condition or injury which prevents normal function of the joint or bone and is deemed Medically Necessary to attain functional capacity of the affected part are Covered Services. Related appliances, however, are not Covered. 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 are Covered Services when not related to a dental procedure.

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

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

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

    a. determined by a licensed dentist, in consultation with the Participant's treating Physician, to require general anesthesia and admission to a Hospital or Outpatient surgery facility to provide dental care effectively and safely; and

    b. under the age of 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.

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

Y. PRESCRIPTION DRUG SERVICES

Medically Necessary prescribed "legend drugs" (defined as drugs not available over the counter) incidental to Outpatient care are Covered Services.

Diabetic supplies to treat diabetes are covered under your prescription drug Benefit. This includes self-injectable insulin, syringes, needles, lancets, test strips, and home blood glucose monitors. Benefits are also available for Flu shots, including administration.

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

Medication Synchronization - Piedmont shall permit and apply a prorated daily cost-sharing

rate to prescriptions that are dispensed by a network pharmacy for a partial supply if the prescribing provider or the pharmacist determines the fill or refill to be in the best interest of the enrollee and the enrollee requests or agrees to a partial supply for the purpose of synchronizing the enrollee's medications. Piedmont shall allow a pharmacy to override any denial codes indicating that a prescription is being refilled too soon for the purposes of synchronizing the enrollee's medications. Dispensing fees for partially filled or refilled prescriptions shall be paid in full for each prescription dispensed, regardless of any prorated copay or fee paid for synchronization services.

Some specialty medications may qualify for third party copayment assistance programs which could lower your Out-of-Pocket costs for those products. Under many of these programs, Piedmont may reduce the copay for the allowable amount for the Specialty Medication by an amount which is equivalent to the maximum benefit of the applicable coupon.

The Member shall not receive credit toward their maximum Out-of-Pocket or Deductible for any Copayment or Coinsurance amounts that are received from a manufacturer coupon. Therefore, only the amount you actually pay for your prescriptions will be applied to your Deductible or maximum Out-of-Pocket when using a non-financial needs based third-party manufacturer copay card (the total amount of financial needs based copay cards may apply to your Deductible or maximum Out-of-Pocket; please check with manufacturer for their requirements). Eligibility for third party copay assistance programs is dependent on the applicable terms and conditions required by that particular manufacturer or its representative.

Your prescription drug Benefits cover prescriptions obtained from a pharmacist and includes injections administered at authorized pharmacies. Self-administered injectable drugs that do not need administration or monitoring by a Provider in an office or facility setting are also Covered Services. Simply choose a retail pharmacy that participates in Piedmont's pharmacy Network and show your ID card to receive Benefits, unless: (i) the drug is subject to restricted distribution by the USFDA; or (ii) special handling, provider coordination, or patient education is required for the drug and cannot be provided by a retail pharmacy. 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.

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

Exception Request for Prescription Drugs Not Included on the Formulary

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

An Exceptions Request Form is available online at https://pchp.net/index.php/member-formsmarketplace.html. Forms may be faxed to CVS/Caremark at 1-855-245-2134. Exceptions requests may also be communicated by phone to CVS/Caremark at 1-855-582-2022. Please note that this exception process only applies to drugs not included on the formulary. If You have been denied Coverage for a drug included on the formulary, You have the right to a full and fair appeal of Our decision and should follow the Plan's appeal process described later in the Evidence of Coverage.

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

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

External Exception Request Review - If the Plan denies an appeal of a standard or expedited request, We have a process in place to allow the request to be reviewed by an independent review organization. Notification of a decision on an external exception request will be given to the Member, representative, or physician no later than 72 hours following receipt of the request if the original request was a standard request. If the original request was an expedited request notification will be given no later than 24 hours following receipt of the request. If an external exception request is approved, the Plan will provide Coverage for the non-formulary drug for the duration of the prescription and without additional cost-sharing beyond that provided for formulary prescription drugs in the Member's covered benefits. For expedited exception requests Coverage of the non-formulary drug will be provided for the duration of the exigency and without additional cost-sharing beyond that provided for formulary prescription drugs in the Member's covered benefits.

There are two exceptions to the formulary requirement:

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

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

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

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

For purposes of this section, the following definitions apply:

"Generic Drugs" means 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" are brand name drugs (including 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" are brand name drugs (including therapeutic biological products) listed on the formulary at a higher tier than generic and 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" 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 highest two 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.

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

Piedmont also covers prescription drugs and devices approved by the FDA for use as contraceptives. This includes Coverage for office visits associated with contraceptive management. Coverage is also provided for up to a 12-month supply of FDA-approved, self-administered hormonal contraceptives, when dispensed or furnished at one time for a covered person by a provider or pharmacy, or at a location licensed or otherwise authorized to dispense drugs or supplies.

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

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

Benefits are provided for prescriptions filled at a pharmacy that is not a Piedmont Provider if that pharmacy or its intermediary agrees in writing to accept the same reimbursement terms as a pharmacy that is a Piedmont Provider.

Piedmont does not provide Coverage for any of the following:

a. Any legend drug prescribed prior to your joining the Plan covered by Piedmont, as determined by Piedmont. However, you may get a new prescription after enrolling with Piedmont and receive Coverage for conditions not excluded under this Policy;

b. Over the counter drugs, unless recommended by the US Preventive Services Task Force and prescribed by a physician;

c. Drugs prescribed primarily for a cosmetic purpose, including but not limited to: (i) Retin-A, when used for any purpose other than treatment for severe acne; and (ii) minoxidil, when used to treat baldness;

d. Drugs and medications for conditions excluded under this Policy;

e. Injectable prescription drugs that are supplied by a Provider other than a pharmacy that is not a Piedmont Provider;

f. Charges to inject or administer drugs;

g. Drugs and medications that are: (1) experimental; (2) investigational, or (3) not approved by the US FDA for the purpose prescribed (except that Benefits for drugs that have been approved by the FDA for use in the treatment of cancer will not be denied on the basis that the drug has not been approved by the FDA for treatment of the specific type of cancer for which the drug has been prescribed, provided that the drug has been recognized as safe and effective for treatment of that specific type of cancer in the American Hospital Formulary Service Drug Information, the National Comprehensive Cancer Network's Drug & Biologics Compendium, or the Elsevier Gold Standard's Clinical Pharmacology);

h. DESI drugs (i.e. drugs which are of questionable therapeutic value as designated by the FDA's Federal Drug Efficacy Study);

i. Any refill dispensed after one year from the date of the original prescription order;

j. Medicine covered by workers' compensation, Occupational Disease Law, state or government agencies;

k. Any other drug not on Piedmont's formulary deemed not Medically Necessary by Piedmont;

l. Infertility drugs; and

m. Any drug for impotence or to enhance arousal, libido or sexual response.

Maintenance Medications

Maintenance Medications are those you take routinely to treat or control a chronic illness. Examples of such illnesses are heart disease, high blood pressure, or diabetes. In addition to the pharmacy, you may purchase Maintenance Medications through your mail order Benefit. This allows you to receive a 90-day or 300-unit supply, whichever costs less, of a Maintenance Medication prescription through the mail for the applicable Copayment, Deductible and/or Coinsurance amount. Piedmont requires additional Copayments, Deductibles and/or Coinsurance amounts and authorization for quantities exceeding unit supply limits. You must have used 75% of your prescription before ordering refills.

To receive your Maintenance Medication by mail:

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

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

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

Piedmont does not prescribe drugs or seek to improperly influence Providers who do. From time-to-time, Piedmont 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 Piedmont's Plan collectively. Piedmont uses these payments to reduce administrative expenses. Piedmont does not credit the payments against an individual's or Providers past, present, or future claims costs. Piedmont will take these payments into account when Piedmont determines future cost trend factors for Premiums or rates.

Z. PREVENTIVE CARE SERVICES

Piedmont covers the following preventive services in accordance with state and federal regulations. **These services are not subject to cost-sharing provisions** (e.g. a Deductible, Copayment amount or Coinsurance percentage) when you receive them from a Piedmont Physician in Piedmont's Network or other Piedmont Provider. Out of Network services will be subject to Out-of-Plan cost-sharing provisions as set forth herein:

(1) Evidenced-based items or services that have in effect a rating of "A" or "B" in the current recommendations of the US Preventive Services Task Force. Examples include screenings for breast cancer, cervical cancer, colorectal cancer, high blood pressure, type 2 diabetes mellitus, cholesterol, and child and adult obesity.

(2) Immunizations 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 adults, evidence-based items or services that have a rating of "A" or "B" from the U.S. Preventive Services Task Force. This includes screening for abdominal aortic aneurysm, alcohol misuse, colorectal cancer, high blood pressure, type 2 diabetes, cholesterol, depression, Hepatitis B and C, HIV, lung cancer, obesity, syphilis, and tobacco use. Also included are counseling for alcohol misuse, nutrition, obesity, sexually transmitted infection prevention, and smoking and tobacco cessation products, including prescription drugs that help you stop smoking or reduce your dependence on tobacco products. This includes smoking cessation products and over the counter nicotine replacement products (limited to nicotine patches and gum) when obtained with a prescription. This also covers aspirin use to prevent cardiovascular disease.

(4) With respect to infants, Children, and adolescents, preventive care and screenings provided for in the comprehensive guidelines supported by the Health Resources and Services Administration and have a rating of "A" or "B" from the U.S. Preventive Services Task Force. Examples include assessments for alcohol and drug use, behavioral, oral health risk, medical history, BMI measurements, screenings for autism (18 and 24 months), blood pressure, cervical dysplasia, depression, development, dyslipidemia, hematocrit or hemoglobin, Hepatitis B, HIV, lead, obesity, sexually transmitted infection (STI), tuberculin, and vision. Also included are counseling for obesity and STI, and supplements for fluoride chemoprevention and iron.

(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 examinations for persons' age 50 and over, and persons age 40 and over who are at high risk for prostate cancer. PSA testing means the analysis of a blood sample to determine the level of prostate specific antigen.

(7) One screening mammogram for Participants between the ages of 35 to 39; a screening mammogram each year for Participants age 40 and over.

(8) Annual Pap smears including coverage for annual testing performed by any FDA-approved gynecologic cytology screening technologies.

(9) 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 fecal occult blood test;
(b) flexible sigmoidoscopy or colonoscopy;
(c) radiologic imaging in appropriate circumstances.

(10) With respect to women, such additional preventive care and screenings, not described in paragraph (1) above, as provided for in comprehensive guidelines supported by the Health Resources and Services Administration, including:

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

(b) Screening for Gestational Diabetes: Screening for gestational diabetes

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

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

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

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

(f) Contraception Methods and Counseling (Females only): All 18 FDA approved contraceptive methods, sterilization procedures/treatments, and patient education and counseling for all women with reproductive capacity are covered at 100% as a preventive care service, including drugs, injectables, patches, rings and devices such as diaphragms, IUDs, and implants. The frequency is as prescribed. Piedmont will cover pharmacy prescription generic oral contraceptives and those brands which do not have generic equivalents at 100% as a preventive care service through Piedmont's 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. Piedmont's standard medical management, Network, and formulary restrictions apply. Coverage is also provided for up to a 12-month supply of FDA-approved, self-administered hormonal contraceptives, when dispensed or furnished at one time for a covered person by a provider or pharmacy, or at a location licensed or otherwise authorized to dispense drugs or supplies.

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

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

You may contact Piedmont at **434-947-4463** or toll free at 800-400-7247 for more

information about preventive care services, or visit the following websites for current federal government recommendations:

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

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

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

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

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

(a) Is billed separately from an office visit, then cost sharing requirements may be imposed on the office visit;

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

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

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

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

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 an illness or disease by x-ray, radium, cobalt, high energy particle sources, or radioactive isotopes is covered. Services include treatment (teletherapy, brachytherapy and intraoperative radiation, photon or high energy particle sources), materials and supplies needed, administration, treatment planning, and certain other covered services.

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

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

"Radiation therapy treatment" means a cancer treatment through which a dose of radiation to induce tumor cell death is delivered by means of proton radiation therapy, intensity

modulated radiation therapy, brachytherapy, stereotactic body radiation therapy, three-dimensional conformal radiation therapy, or other forms of therapy using radiation.

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

CC. RECONSTRUCTIVE SURGERY

Covered Services for reconstructive surgery are to correct: functional impairment; newborn congenital defects and birth abnormalities; significant deformities caused by congenital or developmental abnormalities, disease, trauma, or previous therapeutic process in order to create a more normal appearance (other than for orthognathic surgery), and reconstructive breast surgery following a mastectomy. Coverage includes: inpatient and outpatient dental, oral surgical, and orthodontic services that are medically necessary for the treatment of medically diagnosed cleft lip, cleft palate or ectodermal dysplasia; reconstruction of the breast on which the mastectomy has been performed; surgery and reconstruction of the unaffected breast to produce a symmetrical appearance; and prostheses and physical complications of all stages of mastectomy, including lymphedemas; in a manner determined in consultation with the attending physician and the Participant. Reconstructive breast surgery done at the same time as a mastectomy or following a mastectomy to reestablish symmetry between two breasts is also covered. Hospital stays must be no less than 48 hours for radical mastectomy 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 needed for daily living, such as therapy for a child who is not walking at the expected age. Rehabilitative services include Coverage for therapies to restore and in some cases, maintain, capabilities lost due to: disease; illness; injury; or in the case of speech therapy, loss additionally due to congenital anomaly or prior medical treatment.

Piedmont covers Inpatient and Outpatient facility and professional services for habilitative and rehabilitative services, including medical devices, along with the following therapies when treatment is Medically Necessary for your condition, provided by a licensed therapist, and involves setting goals attainable in a reasonable period of time:

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

2. Physical therapy is covered. This is treatment provided by a licensed therapist by

physical means to relieve or ease pain, teach, keep, improve or restore function or health, and prevent disability after an illness, injury, or loss of an arm or a leg, including hydrotherapy, heat, physical agents, bio-mechanical and neuro-physiological principles and devices, as well as treatment of lymphedema. Services must involve setting goals attainable in a reasonable period of time.

3. 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. Services must involve setting goals attainable in a reasonable period of time.

With regard to Nos. 2 and 3 above, Coverage for Physical/Occupational therapy is limited to 30 visits each per Benefit Year for rehabilitative or habilitative services. In other words, 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.

4. Respiratory therapy, i.e., introduction into the lungs of dry or moist gases, nonpressurized inhalation treatment; intermittent positive pressure breathing treatment, air or oxygen, with or without nebulized medication, CPAP; CNP; chest percussion; therapeutic use of medical gases or aerosol drugs, and equipment such as resuscitators, oxygen tents, and incentive spirometers; broncho pulmonary drainage and breathing exercises, to treat illness or injury, is covered. Pulmonary rehabilitation is also covered and includes Outpatient short-term respiratory care to restore your health after an illness or injury.

5. Speech therapy and speech-language pathology (SLP), i.e., treatment for the correction of a speech impairment, or services necessary to improve or teach speech, which results from disease, surgery, injury, congenital anomaly, or prior medical treatment, is covered**.** Services must involve setting goals attainable in a reasonable period of time. This also includes services to identify, assess, and treat speech, language, and swallowing

disorders in children and adults. Therapy will develop or treat communication or swallowing skills to correct a speech impairment. Therapy services to keep, learn or improve skills needed for daily living, such as therapy for a child who is not talking at the expected age are covered. **This is limited to 30 visits each per Benefit Year for rehabilitative or habilitative services. In other words, rehabilitative speech therapy is limited to 30 visits per Benefit Year, and habilitative speech therapy is limited to 30 visits per Benefit Year.**

6. Chiropractic / Osteopathic / Manipulation therapy is covered. It includes therapy to treat problems of the bones, joints, and the back. The two therapies are similar, but chiropractic therapy focuses on the joints of the spine and the nervous system, while osteopathic therapy also focuses on the joints and surrounding muscles, tendons and ligaments. It also includes services that help you keep or improve skills and functioning for daily living and includes services for people with disabilities in an Inpatient or Outpatient setting. Services must involve setting goals attainable in a reasonable period of time. Benefits will end when the progress toward the goal ends. **This is limited to 30 visits each per Benefit Year for rehabilitative or habilitative chiropractic / osteopathic / manipulation therapy. In other words, rehabilitative chiropractic / osteopathic /**

manipulation therapy is limited to 30 visits per Benefit Year, and habilitative chiropractic / osteopathic / manipulation therapy is limited to 30 visits per Benefit Year.

EE. SERVICES OF NON-PARTICIPATING PROVIDERS

Piedmont does not anticipate a need for you to utilize Providers other than Piedmont Providers except in Emergencies and Urgent Care out-of-Service-Area situations. In the event you receive Covered Services from a non-Piedmont Provider, Piedmont reserves the right to pay its Allowable Charge, less amounts you must pay under this Policy, for these Covered Services: (1) directly to you; (2) the non-Piedmont Provider; (3) or any other person responsible for paying the non-Piedmont Provider's charge. This is subject to applicable Providers 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 non-Piedmont Provider and Piedmont's payment to either you or the Provider. It is your responsibility to apply any payment you receive directly from Piedmont to the non-Piedmont Provider's claim. This applies to non-Emergency care when you are traveling outside the US.

FF. SKILLED NURSING FACILITY

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

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

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

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

GG. SPINAL MANIPULATION AND OTHER MANUAL MEDICAL INTERVENTIONS

Piedmont covers: (1) spinal manipulation (e.g., Chiropractic) services (manual medical

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

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

HH. SURGERY

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

- Accepted operative and cutting procedures;
- Surgeries and procedures to correct congenital abnormalities that cause functional impairment and congenital abnormalities in newborn children;
- Other invasive procedures, such as angiogram, arteriogram, amniocentesis, tap or puncture of brain or spine;
- 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 means use of: (1) interactive audio; (2) interactive video; or (3) other electronic technology or media used, for the purpose of diagnosis, consultation with other health care providers regarding a patient's diagnosis or treatment, prescribing 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.

Telemedicine services are Covered Benefits that require preauthorization, except for Emergency telemedicine services. Technical fees or costs for the provision of telemedicine services are not covered.

JJ. TRANSPLANTS

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

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

When a human organ or tissue transplant is provided from a living donor to a covered person, both the recipient and the donor may receive benefits. When a living donor who is not a Plan Participant provides a human organ or tissue transplant to a Plan Participant, the donor may receive Benefits of the health Plan limited to those not available to the donor from any other source. This includes, but is not limited to, other health insurance, grants, foundations, or other government programs. Reimbursement for reasonable and necessary transportation and lodging costs for the donor are covered when the recipient and donor are both covered by this Plan. No Benefits are provided a Plan Participant who is donating the organ to someone who is not a Plan Participant.

Piedmont also covers limited transportation/lodging costs, subject to prior approval, as follows:

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

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

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

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

KK. VISION SERVICES

Piedmont covers 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.

Piedmont covers eyeglass or contact lens purchase and fitting under this Benefit if:

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

d) Corneal or sclera lenses are required to reduce a corneal irregularity other than astigmatism.

Pediatric Vision Covered Services (Participants up to the end of the month the Participant turns Age 19) include one routine eye exam covered in full every Benefit Year at no charge from a Piedmont Provider. For this exam, services include dilation if professionally indicated. Includes from a Piedmont Provider: (1) one pair of standard single vision, bifocal, trifocal, or progressive eyeglass lenses and one standard frame from a limited collection every Benefit Year; or (2) contact lenses from a limited collection once every Benefit Year in lieu of eyeglasses. Due to Federal law, covered pediatric vision services for Catastrophic plans only are subject to the medical Benefit Year Deductible, except for routine eye exams which are considered preventive and are covered at no charge from a Piedmont Provider. Participants are eligible for these Benefits through the end of the month the Participant turns 19. Out-of-Plan Benefits are not covered.

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

Low vision is a significant loss of vision but not total blindness. Covered low vision services (In-Network only) will include one comprehensive low vision evaluation every 5 years up to the maximum allowed amount; low vision aid up to the maximum allowed amount for items such as high-power spectacles, magnifiers and telescopes; and follow-up care – four visits in any five-year period, up to the maximum allowed amount each visit. Participating providers will obtain the necessary pre-authorization for these services.

SECTION VI: WHAT IS NOT COVERED (EXCLUSIONS)

Piedmont does not cover any service or supply: (1) not Medically Necessary; (2) not a Covered Service (regardless of Medical Necessity) or (3) that is a direct result of receiving a non-Covered Service. The following services are specifically excluded from Coverage under this Policy:

1. **Abdominoplasty**, panniculectomy, abdominal sculpture, tummy tucks, abdominodermatolipectomy, and liposuction.

2. **Abortion:** We do not provide benefits for procedures, equipment, services, supplies, or charges for abortions for which Federal funding is prohibited. Federal funding is allowed for abortions, where a pregnancy is the result of rape or incest, or for a pregnancy which, as certified by a physician, places the woman in danger of death unless an abortion is performed.

3. **Acts of War, Disasters, or Nuclear Accidents:** In the event of a major disaster, epidemic, war, or other event beyond our control, we will make a good faith effort to give you Covered Services. We will not be responsible for any delay or failure to give services due to lack of available Facilities or staff.

   Benefits will not be given for any illness or injury that is a result of war, service in the armed forces, a nuclear explosion, nuclear accident, release of nuclear energy, a riot, or civil disobedience.

4. **Acupuncture.**

5. **Administrative Charges:** Providers charges for: missed appointments; telephone calls and other means of electronic communication; form completion; copying and/or transfer of medical records; returned checks; stop-payment on checks; and other clerical charges, with the exception of covered telemedicine services.

6. **Affiliated Providers:** Services received from a dental or medical department maintained by or on behalf of an employer, mutual benefit association, labor union, trust, academic institution, or similar person or group.

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

8. **Alternative / Complementary Medicine:** services or supplies related to alternative or complementary medicine. Services in this category may include, but are not limited to: neurofeedback/biofeedback therapy (except for the treatment of urinary incontinence) , hypnosis, acupuncture; behavior training; recreational therapy (dance, arts, crafts, aquatic, gambling and nature therapy), except as provided in a Residential Treatment Facility; hair analysis; naturopathy, thermography, orthomolecular therapy, contact reflex analysis, bioenergial synchronization technique (BEST), iridology – study of the iris, auditory integration therapy (AIT),

colonic irrigation, magnetic innervation therapy, electromagnetic therapy, holistic medicine; homeopathic medicine; aroma therapy; Reiki therapy, massage and massage therapy; herbal, vitamin, or dietary products or therapies.

9. **Ambulance:** Usage is not covered when another type of transportation can be used without endangering the Member's health. Any ambulance usage for the convenience of the Member, family or Physician is not a Covered Service. Non Covered Services for Ambulance include but are not limited to, trips to a Physician's office or clinic, or to a morgue or funeral home.

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

10. **Applied Behavioral Analysis**.

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

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

13. **Charges** in excess of any Benefit limitations (e.g. number of days, etc.) and amounts above the Allowable Charge for a service.

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

15. **Clinical Trials:** We do not provide benefits for procedures, equipment, services, supplies or charges for the following:

    - The Investigational item, device, or service; or
    - Items and services that given only to satisfy data collection and analysis needs and that are not used in the direct clinical management of the patient; or
    - A service that is clearly inconsistent with widely accepted and established standards of care for a particular diagnosis;
    - Any item or service that is paid for, or should have been paid for, by the sponsor of the trial.

16. **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.

17. **Supplies and devices for comfort or convenience only** (e.g. radio, television, telephone, and guest meals); and private rooms, unless a private room is Medically Necessary and preauthorized by Piedmont during Inpatient Hospitalization or Inpatient stay at a skilled nursing facility.

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

19. Reconstructive or **Cosmetic surgery, services, procedures**, **treatments, prescription drugs, equipment, or supplies** given for cosmetic services. This includes any service or supply that is a direct result of a non-covered service. Cosmetic surgeries, procedures, or services are performed mainly to preserve, or change how you look, including but not limited to: body piercing; tattooing; or removal of tattoos. No Benefits are available for surgery or treatments to change the texture or look of your skin or to change the size, shape or look of facial or body features (such as your nose, eyes, ears, cheeks, chin, chest or breasts). However, this Exclusion does not apply to: (1) a surgery or procedure to correct deformity caused by disease, trauma, or a previous therapeutic process; (2) surgeries or procedures to correct congenital abnormalities that cause functional impairment, including newborn congenital abnormalities; and (3) reconstructive breast surgery due to a mastectomy. Botox, collagen, and other filler substances are not covered.

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

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

22. **Custodial care**, including Inpatient or Outpatient custodial care, nursing home care, respite care, rest cures, domiciliary or non-skilled convalescent care along with all related services, even when recommended by a professional or performed in a facility, such as a hospital or skilled nursing facility, or at home. This exclusion does not apply to hospice care services.

23. **Dental** services including, but not limited to:

- Treatment of natural teeth due to diseases, routine preventive care;
- Dental care, treatment, supplies, dental x-rays, or oral surgeries (except for Medically Necessary dental services specifically covered), extraction of erupted wisdom teeth, except to prepare the mouth for medical services and treatment, and
  treatment for biting or chewing injuries;
- Dental or oral appliances or devices, including but not limited to, bite guards for teeth grinding, dental implants, dentures, oral appliances for snoring or sleep apnea unless Medically Necessary, and fixed or

removable appliances that involve movement or repositioning of the teeth, repair of teeth (fillings), or prosthetics (crowns, bridges, dentures) for temporomandibular joint (TMJ) pain dysfunction;

- Periodontal care, prosthodontal care or orthodontic care (except for Medically Necessary orthodontic care in cases of accidental injury or for cleft lip, cleft palate or ectodermal dysplasia);
- Shortening of the mandible or maxillae for cosmetic purposes;
- Diagnosis or treatment of natural disease processes of the teeth or surrounding tissue; or
- Restorative services and supplies necessary to promptly repair, remove, or replace sound natural teeth; including the extraction of wisdom teeth unless impacted.

24. **Donor Benefits** are not available if the covered individual is donating an organ to a non-covered member; When the donor is a non-covered member and the person receiving the organ is covered, Benefits are limited to Benefits not available to the donor from any other source.

25. **Donor Searches:** Coverage does not include benefits for donor searches for organ or tissue transplants, including compatibility testing of potential donors who are not immediate blood-related family members (parent, child, sibling), except as required by law or specifically stated as a covered service.

26. **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.

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

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

    - You receive payment from the employer on account of the disease or injury;
    - The Employer 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 failed to comply with procedures set out by the employer to receive these Benefits. It also applies if the employer (or employer's insurance

company or group self-insurance association) reaches any settlement with you for an injury or disease related in any way to employment.

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

30. **Experimental/Investigational Drugs, Items, Devices, Services, or Procedures,** and their complications, except for clinical trial costs required to be covered under law.

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

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

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

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

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

35. **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; sublexations of the foot; treatment of bunions only covered when associated with capsular or bone surgery; fallen aches; weak feet; Tarsalgia; Metatarsalgia; Hyperkeratoses; chronic foot strain; or symptomatic complaints of the feet.
- Foot orthotics, including support devices, arch supports, foot inserts, orthopedic or corrective shoes not part of leg brace and fitting, castings, and other services related to devices of the feet, unless used for an illness affecting the lower limbs;
- Routine foot care, such as removal of corns or calluses and the trimming of toenails, except for treatment of patients with diabetes or vascular disease.

36. **Free Care,** including services the covered Participant would not have to pay for if

not covered by this plan, such as government programs, services received in jail or prison, services from free clinics, and Workers Compensation Benefits.

- 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.

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

- educational therapy, except as provided in a Residential Treatment Facility;
- coma stimulation therapy;
- remedial or special education services;
- services directed toward making one's personality more forceful or dynamic;
- consciousness raising;
- vocational or religious counseling;
- group socialization;
- vocational and recreational therapy, except as provided in a Residential Treatment Facility. Recreational therapy includes; but is not limited to, dance, art, crafts, aquatic, hydro, gambling and nature therapy;
- self-help training, and self-administered services, including biofeedback and related testing; behavioral modification; and
- modalities which include: primal therapy; rolfing or structural integration, bioenergetics therapy; carbon dioxide therapy; guided imagery; Z-therapy; obesity control therapy; training analysis; sedac therapy; dance therapy; music therapy and art therapy.

38. **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.

39. **Government Coverage:** To the extent that they are provided as benefits by any governmental unit, unless otherwise required by law or regulation.

40. **Group speech therapy.**

41. Medication and surgical procedures to treat or manage **Gynecomastia**.

42. Care and treatment for **hair loss** including wigs, hair transplants or any drug that promises hair growth, whether or not prescribed by a Physician, are not covered, except for one wig after chemotherapy.

43. **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.

44. **Hearing** aids or the **examination** to prescribe or fit hearing aids, except as otherwise provided in the Policy under Hearing Services and Durable Medical

Equipment and Supplies.

45. **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.

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

47. **Immunizations for travel or work.** Coverage does not include Benefits for immunizations required for travel or work, unless such services are received as part of the covered preventive care services as defined in Section V of this Policy.

48. Surgical or medical treatment for **Infertility** is not covered. This includes: services; office visits; lab and diagnostic tests; procedures to promote conception once an infertility diagnosis has been established; and reversal of voluntary sterilization. In the absence of a confirmed infertility diagnosis, Coverage for these services ends when drugs are prescribed or surgeries performed to correct the condition. Infertility services not specifically described as covered are not covered. This exclusion does not apply to services required to diagnose and treat conditions resulting in infertility.

49. **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.

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

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

52. **Medical equipment, appliances, devices and supplies** that have both a therapeutic and non-therapeutic use. These include: elastic or leather braces or supports; corsets, or articles of clothing (unless required to recover from surgery or injury); batteries (except for battery for a powered wheelchair) and battery chargers; mattress or mattress covers; other special supplies, appliances, and equipment such as office chairs, sun or heat lamps; rental or purchase of 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, stair glides or Emergency alert equipment; and expenses incurred at a health spa, gym or similar facility. An office visit for the purpose of fitting for a noncovered device or supply is not covered.

53. **Medicare Benefits:** (1) for benefits which are payable for the Member enrolled in Medicare under Medicare Parts A, B and/or D, or for the Member eligible for Medicare due to age, for benefits which would have been payable if the Member had applied for Medicare Part B, except as specified elsewhere in this EOC, or as otherwise prohibited by federal law. If a Member eligible for Medicare due to age, has

not enrolled in Medicare Part B, We will calculate benefits as if the Member had enrolled; (2) for services or supplies provided pursuant to a private contract between the Member and a Provider, for which reimbursement under the Medicare program is prohibited as specified in Section 1802 (42 U.S.C. 1395a) of Title XVII of the Social Security Act.

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

55. Services for which you have **no financial responsibility**. Piedmont will not pay for, or reimburse, the cost of any Covered Service for which the Participant is not financially liable. Examples include: charges for complimentary health screenings; charges for Covered Services provided by an immediate family Participant; and charges incurred as a donor or surrogate for which another individual or entity has assumed financial responsibility (except when assumed by a "Plan," as defined in the "Coordination of Benefits" subsection of this Policy, in which case that subsection applies).

56. Medical **Nutritional Therapy** (Obesity) and **nutritional and/or dietary supplements**, except as described in this booklet or required by law. This exclusion includes but is not limited to nutritional formulas and dietary supplements that are available over the counter and do not require a written prescription.

57. **Outdoor Treatment Programs and/or Wilderness Programs/Camps.**

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

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

60. **Penile implants** and related services.

61. **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.

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

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

- Physician or other practitioners' charges for consulting with Members by telephone, facsimile machine, electronic mail systems or other consultation or medical management service not involving direct (face-to-face) care with the Member. This does not include In-Network telemedicine services with interactive virtual visits.
- Surcharges for furnishing and/or receiving medical records and reports.
- Charges for doing research with Providers not directly responsible for Your care.
- Charges that are not documented in Provider records.
- Charges from an outside laboratory or shop for services in connection with an order involving devices (e.g., prosthetics, orthotics) which are manufactured by that laboratory or shop, but which are designed to be fitted and adjusted by the attending physician.
- For membership, administrative, or access fees charged by physicians or other Providers. Examples of administrative fees include, but are not limited to, fees charged for educational brochures or calling a patient to provide their test results.

64. **Prescription Drugs:** Your Prescription Drug benefits do not cover the following:

- Administration Charges for the administration of any Drug except for covered immunizations as approved by Us or the Pharmacy Benefits Manger (PBM).
- Certain Prescription Drugs may not be covered if You could use a clinically equivalent Drug, unless required by law. "Clinically equivalent" means Drugs that for most Members, will give You similar results for a disease or condition. If You or Your doctor believes You need to use a different Prescription Drug, please have Your doctor or pharmacist get in touch with Us. We will cover the other Prescription Drug only if We agree that it is Medically Necessary and appropriate over the clinically equivalent Drug.
- Prescription Drugs prescribed by a Provider that does not have the necessary qualifications, registrations and/or certifications as determined by Piedmont.
- Non-formulary drugs, except in certain circumstances described in Coverage documents.
- Compound Drugs.
- Drugs given to You or prescribed in a way that is against approved medical and professional standards of practice.
- Charges for delivery of Prescription Drugs.
- Drugs You take at the time and place where You are given them or where the Prescription Order is issued. This includes samples given by a doctor. This Exclusion does not apply to Drugs used with a diagnostic service, Drugs given during chemotherapy as described in the "Chemotherapy" section, or Drugs covered under the "Medical and Surgical Supplies and Medications" benefit – they are Covered Services.

- Drugs that do not need a prescription by federal law (including Drugs that need a prescription by State law, but not by federal law), except for injectable insulin. This exclusion does not apply to over-the-counter drugs that We must cover under federal law when recommended by the U.S. Preventive Services Task Force and prescribed by a physician.
- Drugs which are over any quantity or age limits set by the Plan.
- Drugs in amounts over the quantity prescribed, or for any refill given more than one Year after the date of the original Prescription Order.
- Items Covered as durable medical equipment (DME) - Therapeutic DME, devices and supplies except peak flow meters, spacers, and blood glucose monitors.
- An allergenic extract or vaccine.
- Refills of lost or stolen Drugs.
- Prescription Drugs dispensed by any mail service program other than our PBM's Home Delivery Mail Service, unless We must cover them by law.
- Drugs not approved by the FDA.
- Off label use, unless We must cover the use by law or if We, or the PBM, approve it.
- Drugs for Onychomycosis (toenail fungus) except when We allow it to treat Members who are immuno-compromised or diabetic.
- Drugs, devices and products, or Legend Drugs with over the counter equivalents and any Drugs, devices or products that are therapeutically comparable to an over the counter Drug, device, or product. This includes Prescription Legend Drugs when any version or strength becomes available over the counter.
- Drugs to treat sexual or erectile problems.
- Hypodermic syringes except when given for use with insulin and other covered self- injectable Drugs and medicine.
- Any Drug mainly used for weight loss.
- Drugs used for cosmetic purposes.
- Prescription Drugs used to treat infertility.
- Charges for services not described in Your medical records.
- Services we conclude are not Medically Necessary. This includes services that do not meet Our medical policy, clinical coverage, or benefit policy guidelines.
- Nutritional and/or dietary supplements, except as described in this EOC or that We must cover by law. This exclusion includes, but is not limited to, nutritional formulas and dietary supplements that You can buy over the counter and those You can get without a written Prescription or from a licensed pharmacist.
- Gene Therapy as well as any Drugs, procedures, health care services related to it that introduces or is related to the introduction of genetic material into a person intended to replace or correct faulty or missing genetic material, thus treating a disease or abnormal medical condition.
- Services prescribed, ordered, referred by or received from a member of Your immediate family, including Your spouse, Domestic Partner, child/stepchild, brother/stepbrother, sister/stepsister, parent/stepparent, in-law, or self.

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

66. **Prophylactic mastectomy**, which means the removal of a breast for a Plan

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

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

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

69. **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 a Member's own home arrangements are not available or are unsuitable, and consisting chiefly of room and board, even if therapy is included.
- Care provided or billed by a hotel, health resort, convalescent home, rest home, nursing home or other extended care facility home for the aged, infirmary, school infirmary, institution providing education in special environments, supervised living or halfway house, or any similar facility or institution.
- Services or care provided or billed by a school, custodial care center for the developmentally disabled, or outward bound programs, even if psychotherapy is included.

70. **Residential Care/Residential Treatment Centers:** Coverage does not include benefits for rest cures, custodial, residential, or domiciliary care and services. Whether care is considered residential will be determined based on factors such as whether You receive active 24-hour skilled professional nursing care, daily physician visits, daily assessments, and structured therapeutic services. A Residential Treatment Center must qualify as a substance use disorder center providing a continuous, structured, 24 hour a day program of drug or alcohol treatment and rehabilitation including 24 hour a day nursing care.

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

- Ordered by a physician whose services are not covered;
- Not prescribed, performed, or directed by a Provider licensed to do so;
- Received before the effective date of Coverage or after a covered Participant's Coverage ends;
- Travel, whether or not recommended by a physician, except the limited transportation/lodging costs as stated under Section V, II. Transplants in this booklet;

- Prescribed, ordered, referred by or given by an immediate family member; rendered by a Provider that is a member of the covered person's immediate family;
- Services for which a charge is not usually made; or
- Any types of health services, supplies, or treatments not specifically provided herein. The term "services" as used in this Exclusions section includes supplies or medical items.

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

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

74. **Spinal Manipulation and Manual Medical Therapy Services:** We do not provide benefits for procedures, equipment, services, supplies or charges for the following:

- services for examination and/or treatment of strictly non-neuromusculoskeletal disorders, or conjunctive therapy not associated with spinal or joint adjustment;
- manual medical interventions for illnesses or injuries other than musculoskeletal illnesses or injuries;
- laboratory tests, x-rays, adjustments, physical therapy or other services not documented as medically necessary and appropriate, or classified as experimental or in the research state;
- diagnostic scanning, including magnetic resonance imaging (MRI), CAT scans, and/or other types of diagnostic scanning; thermography;
- educational programs, non-medical self-care or self-help, or any self-help physical exercise training, or any related diagnostic testing;
- air conditioners, air purifiers, therapeutic mattresses, supplies or any other similar devices or appliances;
- vitamins, minerals, nutritional supplements, or any other similar type products; or spinal decompression devices. This includes, but is not limited to, Vertebral Axial Decompression (Vax-D) and DRX9000.

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

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

77. **Therapy – Other:** We do not provide benefits for procedures, equipment, services, supplies or charges for the following:

- gastric electrical stimulation
- hippotherapy
- intestinal rehabilitation therapy
- prolotherapy

- recreational therapy, except as provided in a Residential Treatment Facility
- sensory integration therapy (SIT)

78. **TMJ Disorder Device**, appliances for TMJ pain dysfunction that reposition the teeth, fillings, or prosthetics. Covered services do not include fixed or removable appliance that involve movement or repositioning of the teeth repair of teeth (fillings) or prosthetics (crown, bridges, dentures), Oral hygiene instructions, Repair or replacement of lost/broken appliances are not a covered benefit, material(s) and the procedures used to prepare and place material(s) in the canals (root), Root canal obstruction, internal root repair of perforation defects, incomplete endodontic, treatment and bleaching of discolored teeth.

79. **Transplant: Human Organ and Bone Marrow/Stem Cell/Cord Blood Exclusions:** Non-Covered Services for transportation and lodging include, but are not limited to:

- child care
- meals
- mileage within the medical transplant facility city
- rental cars, buses, taxis, or shuttle service, except as specifically approved by us
- frequent flyer miles
- coupons, vouchers, or travel tickets
- prepayments or deposits
- services for a condition that is not directly related, or a direct result, of the transplant
- telephone calls
- laundry
- postage
- entertainment
- travel expenses for donor companion/caregiver (except for caregiver under age 18)
- return visits for the donor for a treatment of a condition found during the evaluation

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

81. Adult **Vision** services or supplies unless needed due to eye surgery or accidental injury, including routine vision care and materials except as outlined in the Coverage documents; eyeglasses and eyewear, except as included under this plan; sunglasses or safety glasses and accompanying frames.

82. **Pediatric Vision Care:** Your vision care services do not include services incurred for or in connection with any of the items below:

- Vision care for members age 19 and older, unless covered by the medical

benefits of this EOC.

- For any condition, disease, defect, ailment or injury arising out of and in the course of employment if benefits are available under the Workers' Compensation Act or any similar law. This exclusion applies if a Member receives the benefits in whole or in part. This exclusion also applies whether or not the Member claims the benefits or compensation. It also applies whether or not the Member recovers from any third party.
- To the extent that they are provided as benefits by any governmental unit, unless otherwise required by law or regulation.
- For which the Member has no legal obligation to pay in the absence of this or like coverage.
- For services or supplies prescribed, ordered or referred by, or received from a Member of the Member's immediate family, including the Member's spouse or Domestic Partner, child, brother, sister or parent.
- For completion of claim forms or charges for medical records or reports.
- For missed or cancelled appointments.
- For safety glasses and accompanying frames.
- For two pairs of glasses in lieu of bifocals.
- For plano lenses (lenses that have no refractive power).
- For medical or surgical treatment of the eyes, including Inpatient or Outpatient Hospital vision care, except as specified in the "Covered Benefits" section of this EOC.
- Lost or broken lenses or frames, unless the Member has reached their normal interval for service when seeking replacements.
- For services or supplies not specifically listed in this EOC.
- Cosmetic lenses or options, such as special lens coatings or non-prescription lenses, unless specifically listed in this EOC.
- For services or supplies combined with any other offer, coupon or in-store advertisement, or for certain brands of frames where the manufacturer does not allow discounts.
- Services and materials not meeting accepted standards of optometric practice or services that are not performed by a licensed Provider.
- Blended lenses.
- Oversize lenses.
- For sunglasses.

83. **Vision Orthoptic Training:** For vision orthoptic training. This exclusion does not apply to Members through the end of the month in which the Member turns age 19.

84. **Work related** injuries or illnesses, including those injuries that arise out of or in any way result from an illness or injury that is work-related; provided the employer provides, or is required to provide, workers' compensation or similar type coverage for such services. For any condition, disease, defect, ailment, or injury arising out of and in the course of employment if benefits are available under any Worker's Compensation Act or other similar law. If Worker's Compensation Act benefits are not available to You, then this Exclusion does not apply. This exclusion applies if You receive the benefits in whole or in part. This

exclusion also applies whether or not You claim the benefits or compensation. It also applies whether or not You recover from any third party.

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

SECTION VII: ELIGIBILITY AND OTHER TERMS AND CONDITIONS

A. ELIGIBILITY

Persons Not Eligible For Coverage. The following persons are not eligible for Coverage:

- A person age 65 years or older; **or**
- A person eligible for Coverage in any social welfare programs, such as entitled to or enrolled in Medicare Parts A/B and/or D. (NOTE: Eligibility for Medicaid does not make a person ineligible for Coverage under the Plan)
- Eligibility to age 26 does not extend to a spouse of a child receiving dependent Coverage.
- Eligibility to age 26 does not extend to a child of a child receiving dependent Coverage unless the Subscriber or spouse has legal custody of the grandchild.

Insured. To be eligible to enroll as an Insured, a person must be a qualified individual through the Exchange. This Policy insures the Insured, and it may insure eligible family members, originally or by subsequent amendment, upon the application of an adult member of a family who shall be deemed the Insured. Eligible family member means the (i) spouse, (ii) Dependent Child(ren), without regard to whether such Children reside in the same household as the Insured, (iii) Children under a specified age not greater than 26 years, and (iv) any person dependent on the Insured.

Spouse. An Insured may enroll his/her legal spouse as a Participant during the Insured's Open Enrollment Period or within 60 days of the date of the Insured's marriage. To be eligible to enroll as a spouse, a person must meet all eligibility requirements and be the Insured's legal spouse.

Child. To be eligible for Coverage, a "Child" must be either: (1) the Insured's biological or legally adopted, or foster Child; or (2) the biological, legally adopted, or foster Child of the Insured's legal spouse. Except as noted below, there is no requirement the Child: be financially dependent on an individual covered under the Policy; share a residence with an individual covered under the Policy; meet student status requirements; be unmarried; not be employed; or any combination of these factors. Unless a higher age is specified in the Insured's Schedule of Benefits, the "Limiting Age" of a Child otherwise eligible for Coverage under the Policy is age 26.

Except as provided below with respect to the "Insured's Newborn Child Coverage," a spouse or Child not added to the Insured's Coverage at the time of Open Enrollment: (1) may not be added to the Insured's Coverage until the Employer's next Open Enrollment; or (2) in the case of newly eligible Participants other than the Insured, not added to the Insured's Coverage within 60 days of the initial date of eligibility.

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

Insured's Biological Newborn Child. If the Insured's insurance plan provides "Child" Coverage for the Insured's family members, then Piedmont will provide Benefits for the

Insured's newly born biological Child from the moment of birth. The Insured must notify the Federal Marketplace within 60 days of the date of birth to add the child to the Subscriber's Policy. Piedmont also asks that the Insured notify Piedmont in advance of the Child's birth so Piedmont may ensure the Child's claims are paid correctly when Piedmont receives them. However, a failure to notify Piedmont in advance will not result in the denial of an otherwise valid claim for Covered Benefits.

The Insured's Biological Newborn Child's Coverage will be identical to Coverage provided to the Insured; except that, regardless of whether the Coverage would otherwise be provided under the terms and conditions of this Policy, 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 Policy; and

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

If payment of a specific Premium is required to provide Coverage for the eligible Child, you must notify the Federal Marketplace of the birth of the newly born Child and pay the required Premium (or have it paid on your behalf) within 60 days after the date of birth in order to have the Coverage continue beyond the initial 31-day period. If the Insured's newborn Child's mother expects to receive Benefits from another carrier; but, the Insured wishes his newborn Child's claims paid under this Policy, then Piedmont requests the Insured notify Piedmont of that desire in advance of the Child's birth. This is so Piedmont may ensure the Child's claims are correctly paid when Piedmont receives them; but, a failure to notify Piedmont in advance will not result in the denial of an otherwise valid claim for Covered Benefits.

Insured's Adopted Child. If the Insured's insurance plan provides for "Child" Coverage, then when a Child has been placed with an Insured for the purpose of legal adoption, that Child is eligible for Child Coverage from the date of such adoptive or parental placement. However, notification for that Child's Coverage must be submitted to the Federal Marketplace: within 60 days from the date of that eligibility; and along with proof that a legal adoption is pending. If a newborn infant is placed for legal adoption with an Insured within 60 days of birth, Piedmont shall consider this Child a newborn Child of the Insured to the same extent as if that Child had been an Insured's Newborn Biological Child.

Legal Guardianship of a Child. If the Insured's insurance plan provides for "Child" Coverage, then the Insured may enroll a Child or a Child of the Insured's legal spouse through the Federal Marketplace when the Insured is the legal guardian of the Child. The Child for whom the Insured is the Child's legal guardian will be added to the Insured's Policy only during the applicable Open Enrollment Period, or within 60 days of the Insured's assumption of 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 Policy before attaining the Limiting Age, will not have his/her Coverage terminated under this Policy when reaching the Limiting Age if: (1) a qualified Physician furnishes proof of such handicap; and (2) the Insured provides proof of dependency within 31 days of the Child's reaching the Limiting Age. Piedmont may require subsequent proof; but, not more frequently than annually after the two-year period following the Child attaining the Limiting Age. Coverage of the handicapped Child will continue for as long as the Child: (1) remains incapable of self-support because of an intellectual disability or physical handicap (as set forth above); (2) remains unmarried; and (3) remains dependent on the Insured or the Insured's enrolled legal spouse.

Student Dependents. Students, regardless of student status, are considered Covered Dependents to age 26.

Termination of a Dependent's Coverage. You must notify the Federal Marketplace if a Dependent no longer qualifies for Coverage under the Policy. Dependent Coverage ends under these circumstances:

- for a Covered spouse, upon divorce;
- at the end of the month a Covered Dependent Child reaches age 26;
- when a Covered Dependent begins active duty with the Armed Forces;
- death of a Dependent; or
- at the Insured's request.

B. ENROLLMENT

You enrolled for this plan on the Federal Marketplace at healthcare.gov. Your initial coverage date will be determined by the Marketplace. Generally, Your initial Coverage effective date is determined by when You complete Your enrollment application on the Marketplace. Your Coverage will begin when We have received all the required information from the Federal Marketplace and You have paid all required premiums by the due date.

Since You enrolled for this plan on the Federal Marketplace at healthcare.gov, if you need to make a change to Your plan You must go back to the Federal Marketplace. You can go directly to healthcare.gov or call the Marketplace directly. Changes that You must make with the Federal Marketplace include adding or removing a dependent, changing Your address, or changing or ending Your Coverage. Any changes You make to Your plan may change the amount of premium You will have to pay for Coverage.

The Exchange must provide an initial Open Enrollment period and annual Open Enrollment periods. The Exchange may only permit a qualified individual to enroll in a qualified health plan or an Insured to change qualified health plans during the initial Open Enrollment period, the annual Open Enrollment period, or a special enrollment period for which the qualified individual has been determined to be eligible.

The Open Enrollment period typically runs from November 1st through December 15th of each year for enrollment with an effective date beginning January 1st of the following year. This schedule is subject to change, however.

C. EFFECTIVE DATE OF COVERAGE

TIME OF COVERAGE: The Policy becomes effective at 12:01 am on the effective date.

Special Enrollment Periods are allowed due to certain losses of other qualifying Coverage and changes in family status. A qualified individual or Insured has 60 days from the date of triggering event to select a qualified health plan. The Exchange must allow enrollment in or change from one qualified health plan to another as a result of the following triggering events:

- A qualified individual or Dependent loses minimum essential coverage (does not include termination or loss due to failure to pay Premiums on a timely basis or situations allowing for rescission);
- Marital status change: marriage, divorce or death of legal spouse;
- Participant status change: birth, adoption, custody, or placement for adoption or a foster child;
- Child support order or other court order;
- An individual, who was not previously a citizen, national, or lawfully present gains such status;
- Victim or dependent of victim of domestic abuse or spousal abandonment;
- Release from incarceration;
- A qualified individual's enrollment or non-enrollment in a qualified health plan is unintentional, inadvertent, or erroneous and is the result of the error, misrepresentation, or inaction of an officer, employer, or agent of the Exchange or HHS, or its instrumentalities as evaluated and determined by the Exchange. In such cases, the Exchange may take such action as may be necessary to correct or eliminate the effects of such error, misrepresentation, or inaction;
- An Insured adequately demonstrates to the Exchange that the qualified health plan in which he or she is enrolled substantially violated a material provision of its contract in relation to the Insured;
- An individual is determined newly eligible or newly ineligible for advance payments of the premium tax credit or has a change in eligibility for cost-sharing reductions, regardless of whether such individual is already enrolled in a qualified health plan. The Exchange must permit individuals whose existing coverage through an eligible employer-sponsored plan will no longer be affordable or provide minimum value for his or her employer's upcoming plan year to access this special enrollment period prior to the end of his or her coverage through such a plan;
- A qualified individual or Insured gains access to new qualified health plans as a result of a permanent move, provided he or she had minimum essential coverage in effect for one or more days of the 60 days prior to the move;
- New eligibility verification information;
- Medicaid/FAMIS eligibility determination delay;
- An Indian, as defined by Section 4 of the Indian Health Care Improvement Act, may enroll in a qualified health plan or change from one to another one time per month; and

- A qualified individual or Insured demonstrates to the Exchange, in accordance with guidelines issued by HHS, that the individual meets other exceptional circumstances as the Exchange may provide.

NOTE: Special enrollment for marriage – only applies if at least one spouse was enrolled in an exchange plan at least 1 day in the 60 days before marriage; or lived abroad for 1 or more days in the 60 days before marriage; or is an American Indian or Alaskan Native.

The effective date of Coverage for special enrollments will be:

- The first day of the following month for a qualified health plan selection received by the Exchange from a qualified individual between the first and the fifteenth day of any month; and

- The first day of the second following month for a qualified health plan selection received by the Exchange from a qualified individual between the sixteenth and the last day of any month.

- In the case of birth, adoption or placement for adoption, or placement of a foster child, the Exchange must ensure that Coverage is effective on the date of birth, adoption, or placement for adoption, or placement of a foster child, but advance payments of the premium tax credit and cost- sharing reductions, if applicable, are not effective until the first day of the following month, unless the birth, adoption, or placement for adoption, or placement of a foster child occurs on the first day of the month; and

- In the case of marriage, or in the case where a qualified individual loses minimum essential coverage, as described in this section, the Exchange must ensure coverage is effective on the first day of the following month.

D. TERMINATION OF COVERAGE

TIME OF TERMINATION: The time of Coverage termination is 11:59 pm on the termination date.

TERMINATION BY THE INSURED: The Insured may terminate his or her Coverage at any time by written notice delivered or mailed to Piedmont effective upon receipt or on such later date as may be specified in the notice. You must also go back to the Federal Marketplace and terminate Your Policy. In the event of termination, Piedmont shall promptly return the unearned portion of any Premium paid. The earned Premium shall be computed pro rata. Termination shall be without prejudice to any claim originating prior to the effective date of termination. The Policy will terminate at 11:59 p.m. on the date for which it is effective.

TERMINATION BY PIEDMONT: Piedmont may terminate this Policy at any time by written notice, for only the circumstances shown in detail below, delivered to the Participant, or mailed to his or her last address as shown by the records of Piedmont, stating when, no less than 31 days thereafter, the termination shall be effective. In the event of termination, Piedmont will promptly return the unearned portion of any Premium paid. The earned

Premium shall be computed pro rata. Termination shall be without prejudice to any claim originating prior to the effective date of termination.

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

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

1. **Termination for Cause.** If the Insured's Coverage is terminated for cause, then the Coverage for all Participants who are Dependents of that Insured is terminated as well. 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 Participant's card, Piedmont may recall the card and terminate your Coverage immediately upon 31 days' written notice.
    b. You represent that all information contained in applications, questionnaires, forms or statements submitted to Piedmont is true, correct, and complete. 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 upon 31 days' written notice. Participants so terminated shall be responsible to pay for all services provided to the Participant hereunder that are related to such information or activity.

2. **Termination for Loss of Eligibility**. The Coverage of any Participant who ceases to be eligible will terminate at the end of the day upon which eligibility ceased. This includes if the enrollee is no longer eligible for coverage in a qualified health plan through the Exchange (examples: divorce, overage Dependent, moves outside the Service Area, etc.). In the event of the Insured's death, the spouse of the Insured, if Covered under the Policy, shall become the new Insured. If no spouse is covered under the Policy at the time of the Insured's death, then Coverage will terminate for all covered Dependents of the Insured on the last day of the period for which payments have been made by or on behalf of the Insured.

3. **Termination for Failure to Pay Premium**. Only Participants for whom Piedmont has received the required Premiums shall be entitled to Covered Services, and then only for the period(s) for which such payment(s) is / are received. Except as otherwise provided in this paragraph, the Insured must pay the required Premium for coverage in full on or before the 1st day of each Coverage month. There is one exception. A grace period will be granted for payment of every Premium except the first Premium. The grace period is an additional period of time during which Coverage remains in effect and refers to either the 31-day grace period for

individuals not receiving advance payments of the premium tax credit APTC), or the 3-month grace period required for individuals receiving APTC. Coverage will remain in force during the grace period, unless you provide Piedmont with notice of your wish to discontinue Coverage in advance of the date of discontinuance.

At Our discretion if Your Policy is cancelled due to nonpayment of premium We may allow reinstatement of Your Coverage. We must receive all premium due payment in order to have Your Coverage reinstated. Your payment must be in the form of cash, certified check, or money order. Once We receive payment Coverage will be reinstated without a break in Coverage.

Participant does not receive APTC - If the Participant does not receive APTC, the grace period will begin on the Premium due date and continue for 31 days, unless you provide Piedmont with notice of your wish to discontinue Coverage in advance of the date of discontinuance. If you do not make the full payment of any premium due during the grace period, the Policy will be terminated and the last day of coverage is the last day of the grace period. You will be liable to Piedmont for the Premium payment due, including for the grace period, or for the payment of a pro rata Premium for the time the contract was in force during any part of the grace period. You will also be liable to Piedmont for any claims payments made for services incurred after the last day of the grace period.

Participant does receive APTC – If the Participant does receive APTC, a grace period of three consecutive months is allowed for individuals who have previously paid at least one month's premium in a benefit year. During the grace period, we must apply any payment received to the first billing cycle in which payment was delinquent and continue to collect the APTC. If the required full Premium is not paid before the end of the grace period, the last day of coverage will be the last day of the first month of the 3-month grace period. We must pay claims during the first month of the grace period but may pend claims in the second and third months subject to our right to terminate the Policy as provided herein. You will be liable to Piedmont for the Premium payment due including those for the grace period, or for the payment of a pro rata Premium for the time the contract was in force during any part of the grace period. You will be responsible for any claims incurred after the last day of the first month of the 3-month grace period.

4. **Termination for Other Events.** An enrollee's coverage in a qualified health plan may also be terminated for the following reasons:

- The Participant's Coverage is rescinded;
- The qualified health plan terminates or is decertified;
- We can refuse to renew Your EOC if We decide to discontinue a health coverage product that We offer in the individual market. If We discontinue a health coverage product, We will provide You with at least 90 days notice of the discontinuation. In addition, You will be given the option to purchase any health coverage plan that We currently offer without regard to claims status or health history. Nonrenewal will not affect an existing claim;

- If We elect to discontinue offering all health insurance coverage in the individual market in the state, health insurance coverage may be discontinued by Us only if: (i) We provide notice to the Commission and to each individual of such discontinuation at least 180 days prior to the date of the expiration of such coverage, and (ii) all health insurance issued or delivered for issuance by Us in this state in such market is discontinued and coverage under such health insurance coverage in such market is not renewed;
- We may refuse to renew Your Plan or end coverage if You have failed to maintain legal residence in the Service Area for six months;
- We may refuse to renew Your Plan if You become eligible for Medicare, provided that coverage may not end with respect to other individuals insured under the same Plan and who are not eligible for Medicare; or
- The Participant changes from one qualified health plan to another during an annual open enrollment period or special enrollment period.

A "rescission" is a termination or discontinuance of Coverage that has retroactive effect. For example, a termination that treats a Policy and the Coverage as void from the time of individual'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 that paid the Premiums.

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

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

A termination or discontinuance of Coverage with only prospective effect is not a rescission. Neither is a termination or discontinuance that is effective retroactively because of a failure to pay the required premium due by the Policy.

E. CONTINUATION OF COVERAGE

Death of Insured. If your Coverage under this Policy terminates as a result of the Insured's death, then you may exercise the privilege of continuing individual Coverage as an Insured if you are already Covered as the deceased Insured's spouse

under this Policy. In order to exercise continuation of coverage, you need to contact Piedmont and let us know of your intentions. Upon receipt of a completed enrollment form, proof of the Insured's death, and first month's premium, Piedmont will enroll you as the Insured.

F. COORDINATION OF BENEFITS

Special Coordination of Benefits (COB) rules apply when you or members of your family have additional Coverage through other health insurance Plans, including but not limited to:

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

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

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

Coordination with Group Coverage

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

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

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

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

Coordination with Plans other than Group Coverage

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

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

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

- If a Participant is the named insured under both coverages, generally the one that covers him or her for the longer period of time will be primary.
- If the Participant is enrolled as a dependent child under both coverages (e.g. when both parents cover their child), typically the coverage of the parent whose birthday falls earliest in the Benefit Year will be the primary.

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

Coordination with Medicare

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

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

Overpayment of Benefits

If Piedmont overpays Benefits because of COB, it has the right to recover the excess from:

- Any person to, or for whom such payments were made;

- Any insurance company; or
- Any other organization.

Right to Receive and Release Information

By accepting Coverage under this Policy, you should:

- Provide Piedmont with information about other Coverage and promptly notify Piedmont of any Coverage changes;
- Promptly respond to any requests for information from Piedmont;
- Grant Piedmont the right to obtain information as needed from others to coordinate Benefits;
- Promptly return any excess amounts to Piedmont if it makes a payment and later discovers or determines the other Coverage should have been primary.

G. DUPLICATE COVERAGE

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

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

H. RELATIONSHIP OF CONTRACTING PARTIES

Piedmont Providers maintain the physician-patient relationship with you. Piedmont Providers are solely responsible for all medical Services. The relationship between Piedmont and Piedmont Providers of Covered Services is an independent contractor relationship. Piedmont Providers of Covered Services are not: employees; or agents of Piedmont. Neither Piedmont nor any Employee of Piedmont is an Employee or agent of any Piedmont Provider. For the purposes of this Policy, no Participant or Provider is the agent or representative of Piedmont and none shall be liable for any acts or omissions of: Piedmont; its agents; Piedmont Employees; nor any other person or organization with which Piedmont has made or hereafter shall make arrangements for the provision of Covered Services.

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

I. MEDICAL INFORMATION

Piedmont may request (from any Provider of Covered Services to you) information necessary in connection with the administration of this Policy subject to all applicable confidentiality

requirements. Information from your medical records and information from physicians, surgeons, or Hospitals incidental to the doctor-patient or Hospital-patient relationship shall be kept confidential. This information may not be disclosed without your consent except as permitted by any applicable state and federal law.

J. POLICIES AND PROCEDURES

To promote orderly and efficient administration of Coverage under this Policy, Piedmont may: adopt policies; procedures; rules; and interpretations.

K. MODIFICATIONS

Subject to, and as permitted by applicable law, with 75 days advance notice before the effective date of any material modification, any: provision; term; Benefit; or condition of Coverage of this Policy may be amended, revised, or deleted by Piedmont. This may be done without the Participant's consent or concurrence.

L. NOTICES

1. **From Piedmont to You.** A notice sent to you by Piedmont is considered "given" when received by the Insured at the Insured's last known address as shown in Piedmont's enrollment records. "Notices" include any information, which Piedmont may send you, including ID cards.

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

M. CLAIMS REVIEW

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

Piedmont will review a:

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

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

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

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

You will have 45 days after you receive such an extension notice to provide the information. Piedmont's time to review a claim is "tolled" or stops between the date it sends the extension notice and the date Piedmont receives the requested information.

2. Expedited Decisions for Urgent Care Claims or Requests:

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

For the purposes of this paragraph and the "Claims and Eligibility Appeals" and "Claims Notices" paragraphs of this Section, an "Urgent Care Claim" is any claim or urgent request for medical care or treatment for a Benefit for which the application of post-service or pre-service time frames or our normal preauthorization standards:

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

Piedmont will notify the claimant of a Benefit determination (whether adverse or not) with respect to an Urgent Care Claim as soon as possible, taking into account the medical exigencies, but not later than 72 hours after Piedmont receives the claim or request. If the claimant fails to provide sufficient information to determine whether, or to what extent, Benefits are Covered or payable under this Policy, we will notify the claimant within 24 hours of receipt of the claim or request that additional information is required to make a decision.

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

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

N. CLAIMS AND ELIGIBILITY APPEALS

1. Internal Appeals:

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

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

"Rescission of Coverage" does not include:

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

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

In addition, the internal appeals process does not apply to any Adverse Benefit Determination, reconsideration, or final adverse decision rendered solely on the basis that your health benefit plan does not provide Benefits for the health care services provided or requested to be provided.

The appeal should be in writing and include: your name; Piedmont ID number; the reason for the appeal; the resolution you are requesting; and supporting information regarding the medical Providers involved and services received or requested. To ensure proper handling, an appeal must be filed with Piedmont's Appeals Coordinator at this address:

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

If you need assistance with an internal appeal, you may contact the Office of Managed Care Ombudsman at the Virginia Bureau of Insurance. Contact information for that office is set forth in the "Complaints and Assistance" Section of this Policy.

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

You may submit: written comments, documents, records, and other information relating to the claim, even though the information had not been considered when the initial decision was made. Upon request, Piedmont will identify the health care professional whom it consulted, whether or not it relied on his or her advice in reaching Piedmont's adverse decision. You may request, and Piedmont 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, Piedmont will provide to you free of charge with any new information that it relied on or generated for the appeal sufficiently far in advance of its final determination so that you may respond, if you choose to do so.

Piedmont will conduct the appeal without deferring to the original adverse decision. The individual who conducts the appeal will not be the person who made the initial decision or that person's subordinate. Piedmont 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 Piedmont consults for the appeal will not be the person whom we consulted in making the initial decision or that person's subordinate.

2. Expedited Internal Appeals

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

If your internal appeal involves a concurrent review decision, for example, a continuing stay in an Inpatient setting, then Piedmont will provide continued Coverage pending the outcome of your appeal up to the limits of your Coverage under this Policy. Any reduction or termination of a course of treatment Piedmont has approved in advance (other than by health Benefit Plan amendment or termination) to be provided over a period of time or number of treatments is considered to be an Adverse Benefit Determination. Piedmont will notify you of the Adverse Benefit Determination in time for you or your authorized representative to file an internal appeal with Piedmont and receive a decision before the Covered Benefit is reduced or terminated.

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

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

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

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

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

3. External Appeals:

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

The Bureau's external review program is available for a specific set of adverse determinations. First, you or your authorized representative must have exhausted the health Plan's internal appeal process (set forth above). Second, to be eligible for external review, the adverse determination must be for an admission, the availability of care, continued stay or

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

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

You must file your request for external review with the Virginia Bureau of Insurance within 120 days after your/the receipt of Piedmont's denial of payment or denial of a request for Coverage of a health care service or treatment. You may also file a request for an expedited external review with the Bureau of Insurance. Piedmont will make a preliminary determination as to whether the Adverse Benefits Determination is eligible for an external appeal. Piedmont will advise you and the Bureau of Insurance of its 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 Participant except to the extent that the Participant has other remedies available under applicable federal or state law. You or your authorized representative may not file a subsequent request for an external review involving the same adverse determination or final adverse determination for which you or your representative has already received an external review decision by the Bureau of Insurance.

O. AUTHORIZED REPRESENTATIVE

You may authorize a representative to act on your behalf in pursuing a claims review or claims appeal. Piedmont may require you identify your authorized representative to Piedmont in writing in advance. Piedmont 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

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

P. COMPLAINTS AND ASSISTANCE

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

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

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

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

The Virginia Bureau of Insurance has established an **"Office of Managed Care Ombudsman"** to assist Virginia consumers in understanding and exercising their rights under their managed care programs. If you have any question about an appeal or complaint involving a service that Piedmont has provided or that you contend Piedmont has not satisfactorily addressed, you may contact the Bureau of Insurance's Office of Managed Care Ombudsman for assistance. You may contact this office in any of the following ways:

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

Q. ASSIGNMENT OF BENEFITS AND PAYMENTS

1. The Covered Services available under this Policy are personal to you. You may not assign your right to receive Covered Services.

2. Except for payments assigned to oral surgeons and dentists who provide Covered Services to you, you may not assign your right to receive payment for Covered Services. Prior payments to anyone, whether or not there has been an assignment of payment, shall not constitute a waiver of, or otherwise restrict, Piedmont's right to direct future payments to you or any other individual or facility.

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

S. PIEDMONT'S CONTINUING RIGHTS

On occasion, Piedmont may not insist on your strict performance of all terms of this Policy. Piedmont's failure to always apply terms or conditions against you, however, does not mean Piedmont waives or gives up any future rights it may have under this Policy.

T. USE OF PERSONAL INFORMATION

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

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

U. PROVIDER NONDISCRIMINATION

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

V. NONDISCOURAGEMENT / NONDISCRIMINATORY BENEFIT DESIGN

Piedmont does not offer Benefit designs that will have the effect of discouraging the enrollment of individuals with significant health needs in its plans. Nor does Piedmont discriminate on the basis of: health status; race; color; creed; national origin; ancestry; marital status; lawful occupation; disability; age; sex; gender identity; or sexual orientation.

SECTION VIII: REQUIRED PROVISIONS

A. ENTIRE CONTRACT; CHANGES

This Policy, including the endorsements and the attached papers, if any, and the individual enrollment applications of Participants constitute the entire contract of insurance. A copy of the application of the policy owner shall be attached to policy when issued. All statements made by an Insured in connection with the application for insurance coverage shall be considered representations and not warranties. No written statement made by any person insured shall be used in any contest unless a copy of the statement is furnished to the person, his beneficiary or personal representative. No change in this Policy shall be valid until approved by an executive officer of Piedmont and unless such approval is endorsed hereon or attached hereto. No agent has authority to change this Policy or to waive any of its provisions.

B. TIME LIMIT ON CERTAIN DEFENSES

Misstatements in the application: After two years from the date of this Policy, only fraudulent misstatements in the application may be used to void the Policy or deny any claim for loss incurred or disability (as defined in the Policy) that starts after the two-year period.

C. GRACE PERIOD

The policyholder is entitled to a grace period for the payment of any premium due, except the first premium. This Policy has a 31-day grace period for individuals not receiving advance payments of the premium tax credit. This means that if a renewal Premium is not paid on or before the date it is due, it may be paid during the following 31 calendar days. During the grace period, the Policy shall continue in force subject to the right of Piedmont to terminate in accordance with the termination provision. A 3-month grace period is allowed for individuals receiving advance payments of the premium tax credit.

D. NOTICE OF CLAIM

Written notice of a claim can be given to Piedmont at 2316 Atherholt Road, Lynchburg, VA 24501, or to Piedmont's agent. Notice should include the name of the Insured, and Claimant if other than the Insured, the Insured's member number, the name and address of the provider, the date of the services, the diagnosis and type of services received, and the charge for each type of service. You should follow this procedure when services are rendered by non-Piedmont providers.

E. CLAIM FORMS

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

F. PROOFS OF LOSS

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

G. TIME OF PAYMENT OF CLAIMS

After receiving written proof of loss, Piedmont will pay within 30 days all Benefits then due for any loss covered by this Policy. Benefits for any other loss covered by this Policy will be paid as soon as Piedmont receives proper written proof.

H. PAYMENT OF CLAIMS

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

I. PHYSICAL EXAMINATIONS AND AUTOPSY

Piedmont at its own expense has the right to have the Insured examined as often as reasonably necessary while a claim is pending. It may also have an autopsy made unless prohibited by law.

J. LEGAL ACTIONS

No legal action may be brought to recover on this Policy within 60 days after written proof of loss has been given as required by this Policy. No legal action may be brought after three years from the time the written proof of loss is required to be given.

K. CHANGE OF BENEFICIARY

The Insured can change the beneficiary at any time by giving Piedmont written notice. The beneficiary's consent is not required for this or any other change in the Policy, unless the designation of the beneficiary is irrevocable.

L. TERMINATION BY INSURED

The Insured may terminate this Policy at any time by written notice delivered or mailed to Piedmont effective upon receipt or on such later date as may be specified in the notice. You must also go back to the Federal Marketplace and terminate Your Policy. In the event of termination, Piedmont shall return promptly the unearned portion of any

Premium paid. The earned Premium shall be computed pro rata. Termination shall be without prejudice to any claim originating prior to the effective date of termination.

SECTION IX: OTHER PROVISIONS

A. MISSTATEMENT OF AGE

If the Insured's age has been misstated, the Benefits will be those the Premium paid would have purchased at the correct age.

B. OTHER INSURANCE IN THIS COMPANY

Insurance effective at any one time on the Insured under a like policy or policies with Piedmont is limited to the one such policy elected by the Insured, his beneficiary or his estate, as the case may be, and Piedmont will return all Premiums paid for all other such Policies.

C. CONFORMITY WITH STATE STATUTES

Any provision of this Policy that on its effective date is in conflict with the laws of the state in which the Insured resides on that date is amended to conform with the minimum requirements of those laws.

PARTICIPANT RIGHTS AND RESPONSIBILITIES

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

Piedmont is committed to:

- Recognizing and respecting you as a Participant.
- Encouraging your open discussions with your health care professionals and Providers.
- Providing information to help you become an informed health care consumer.
- Providing access to health Benefits and our Network Providers.
- Sharing our expectations of you as a Participant.

You have the right to:

- Participate with your health care professionals and Providers in making decisions about your health care.
- Receive the Benefits for which you have Coverage.
- Be treated with respect and dignity.
- Preserve the privacy of your personal health information, consistent with state and federal laws, and our policies.
- Receive information about our organization and services, our Network of health care professionals and Providers, and your rights and responsibilities.
- Candidly discuss with your physicians and Providers appropriate and Medically Necessary care for your condition, regardless of cost or Benefit Coverage.
- Make recommendations regarding the rights and responsibilities of Participants as set forth in this Policy.
- 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 a Primary Care Physician for services.
- 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 Piedmont and/or your health care professionals and Providers need to provide care.
- Follow the plans and instructions for care that you have agreed on with your health care professional and Provider.
- Tell your health care professional and Provider if you do not understand your treatment plan or what is expected of you.
- Follow all health benefit plan guidelines, provisions, policies and procedures.
- Let Piedmont know if you have any changes to your: name; address; or family members covered under your Policy.
- Provide Piedmont 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.