Piedmont Individual Health Care Coverage Plan

2024 Piedmont HMO

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

PCHC_HMO_EOC_HIX_01-24

PIEDMONT COMMUNITY HEALTHCARE HMO, INC.

IMPORTANT INFORMATION REGARDING YOUR INSURANCE

THIS PLAN IS A HEALTH MAINTENANCE ORGANIZATION (HMO) PRODUCT

CONTACT US

Piedmont Community Healthcare HMO, Inc.
2316 Atherholt Road, Lynchburg, Virginia 24501
Local: (434) 947-4463, Toll Free: (800) 400-7247 (TTY: 711)
Fax: (434) 947-3670, Website: www.pchp.net

RIGHT TO RETURN POLICY WITHIN TEN DAYS

If for any reason You are not satisfied with Your Policy, You may return this Policy to Us within 10 days of the date You received it and the Premium You paid will be promptly refunded.

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

THIS POLICY MAY NOT APPLY WHEN YOU HAVE A CLAIM! PLEASE READ!

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

GUARANTEED RENEWABILITY

Coverage under this Policy is guaranteed renewable, except as permitted to be terminated, canceled, rescinded, or not renewed under applicable state and federal law, provided that You are a Qualified Individual as determined by the Exchange. You may renew this Policy by payment of the renewal Premium by the end of the grace period of the Premium due date, provided the following requirements are satisfied:

- Eligibility criteria as a Qualified Individual continues to be met.
- There are no fraudulent or intentional misrepresentations of material fact on the application or under the terms of this Policy.
- This Policy has not been terminated by the Exchange.

Table of Contents

SECTION I: Definitions

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

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

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

Benefit(s) or Covered Benefit(s) means the payouts to Providers that We are contractually obligated to make pursuant to a Covered Person's coverage.

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

Child or **Children** means 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.

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

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

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

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

Covered Service(s) means those health services and Benefits to which a Covered Person is entitled under the terms of this Policy. Except as otherwise provided, Covered Services must be Medically Necessary.

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

Dependent(s) means the Subscriber's Child, spouse, or Domestic Partner who meets all the eligibility requirements of this Policy and for whom We have received the required Premium.

Emergency Medical Condition or **Emergencies** means a medical condition manifesting itself by acute symptoms of sufficient severity, including severe pain, so that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in:

1. serious jeopardy to the mental or physical health of a Covered Person;
2. danger of serious impairment to bodily functions;
3. serious dysfunction of any bodily organ or part; or
4. in the case of a pregnant woman, serious jeopardy to the health of the fetus.

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

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. This definition will always follow the requirements laid out by the Secretary of the US Department of Health and Human Services (HHS) pursuant to the authority of the Affordable Care Act.

Exchange means the Virginia Health Benefit Exchange, otherwise known as Virginia's Insurance Marketplace, through which Qualified Health Plans and qualified dental plans are made available to Qualified Individuals. Individuals can shop for coverage by visiting the Exchange website at https://www.marketplace.virginia.gov or by calling (888) 687-1501.

Experimental/Investigational means a drug, device, medical treatment, or procedure may be considered Experimental/Investigational if:

1. The majority of the medical community does not support the use of this drug, device, medical treatment, or procedure; or
2. The use of this drug, device, medical treatment, or procedure may have been shown to be unsafe and/or of no or questionable use as reported by current scientific literature and/or regulatory agencies; or
3. The research regarding this drug, device, medical treatment, or procedure may be so limited that an evaluation of safety and efficacy cannot be made; or
4. The drug or device is not approved for marketing by the Food and Drug Administration (FDA); or
5. The drug, device, or medical treatment is approved as Category B Non-Experimental/ Investigational by the FDA; or
6. The drug, device, medical treatment, or procedure is:
    a. currently under study in a Phase I or II clinical trial or

b. an Experimental study/Investigational arm of a Phase III clinical study or
c. otherwise under study to determine safety and efficacy/compare its safety and efficacy to current standards of care.

Facility means an institution providing health care related services or a health care setting, including but not limited to hospitals and other licensed inpatient centers; ambulatory surgical or treatment centers; skilled nursing centers; residential treatment centers; diagnostic, laboratory, and imaging centers; and rehabilitation and other therapeutic health settings.

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

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

In-Network Physician means a Physician who has independently contracted with Piedmont or its designee to provide medical services to Covered Persons.

In-Network Provider means: a medical group, In-Network Physician, Hospital, skilled nursing Facility, pharmacy, or any other duly licensed institution or health professional that has contracted with Piedmont or its designee to provide Covered Services to Covered Persons. A list of In-Network Providers is made available to each Covered Person upon issuance of the Policy and is available upon request from Us and viewable online at **www.pchp.net**. We will revise the list of In-Network Providers as We deem necessary or at such other time as applicable law requires.

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

Limiting Age means the age after which a Subscriber's Dependent Child is no longer eligible for coverage under this Policy. The Limiting Age for Dependent Children is age 26.

Maximum Out-of-Pocket means the amount over the determined Allowable Charge that a Covered Person incurs will be payable at 100% (except for those charges excluded from the Out-of-Pocket limit) for the remainder of that Benefit Year.

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

(6) with respect to Inpatient care, are provided to treat a condition requiring acute care as a bed patient. We will determine the Medical Necessity of a given service or procedure.

Network or **In-Network** refers to Providers that have contracted with Piedmont to provide health care services to Covered Persons.

Open Enrollment Period (OEP) refers to the period each year during which a Qualified Individual may apply to newly enroll for coverage or otherwise change coverage in a Qualified Health Plan through the Exchange.

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

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

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

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

Piedmont means Piedmont Community Healthcare HMO, Inc.

Policy means this document, the Schedule of Benefits, the Subscriber'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) means the monthly payment due from the Subscriber to Piedmont as specified in the Policy and related documents as a condition precedent for Covered Persons to receive coverage.

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

- **Preventive Drugs (Tier 0)** are those considered to be used for preventive purposes if it is being prescribed primarily (1) to prevent the symptomatic onset of a condition in a person who has developed risk factors for a disease that has not yet become clinically apparent or (2) to prevent recurrence of a disease or condition from which the patient has recovered. A drug is not considered preventive if it is being prescribed to treat an existing, symptomatic illness, injury or condition.

- **Generic Drugs (Tier 1)** are non-brand drugs (including Specialty Drugs and therapeutic biological products), sold at a lower cost than the equivalent brand. A Generic Drug is the therapeutic equivalent of a brand name drug, i.e., it contains the same active ingredients and is identical in strength, concentration, and dosage form.
- **Preferred Drugs (Tier 2)** are brand name drugs (including therapeutic biological products) listed on the formulary at a higher tier than Generic Drugs. A pharmacy and therapeutics committee have reviewed these drugs to insure high standards for clinical efficacy and safety. These are the lower cost brand name drugs in a therapeutic category.
- **Non-Preferred Drugs (Tier 3)** are brand name drugs (including therapeutic biological products) listed on the formulary at a higher tier than Generic Drugs 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. 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 ability to provide a 90-day supply of a Specialty Drug may be limited by the storage requirements of that drug. The two tiers of Specialty Drugs are as follows:
    a. **Preferred Specialty Drugs (Tier 4)** are the lower cost brand name drugs in the Specialty Drugs therapeutic category.
    b. **Non-preferred Specialty Drugs (Tier 5)** are classified as higher cost drugs in the Specialty Drugs therapeutic category.

Primary Care Physician or **PCP** means the In-Network Physician You select to provide primary health care and to coordinate the other Covered Services You may require. Each Covered Person may choose any available PCP in accordance with the terms and conditions of this Policy.

Provider(s) means any professional organization, association or entity which furnishes or causes to be furnished primary or specialty care services, pharmacy, Hospital services or ancillary medical services.

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

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

Qualified Health Plan (QHP) means a health benefit plan that has in effect a certification that the plan meets the criteria for certification described in § 1311(c) of the Federal Act and § 38.2-6506 of the Code of Virginia.

Qualified Individual (QI) means an individual, including a minor, who:

1. is seeking to enroll in a qualified health plan or qualified dental plan offered to individuals through the Exchange;
2. resides in the Commonwealth;
3. is not incarcerated at the time of enrollment, other than incarceration pending the disposition of charges; and
4. is, and is reasonably expected to be, for the entire period for which enrollment is sought, a citizen or a national of the United States or an alien lawfully present in the United States.

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

Special Enrollment Period (SEP) means a time outside the annual OEP when You can sign up for health insurance. You qualify for a SEP if You have had certain life events, including losing health coverage, moving, getting married, having a baby, or adopting a Child. If You qualify for a SEP, You usually have up to 60 days following the event to enroll in a plan. If You miss that window, You must wait until the next OEP to apply.

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

Subscriber means the individual who has applied for this Policy, meets all the eligibility requirements of this Policy, and for whom Piedmont has received the required Premium. The Subscriber is responsible for Premium payment and maintaining the Policy. Any changes to eligibility and Benefits of the Subscriber affect all eligible Dependent(s).

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

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

Usual and Customary means the amount 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.

You, Your, refers to the Subscriber.

SECTION II: Responsibilities

A. Your Responsibilities

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

Pay Your Monthly Premium. This Policy is issued to You. We agree 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. We reserve the right to charge an administrative fee of $35 for any check, automatic deduction, or Electronic Funds Transfer which is returned or dishonored by the financial institution as non-payable to Us for any reason. Your Premium will be considered unpaid until the administrative fee and outstanding Premium are received by Piedmont.

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

Changes in Coverage. 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 the Exchange is notified as soon as possible, but no more than 60 days after any of the following changes occur:

1. Change in Your marital status (due to marriage or divorce);
2. A Covered Person begins active duty with the Armed Services;
3. Death of a Dependent; or
4. A Dependent Child is born to or adopted by You.

Failure to provide proper notice of changes in coverage may affect Your coverage. We are not responsible for any lapse in coverage due to Your failure to provide proper notice of a change in coverage as required.

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

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

- Be on time for appointments and give prompt notice to Providers if You or the Covered Person need to cancel or reschedule appointments.
- Obtain Covered Services through the Primary Care Physician (PCP) and other Providers within Piedmont's Network.
- Obtain prior authorization before treatment is received for Covered Services that require it.
- Obtain a prior authorization from Us and a referral from the PCP before treatment is received from an Out-of-Network Provider, if care from an Out-of-Network Provider is necessary. Failure to obtain the prior authorization will result in the Benefits not being Covered Services.
- Follow guidance given by the PCP or other In-Network Provider.
- Make the lifestyle changes recommended by the In-Network Physician or Piedmont.
- Know prescribed medications, reasons for taking them, and procedures for taking them.
- Learn to differentiate between true Emergency situations and Urgent Care needs; and how to handle them.
- Pay Copayments, Coinsurance, and/or Deductibles at the time the Covered Service is rendered.
- Make sure to notify the Exchange of any change in the Covered Person's eligibility, including but not limited to name, address, phone number, income, etc.
- Utilize grievance and appeal procedures discussed further in this Policy to resolve concerns and complaints.
- Provide Us with (1) requested information, including medical records; (2) Physician statements regarding care and treatment; and (3) any information regarding Your or the Covered Person's physical condition.
- Provide Us with the necessary information so Coordination of Benefits may take place.

B. Piedmont's Responsibilities

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

- Provide all Benefits described in this Policy subject to its terms, conditions, limitations, and exclusions.
- Keep You informed regarding changes in procedures, Benefits, and In-Network Providers. We do not guarantee the continued availability of an In-Network Provider.
- Keep all medical records confidential in accordance with federal and state privacy protection laws.
- Provide courteous, prompt resolution of questions, concerns, complaints or appeals.
- Assist in getting an appointment with and changing Providers in Piedmont's Network when requested.
- Make Network arrangements so the In-Network Physician (or another Physician with whom the In-Network Physician has made arrangements) is available 24/7 to refer or direct for prompt medical care where there is an immediate, urgent need or Emergency.
- Always have Piedmont's or its designee's personnel available for prior authorization when it is required. We require Providers (or a Covered Person acting on their own behalf) to make prior authorization arrangements during regular business hours. Our prior authorization is not required for Emergencies anytime or Urgent Care situations after hours.

- Offer the right to make recommendations about rights and responsibilities.

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

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

C. Important Information Regarding Your Insurance

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

Piedmont Community Healthcare HMO
Customer Service Department
2316 Atherholt Road, Lynchburg, Virginia 24501
Local: (434) 947-4463, Toll Free: (800) 400-7247 (TTY: 711)
Fax: (434) 947-3670, Website: www.pchp.net

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

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

D. Non-Discrimination and Language Assistance

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

- We provide free aids and services to people with disabilities to communicate effectively with Us, such as:
    - Qualified sign language interpreters
    - Written information in other formats (large print, audio, accessible electronic formats, other formats)
- We provide free language services to people whose primary language is not English, such as:
    - Qualified interpreters

- Information written in other languages

If You need these services, contact Our Customer Service at 1-800-400-7247, Option 2 (TTY: 711).

If You believe that We have failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, You can file a grievance with Our Grievance Coordinator by mail or phone:

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

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

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

Complaint forms are available at https://www.hhs.gov/ocr/complaints/index.html.

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

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

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

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

Written correspondence is preferable so that a record of Your inquiry is maintained. When contacting Your agent, Piedmont, or the Bureau of Insurance, please have Your Policy number (on

Your ID card) available. We recommend that You review Our grievance procedure and make use of it before taking any other action.

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 a Subscriber of this Policy, You agree to abide by the 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 Our employees, will 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.

E. Regulatory Agencies

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

SECTION III: How to Use Your Benefits

A. Choosing A Primary Care Physician (PCP)

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

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

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

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

B. Covered Providers

This plan is a Health Maintenance Organization (HMO) plan. Referrals are never needed to visit an In-Network Specialist Physician, including behavioral health Providers. This Benefit plan is a Network product that allows the Covered Person to receive Services from In-Network Providers. A Covered Person who receives Covered Services from Providers other than In-Network Providers (Out-of-Network Providers) will result in the Benefits not being Covered Services.

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

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

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

Ancillary Providers: These are Providers of laboratory, radiology, pharmacy or rehabilitative services, physical therapy, occupational therapy, speech therapy, home health services, dialysis, durable medical equipment, or medical supplies dispensed by order or prescription of a Provider with the appropriate prescribing authority. When using any In-Network Provider, Covered Services provided by an Out-of-Network ancillary Provider are covered as In-Network services. We will count cost-sharing paid by the Covered Person for the Covered Service by the Out-of-Network ancillary Provider at the In-Network setting towards the In-Network annual Maximum Out-of-Pocket.

Services Not Available In-Network: For receipt of In-Network Benefits when required Covered Services are not available from In-Network Providers, the Covered Person (or his or her In-Network Physician) will contact Us and provide information about the required Covered Services needed that are not available from In-Network Providers. We will review the information with You or the Covered Person and/or the In-Network Physician, as necessary. We will arrange for the Covered Services to be provided as In-Network Benefits by Providers outside the Service Area (or outside Piedmont's Network of Providers) with whom We have planned to provide these Covered Services.

Ongoing Specialized Treatment is Medically Necessary: If the Covered Person has an ongoing special condition as determined by Us that causes the Covered Person to see an Out-of-Network Specialist Physician often, the Covered Person may receive a standing referral. We or the PCP working in association with Us will refer the Covered Person to seek care from an Out-of-Network Specialist Physician for treatment of the ongoing special condition. "Special condition" means a condition or disease that is:

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

The standing referral will allow the Out-of-Network Specialist Physician to treat the Covered Person without obtaining further authorizations. The Out-of-Network Specialist Physician may authorize referrals, procedures, tests, and other medical services related to the special condition. Please contact Us yearly about the standing referral to ensure continued coverage.

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

C. Services Requiring Prior Authorization

Certain Covered Services will require prior authorization from Us, except in an Emergency or Urgent Care situation after hours (see below). The In-Network Physician will work with You or the Covered Person and Us to handle these prior authorization requirements. Examples of these Covered Services include, but are not limited to, the following:

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

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

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

Prior authorization is certification by Piedmont of Medical Necessity and not a guarantee of payment. For Benefits to be Covered Services, on the date the Covered Person gets service:

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

D. Obstetrical and Gynecological Care Does Not Require Prior authorization by Piedmont

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

E. Interhospital Transfers for Newborn or Mother Do Not Require Prior authorization by Piedmont

We do not require prior authorization for the interhospital transfer of:

1. a newborn infant experiencing a life-threatening emergency condition; or
2. the hospitalized mother of such newborn infant to accompany the infant.

F. Emergency Services Do Not Require A Network Provider or Prior authorization by Piedmont

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

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

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

1. Regardless of whether the Provider furnishing the Emergency Services is an In-Network Provider with respect to the services;
2. Without the need for prior authorization by Us, even if an Out-of-Network Provider provides the Emergency Services;
3. Regardless of the final diagnosis rendered to the Covered Person; and
4. If an Out-of-Network Provider provides the Emergency Services, without imposing any administrative requirement or limitation on coverage that is more restrictive than the requirements or limitations that apply to Emergency Services received from In-Network Providers.
5. Please see **Section V: What is Covered** for additional information regarding cost-sharing for Emergency Services received from an Out-of-Network Provider.

G. Continuity of Care

If the Covered Person's In-Network Provider leaves Piedmont's Network, the Covered Person may continue to receive Covered Services from the Provider in the following cases:

1. A Covered Person may receive Covered Services from the Provider for a period of 90 days from the date of the Provider's termination from Piedmont's Network.
2. A Covered Person who has been medically confirmed to be pregnant at the time of the Provider's termination from Piedmont's Network. This continuation of maternity coverage will include Covered Services for postpartum care directly related to the delivery.

3. A Covered Person determined to be terminally ill (as defined by Section 1861 (dd) (3) (A) of the United States Social Security Act) at the time of the Provider's termination from Piedmont's Network. The Covered Person 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.
4. A Covered Person who has been determined by a medical professional to have a life-threatening condition at the time of the Provider's termination from Piedmont's Network. The Covered Person has the option to continue receiving Covered Services from this Provider for up to 180 days for care directly related to the life-threatening condition.
5. A Covered Person who is admitted to and receiving treatment in any In-Network Inpatient Facility at the time of the Provider's termination from Piedmont's Network. The Covered Person shall be permitted to continue receiving Covered Services from this Provider until the they are discharged from the In-Network Inpatient Facility.

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

H. Case Management

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

I. Utilization Management Program

The Utilization Management (UM) program 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 Our prior authorization before they are received. If Our requirements for prior authorization are not followed, We may not pay for these services. The PCP and other In-Network Providers have been given detailed information about Our prior authorization procedures and they are responsible for meeting these requirements and obtaining the needed prior authorization. Since the prior authorization is the responsibility of Our In-Network Providers, any reduction or denial of Benefits due to not obtaining a prior authorization should not affect You.

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

UM decision making is based only on the appropriateness of the care and service(s) requested and existence of coverage. We do not reward or compensate practitioners or other individuals conducting utilization review for issuing denials of coverage or service. Financial incentives for UM decision makers do not encourage decisions that result in underutilization. If requested by a Covered Person, or contracted Provider, We will furnish the criteria used to determine medical necessity within 30 days of such request.

SECTION IV: What You Pay for Benefits

All Covered Services or supplies the Covered Person receives are subject to the terms, conditions, definitions, limitations, and exclusions described elsewhere in this Policy. We will only pay for Medically Necessary Covered Services. Additionally, We will only pay the charges incurred when the Covered Person is eligible for the Covered Services received (e.g., Premiums have been paid).

A. Deductible (When Applicable)

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

B. Copayment/Coinsurance Amounts

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

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

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

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

C. Benefit Payment

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

D. Maximum Out-of-Pocket Limit

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

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

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

- Non-Covered Services described in this Policy;
- Charges more than 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

You will only have to pay Your Copayment, Deductible, and/or Coinsurance and will not be Balance Billed by In-Network Providers for amounts above the Allowable Charge.

F. Balance Billing Prohibited for Certain Services

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

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

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

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

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

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

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

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

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

SECTION V: What is Covered

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

A. Allergy Treatment

Medically Necessary allergy testing, diagnosis, and treatment are Covered Services, including allergy serum and allergy shots.

B. Ambulance (Including Air Ambulance) Services

Ambulance services in an Emergency are Covered Services without the need for Our prior authorization. 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. Medically Necessary nonemergent ambulance services are Covered Services if We authorize these services in advance.

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

Reimbursement will be made directly to the Provider when We are presented with an assignment of benefits by the person or entity providing such services. Balance Billing by Out-of-Network Emergency air ambulance services is prohibited. You can find more information regarding services where Balance Billing is prohibited in Section IV, Subsection F of this Policy.

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 will 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. Within this Section, "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. We will not deny a qualified individual participation in an approved clinical trial, deny or limit, or impose additional conditions on the coverage of routine patient costs for items or services furnished in connection with participation in the approved clinical trial. We will not discriminate against the individual based on the individual's participation in the approved clinical trial.

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

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:

1. The National Institutes of Health (NIH). (Includes the National Cancer Institute (NCI));
2. The Centers for Disease Control and Prevention;
3. The Agency for Health Care Research and Quality;
4. The Centers for Medicare and Medicaid Services;
5. 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;
6. A qualified non-governmental research entity identified in the guidelines issued by the National Institutes of Health for center support grants;
7. 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;
8. 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);
9. The FDA in the form of an Investigational new drug application; or

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

Our payment for Covered Services the Covered Person receives during participation in clinical trials for treatment studies on life threatening diseases will be determined in the same manner as We determine payment for other Covered Services. Durational limits, dollar limits, Deductibles, Copayments, Coinsurance, and Allowable Charge limits for these services will be no less favorable than for other Covered Services. Covered Services mean Medically Necessary health care services that are incurred as a result of the treatment being provided for the purposes of a clinical trial. "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: (1) the investigational item, device, or service itself; (2) 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; (3) a service that is clearly inconsistent with widely accepted and established standards of care for a particular diagnosis; or (4) any item or service that is paid for, or should have been paid for, by the sponsor of the trial.

E. Diabetes Care Management

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

- Medically Necessary insulin pumps;
- Home blood glucose monitors, lancets, blood glucose test strips, syringes, and hypodermic needles when purchased from a pharmacy;
- Diabetic education may be received from pharmacies that are authorized to perform this service; 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 In-Network Providers for this health service. We will not repair or replace lost or damaged equipment due to 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, 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, QCT Bone Densitometry, diagnostic CT Colonography, nuclear cardiology, BRCA and fetal screenings, and non-preventive diagnostic colonoscopy and diagnostic mammography performed in an Inpatient or Outpatient Facility are covered under the Inpatient or Outpatient Facility Benefit. Preventive screening mammography and screening colonoscopy services may be covered without requirement of further payment. Diagnostic tests include lab and pathology services as well as the professional services for test interpretation, x-ray reading, lab interpretation and scan reading. Diagnostic tests are covered in both an Inpatient and Outpatient setting. We cover diagnostic sleep testing and treatment (see Subsection I. Durable Medical Equipment and Supplies within Section V: What is Covered, for specifics).

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

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

Advanced Imaging Services include but are not limited to:

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

G. Dialysis

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

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

- home continuous ambulatory peritoneal dialysis (CAPD).

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

H. Doctor Visits and Services

We cover visits to an In-Network Doctor's office (including second surgical opinions), including:

- office visits to a PCP, a Specialist Physician, APRN, PA, and any other Provider(s) as defined in this Policy;
- Doctor's visits to the Covered Person's home;
- visits to an Urgent Care center for urgent but non-emergent care;
- visits to a Hospital Outpatient department;
- visits to the Emergency room;
- visits to Retail Health Clinics (walk-ins) for routine care and common illnesses;
- visits for shots needed for treatment (including allergy shots); and
- interactive telemedicine services, including online visits with the Doctor by a webcam, chat, or voice. We cover online visits and webcam, chat, or voice in place of a physical office visit, if the 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 prior authorization; or
- Doctor to Doctor discussions.

Specialist office visits include office surgeries and second surgical opinions. Physician (Doctor) includes PCP, Specialist Physician, APRN, PA, 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 Us) is a Covered Service, when:

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

To receive Benefits, durable medical equipment must be obtained from designated In-Network Providers for this Covered Service. Covered durable medical equipment, including the cost of fitting, adjustment, and repair, is listed below:

1. Hospital-type beds;
2. Bedside commode and tub rails;
3. Canes, crutches, walkers, slings, splints, cervical collars, and traction apparatus;

4. Wheelchairs and Medically Necessary wheelchair accessories and supplies;
5. Oxygen and oxygen equipment for administration, including devices and supplies for sleep treatment such as APAP, CPAP, BPAP and oral devices, oxygen concentrator, ventilator;
6. Colostomy and other related ostomy supplies, including bags, flanges, and belts; *
7. Indwelling catheters, straight catheters, and catheter bags; *
8. Respirators;
9. Jobst stockings or equivalent when prescribed by a vascular surgeon prior to or following vascular surgery;
10. The first pair of contact lenses or eyeglasses following approved cataract surgery without implant or for the treatment of accidental eye injury;
11. Prosthetic devices and components, including artificial limbs and components Medically Necessary for daily living, 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;
12. Breast prosthesis following mastectomy;
13. Nebulizers;
14. One wig per Benefit Year following chemotherapy or cancer treatment;
15. Negative pressure wound therapy devices or "wound VAC";
16. Orthotics (braces, boots, splints), other than foot orthotics;
17. Phototherapy lights; and
18. Lymphedema sleeves.

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

We cover maintenance and necessary repairs of durable medical equipment except when damage is due to neglect. We will not replace lost durable medical equipment.

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

We will consider replacement of durable medical equipment if:

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

J. Early Intervention Services

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

K. Emergency and Urgent Care Services

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

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

1. Regardless of whether the Provider furnishing the Emergency Services is an In-Network Provider with respect to the services;
2. Without the need for Our prior authorization, even if an Out-of-Network Provider provides the Emergency Services;
3. Regardless of the final diagnosis rendered to the Covered Person; and
4. If an Out-of-Network Provider provides the Emergency Services, without imposing any administrative requirement or limitation on coverage that is more restrictive than the requirements or limitations that apply to Emergency Services received from In-Network Providers.

Cost-Sharing for Emergency Services
The Deductible and Coinsurance for Emergency Services received from an Out-of-Network Provider are the same as the Deductible and Coinsurance for Emergency Services received from an In-Network Provider. Additionally, the Maximum Out-of-Pocket amount for In-Network Covered Benefits will apply to any Emergency Services received from an Out-of-Network Provider. Medically Necessary Emergency Services will be covered whether the Covered Person gets care from an In-Network or Out-of-Network Provider. Emergency care from an Out-of-Network Provider will be covered as an In-Network service.

Emergency and Urgent Care Services Within the Service Area.

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

Emergency and Urgent Care Services Outside the Service Area

- We cover Urgent Care and Emergency Services outside the Service Area if the Covered Person sustains an injury or becomes ill while temporarily away from the Service Area, which includes outside of the United States. Accordingly, Benefits for these services are limited to care required immediately and unexpectedly. In-Network Benefits do include earlier complications of pregnancy or unexpected delivery occurring outside the Service Area.
- If an Emergency or Urgent Care situation occurs when a Covered Person is temporarily outside the Service Area, please obtain care at the nearest Hospital or skilled medical Facility. The Covered Person or his/her representative is responsible for notifying Us within 24 hours, on the next working day, or as soon as he/she is physically/mentally capable of doing so.
- Benefits for continuing or follow-up treatment must be pre-arranged by Us in order to be Covered as In-Network Benefits. This is subject to all provisions of this Policy.

Notification for Emergency Services

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

L. Gender Identity / Transgender Services

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

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

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

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

1. outpatient psychotherapy and mental health services for gender dysphoria and associated co-morbid psychiatric diagnoses;

2. continuous hormone replacement therapy;
3. outpatient laboratory testing to monitor continuous hormone therapy; and
4. gender reassignment surgeries.

M. Hearing Services

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

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

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

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

N. 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 the Covered Person or Family members are trained to provide infusion therapy at home to achieve optimal health and cost effectiveness.
- "State-approved hemophilia treatment center" means a Hospital or clinic that receives federal or state Maternal and Child Health Bureau, and/or Centers for Disease Control funds to conduct comprehensive care for persons with hemophilia and other congenital bleeding disorders.

O. Home Health Care

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

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

  The following are not Covered Services:
    - homemaker services;
    - maintenance therapy;
    - food and home-delivered meals;
    - custodial care (including Outpatient custodial care);
    - respite care; and/or

    - other non-medical services.
- **Home Health Limits: Maximum of 100 visits per Benefit Year. This home health care visit limit applies to any combination of physical, occupational, speech therapy, or cardiac rehabilitation received in the home instead of any individual therapy limits. This home health care limit does not apply to home infusion therapy or home dialysis.** Physical, speech, and occupational therapy services provided as part of home care are not subject to separate visit limits for therapy services.
- **House Calls.** House calls determined to be Medically Necessary by the In-Network PCP and Us are Covered Services.
- **Remote Patient Monitoring Services**. Remote patient monitoring services are used to enhance the delivery of care in the home health setting by measuring patient vitals, medication adherence, and other condition-specific data. For additional information on telemedicine services, including remote patient monitoring, please refer to **Subsection HH. Telemedicine Services** later in this Section.

P. Hospice Services

Hospice services are Covered Services when:

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

Covered Hospice Services include:

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

Q. Hospital Services

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

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

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

We cover surgery charges when treatment is received at an: (1) Inpatient; (2) Outpatient or ambulatory surgery Facility; or (3) Physician's office. Professional Inpatient services are covered including Physician, surgical, and general nursing services. We cover Medically Necessary care in a semi-private room or intensive or special care unit. This includes:

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

We cover a private room charge if the Covered Person needs a private room because he/she has a highly contagious condition or are at greater risk of contracting an infectious disease because of the medical condition. Otherwise, Inpatient Benefits would cover the Hospital's charges for a semi-private room. If chosen to occupy a private room, the Covered Person will be responsible for paying

the daily difference between the semi-private and private room rates in addition to any Copayment and Coinsurance.

- Inpatient services and supplies furnished by a Hospital are Covered Services and require prior authorization. We reserve the right to determine whether the continuation of any Hospital admission is Medically Necessary. Special rules apply in Emergencies and for transplant services.
- The room and board and nursing care furnished by a Skilled Nursing Facility (SNF) are Covered Services when:
    - The Covered Person is confined in a bed as a patient in the Facility;
    - The attending Physician completes a treatment plan that describes the type of care that is needed; and
    - We authorize the services provided.

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

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

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;
- infusion of special medical formulas as the critical source of nutrition for a Covered Person with inborn errors of amino acid or organic acid metabolism, metabolic abnormality or severe protein or soy allergies;

- chemotherapy;
- nursing;
- durable medical equipment; and
- drugs that are delivered and administered by a health care Provider as part of a Doctor's visit, home care visit, or at an Outpatient Facility. These services include coverage of all medications administered intravenously and/or parenterally.

S. Lymphedema

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

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

T. Maternity Care

1. **Pregnancy and Childbirth.** Covered Services are:
    - pregnancy testing;
    - maternity care (see below for details);
    - maternity-related checkups;
    - breast pumps (limit of one pump per pregnancy); and
    - pre-natal and post-natal care for a female Covered Person, including a covered Dependent who becomes pregnant.

    Coverage is included for victims of rape or incest. Services related to surrogacy if the Covered Person is not the surrogate are not Covered Services.

    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;
    - Covered US Preventive Services Task Force Grades A and B recommendations for which there is **no cost-sharing for required preventive services**; and
    - 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.
- Screenings for pregnant women for asymptomatic bacteriuria, anemia, gestational diabetes, Hepatitis B, Rh incompatibility, and urinary tract or other infection.
- folic acid supplements for pregnant Covered Persons;
- expanded tobacco intervention and counseling for pregnant users;
- Inpatient and Outpatient dental, oral surgical, and orthodontic services that are Medically Necessary for the treatment of medically diagnosed cleft lip, cleft palate, or ectodermal dysplasia;
- Fetal screenings, i.e., tests for the genetic and/or chromosomal status of the fetus. The term also means anatomical, biochemical or biophysical tests, to better define the likelihood of genetic and/or chromosomal anomalies;
- Medically Necessary diagnostic genetic testing and counseling; and
- Injectables; x-ray; and laboratory services.
- 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 will be provided incorporating any changes in these Guidelines or Standards within a maximum of 6 months of the publication of these Guidelines or Standards or any official amendment to them.

2. **Elective Abortions** are not Covered Services; this limitation will not apply to an abortion performed (1) when the life of the mother is endangered by a physical disorder, physical illness, or physical injury, including a life-endangering physical condition caused by or arising from the pregnancy itself, or (2) when the pregnancy is the result of an alleged act of rape or incest.

3. **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 (10)(a) and (10)(f). Covered Services do not include any drug for: impotence; or to enhance arousal, libido, or sexual response.

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

5. **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 an In-Network Provider. Examples include:

- Hypodermic needles, syringes, surgical dressings, splints, and other equivalent 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 the Physician; and
- Prescription medications infused through IV therapy in the Physician's office or Outpatient Facility.

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

V. Medically Necessary Formula and Enteral Nutrition Products

Medically Necessary Formula and Enteral Nutrition Products means any liquid or solid formulation of formula and enteral nutrition products for Covered Persons requiring treatment for an inherited metabolic disorder and for which the Covered Person's Physician has issued a written order stating that the formula or enteral nutrition product is Medically Necessary and has been proven effective as a treatment regimen for the Covered Person and that the formula or enteral nutrition product is a critical source of nutrition as certified by the Physician by diagnosis. The Medically Necessary formula or enteral products do not need to be the Covered Person's primary source of nutrition.

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

This coverage will:

- Apply to the partial or exclusive feeding of a Covered Person by means of oral intake or enteral feeding by tube;

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

W. Mental/Behavioral Health and Substance Use Disorder Services

We will provide mental/behavioral health and substance use disorder services provided in a Hospital or treatment Facility, including a residential treatment Facility/center (RTF or RTC), 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, We require a prior authorization for any Inpatient or Outpatient mental/behavioral health and substance use disorder Facility services. 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/center (RTF or RTC), that is licensed to provide a continuous, structured program of treatment and rehabilitation, including 24 hour-a-day nursing care;
- individualized and intensive treatment includes observation and assessment by a psychiatrist at least weekly;
- rehabilitation;
- therapy;
- education; and
- recreational or social activities.

Care from a residential treatment Facility/center (RTF or RTC) 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 services in any Hospital or Inpatient Facility setting includes:

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

Mental/behavioral health or substance use disorder Outpatient care services in any Outpatient Facility or office setting includes:

- visits for medication checks; and

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

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

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

Mobile crisis response services and support and stabilization services provided in a residential crisis stabilization unit to the extent such services are covered in other settings or modalities are considered Covered Services.

Mobile crisis response services means services delivered to provide for rapid response to, assessment of, and early intervention for individuals experiencing an acute mental health crisis that are deployed at the location of the individual.

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

Diagnosis and treatment of **Autism Spectrum Disorder** of any age is a Covered Service. Physical, speech, and occupational therapy services for the treatment of Autism Spectrum Disorder are not subject to separate visit limits for therapy services.

Applied Behavioral Analysis (ABA) means the design, implementation, and evaluation of environmental modifications, using behavioral stimuli and consequences, to produce socially significant improvement in human behavior, including the use of direct observation, measurement, and functional analysis of the relationship between environment and behavior. Use of ABA as a treatment of Autism Spectrum Disorder is a Covered Service.

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

Medically Necessary, in this subsection, means in accordance with the generally accepted standards of mental disorder or condition care and clinically appropriate in terms of type, frequency, site, and duration, based upon evidence and reasonably expected to do any of the following:

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

Autism Spectrum Disorder diagnosis means Medically Necessary assessments, evaluations, or tests to diagnose whether an individual has an Autism Spectrum Disorder. Autism Spectrum Disorder treatment will be identified in a treatment plan. This includes the following care prescribed or ordered for a Covered Person diagnosed with Autism Spectrum Disorder by a licensed Physician, or a licensed psychologist who determines the care to be Medically Necessary:

- Behavioral Health Treatment;
- Pharmacy Care;
- Psychiatric Care;
- Psychological Care; and
- Therapeutic Care.

Mental Health Parity and Addiction Equity Act

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

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

X. New Technology

We regularly evaluate new and existing technologies for inclusion as a Covered Service. Confirmation that the appropriate regulatory body has assessed such new or existing technology must occur prior to approval, where required by law. To be considered Covered Services, new and

existing technologies must demonstrate a marked improvement in health outcomes, health risks, and health benefits when compared with established procedures and products based on clinical evidence reported by Peer Reviewed Medical Literature.

Y. 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 We determine are functional repairs necessary for working properly are Covered Services. This includes:

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

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

1. Medically Necessary dental services to correct 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 or biting are not Covered Services.
3. The cost of dental services and dental appliances are Covered Services only when required to diagnose or treat an accidental injury to the teeth. Repair of dental appliances damaged as a result of accidental injury to the jaw, mouth or face are Covered Services. Major adult dental care and adult orthodontia are covered as Medically Necessary as a result of an accidental injury.
4. Dental services and dental appliances furnished to a newborn or any Covered Person when required to treat medically diagnosed cleft lip, cleft palate, or ectodermal dysplasia are Covered Services.
5. Dental services to prepare the mouth for medical services and treatments such as radiation therapy to treat cancer and prepare for transplants are Covered Services, including dental x-rays, extractions, and anesthesia. Also covered is treatment of non-dental lesions, such as removal of 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 Services. 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. We cover Medically Necessary general anesthesia and Hospitalization or Outpatient Facility charges by a Facility licensed to provide Outpatient surgical procedures for dental care provided to any Covered Person who is:
    a. determined by a licensed dentist, in consultation with the treating Physician, to require general anesthesia and admission to a Hospital or Outpatient surgery Facility to provide dental care effectively and safely; and
    b. under the age of 5, or severely disabled, or has a medical condition and requires admission to a Hospital or Outpatient surgery Facility and general anesthesia for dental care.

We require prior authorization to the same extent required for other procedures or admissions. Only the services of Providers and facilities licensed to provide anesthesia services are Covered Services. Except as otherwise provided 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, We will consider whether the Covered Person's age, physical condition or mental condition requires the utilization of general anesthesia and the admission to a Hospital or Outpatient surgery Facility to provide the underlying dental care safely.

Z. Prescription Drug Services

We use a managed network of pharmacies to provide access to Prescription Drugs for every Covered Person. You will pay less if You utilize a pharmacy in the managed Network. If You fill a prescription at an Out-of-Network pharmacy, You will be required to pay 100% of the cost of the medication. Our list of Network pharmacies is available at www.pchp.net, or You may call Our customer service department at **800-400-7247 (or local at 434-947-4463)**.

We will cover each prescription under the applicable Copayment, Deductible and/or Coinsurance amount referenced in the Schedule of Benefits. Please note that certain age, gender and quantity limitations apply. Our program requires "mandatory" generic substitution if the FDA has determined the generic equivalent to the brand product. Generic drugs will be dispensed except when a Physician requires brand name drugs. In this case, You will still have to pay the difference between the brand name drug and the Generic Drug in addition to the 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 the appropriate Copayment, Deductible and/or Coinsurance amount.

Medically Necessary prescribed "legend drugs" (defined as drugs not available over the counter) incidental to Outpatient care are Covered Services. Benefits will not be denied for any Drugs that

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

Diabetic supplies to treat diabetes are covered under the Prescription Drug Benefit. This includes self-injectable insulin and related supplies and equipment.

Flu shots are covered under the Prescription Drug Benefit, including administration.

Special food products or supplements are covered under the Prescription Drug Benefit, when prescribed by a doctor if Medically Necessary.

Some specialty medications may qualify for third party Copayment assistance programs, which could lower the Out-of-Pocket costs for those drugs. Under these programs, We will apply the dollar amount of the drug discount coupon toward the Deductible (where applicable) and Maximum Out-of-Pocket.

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

Any claim submitted by a Covered Person 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 to be covered under this Policy.

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

Medication Synchronization: We will permit and apply a prorated daily cost-sharing rate to prescriptions that are dispensed by a Network pharmacy for a partial supply if the Covered Person requests or agrees to a partial supply to synchronize their medication, and the prescribing Provider

or the pharmacist determines the fill or refill to be in their best interest. We will allow a pharmacy to override any denial codes indicating that a prescription is being refilled too soon for the purposes of synchronizing the medications. Dispensing fees for partially filled or refilled prescriptions will be paid in full for each prescription dispensed, regardless of any prorated Copayment or fee paid for synchronization services.

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

We and Our PBM ensure that Our step therapy protocols:

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

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

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

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

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

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

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

Formulary: The Prescription Drug coverage is limited to only those drugs listed on Our formulary. Our formulary is reviewed at least annually by a pharmacy & therapeutics committee of Our Pharmacy Benefit Manager (PBM) as required by state and federal laws and regulations. Most Prescription Drugs are listed on this formulary, however, certain Prescription Drugs with clinically equivalent alternatives may be excluded. We may add or delete Prescription Drugs from the formulary from time to time. A description of the formulary is available upon request by calling Our customer service department at **800-400-7247 (or local at 434-947-4463)** and at **pchp.net/marketplace/prescription-drug-formulary**.

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

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

An Exceptions Request Form is available online at pchp.net/member-forms-marketplace. Forms may be faxed to CVS/Caremark at 1-855-245-2134. Exception requests may also be communicated by phone to CVS/Caremark at 1-855-582-2022. Please note that this exception process only applies to drugs not included on the formulary. If a Covered Person has been denied coverage for a drug included on the formulary, You have the right to a full and fair appeal of Our decision and should follow the appeal process described later in the Policy.

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

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

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

There are two exceptions to the formulary requirement:

1. Coverage may be obtained without additional cost-sharing beyond that which is required of formulary Prescription Drugs for a non-formulary drug if We determine, after consulting with the prescribing Physician, the formulary drugs are inappropriate therapy for the condition.
2. Coverage may be obtained without additional cost-sharing beyond that which is required of formulary Prescription Drugs for a non-formulary drug if:
    - the Covered Person has been taking or using the non-formulary Prescription Drug for at least six months prior to its exclusion from the formulary; and
    - The prescribing Physician determines that either the formulary drugs are inappropriate therapy for the condition, or that changing drug therapy presents a significant health risk.

We also cover Prescription Drugs and devices approved by the FDA for use as contraceptives. This includes coverage for office visits associated with contraceptive management. Coverage is also provided for up to a 12-month supply of FDA-approved, self-administered hormonal contraceptives, when dispensed or furnished at one time for a Covered Person by a Provider or pharmacy, or at a location licensed or otherwise authorized to dispense drugs or supplies.

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

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

Benefits are provided for prescriptions filled at a pharmacy that is an Out-of-Network Provider if that pharmacy or its intermediary agrees in writing to accept the same reimbursement terms as a pharmacy that is an In-Network Provider.

We do not provide coverage for any of the following:

1. Any legend drug prescribed prior to Your joining this plan. However, You may get a new prescription after enrolling with Piedmont and receive coverage for conditions not excluded under this Policy;
2. Over the counter drugs, unless recommended by the US Preventive Services Task Force and prescribed by a Physician;
3. Drugs prescribed primarily for a cosmetic purpose, including but not limited to: (1) Retin-A, when used for any purpose other than treatment for severe acne; and (2) minoxidil, when used to treat baldness;
4. Drugs and medications for conditions excluded under this Policy;
5. Injectable Prescription Drugs that are supplied by a Provider other than a pharmacy that is not an In-Network Provider;
6. Charges to inject or administer drugs;
7. Drugs and medications that are: (1) Experimental; (2) Investigational, or (3) not approved by the FDA for the purpose prescribed (except for Drugs that have been approved by the FDA to treat (i) cancer because the Drug has not been approved by the FDA for that specific type of cancer for which the Drug has been prescribed, or (ii) a covered indication if the Drug has been approved by the FDA for at least one indication, if the Drug is recognized in standard reference compendia as safe and effective for treatment of that specific type of cancer, or that covered indication, respectively.);
8. DESI drugs (i.e., drugs which are of questionable therapeutic value as designated by the FDA's Federal Drug Efficacy Study);
9. Any refill dispensed after one year from the date of the original prescription order;

10. Medicine covered by workers' compensation, Occupational Disease Law, state or government agencies;
11. Any other drug not on Piedmont's formulary deemed not Medically Necessary by Piedmont;
12. Infertility drugs; and
13. 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.
We require additional Copayments, Deductibles and/or Coinsurance amounts and authorization for quantities exceeding unit supply limits. 75% of the prescription must be used before ordering refills. In addition to filling the prescription at the pharmacy, maintenance medications may be purchased through the mail order Benefit. This allows the Covered Person 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.
To receive maintenance medication by mail:

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

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

AA. Preventive Care Services

We cover 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 the Covered Person receives them from an In-Network Physician or other In-Network Provider:

1. Evidenced-based items or services that have in effect a rating of "A" or "B" in the current recommendations of the US Preventive Services Task Force. Examples include screenings for breast cancer, cervical cancer, COVID-19, 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 stop smoking or reduce dependence on tobacco products. This includes smoking cessation products and over the counter nicotine replacement products (limited to nicotine patches and gum) when obtained with a prescription. This also covers aspirin use to prevent cardiovascular disease.
4. With respect to infants, children, and adolescents, preventive care and screenings provided for in the comprehensive guidelines supported by the Health Resources and Services Administration and have a rating of "A" or "B" from the U.S. Preventive Services Task Force. Examples include assessments for alcohol and drug use, behavioral, oral health risk, medical history, BMI measurements, screenings for autism (18 and 24 months), anxiety, 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 aged 50 and over, and persons aged 40 and over who are at high risk for prostate cancer. PSA testing means the analysis of a blood sample to determine the level of prostate specific antigen.
7. One screening mammogram for Covered Person between the ages of 35 to 39; a screening mammogram each year for Covered Person aged 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. Preventive colonoscopy including follow-up colonoscopies following a positive non-invasive stool-based screening test. Benefit also includes polyp removal during or anesthesia provided in connection with a preventive screening colonoscopy.

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 FDA approved contraceptive methods, sterilization procedures/treatments, and patient education and counseling for all women with reproductive capacity are covered at 100% as a preventive care service, including drugs, injectables, patches, rings and devices such as diaphragms, IUDs, and implants. The frequency is as prescribed. We will cover pharmacy prescription generic oral contraceptives and those brands which do not have generic equivalents at 100% as a preventive care service through Our Network retail pharmacies or mail order. Brand contraceptives with a generic equivalent will be covered subject to the appropriate plan Prescription Drug Copayment. Over-the-counter contraceptives are not covered. Medical/surgical type contraceptives/sterilizations (office/Facility based medical and surgical) will be covered at 100% as a preventive care service. Our standard medical management, Network, and formulary restrictions apply. Coverage is also provided for up to a 12-month supply of FDA-approved, self-administered hormonal contraceptives, when dispensed or furnished at one time for a Covered Person by a Provider or pharmacy, or at a location licensed or otherwise authorized to dispense drugs or supplies.
    g) Breastfeeding Support, Supplies, and Counseling: Comprehensive lactation support and counseling, by a trained Provider during pregnancy and/or in the postpartum

period, and costs for renting breastfeeding equipment are covered at 100% as a preventive care service. **Benefits for breast pumps are limited to one pump per pregnancy**. Frequency is in conjunction with each birth. Our standard medical management and Network restrictions apply.

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

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

https://www.healthcare.gov/coverage/preventive-care-benefits/

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

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

https://www.hrsa.gov/womens-guidelines/index.html

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

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

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

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

BB. 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.

CC. Radiation Therapy

Radiation therapy and its administration, including rental or cost of radioactive materials

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

Standard of clinical evidence for decisions on coverage for proton radiation therapy:
"Proton radiation therapy" means the advanced form of radiation therapy treatment that utilizes protons as an alternative radiation delivery method for the treatment of tumors.

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

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

DD. Reconstructive Surgery

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

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

EE. Rehabilitative and Habilitative Services

Habilitative services include coverage for health care services that help a person keep, learn, or improve skills and functioning needed for daily living, such as therapy for a Child who is not walking at the expected age. Rehabilitative services include coverage for therapies to restore and in some

cases, maintain, capabilities lost due to: disease; illness; injury; or in the case of speech therapy, due to congenital anomaly or prior medical treatment.

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

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 the Covered Person after a cardiac event (heart problem). Benefits do not include home programs (other than home health care services), on-going conditioning, or maintenance care. Rehabilitative services must involve setting goals attainable in a reasonable period of time.
2. Rehabilitative physical therapy is covered. This is treatment provided by a licensed therapist by physical means to relieve or ease pain, restore health, and prevent disability after an illness, injury, or loss of an arm or leg, including hydrotherapy, heat, physical agents, bio-mechanical and neuro-physiological principles and devices, as well as treatment of lymphedema. Services must involve setting goals attainable in a reasonable period of time.
3. Rehabilitative occupational therapy is covered. This is treatment 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.
4. Habilitative physical/occupational therapy is covered. This is treatment provided by a licensed therapist to keep, learn, or improve skills needed for daily living, such as therapy for a child who is not walking at the expected age.

Regarding item numbers 2 through 4 above, rehabilitative physical and occupational therapy is limited to 30 visits per Benefit Year combined and habilitative physical and occupational therapy is limited to 30 visits per Benefit Year combined.

5. Respiratory therapy is covered. This includes:
    - introduction into the lungs of dry or moist gases;
    - non-pressurized inhalation treatment;
    - intermittent positive pressure breathing treatment, air or oxygen, with or without nebulized medication, CPAP; CNP;
    - chest percussion;
    - therapeutic use of medical gases or aerosol drugs;
    - equipment such as resuscitators, oxygen tents, and incentive spirometers; and
    - bronchopulmonary drainage and breathing exercises, to treat illness or injury.
6. Pulmonary rehabilitation is covered and includes Outpatient short- term respiratory care to restore the Covered Person's health after an illness or injury. Services must involve setting goals attainable in a reasonable period of time.

7. Rehabilitative Speech therapy and speech-language pathology (SLP) is covered. This 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. Services must involve setting goals attainable in a reasonable period of time.
8. Habilitative Speech therapy and speech-language pathology (SLP) is covered. This includes services necessary to teach speech and therapy to develop communication or swallowing skills to correct a speech impairment. Therapy to keep, learn or improve skills needed for daily living, such as therapy for a child who is not talking at the expected age.

Regarding item numbers 7 and 8 above, rehabilitative speech therapy is limited to 30 visits per Benefit Year, and habilitative speech therapy is limited to 30 visits per Benefit Year.

9. Rehabilitative 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. Services must involve setting goals attainable in a reasonable period of time. Benefits will end when the progress toward the goal ends.
10. Habilitative 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 the Covered Person keep or improve skills and functioning for daily living and includes services for people with disabilities in an Inpatient or Outpatient setting.

Regarding items numbers 9 and 10 above, rehabilitative, chiropractic, osteopathic, or manipulation therapy is limited to 30 visits per Benefit Year, and habilitative chiropractic, osteopathic, or manipulation therapy is limited to 30 visits per Benefit Year.

FF. Services from Out-of-Network Providers

We do not anticipate a need for You to utilize Providers other than In-Network Providers except in Emergencies and Urgent Care situations, unless the Covered Person has obtained a prior authorization from Us. In the event a Covered Person that has obtained a prior authorization from Us receives Covered Services from an Out-of-Network Provider, We reserve the right to pay the Allowable Charge, less amounts You must pay under this Policy, for these Covered Services:

- directly to the Covered Person;
- the Out-of-Network Provider; or
- any other person responsible for paying the Out-of-Network Provider's charge. This is subject to applicable 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 Out-of-Network Provider and Our payment to either You or the

Provider, otherwise known as Balance Billing. It is Your responsibility to apply any payment You receive directly from Us to the Out-of-Network Provider's claim.

Certain services, such as Emergencies, or receiving nonemergency surgical or ancillary services provided by an Out-of-Network Provider at an In-Network Facility, are exempt from Balance Billing. For more information on the services that You cannot be Balanced Billed for, please see Section IV (F).

GG. Skilled Nursing Facility

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

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

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

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

HH. Spinal Manipulation and Other Manual Medical Interventions

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

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

II. Surgery

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

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

JJ. Telemedicine Services

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

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

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

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

KK. TMJ Diagnostic and Surgical Procedures

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).

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.

LL. Transplants

We cover Medically Necessary human organ, tissue, and bone marrow/stem cell transplants and infusions when provided as part of: Physician services; Inpatient Facility services; or Outpatient Facility services. This includes autologous bone marrow transplants for breast cancer. We will provide Benefits for such Medically Necessary transplant services only when a prior authorization has been obtained from Us for those services. We will also cover complications from the donor procedure for up to six weeks from the date of procurement. Benefits include coverage for necessary acquisition procedures, mobilization, harvest, and storage, and include Medically Necessary preparatory myeloablative therapy, reduced intensity preparatory chemotherapy, radiation therapy, or a combination of these therapies.

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

Individuals who are a candidate to receive an anatomical gift for organ, eye, or tissue transplantation and who would otherwise be eligible to receive such a gift will not be deemed ineligible by Us to receive the anatomical gift, and We will not deny services related to organ, eye, or tissue transplantation solely because of his or her physical, intellectual, developmental, or other disability.

Regarding coverage for services related to organ, eye, or tissue transplantation, including referral to a transplant center or specialist, inclusion on an organ, eye, or tissue transplantation waiting list, evaluation, surgery and related health care services, counseling, and post-transplantation treatment and services, We will not:

- deny coverage to a Covered Person solely based on the person's disability;
- deny a person eligibility or continued eligibility to enroll or to renew coverage under the Policy, contract, or plan for the purpose of avoiding the nondiscrimination requirement;
- penalize a health care Provider, reduce or limit the reimbursement of a health care Provider, or provide monetary or nonmonetary incentives to a health care Provider to induce such health care Provider to act in a manner inconsistent with nondiscrimination requirement; or
- reduce or limit coverage for services related to organ, eye, or tissue transplantation, including referral to a transplant center or specialist, inclusion on an organ, eye, or tissue transplantation waiting list, evaluation, surgery and related health care services, counseling, and post-transplantation treatment and services.

When a human organ or tissue transplant is provided from a living donor to a Covered Person, both the recipient and the donor may receive Benefits. When a living donor who is not a Covered Person provides a human organ or tissue transplant to a Covered Person, the donor may receive Benefits of the health plan limited to those not available to the donor from any other source. This includes, but is not limited to, other health insurance, grants, foundations, or other government programs. 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 to any Covered Person who is donating the organ to someone who is not a Covered Person on this Policy.

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

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

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

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

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

MM. Vision Benefits

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

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

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

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

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

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

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

SECTION VI: What is Not Covered (Exclusions)

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

1. **Abdominoplasty**, panniculectomy, abdominal sculpture, tummy tucks, abdomendermatolipectomy, 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, except for covered telemedicine services.
6. **Affiliated Providers**: Services received from a dental or medical department maintained by or on behalf of an employer, mutual benefit association, labor union, trust, academic institution, or similar person or group.
7. **After Hours or Holidays Charges**: Additional charges beyond the Maximum Allowed Amount for basic and primary services for services requested after normal Provider service hours or on holidays.
8. **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, Bio-Energetical Synchronization Technique (BEST); iridology – study of the iris; Auditory Integration Therapy (AIT); colonic irrigation; magnetic innervation therapy; electromagnetic therapy; holistic medicine; homeopathic medicine; aroma therapy; Reiki therapy; massage and massage therapy; herbal, vitamin, or dietary products or therapies.
9. **Ambulance**: Usage is not covered when another type of transportation can be used without endangering the Covered Person's health. Any ambulance usage for the convenience of the Covered Person, Family, or Physician is not a Covered Service. Non-Covered Services for Ambulance include but are not limited to, trips to a Physician's office or clinic, or to a morgue

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

10. **Breast reductions**, unless related to surgical interventions following a mastectomy.
11. **Charges** more than any Benefit limitations (e.g., number of days, etc.) and amounts above the Allowable Charge for a service.
12. **Charges Not Supported by Medical Records**: Charges for services not described in the Covered Person's medical records.
13. **Clinical Trials**: We do not provide Benefits for procedures, equipment, services, supplies or charges for the following:
    - The Investigational item, device, or service; or
    - Items and services that given only to satisfy data collection and analysis needs and that are not used in the direct clinical management of the patient; or
    - A service that is clearly inconsistent with widely accepted and established standards of care for a particular diagnosis; or
    - Any item or service that is paid for, or should have been paid for, by the sponsor of the trial.

    Covered Services for clinical trials can be found under Section V, D. Clinical Trials for Life-Threatening Diseases/Conditions.
14. **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.
15. **Supplies and devices for comfort or convenience only** (e.g., radio, television, telephone, and guest meals); and private rooms, unless a private room is Medically Necessary and a prior authorization has been provided by Us during Inpatient Hospitalization or Inpatient stay at a skilled nursing Facility.
16. **Non-prescription and Over-the-counter contraception** methods and devices.
17. **Reconstructive or Cosmetic surgery, services, procedures, treatments, Prescription Drugs, equipment, or supplies** given for cosmetic services. This includes any service or supply that is a direct result of a non-Covered Service. Cosmetic surgeries, procedures, or services are performed to preserve, or change how the Covered Person looks, including but not limited to: body piercing; tattooing; or removal of tattoos. No Benefits are available for surgery or treatments to change the texture or look of the Covered Person's skin or to change the size, shape or look of facial or body features (such as the Covered Person's nose, eyes, ears, cheeks, chin, chest, or breasts). However, this Exclusion does not apply to: (1) a surgery or procedure to correct deformity caused by disease, trauma, or a previous therapeutic process; (2) surgeries or procedures to correct congenital abnormalities that cause functional impairment, including newborn congenital abnormalities; and (3) reconstructive breast surgery due to a mastectomy. Botox, collagen, and other filler substances are not covered.

18. **Counseling Services**: Counseling Services and treatment related to religious counseling, marital/relationship counseling, vocational or employment counseling, and sex therapy.
19. **Court Ordered Testing**: Court ordered testing or care unless Medically Necessary.
20. **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.
21. **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, prosthodontic care, or orthodontic care (except for Medically Necessary orthodontic care in cases of accidental injury or for cleft lip, cleft palate, or ectodermal dysplasia);
    - Shortening of the mandible or maxillae for cosmetic purposes;
    - Diagnosis or treatment of natural disease processes of the teeth or surrounding tissue; or
    - Restorative services and supplies necessary to promptly repair, remove, or replace sound natural teeth; including the extraction of wisdom teeth unless impacted.
22. **Donor Benefits** are not available if the Covered Person is donating an organ to a non-covered individual. When the donor is a non-covered individual and the person receiving the organ is covered, the donor may receive Benefits of the health plan, limited to Benefits that are not available to the donor from any other source.
23. **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.
24. **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.
25. **Educational, Vocational, or Self-Training Services** or supplies, classes, programs, and support groups.
26. Services for injuries or diseases related in any way to **employment**, when:

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

This exclusion applies whether or not You have waived Your rights to payment for the services available; or did not comply with procedures set out by the employer to receive these Benefits. It also applies if the employer (or employer's insurance company or group self-insurance association) reaches any settlement with You for an injury or disease related in any way to employment.

27. **Examinations**:
    - Required specifically for:
        - insurance;
        - employment;
        - school;
        - sports;
        - camp;
        - licensing;
        - adoption;
        - marriage;
    - Ordered by a third party;
    - Ordered by a court, including court-ordered care; or
    - Relating to research screenings.
28. **Experimental/Investigational Drugs, Items, Devices, Services, or Procedures**, and their complications, except for clinical trial costs required to be covered under law.
29. **Eye Exercises**, such as orthoptics and vision training/vision therapy.
30. **Eyeglasses and Contact Lenses for Adults**, except after a covered eye surgery or accidental eye injury.
31. **Eye surgery**, including services for radial keratotomy and other surgical procedures to correct refractive defects; Laser-Assisted In Situ Keratomileusis (LASIK) procedures.
32. **Family Planning Services:** The following are excluded:
    - Assisted reproductive technologies (ART) and related diagnostic tests and drugs, including artificial insemination, in vitro fertilization, zygote intrafallopian transfer (ZIFT), or gamete intrafallopian transfer (GIFT), or any other types of artificial or surgical means of conception including any drugs administered in connection with these procedures;
    - Drugs used to treat infertility;
    - Surrogate pregnancy expenses when the person is not covered under this plan;
    - Reversals of voluntarily induced sterilization and complications incidental to such procedures; or
    - Paternity testing.
33. **Foot care** (palliative or cosmetic), including:
    - cleaning and preventive foot care when there is no illness or injury to the foot;
    - surgical treatment of flat foot conditions;
    - subluxations of the foot;

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

34. **Free Care**, including services the Covered Person would not have to pay for if not covered by this plan, such as government programs, services received in jail or prison, services from free clinics, and Workers Compensation Benefits.
    - Care for military service-connected disabilities and conditions for which the Covered Person is legally entitled to health services and for which facilities are reasonably accessible.
35. **General**: 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.
36. **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.
37. **Government Coverage**: To the extent that they are provided as benefits by any governmental unit, unless otherwise required by law or regulation.
38. **Group speech therapy**.
39. Medication and surgical procedures to treat or manage **Gynecomastia**.

40. 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.
41. **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.
42. **Hearing aids** or the **examination** to prescribe or fit hearing aids, except as otherwise provided in the Policy under Hearing Services.
43. **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.
44. **Hyperhidrosis**: For treatment of hyperhidrosis (excessive sweating).
45. **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.
46. 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.
47. **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.
48. **Long-Term/Custodial Nursing Home care**.
49. Services and supplies deemed **not Medically Necessary**.
50. **Medical equipment, appliances, devices and supplies** that have both a therapeutic and non-therapeutic use. These include:
    - elastic or leather braces or supports;
    - corsets, or articles of clothing (unless required to recover from surgery or injury);
    - batteries (except for battery for a powered wheelchair) and battery chargers;
    - mattress or mattress covers;
    - other special supplies, appliances, and equipment such as office chairs, sun or heat lamps;
    - rental or purchase of Transcutaneous Electrical Nerve Stimulation (TENS) units;
    - orthotic shoe inserts;
    - personal hygiene, comfort, and convenience items including but not limited to grab/tub bars, tub benches, telephone, television, guest meals and accommodations, take home medications, and supplies;
    - 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 fitting a non-covered device or supply is not covered.

51. Charges for **Missed** or **Canceled Appointments**.
52. Services for which there is **no financial responsibility**. We will not pay for, or reimburse, the cost of any Covered Service for which the Covered Person is not financially liable. Examples include:
    - charges for complimentary health screenings;
    - charges for Covered Services provided by an immediate Family member; and
    - charges incurred 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).
53. 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.
54. **Over-the-counter convenience and hygienic items**.
55. **Paternity testing**: Your coverage does not include Benefits for paternity testing.
56. **Penile implants** and related services.
57. **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.
58. **Physician Stand-by Charges**: For stand-by charges of a Physician.
59. **Physician/Other Practitioners' Charges**: Physician/Other Practitioners' Charges including:
    - Physician or other practitioners' charges for consulting with the Covered Person by telephone, facsimile machine, electronic mail systems or other consultation or medical management service not involving direct (face-to-face) care with the patient. This does not include In-Network telemedicine services with interactive virtual visits.
    - Surcharges for furnishing and/or receiving medical records and reports.
    - Charges for doing research with Providers not directly responsible for the Covered Person's care.

- Charges that are not documented in Provider records.
- Charges from an outside laboratory or shop for services in connection with an order involving devices (e.g., prosthetics, orthotics) which are manufactured by that laboratory or shop, but which are designed to be fitted and adjusted by the attending Physician.
- For membership, administrative, or access fees charged by Physicians or other Providers. Examples of administrative fees include, but are not limited to, fees charged for educational brochures or calling a patient to provide their test results.

60. **Prescription Drugs**: The Prescription Drug Benefits do not cover the following:
    - Administration charges for the administration of any drug except for covered immunizations as approved by Us or the Pharmacy Benefits Manger (PBM).
    - Certain Prescription Drugs may not be covered if a clinically equivalent drug could be used, unless required by law. "Clinically equivalent" means drugs that for most patients, will give equivalent results for a disease or condition. If the Covered Person or the Doctor believes the Covered Person needs to use a different Prescription Drug, please have the Doctor or pharmacist contact 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 Us.
    - Non-formulary drugs, except in certain circumstances described in coverage documents.
    - Compound drugs are not covered unless there is at least one ingredient that the Covered Person needs a prescription for, and the drug is not essentially a copy of a commercially available drug product.
    - Drugs given to the Covered Person or prescribed in a way that is against approved medical and professional standards of practice.
    - Charges for delivery of Prescription Drugs.
    - Drugs taken at the time and place where they are given or where the prescription order is issued. This includes samples given by a Doctor. This exclusion does not apply to drugs used with a diagnostic service, Drugs given during chemotherapy as described in the "Chemotherapy" Section, or drugs covered under the "Medical and Surgical Supplies and Medications" Benefit – they are Covered Services.
    - Drugs that do not need a prescription by federal law (including drugs that need a prescription by State law, but not by federal law), except for injectable insulin. This exclusion does not apply to over-the-counter drugs that We must cover under federal law when recommended by the U.S. Preventive Services Task Force and prescribed by a Physician.
    - Drugs which are over any quantity or age limits set by the plan.
    - Drugs in amounts over the quantity prescribed, or for any refill given more than one year after the date of the original prescription order.
    - Items Covered as durable medical equipment (DME) - Therapeutic DME, devices and supplies except peak flow meters, spacers, and blood glucose monitors.
    - Refills of lost or stolen drugs.

- Prescription drugs dispensed by any mail service program other than Our PBM's Home Delivery Mail Service unless We must cover them by law.
- Drugs not approved by the FDA.
- Off label use, unless We must cover the use by law or if We, or the PBM, approve it.
- Drugs for Onychomycosis (toenail fungus) except when We allow it to treat individuals who are immuno-compromised or diabetic.
- Drugs, devices and products, or legend drugs with over-the-counter equivalents and any drugs, devices or products that are therapeutically comparable to an over-the-counter drug, device, or product. This includes prescription legend drugs when any version or strength becomes available over the counter.
- Drugs to treat sexual or erectile problems.
- Any drug mainly used for weight loss.
- Drugs used for cosmetic purposes.
- Prescription drugs used to treat infertility.
- Charges for services not described in the Covered Person's medical records.
- Services We conclude are not Medically Necessary. This includes services that do not meet Our medical policy, clinical coverage, or Benefit policy guidelines.
- Nutritional and/or dietary supplements, except as described in this Policy or that We must cover by law. This exclusion includes, but is not limited to, nutritional formulas and dietary supplements that the Covered Person can buy over the counter and those the Covered Person can get without a written prescription or from a licensed pharmacist.
- 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, brother/stepbrother, sister/stepsister, parent/stepparent, in-law, or self.

61. **Private duty nursing** in an Inpatient setting.
62. **Prophylactic mastectomy**, which means the removal of a breast for a Covered Person who: (a) has not been diagnosed with breast cancer or another life- threatening condition that necessitates the removal; or (b) is not at high risk of developing breast cancer or another life-threatening condition if the breast is not removed. We determine "high risk" in accordance with generally accepted standards of medical practice.
63. **Prosthetics for Sports or Cosmetic Purposes**, including wigs and scalp hair prosthetics, except for wigs needed after cancer treatment.
64. Non-covered **Providers**, including massage therapists and physical therapist technicians.
65. **Residential Accommodations**: Residential accommodations to treat medical or behavioral health conditions, except when provided in a Hospital, Hospice, Skilled Nursing Facility, or residential treatment center. This Exclusion includes procedures, equipment, services, supplies, or charges for the following:

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

66. **Residential Care/Residential Treatment Centers**: Coverage does not include Benefits for rest cures, custodial, residential, or domiciliary care and services. Whether care is considered residential will be determined based on factors such as whether the Covered Person receives active 24-hour skilled professional nursing care, daily Physician visits, daily assessments, and structured therapeutic services. A residential treatment center must qualify as a substance use disorder center providing a continuous, structured, 24 hour a day program of drug or alcohol treatment and rehabilitation including 24 hour a day nursing care.
67. **Services or supplies** if they are:
    - Ordered by a Physician whose services are not covered;
    - Not prescribed, performed, or directed by a Provider licensed to do so;
    - Received before the effective date of coverage or after a Covered Person's coverage ends;
    - Travel, whether or not recommended by a Physician, except the limited transportation/lodging costs as stated under Section V, JJ. Transplants in this booklet;
    - Prescribed, ordered, referred by or given by an immediate Family member; rendered by a Provider that is a member of the Covered Person's immediate Family;
    - Services for which a charge is not usually made; or
    - Any types of health services, supplies, or treatments not specifically provided in this Policy. The term "services" as used in this Exclusions Section includes supplies or medical items.
68. **Sexual Dysfunction Treatment**: including services, supplies or drugs for male or female sexual problems. Drugs to treat sexual or erectile problems.
69. **Shock Wave Treatment**: Extracorporeal Shock Wave Treatment for plantar fasciitis and other musculoskeletal conditions.
70. **Skilled nursing Facility stays** are not covered when the skilled nursing Facility is used for care of the aged, custodial or domiciliary care, a place for rest, educational, or similar services; a private room is not covered unless Medically Necessary.
71. **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.

72. Services related to **surrogacy** if the Covered Person is not the surrogate.
73. Non-interactive **telemedicine services**, such as audio-only telephone conversations, electronic mail message or fax transmissions.
74. **Therapy – Other**: We do not provide Benefits for procedures, equipment, services, supplies or charges for the following:
    - gastric electrical stimulation;
    - hippotherapy;
    - intestinal rehabilitation therapy;
    - prolotherapy;
    - recreational therapy, except as provided in a residential treatment Facility; or
    - sensory integration therapy (SIT).
75. **Temporomandibular Joint (TMJ) Disorder Device**, appliances for TMJ pain dysfunction that reposition the teeth, fillings, or prosthetics. Covered services do not include fixed or removable appliance that involve movement or repositioning of the teeth repair of teeth (fillings) or prosthetics (crown, bridges, dentures), oral hygiene instructions, repair or replacement of lost/broken appliances are not a Covered Benefit, material(s) and the procedures used to prepare and place material(s) in the canals (root), root canal obstruction, internal root repair of perforation defects, incomplete endodontic, treatment and bleaching of discolored teeth.
76. **Transplant: Human Organ and Bone Marrow/Stem Cell/Cord Blood Exclusions**: Non-Covered Services for transportation and lodging include, but are not limited to:
    - Childcare;
    - meals;
    - mileage within the medical transplant Facility city;
    - rental cars, buses, taxis, or shuttle service, except as specifically approved by Us;
    - frequent flyer miles;
    - coupons, vouchers, or travel tickets;
    - prepayments or deposits;
    - services for a condition that is not directly related, or a direct result, of the transplant;
    - telephone calls;

- laundry;
- postage;
- entertainment;
- travel expenses for donor companion/caregiver (except for caregiver under age 18); and
- return visits for the donor for a treatment of a condition found during the evaluation.

77. **Treatment of varicose veins or telangiectatic dermal veins (spider veins)** when services are rendered for cosmetic purposes.
78. **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.
79. **Pediatric Vision Care**: Vision care services do not include services incurred for or in connection with any of the items below:
    - Vision care for a Covered Person aged 19 and older, unless covered by the medical Benefits of this Policy.
    - For any condition, disease, defect, ailment, or injury arising out of and in the course of employment if benefits are available under the Workers' Compensation Act or any similar law. This exclusion applies if a Covered Person receives the benefits in whole or in part. This exclusion also applies whether or not the Subscriber or Dependent claims the benefits or compensation. It also applies whether or not the Covered Person recovers from any third party.
    - To the extent that they are provided as benefits by any governmental unit, unless otherwise required by law or regulation.
    - For which, the Subscriber 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 Subscriber's immediate Family, including the Subscriber'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 canceled 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 Policy.
    - Lost or broken lenses or frames, unless the Covered Person has reached their normal interval for service when seeking replacements.
    - For services or supplies not specifically listed in this Policy.

- Cosmetic lenses or options, such as special lens coatings or non-prescription lenses, unless specifically listed in this Policy.
- 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.

80. **Vision Orthoptic Training**: For vision orthoptic training. This exclusion does not apply to any Covered Person through the end of the month in which he or she turns age 19.
81. **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.
82. **Weight loss** programs, whether or not under medical supervision, except as stated as covered, including:
    - commercial weight loss and fasting programs;
    - bariatric surgery, including laparoscopic gastric bypass or other gastric bypass surgery, gastroplasty, or gastric banding procedures; or
    - drugs used mainly for weight loss.

SECTION VII: Eligibility and Coordination of Benefits

A. Eligibility

The Benefits, terms, and conditions of this Policy apply to individuals who are determined by the Exchange to be Qualified Individuals for purposes of enrollment in a Qualified Health Plan (QHP).

Subscriber Eligibility

To be eligible for membership as a Subscriber under this Policy, You must:

1. Be determined by the Exchange to be a Qualified Individual for enrollment in a QHP;
2. Be a United States citizen or national; or
3. Be a lawfully present non-citizen for the entire period for which coverage is sought; and
4. Be a resident of the State of Virginia and meet the following applicable residency standards:
    a. For a Qualified Individual aged 21 and over, You must:
        - Not be living in an institution;
        - Be capable of indicating intent;
        - Not be receiving optional State Supplementary Payments (SSP); and
        - Reside in the Service Area applicable to this Policy.
    b. For a Qualified Individual under age 21, You must:
        - Not be living in an institution;
        - Not be emancipated;
        - Not be receiving optional State Supplementary Payments (SSP); and
        - Reside in the Service Area applicable to this Policy.
5. Reveal any coordination of benefits arrangements or other health benefit arrangements for the Covered Person as they become effective;
6. Not be incarcerated (except pending disposition of charges);
7. Not be entitled to or enrolled in Medicare Parts A/B and/or D.

Dependent Eligibility

To be eligible for coverage to enroll as a Dependent, they must be listed on the enrollment form completed by the Subscriber, be determined by the Exchange to be a Qualified Individual, meet all Dependent eligibility criteria established by the Exchange and be:

1. Your legal spouse.
2. Your Domestic Partner – "Domestic Partner" or "Domestic Partnership" means a person of the same or opposite sex for whom all of the following are true: he or she is Your sole Domestic Partner and has been for 12 months or more; he or she is mentally competent; neither You nor the Domestic Partner is related in any way (including by adoption or blood) that would prohibit him or her from being married under state law; he or she is not married to or separated from anyone else; and he or she is financially interdependent on You.
    a. For purposes of this Policy, a Domestic Partner will be treated the same as a spouse, and a Domestic Partner's Child, adopted Child, or Child for whom a Domestic Partner has legal guardianship will be treated the same as any other Child.
    b. Domestic Partner's or a Domestic Partner's Child's Coverage ends at the end of the month of the date of dissolution of the Domestic Partnership.

c. To apply for coverage as Domestic Partners, both You and the eligible Domestic Partner are required to complete and sign an Enrollment Application, meet all criteria stated on the Enrollment Application and submit the Enrollment Application to the Exchange. The Exchange will make the ultimate decision in determining eligibility of the Domestic Partner.

3. Your or Your spouse's Children, including stepchildren, newborn, foster Children, and legally adopted Children, including Children placed for adoption, who are under age 26.
4. Children for whom You or Your spouse is a legal guardian and who are under age 26.

Eligibility will be continued past the age limit only for those already enrolled Dependents who cannot work to support themselves by reason of intellectual or physical disability. These Dependents must be allowed as a federal tax exemption by You or Your spouse. The Dependent's disability must start before the end of the period he or she would become ineligible for coverage. The Exchange must certify the Dependent's eligibility. The Exchange must be informed of the Dependent's eligibility for continuation of coverage within 60 days after the date the Dependent would normally become ineligible. You must notify the Exchange if the Dependent's tax exemption status changes and if he or she is no longer eligible for continued coverage.

The Exchange may require You to submit proof of continued eligibility for any Dependent. Your failure to provide this information could result in termination of a Dependent's coverage.

Temporary custody is not sufficient to establish eligibility under this Policy.

Newborn and Adopted Child Coverage
Your or Your spouse's newborn Children will be covered for an initial period of 31 days from the date of birth. To continue coverage beyond the first 31 days, please contact the Exchange within 60 days of the date of birth to add the Child to Your Policy and You must pay for any additional Premium due on a timely basis.

A Child will be considered adopted from the earlier of: (1) the moment of placement for adoption; or (2) the date of an entry of an order granting custody of the Child to You. The Child will continue to be considered adopted unless the Child is removed from Your home prior to issuance of a legal decree of adoption. Please contact the Exchange within 60 days of the placement for adoption or date of adoption to add the Child to Your Policy and You must pay for any additional Premium due on a timely basis.

Court-Appointed Guardianship of a Child
If You or Your spouse files an application for appointment of guardianship of a Child, an application to cover the Child under Your Policy must be submitted to the Exchange within 60 days of the date the appointment of guardianship is granted. Coverage will be effective on the date the appointment of guardianship is awarded by the court.

B. Enrollment

The Exchange will provide an annual Open Enrollment Period (OEP). The Exchange may only permit a Qualified Individual to enroll in a Qualified Health Plan (QHP) or a Subscriber to change QHPs during the annual OEP, or a Special Enrollment Period (SEP) for which the Qualified Individual has been determined to be eligible. The annual OEP is typically active from November 1st through January 15th of each year.

SEPs are allowed due to certain losses of other qualifying coverage and changes in Family status. A Qualified Individual or Subscriber has 60 days from the date of the triggering event to select a Qualified Health Plan. The Exchange will allow enrollment in or change from one Qualified Health Plan to another due to one 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;
- Subscriber 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 Piedmont, or its instrumentalities as evaluated and determined by Piedmont. In such cases, We may take such action as may be necessary to correct or eliminate the effects of such error, misrepresentation, or inaction;
- A Subscriber adequately demonstrates to Piedmont that the Qualified Health Plan in which he or she is enrolled substantially violated a material provision of its contract in relation to the Subscriber;
- An individual is determined newly eligible, regardless of whether such individual is already enrolled in a Qualified Health Plan. Piedmont 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 Subscriber 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;
- Newly eligible for premium tax credit/subsidies;
- 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.

NOTE: Special enrollment for marriage – only applies if at least one spouse was enrolled in a Qualified Health 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.

C. Effective Date of Coverage

Time of Coverage: The Policy becomes effective at 12:00 a.m. on the effective date.

Coverage Effective Date – Open Enrollment Period (OEP): The coverage effective date for applications submitted during the annual OEP are generally January 1st of the following year.

Coverage Effective Date – Special Enrollment Period (SEP) – The coverage effective date for applications submitted, that qualify as a SEP are:

- 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; or
- 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; or
- 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; or
- 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

This Section describes how coverage for You may be terminated and includes information relative to such termination.

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

Termination Effective Date – Termination of coverage is effective on the following date:

1. If termination is requested by You, the termination date would be the requested date. Requests must be provided to the Exchange in advance, or at a minimum, the same day coverage needs to be ended.
2. In the case where You are no longer eligible for coverage in a QHP through the Exchange (examples: divorce, dissolution of Domestic Partnership, overage Dependent, move outside the Service Area, etc.), the last day of coverage is the last day of the month following the

month in which notice is sent by the Exchange, unless You request an earlier termination date.
3. In the case of a termination when You change QHPs, the last day of coverage in Your prior QHP is the day before the effective date of coverage in his or her new QHP.
4. In the case of a termination for non-payment of Premium and You are not receiving advance payments of premium tax credit (APTC), the last day of coverage is the last day of the 31-day grace period.
5. In the case of a termination for non-payment of Premium and You are receiving advance payments of premium tax credit (APTC), the last day of coverage is the last day of the first grace month of the 3-month grace period.

Termination of the Subscriber

Unless prohibited by law, Your coverage will terminate if any of the following occurs:

1. You terminate Your coverage with appropriate notice to the Exchange;
2. You no longer meet eligibility requirements for coverage in a QHP through the Exchange (examples: divorce, dissolution of Domestic Partnership, moves outside the Service Area, etc.). In this case, the Exchange will send a notice to You. Coverage ends on the last day of the month following the month in which the Exchange notifies You (unless You request an earlier termination date);
3. You fail to pay Your Premium, and the grace period has been exhausted;
4. Rescission of Your coverage;
5. The QHP terminates or is decertified;
6. You change to another QHP; or
7. The QHP Issuer may terminate coverage as permitted by the Exchange. You will be notified by the QHP Issuer as required by law.

When Your Policy is terminated, We will promptly return the unearned portion of any Premium paid to You. The earned Premium will be computed pro rata. Termination will be without prejudice to any claim originating prior to the effective date of termination. We will not terminate Your coverage based on the status of Your health or because You have exercised Your rights under the grievance or appeal systems described within this Policy by registering a complaint against Us or an appeal of Our determination of Benefits.

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.

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

Grace Period – Subscribers not receiving Advance Payments of the Premium Tax Credit (APTC)
You are entitled to a grace period of 31 days for any Premium due except the first Premium. During the grace period, coverage will remain in effect unless You contact the Exchange and requests termination of the Policy. If We do not receive all Premium that is due, Your Policy will be terminated due to non-payment of Premium, and Your termination effective date will be the last day of the grace period. You will be liable 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 for any claim payments made for services incurred after the last day of the grace period.

If Your Policy is canceled or terminated due to non-payment of Premium, You may request that We review Your Policy for reinstatement. At Our discretion, if We grant reinstatement of Your Policy, all Premiums currently due must be paid prior to reinstatement of Your Policy. Once We receive payment, Your Policy will be reinstated without a break in coverage.

Grace Period – Subscribers receiving Advance Payments of the Premium Tax Credit (APTC)
If You receive APTC, You are entitled to a grace period of three consecutive months if at least one month's Premium has already been paid 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 and will pend claims in the second and third months of the grace period. Also, any drugs filled during the second and third months of the grace period will process at 100% patient responsibility. You may file a paper claim to be reimbursed for the drug cost once the outstanding Premium balance has been paid and Your grace period has been reset. You will be liable 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.

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E. Coordination of Benefits

Special Coordination of Benefits (COB) rules apply when You or members of Your Family have additional coverage through other health insurance plans, including but not limited to:

- Group and individual health insurance plans, Health Maintenance Organization (HMO), and other prepaid coverage;
- Labor management trustee plans, union welfare plans, employer welfare plans, employer organization plans, or Employee Benefit organization plans; and
- Coverage under any tax-supported or government program to the extent allowed by law.

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

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 an HMO, 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 Covered Person 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 Covered Person is enrolled as: (1) the named Subscriber under one coverage; and (2) a Dependent under another, then generally the one that covers him or her as the named Subscriber will be primary.
- If a Subscriber is the named Subscriber under both coverages, the one that covers him or her for the longer period of time will be primary.
- If the Subscriber is enrolled as a Dependent Child under both coverages (e.g., when both parents cover their Child), typically the coverage of the parent whose birthday falls earliest in the Benefit Year will be the primary.
- Special rules apply when a Subscriber is enrolled as a Dependent Child under two coverages and the Child's parents are separated or divorced. Generally, the coverage of the parent or stepparent with 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 any Covered Person do not duplicate any Benefit provided by Medicare. Where Medicare is the responsible payor, all sums payable by Medicare for services provided to any Covered Person will be reimbursed by or on behalf of the Covered Person to the plan, to the extent the plan has made payment for such services.

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

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

F. Right to Receive and Release Information

By accepting coverage under this Policy, You should:

- Provide Us with information about other coverage and promptly notify Us of any coverage changes;
- Promptly respond to any requests for information from Us;

- Grant Us the right to obtain information as needed from others to coordinate Benefits;
- Promptly return any payments made on Your behalf by Piedmont if We later discover or determine the other coverage should have been primary.

G. Duplicate Coverage

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

Cooperation. You must complete and submit to Us such consents, releases, applications, assignments, and other documents as may be requested by Us 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.

SECTION VIII: Determinations – Claims, Appeals, and Complaints

A. Claims Review

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

We will review a:
- Post-service claim within 15 days after We receive it; and
- Pre-service claim within 15 days after We receive it.

A "post-service claim" is any claim under this Policy for a Benefit for which the Covered Person 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 Covered Person must receive approval (prior authorization) before receiving the Benefit.

We may extend the time to review a claim for an additional 15 days if We: (1) decide that an extension is necessary for reasons beyond Our control; (2) notify You of the reason for the extension in writing before the initial review period ends; and (3) tell You when We expect to make Our final decision. If the extension is because We did not receive necessary information, the extension notice will describe the needed information. You will have 45 days after You receive such an extension notice to provide the information. Our time to review a claim is "tolled" or stops between the date We send the extension notice and the date We receive the requested information.

2. **Expedited Decisions for Urgent Care Claims or Requests**:

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

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

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

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

We 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 Us that Your claim is an Urgent Care Claim, then We will treat it as such.

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

B. Appeals

1. Internal Appeals:

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

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

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 Our Appeals Coordinator at this address:

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

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 "Appeals" paragraph, We 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 of a pre-service Adverse Benefit Determination; or
- 60 days after receipt of the appeal of a post-service Adverse Benefit Determination.

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

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

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

2. **Expedited Internal Appeals:**

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 72 hours after receipt of the appeal:

- A final adverse decision for a prescription to alleviate cancer pain; and

- By telephone call, which is initiated by the treating health care Provider, when he or she believes Our adverse decision warrants an immediate appeal.

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

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

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

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

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

3. **External Appeals:**

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

appeal, You will be required to authorize the release of any medical records required for review in order to reach a decision on the external appeal.

The Bureau's external review program is available for a specific set of adverse determinations. First, You or Your authorized representative must have exhausted the health plan's internal appeal process (set forth above), with the exception of Adverse Benefit Determinations related to cancer. Second, to be eligible for external review, the adverse determination must be for an admission, the availability of care, continued stay or other health care service that: (1) We have determined does not meet 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 Us.

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

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

C. Authorized Representative

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

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

D. Complaints and Assistance

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

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

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

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

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

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

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

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

SECTION IX: General Provisions

A. Relationship of Contracting Parties

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

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

B. Medical Information

We may request from any Provider of Covered Services 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 will be kept confidential. This information may not be disclosed without Your consent except as permitted by any applicable state and federal law.

C. Policies and Procedures

We may adopt policies, procedures, rules, and interpretations to promote orderly and efficient administration of coverage under this Policy. Any provision, term, benefit, or condition of coverage and this Policy may be amended, revised, or deleted by Us upon 31 days written notice, except for Deductible increases. Deductible increases can only occur upon plan renewal, and You will be notified of a Deductible increase 75 days in advance of the change. No change in the Policy will be valid unless evidenced by an amendment, which is signed by an authorized officer of Piedmont.

D. Notices

From Piedmont to You. A notice sent to You by Piedmont is considered "given" when We issue the notice to the United States Postal Service to be delivered to the Covered Person's last known address as shown in Our enrollment records. "Notices" include any information, which We may send You, including ID cards.

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

E. Assignment of Benefits and Payments

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

F. Third Party Premium Payments

We will accept Premium payments made on behalf of the Subscriber if the Premium is paid by the following persons or entities:

- The Ryan White HIV/AIDS Program;
- Other Federal and State government programs that provide Premium and cost-sharing support for specific individuals;
- Indian tribes, tribal organizations, and urban Indian organizations; or
- A relative or legal guardian on behalf of a Subscriber.

Unless required by law, We do not accept Premium payments from third parties that are not listed above. Examples of third parties from whom We will not accept Premium payments include, but are not limited to, Providers, Hospitals, not-for-profit organizations (including religious organizations) that have or whose primary donors have a financial interest in the Benefits of the Policy, commercial entities with a direct or indirect financial interest in the Benefits of the Policy and employers that offer coverage under an employer health plan.

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

H. Piedmont's Continuing Rights

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

I. Use of Personal Information

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

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

J. Provider Non-Discrimination

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

K. Non-Discouragement/Non-Discriminatory Benefit Design

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

L. Notice of Claim

Written notice of a claim can be given to Us at 2316 Atherholt Road, Lynchburg, VA 24501, or to Your agent. Notice should include Your name, and claimant if other than You, Your 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 Out-of-Network Providers render services.

M. Claim Forms

When We receive a notice of claim, We will send You forms for filing proof of loss. If these forms are not given to You within 15 days after the giving of such notice, then You will meet the proof of loss requirements by giving Us 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 Out-of-Network Providers render services.

N. Proofs of Loss

If the Policy provides for periodic payment for a continuing loss, written proof of loss must be given to Us within 90 days after the end of each period for which We are 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, We will 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 Out-of-Network Providers render services.

O. Time of Payment of Claims

After receiving written proof of loss, We 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 We receive proper written proof.

P. 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 You reside on that date is amended to conform with the minimum requirements of those laws.

Q. Entire Contract

This Policy and any amendments to it constitutes the entire contractual agreement between the parties involved and that no portion of the charter, bylaws, or other document of the HMO will constitute part of the contract unless it is set forth in full in the contract.

R. Geographical Service Area

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

SECTION X: Subscriber 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 them, and should You have any questions, please give Us a call.

Piedmont is committed to:

- Recognizing and respecting You as a Subscriber.
- 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 Subscriber.

You have the right to:

- Participate with Your health care professionals and Providers in making decisions about Your health care.
- Receive the Benefits for which You have coverage.
- Be treated with respect and dignity.
- Preserve the privacy of Your personal health information, consistent with state and federal laws, and Our policies.
- Receive information about Our organization and services, Our Network of health care professionals and Providers, and Your rights and responsibilities.
- Candidly discuss with Your Physicians and Providers appropriate and Medically Necessary care for Your condition, regardless of cost or Benefit coverage.
- Make recommendations regarding the rights and responsibilities of any Covered Person as set forth in this 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; in writing: Virginia Bureau of Insurance, 1300 East Main Street, P.O. Box 1157, Richmond, VA 23218; or by email: bureauofinsurance@scc.virginia.gov.

You have the responsibility to:

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

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