

MyHealth360°

PHC & Me



SUMMARY PLAN DESCRIPTION

FOR PIEDMONT HEALTHCARE, INC. COMPREHENSIVE HEALTH AND WELFARE BENEFITS PLAN MyHealth360 Medical Benefit Programs

Amended Plan Effective January 1, 2018

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INTRODUCTION

This document provides you with a description of the benefits you may receive while you are enrolled in the Piedmont Healthcare, Inc. MyHealth360 Medical Benefit Program (hereinafter the "Plan") offered under the Piedmont Healthcare, Inc. Comprehensive Health and Welfare Benefits Plan sponsored by Piedmont Healthcare, Inc. ("Employer"). This document is intended to satisfy the summary plan description ("SPD") requirements of the Employee Retirement Income Security Act ("ERISA").

Coverage under the Plan will take effect for an eligible Employee and the Employee's designated Dependents when the Employee and such Dependents satisfy the Waiting Period and all the eligibility requirements of the Plan described herein.

The Employer reserves the right to terminate, suspend, discontinue or amend the Plan at any time, in whole or in part, and for any reason in its sole discretion, without advance notice subject to any outstanding contractual agreements or requirements of law. Changes in the Plan may occur in any or all parts of the Plan including benefit coverage, deductibles, maximums, copayments, exclusions, limitations, definitions, eligibility and the like.

The Plan will pay benefits only for eligible expenses incurred while this coverage is in force. No benefits are payable for expenses incurred before coverage began or after coverage terminated, even if the expenses were incurred as a result of an accident, injury or disease that occurred, began, or existed while coverage was in force. An expense for a service or supply is incurred on the date the service or supply is furnished.

If the Plan is terminated, the rights of Covered Persons are limited to covered charges incurred before termination.

ELIGIBILITY, EFFECTIVE DATE AND TERMINATION PROVISIONS

Eligible Classes of Employees.

All Full-Time and Part-Time Employees of the Employer, are eligible to participate in the Plan once they satisfy the Waiting Period.

Eligibility Requirements for Employee Coverage.

- You are considered a "Full-Time" Employee if you are regularly scheduled to work at least 64 hours per pay period for full-time employees;
- You are considered a "Part-Time" Employee if you are regularly scheduled to work at least 32 hours per pay period; or
- The "Waiting Period" ends on 1st of month following 30 days of benefits eligible service.

You are not considered an "Employee" if you are classified as an independent contractor under the Employer's customary work classification practices (whether or not the individual is an employee or reclassified as an employee by the Internal Revenue Service, administrative agency or a court of competent jurisdiction).

Eligible Dependents Under the Plan Include The Following Persons.

Eligible Dependents under the Plan include a covered Employee's:

(1) Spouse.

(2) Domestic Partner.

(3) Children from birth to age of 26, regardless of (i) the child's employment, student, marital status; (ii) whether the child is the covered Employee's financial dependent; (iii) whether the child resides with the covered Employee; and (iv) whether the child is eligible for coverage under another health plan. Coverage of Children will terminate at 11:59 p.m. on the last day of the calendar month in which the covered Employee's child attains age of 26.

(4) Children who are Totally Disabled, incapable of self-sustaining employment by reason of mental or physical handicap, primarily dependent upon the covered Employee for support and maintenance and are unmarried.

(5) Step-Children from birth to age 26. Coverage of step-children will terminate at 11:59 p.m. on the last day of the calendar month in which the covered Employee's step-child attains age of 26.

(6) Special Open Enrollment Eligibility Period. In case of birth and adoption, the day of the event. Other events, as soon as administratively possible.

(7) If your spouse / domestic partner has medical coverage available through his/her employer, he/she is not eligible to enroll in Piedmont's medical coverage. When you enroll your dependents in our benefit programs, you will be required by an independent verifier to provide documentation of your dependents' eligibility.

A "Domestic Partner" of a covered Employee is an eligible Dependent under the Plan as long as the following criteria are met:

1. The partners are at least 18 years of age and mentally competent to consent to contract;
2. The partners share the same primary, regular and permanent residence and have lived together for the previous twelve (12) months;

3. The partners are living in a committed personal relationship that is mutually interdependent and jointly responsible for the necessities of life of each other;
4. The partners are not related by blood closer than permissible by the law for legal marriage in the state in which they reside;
5. The partners are neither married nor legally separated under the laws of the state in which they reside; and
6. The partners are each other's sole domestic partner and intend to remain so indefinitely.

Determination of eligibility will be based on receipt of the appropriate documentation and subsequent proof of Domestic Partnership may be required on an annual basis to ensure that eligible dependents continue to meet the criteria above.

The term "Spouse" shall mean the same or opposite sex individual with whom an Employee is legally married under state or foreign law regardless of whether the married couple is domiciled in a state that does not recognize the validity of same-sex marriages.

The Plan Administrator may require documentation proving eligibility for all dependents.

The term "child" or "children" shall include natural children, adopted children, step-children, children placed with the Employee in anticipation of adoption or becoming the Employee's foster child, unmarried child for whom the Employee is the court-appointed legal guardian.

The phrase "child placed with a covered Employee in anticipation of adoption" refers to a child whom the Employee intends to adopt, whether or not the adoption has become final, who has not attained the age of eighteen (18) as of the date of such placement for adoption. The term "placed" means the assumption and retention by such Employee of a legal obligation for total or partial support of the child in anticipation of adoption of the child. The child must be available for adoption and the legal process must have commenced.

Any child of a covered Employee who is an alternate recipient under a qualified medical child support order shall be considered as having a right to Dependent coverage under this Plan.

The following persons are excluded from the definition of Eligible Dependents under the Plan:

1. Other individuals living in the covered Employee's home, but who are not eligible as defined;
2. The legally separated or divorced former Spouse of the Employee; and
3. Foster children who are not eligible to be covered under the Patient Protection and Affordable Care Act ("ACA"), i.e., those who have not been placed for adoption or made the responsibility of the Employee pursuant to the terms of a valid court order.

If a person covered under this Plan changes status from Employee to Dependent or Dependent to Employee, and the person is covered continuously under this Plan before, during and after the change in status, credit will be given for deductibles and all amounts applied to maximums.

Eligibility Requirements for Dependent Coverage. A family member of an Employee will become eligible for Dependent coverage on the first day that the Employee is eligible for Employee coverage and the family member satisfies the requirements for Dependent coverage.

At any time, the Plan Administrator may require proof that a Spouse or a child qualifies or continues to qualify as a Dependent as defined by this Plan. With respect to Dependent children who are disabled, the Plan Administrator may require, at reasonable intervals during the two years following the Dependent's reaching age 26, subsequent proof of the child's Total Disability and dependency. After such two-year period, the Plan Administrator may require subsequent proof not more than once each year. The Plan Administrator reserves the right to have such Dependent examined by a Physician of the Plan Administrator's choice, at the Plan's expense, to determine the existence of such incapacity.

ENROLLMENT

Definitions You Need to Know

Benefit Year is the twelve month period beginning on the first day of the Plan Year. This is the date by which all Plan deductibles, Plan maximums, visit maximums, etc., are tracked.

Refer to Page 14

Enrollment Requirements. An eligible Employee must enroll for coverage by filling out and signing an enrollment application along with the appropriate payroll deduction authorization if applicable. The Employee can also enroll on-line.

Enrollment Requirements for Newborn Children.

Routine well baby nursery expenses (Mother & newborn child discharged from hospital same date)

The newborn child of a covered Participant is automatically eligible for routine newborn care (in-patient hospital and physician services) by the Plan from birth through discharge regardless of whether the covered Employee enrolls the newborn as a Dependent under the Plan.

Non-routine or sick baby nursery and ongoing expenses

(Mother & newborn child discharged from hospital separate dates)

The covered Employee must enroll the newborn as a Dependent under the plan with 31 days from the date of birth. If the newborn child is not enrolled in the Plan within 31 days of birth, there will be no coverage for non-routine services from the date of birth, nor will routine care after the discharge date be eligible for coverage. The child will not be eligible for coverage under this Plan until the next Open Enrollment or subsequent Special Enrollment Period, if applicable.

TIMELY AND LATE ENROLLMENT

- (1) **Timely Enrollment** - Enrollment is "timely" if the on-line enrollment & completed form is received by the Plan Administrator no later than 31 days after the person becomes eligible for the coverage, either initially or under a Special Enrollment Period.

If two Employees (who are Spouses as that term is defined herein) are covered under the Plan and the Employee who is covering the Dependent children terminates coverage, the Dependent coverage may be continued by the other covered Employee with no waiting period as long as coverage has been continuous.

- (2) **Late Enrollment** - Enrollment is "late" if it is not made on a "timely basis" or during a Special Enrollment Period. Late Enrollees and their Dependents who are not eligible to enroll in the Plan during a Special Enrollment Period may enroll only during Open Enrollment.

If an individual loses eligibility for coverage as a result of terminating employment or a general suspension of coverage under the Plan, then upon becoming eligible again due to resumption of employment or due to resumption of Plan coverage, only the most recent period of eligibility will be considered for purposes of determining whether the individual is a Late Enrollee.

SPECIAL ENROLLMENT PERIODS

The Enrollment Date for anyone who enrolls under a Special Enrollment Period is the first date of coverage, as defined below.

- (1) **Individuals losing other coverage.** An Employee or Dependent who is eligible, but not enrolled in this Plan, may enroll if each of the following conditions is met:

- (a) The Employee or Dependent was covered under a group health plan or had health insurance coverage at the time coverage under this Plan was previously offered to the individual.
- (b) If required by the Plan Administrator, the Employee stated in writing at the time that coverage was offered that the other health coverage was the reason for declining enrollment.
- (c) The coverage of the Employee or Dependent who had lost the coverage was under COBRA and the COBRA coverage was exhausted, or was not under COBRA and either the coverage was terminated as a result of loss of eligibility for the coverage (including as a result of legal separation, divorce, death, termination of employment or reduction in the number of hours of employment) or employer contributions towards the coverage were terminated.
- (d) The Employee or Dependent requests enrollment in this Plan not later than 31 days after the date of exhaustion of COBRA coverage or the termination of coverage or employer contributions, described above.

If the Employee or Dependent lost the other coverage as a result of the individual's failure to pay premiums or required contributions or for cause (such as making a fraudulent claim), that individual does not have a Special Enrollment right.

(2) Dependent beneficiaries. If:

- (a) The Employee is a participant under this Plan (or has met the Waiting Period applicable to becoming a participant under this Plan and is eligible to be enrolled under this Plan but for a failure to enroll during a previous enrollment period); and
- (b) A person becomes a Dependent of the Employee through marriage, birth, adoption or placement for adoption.

then the Dependent (and if not otherwise enrolled, the Employee) may be enrolled under this Plan as a covered Dependent of the covered Employee. In the case of the birth or adoption of a child, the Spouse of the covered Employee and other eligible dependents of the employee may be enrolled as a Dependent of the covered Employee if the Spouse is otherwise eligible for coverage.

The Dependent Special Enrollment Period is a period of 31 days and begins on the date of the marriage, birth, adoption or placement for adoption.

The coverage of the Dependent enrolled in the Special Enrollment Period will be effective:

- (a) in the case of marriage, the first day of the first month beginning after the date of the completed request for enrollment is received;
- (b) in the case of a Dependent's birth, as of the date of birth; or
- (c) in the case of a Dependent's adoption or placement for adoption, the date of the adoption or placement for adoption.

(3) Children's Health Insurance Program Reauthorization Act of 2009 ("CHIP")

The purpose of the Children's Health Insurance Program Reauthorization Act of 2009 ("CHIP") is to provide funding for Children's Health Insurance under Medicaid and State Children's Programs and permits a group health plan to allow special enrollment for eligible but not enrolled Employees or Dependent children who either:

(1) lose coverage under a Medicaid or a State Children’s Health Insurance Plan (SCHIP) under titles XIX and XXI of the Social Security Act, respectively, or

(2) become eligible for group health plan consideration assistance under Medicaid or SCHIP (Special Enrollment Right). The Employee or Dependent must request coverage no later than sixty (60) days after the date eligibility is lost or the date Employee and/or Dependent is determined to be eligible for State contribution assistance.

MID-YEAR ELECTION CHANGES

You cannot change your elections during the plan year unless you experience a qualified change in status event (“**qualified life event**”), and the change you want to make is consistent with the qualified life event.

Any of the following events are qualified life events:

- You or your eligible Dependent become eligible or ineligible for coverage on account of a change in:
 - legal marital status (for example: marriage, divorce, legal separation, annulment);
 - number of dependents (for example: birth, death, adoption, placement for adoption);
 - your employment status or your eligible Dependent’s employment status (for example, termination or commencement of employment, taking or returning from an unpaid leave of absence - including those protected under the FMLA, changing from part-time to full-time, or union to non-union, or *vice versa*);
 - residence or work site; or
 - a dependent’s status (for example, a dependent becomes eligible or ineligible for benefits under the Plan).

Remember the Qualified Life Event Must Cause a Gain Or Loss of Eligibility

The qualified life event must cause you or your eligible Dependents to gain or lose coverage under this Plan or another group health plan and your election changes must be consistent with the qualified life event.

- A change in coverage due to an election made by your spouse or Dependent under the spouse’s or Dependent’s employer’s benefit plan if:
 - the other employer plan has a different open enrollment period that relates to a period that is different from the plan year for this Plan (for example, your spouse’s open enrollment period is in January and your spouse changes coverage); or
 - the other employer plan allows an election change for a qualified life event as provided under the cafeteria plan regulations.
- A change in the availability of benefit options or coverage (addition or removal) under the Plan or under your spouse’s or Dependent’s employer’s benefit plan (for example, a new HMO or PPO option is added).
- A significant increase or decrease in the cost of coverage during the plan year. The Plan Administrator in its sole discretion and on a uniform and consistent basis will determine whether an increase or decrease is significant.
- you or your eligible Dependent becomes eligible for COBRA Continuation Coverage or extended coverage under USERRA;
- a judgment, decree, or order, resulting from a divorce, legal separation, annulment, or change in legal guardianship (including a Qualified Medical Child Support Order), is entered by a court of competent jurisdiction that requires health coverage for your child under this Plan or requires another individual to provide coverage to the child;

- you or your eligible Dependent becomes enrolled or loses coverage under Part A or Part B of Medicare or Medicaid (other than coverage solely with respect to the distribution of pediatric vaccines);
- you or your eligible Dependent loses coverage under any group health coverage sponsored by a government or educational institution including a State children's health program (CHIP); a medical care program of an Indian Tribal government, the Indian Health Service or a tribal organization; a State health benefits risk pool; or a Foreign government group health plan; or
- you or your eligible Dependent are eligible for a Special Enrollment Period.

Consistency Rule

Your election changes must be consistent with the qualified life event that affects your coverage. For example:

- if one of your eligible Dependents no longer qualifies as an eligible Dependent, you could cancel coverage for that dependent, but you could not cancel coverage for your other eligible Dependents; or
- if you have single coverage and you marry, you may elect spouse or family coverage.

Some of the qualified life events may allow you the option of either adding or removing coverage. For example, your spouse changing an election under his or her employer's plan may allow you to add or remove coverage under this Plan, so long as your choice is consistent with your Spouse's election.

If you are not sure the election change you would like to make is consistent with the qualified life event, you should contact the HR Service Center at 678-503-1900.

Procedures for Changing Elections Mid-Year

If you want to change your benefit elections because of a qualified life event, you may do so by notifying the HR Service Center of the qualified life event at 678-503-1900 and specifying how you want your elections changed. You must provide this notice and submit proof of the qualified life event within 31 days of the qualified life event. If you file a request more than 31 days after the qualified life event, no changes will be made to your elections, but you may make the necessary changes during the next annual enrollment period.

For a dependent who no longer qualifies as an eligible Dependent, the change in coverage will automatically take effect as of the last day of the month in which the Dependent is no longer eligible for the Plan, regardless of whether you request an election change within the 31-day period. Failure to inform the Plan that a dependent is no longer eligible for coverage is considered an intentional misrepresentation of material fact entitling the Plan to retroactively cancel the dependent's coverage. The Plan has the right to recover from you any payments the Plan makes on behalf of the ineligible dependent.

EFFECTIVE DATE

Effective Date of Employee Coverage. Coverage for a newly hired Full-Time Employee or Part-Time Employee will take effect on the date 1st day of the month following 30 days if employment Eligibility Requirements and all Enrollment Requirements are met.

Effective Date of Dependent Coverage. A Dependent's coverage will take effect on the day that the Eligibility Requirements are met; the Employee is covered under the Plan; and all Enrollment Requirements are met.

TERMINATION OF COVERAGE

When Employee Coverage Terminates. Employee coverage will terminate on the earliest of these dates (except in certain circumstances, a covered Employee may be eligible for COBRA continuation coverage. For a complete explanation of when COBRA continuation coverage is available, what conditions apply and how to select it, see the section entitled COBRA Continuation Options):

- (1) The date the Plan is terminated;
- (2) The last day of the calendar month in which the covered Employee ceases to be in one of the Eligible Classes. This includes termination of Employment of the covered Employee. (See the COBRA Continuation Options);
- (3) The last day of the calendar month for which the required contribution has been paid if the charge for the next period is not paid when due; and
- (4) Following 30 days' notice to the Covered Person where the Covered Person performs an act, practice, or omission that constitutes fraud or an intentional misrepresentation of a material fact. Coverage termination will be last day of month.

Continuation During Periods of Employer-Certified Disability, Leave of Absence or Layoff. A person may remain eligible for a limited time if employment ceases due to disability, leave of absence or layoff. This continuation will end as follows:

For disability leave only: the date the Employer ends the continuation, in accordance with Human Resources policies.

For leave of absence or layoff only: the date the Employer ends the continuation, in accordance with Human Resources policies.

While continued, coverage will be that which was in force on the last day worked prior to the date of disability or leave of absence. However, if benefits reduce for others in the class, they will also reduce for the continued person.

Continuation During Family and Medical Leave. Regardless of the established leave policies mentioned above, this Plan shall at all times comply with the Family and Medical Leave Act of 1993 as promulgated in regulations issued by the Department of Labor.

During any leave taken under the Family and Medical Leave Act, the Employer will maintain coverage under this Plan on the same conditions as coverage would have been provided if the covered Employee had been continuously employed during the entire leave period.

If Plan coverage terminates during the FMLA leave, coverage will be reinstated for the Employee and his or her covered Dependents if the Employee returns to work in accordance with the terms of the FMLA leave.

Coverage will be reinstated only if the person(s) had coverage under this Plan when the FMLA leave started, and will be reinstated to the same extent that it was in force when that coverage terminated.

For example, Waiting Periods will not be imposed unless they were in effect for the Employee and/or his or her Dependents when Plan coverage terminated.

Rehiring a Terminated Employee. A terminated Employee who is rehired after 30 days will be treated as a new hire and be required to satisfy all Eligibility and Enrollment requirements, with the exception of an Employee returning to work directly from COBRA coverage or bridged rehires. This Employee and those rehired within 30 days does not have to satisfy a new Waiting Period if the Employee previously satisfied the Waiting Period.

Employees on Military Leave. Employees going into or returning from military service may elect to continue Plan coverage as mandated by the Uniformed Services Employment and Reemployment Rights Act under the following circumstances. These rights apply only to Employees and their Dependents covered under the Plan before leaving for military service.

- (1) The maximum period of coverage of a person under such an election shall be the lesser of:
 - (a) The 5 year period beginning on the date on which the person's absence begins; or
 - (b) The day after the date on which the person was required to apply for or return to a position or employment and fails to do so.
- (2) A person who elects to continue health plan coverage may be required to pay up to 102% of the full contribution under the Plan, except a person on active duty for 30 days or less cannot be required to pay more than the Employee's share, if any, for the coverage.
- (3) An exclusion or Waiting Period may not be imposed in connection with the reinstatement of coverage upon reemployment if one would not have been imposed had coverage not been terminated because of service. However, an exclusion or Waiting Period may be imposed for coverage of any Illness or Injury determined by the Secretary of Veterans Affairs to have been incurred in, or aggravated during, the performance of uniformed service.

When Dependent Coverage Terminates. A Dependent's coverage will terminate on the earliest of these dates (except in certain circumstances, a covered Dependent may be eligible for COBRA continuation coverage. For a complete explanation of when COBRA continuation coverage is available, what conditions apply and how to select it, see the section entitled COBRA Continuation Options):

- (i) The date the Plan or Dependent coverage under the Plan is terminated;
- (ii) The last day of the calendar month that the Employee's coverage under the Plan terminates for any reason including death. (See the COBRA Continuation Options);
- (iii) The last day of the calendar month a covered Spouse loses coverage due to loss of dependency status. (See the COBRA Continuation Options); and
- (iv) On the last day of the calendar month in which a Dependent child reaches the limiting age of 26.

Dependents who fail to be verified as eligible members and are subsequently terminated from coverage, may be re-enrolled in the plan effective on the first day of the month following successful completion of the verification process.

Piedmont Healthcare Language Services

ATTENTION: If you speak [insert language], language assistance services, free of charge, are available to you. Call 678-503-1900.

(Spanish)

ATENCIÓN: Si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística.

Llame al 678-503-1900.

(Vietnamese)

CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số 678-503-1900.

(Korean)

주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 678-503-1900. 번으로 전화해 주십시오.

(Chinese)

注意：如果您使用繁體中文，您可以免費獲得語言援助服務。請致電 678-503-1900.

(Gujarati)

સુચના: જો તમે ગુજરાતી બોલતા હો, તો નિ:શુલ્ક ભાષા સહાય સેવાઓ તમારા માટે ઉપલબ્ધ છે. ફોન કરો 678-503-1900.

(French)

ATTENTION : Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le 678-503-1900.

(Arabic)

ملحوظة: إذا كنت تتحدث اذكر اللغة، فإن خدمات المساعدة اللغوية تتوافر لك بالمجان. اتصل برقم 678-503-1900

(Amharic)

ማስታወሻ: የሚናገሩት ቋንቋ አማርኛ ከሆነ የትርጉም እርዳታ ድርጅቶች፣ በነጻ ሊያገዝዎት ተዘጋጅተዋል፡ ወደ ሚከተለው ቁጥር ይደውሉ 678-503-1900.

(Hindi)

□□ उपलब्ध □□□□ 678-503-1900.

French Creole (Haitian Creole)

ATANSYON: Si w pale Kreyòl Ayisyen, gen sèvis èd pou lang ki disponib gratis pou ou. Rele 678-503-1900.

(Russian)

ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните 678-503-1900.

(Portuguese)

ATENÇÃO: Se fala português, encontram-se disponíveis serviços linguísticos, grátis. Ligue para 678-503-1900.

Persian (Farsi)

توجه: اگر به زبان فارسی گفتگو می کنید، تسهیلات زبانی بصورت رایگان برای شما فراهم می باشد. با (678-503-1900) تماس بگیرید.

(German)

ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Rufnummer: 678-503-1900.

(Japanese)

注意事項：日本語を話される場合、無料の言語支援をご利用いただけます。678-503-1900
まで、お電話にてご連絡ください。

OPEN ENROLLMENT

Every year during the annual Open Enrollment period, covered Employees and their eligible covered Dependents will be able to change their current benefit elections based on which benefits are right for them.

In addition, every year, during the annual Open Enrollment period, Employees and their Dependents who are Late Enrollees will be able to enroll in the Plan.

Benefit choices made during the Open Enrollment period will become effective January 1st, and will remain in effect until the next January 1st, unless there is a Qualifying Life Event.

Plan Participants will receive detailed information regarding Open Enrollment from their Employer.

YOUR BENEFITS

Verification of Eligibility 1-877-601-3835

Call this number to verify a Covered Person's eligibility for Plan benefits **before** the charge is incurred.

WHAT ARE THE BENEFITS?

All benefits described in the Schedule of Benefits are subject to the exclusions and limitations described more fully herein including, but not limited to, the Claims Administrator's determination that: care and treatment is Medically Necessary; that charges are according to the plan allowable charges; and that services, supplies and care are not Experimental and/or Investigational. The meanings of these capitalized terms are in the Defined Terms section of this document.

It is the Covered Person's choice as to which Provider to use, but some services are not covered or are only partially covered when provided by an Out-of-Network Provider. Review the Schedule of Benefits and remainder of this document carefully.

If you or a covered Dependent need covered services recommended by your physician that are not available within the Network, the Care Management/Claims Administrator may, at its discretion, determine the medical necessity, and approve the use of an Out-of-Network Provider. When approved through Care Management and/or the Claims Administrator, benefits for use of these providers will be payable at the same level as those of the Tier 2 Network level providers, had those services been available. Reimbursement will be considered based on billed charges. Please note you will still be responsible for the applicable out of pocket payments.

Participating Provider Plan

This Plan or its Claims Administrator has entered into an agreement with certain Hospitals, Physicians and other health care providers, which are called Participating Providers. Because these Participating Providers have agreed to charge reduced fees to persons covered under the Plan, the Plan can afford to reimburse a higher percentage of their fees.

Therefore, when a Covered Person uses a Participating Provider, that Covered Person will receive a higher benefit from the Plan than when an Out-of-Network Provider is used. It is the Covered Person's choice as to which Provider to use. Some services are not covered when provided by an Out-of-Network Provider. Review the Schedule of Benefits and remainder of this document carefully.

HOW TO IDENTIFY PARTICIPATING PROVIDERS

You can find a listing of the Plan's Participating Providers in: myhealth360piedmont.com or call **1-877-601-3835**.

PLAN OPTIONS AND THE BASIS OF PLAN PAYMENTS:

The Plan includes three tiers of coverage. The participating providers and the benefits vary between each tier. Please refer to the Schedule of Benefits for the benefit coverage and costs associated with each tier.

- (1) **Piedmont Healthcare Network Providers (Tier 1): This includes: All Piedmont Clinic physicians; Piedmont facilities; Children's Healthcare of Atlanta (CHOA facilities); Participating providers under The Children's Healthcare Network (TCHN).** Plan payments are based on the charge determined by Piedmont Healthcare to be reasonable for the type of service you receive. This amount is referred to in this booklet as the "Plan Allowable Charges". Tier 1 providers have agreed to accept this amount as payment in full for their services. This means if your provider's normal charges are more than the contract charge, you will not be billed for the difference between your provider's regular fee and the contract amount. You are responsible for any deductibles, coinsurance, or copayments for services as outlined in the schedule of benefits.

(2) **Cigna OPEN ACCESS PLUS Network Providers (Tier 2):**

Plan payments are based on the charge determined by Cigna OPEN ACCESS PLUS (OAP) to be reasonable for the type of service you receive. This amount is referred to in this document as the “Plan Allowable Charges”. Cigna OPEN ACCESS PLUS Network providers have agreed to accept this amount as payment in full for their services. This means if your provider’s normal charges are more than the contract charge, you will not be billed for the difference between your provider’s regular fee and the contract amount. You are responsible for any deductibles, coinsurance, or copayments for services as outlined in the Schedule of Benefits.

(3) **Out-of-Network Providers (Tier 3):** Plan payments for Out-of-Network provider services are based on the “Plan Allowable Charges” for the service you receive. Charges in excess of the Plan Allowable Charges are not considered covered charges under this Plan and do not accrue towards any maximum out-of-pocket allowances. You are responsible for any deductibles, coinsurance, or copayments for services as outlined in the Schedule of Benefits. Any out-of-network excess charge can be billed to the patient.

Definition You Need to Know

PLAN ALLOWABLE CHARGES are charges that do not exceed the maximum dollar amount the Plan will recognize for a covered service, procedure or supply by other network providers of similar profession. They are also referred to as the Plan’s “Fee Schedule.”

- Charges in excess of the *Plan's Allowable Charges* are not considered covered charges, and do not accrue towards your out-of-pocket maximum.

ANTI-ASSIGNMENT

Subject to the provisions of the Plan relating to qualified medical child support orders and the third party recovery provisions (right of subrogation, reimbursement and refund/recovery), a Covered Person may not assign, transfer, pledge, sell, or alienate, by operation of law or otherwise, any payment for any benefit that he or she is entitled to receive from the Plan, or any other rights, benefits, or interest under this Plan. Any attempt at such transaction(s) shall be void. In addition, except as may be prescribed by law, no benefits shall be subject to attachment or garnishment of or for a Covered Person’s debts or contracts, except for recovery of overpayments made on a Covered Person’s behalf by this Plan. If applicable, a Covered Person may authorize the Plan to directly pay the service provider or hospital that provided the Covered Person’s covered care and treatment. The payment of benefits directly to a provider or hospital, if any, will be done as a convenience to a Covered Person and will not constitute an assignment of rights, benefits, or any other interest under the Plan or a waiver of this anti-assignment provision.

MyHealth360 Medical Benefit Program SCHEDULE OF BENEFITS

Plan Provision	Tier 1 ⁽²⁾	Tier 2 ⁽²⁾ Cigna OAP Network	Tier 3 ⁽²⁾ Out-of-Network
<u>Annual Deductible</u> <u>*Tier Coverage</u>			
• Employee Only	\$1,500	\$3,000	\$3,000
• Family, Employee + Spouse, Employee + Child	\$3,000	\$6,000	\$6,000
	Deductibles combined Tier 1 and Tier 2		
<p>*Employees with Single Coverage must satisfy their Individual deductible before Coinsurance applies, except for wellness related services.</p> <p>*Employees with Family, Employee + Spouse, or Employee + Child Coverage must satisfy their Family deductible before Coinsurance applies, except for wellness related services.</p>			
Coinsurance	90% plan pays	70% plan pays	50% plan pays
<u>Maximum Out of Pocket</u>			
• Employee Only	\$3,500	\$6,850	\$10,000
• Family, Employee + Spouse, Employee + Child	\$6,850	Note: One family member within this Tier cannot exceed \$6,850; Overall maximum: \$13,700	\$20,000
	Out of Pocket maximum combined Tier 1 and Tier 2		
	Out-of-pocket Maximum includes Deductibles, Coinsurance, Medical Copayments, Prescription Copayments, but does not include non-covered amounts above the plan's Fee Schedule or allowable charge or any pre-authorization penalties.		
<p>*Employees with Single Coverage must satisfy their Individual Out-of-Pocket maximum before 100% of plan's allowable is reimbursed.</p> <p>*Tier 1 & Tier 3 Employees with Family, Employee + Spouse, or Employee + Child Coverage must satisfy Family, Employee+Spouse, or Employee + Child Out-of-Pocket maximum before 100% of plan's allowable is reimbursed.</p> <p>** Tier 2 - Out-of-Pocket maximum - one family member within Tier 2 cannot exceed \$6,850</p>			
Lifetime Maximum	NONE		
Pre-certification	There is no pre-certification fixed dollar penalty under the Plan, but if either you or your physician do not pre-certify care when required based on the pre-certification requirements described in this document prior to receipt of services, plan payments may be reduced or denied.		

- (1) Pre-authorization: Certain services require Pre-authorization. See Medical Management section for the Pre-Authorization list.
- (2) Reimbursement to all providers is based on the "Plan Allowable Charges". Any Tier 3 provider can balance bill the patient for any amounts in excess of the Plan Allowable Charges. This excess amount is considered a non-covered amount and does not accrue towards the Out-of-Pocket maximum.

Plan Provision	Tier 1 ⁽²⁾	Tier 2 ⁽²⁾ Cigna OAP Network	Tier 3 ⁽²⁾ Out-of-Network
Hospital Services			
In-patient Admissions ⁽¹⁾ Semi-private R&B Elective / Non – Emergent Admits • Hospital	Deductible, 90%	Deductible, 70% Fee Schedule	Deductible, 50% of Allowable Charges
• Physician & all other related services	Deductible, 90%	Deductible, 70% Fee Schedule	Deductible, 50% of Allowable Charges
Maternity Care ⁽¹⁾ • In-patient Admit	\$750 Copay	Refer to In-patient Admissions above	Refer to In-patient Admissions above
• w/ initial office visit	100%	Deductible, 70% Fee Schedule	Deductible, 50% of Allowable Charges
• After Initial Visit	100%	Deductible, 70% Fee Schedule	Deductible, 50% of Allowable Charges
• Ultrasound (Greater than 3 requires authorization)	100%	Deductible, 70% Fee Schedule	Deductible, 50% of Allowable Charges
Note: Dependent child maternity is Covered			
Emergency Admissions • Hospital	Deductible, 90%	Deductible, 90% Fee Schedule Subject to Tier 1 benefit	Deductible, 90% of Fee Schedule
• Physician & all other related services	Deductible, 90%	Deductible, 90% Fee Schedule Subject to Tier 1 benefit	Deductible, 90% of Fee Schedule
*Note: Notification within 2 Business Days if admitted – call Care Management			
Emergency Room Service: • Hospital	Deductible, 90%	Deductible, 90% Fee Schedule Subject to Tier 1 benefit	Deductible, 90% of Fee Schedule
• Physician & all other related services	Deductible, 90%	Deductible, 90% Fee Schedule Subject to Tier 1 benefit	Deductible, 90% of Fee Schedule
• Urgent Care Center	\$20 copay	\$50 copay	\$50 copay

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Same Day Surgery ⁽¹⁾ • Hospital Charges	Deductible, 90%	Deductible, 70% Fee Schedule	Deductible, 50% of Allowable Charges
• Physician Charges	Deductible, 90%	Deductible, 70% Fee Schedule	Deductible, 50% of Allowable Charges
• Free Standing Surgery Center	Deductible, 90%	Deductible, 70% Fee Schedule	Deductible, 50% of Allowable Charges
Extended Care / Skilled Nursing ⁽¹⁾ 60 day maximum per calendar year	N/A	Deductible, 70% Fee Schedule	Deductible, 50% of Allowable Charges
Physician Services			
Office visits • PCP	\$20 copay	\$20 copay	Deductible, 50% of Allowable Charges
• Specialist	\$70 copay	Deductible, 70% Fee Schedule	Deductible, 50% of Allowable Charges
• Consultation	\$70 copay	Deductible, 70% Fee Schedule	Deductible, 50% of Allowable Charges
Tier 1 & Tier 2 PCP Office visits and Tier 1 only Specialist Office visits: Services and procedures performed during a non-routine Tier 1 or Tier 2 PCP or Tier 1 Specialist office visit, will be covered under the office visit copay. Deductible and coinsurance is applied when services and procedures are provided outside physician's office.			
Allergy Injections • w/ office visit	\$70 copay	Deductible, 70% Fee Schedule	Deductible, 50% of Allowable Charges
• w/o office visit	100%	Deductible, 70% Fee Schedule	Deductible, 50% of Allowable Charges
Allergy Test • w/ office visit	\$70 copay	Deductible, 70% Fee Schedule	Deductible, 50% of Allowable Charges
• w/o office visit	100%	Deductible, 70% Fee Schedule	Deductible, 50% of Allowable Charges
Well Baby Exam • Routine	100%	100%	Not Covered
Non – Routine - PCP	\$20 copay	\$20 copay	Deductible, 50% of Allowable Charges
Circumcision	Deductible, 90%	Deductible, 70% Fee Schedule	Deductible, 50% of Allowable Charges

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Preventative Immunizations			
• Child	100%	100%	Not Covered
• Adult	100%	100%	Deductible, 50% of Allowable Charges
Other Immunizations			
• HPV Ages 9 – 26 Male & Female	100%	100%	Not Covered
-If one or two of the series is done before age 26 then the complete series is covered			
• Flu	100%	100%	Deductible, 50% of Allowable Charges
• Out of Country	Not Covered	Not Covered	Not Covered
• Sports	Not Covered	Not Covered	Not Covered
Wellness Schedule		Refer to Wellness Schedule for Details	
Adult Exam			
• Routine	100%	100%	Not Covered
• Non – Routine – PCP	\$20 copay	\$20 copay	Deductible, 50% of Allowable Charges
• Non – Routine – Specialist	\$70 copay	Deductible, 70% Fee Schedule	Deductible, 50% of Allowable Charges
Gynecological Exam			
• Routine	100%	100%	Not Covered
• Non – Routine - PCP	\$20 copay	\$20 copay	Deductible, 50% of Allowable Charges
Pap Smear			
• Routine	100%	100%	Not Covered
Non – Routine- PCP	100%	100%	Deductible, 50% of Allowable Charges
Mammography			
• Routine	100%	100%	Not Covered
• Non – Routine	100%	100%	Deductible, 50% of Allowable Charges
Colonoscopy			
• Routine	100%	100%	Not Covered
• Non – Routine	100%	100%	Deductible, 50% of Allowable Charges
Chiropractic Services 20 visits per year Modalities included in office visit	N/A	Deductible, 70% Fee Schedule	Deductible, 50% of Allowable Charges
Pre-Certification required for persons under age of 13			

- (1) Pre-authorization: Certain services require Pre-authorization. See Medical Management section for the Pre-Authorization list.
- (2) Reimbursement to all providers is based on the “Plan Allowable Charges”. Any Tier 3 provider can balance bill the patient for any amounts in excess of the Plan Allowable Charges. This excess amount is considered a non-covered amount and does not accrue towards the Out-of-Pocket maximum.

Podiatry Services <ul style="list-style-type: none">Routine	\$70 copay	Deductible, 70% Fee Schedule	Deductible, 50% of Allowable Charges
<ul style="list-style-type: none">Non – Routine	\$70 copay	Deductible, 70% Fee Schedule	Deductible, 50% of Allowable Charges
	Routine Services only when medically necessary for diabetes and other systemic diseases.		
Diagnostic Services: Lab & X-ray			
Laboratory <ul style="list-style-type: none">Hospital	100%	Deductible, 70% Fee Schedule	Deductible, 50% of Allowable Charges
<ul style="list-style-type: none">Physician's Office	100%	100%	Deductible, 50% of Allowable Charges
<ul style="list-style-type: none">Free Standing Facility	100%	100%	Deductible, 50% of Allowable Charges
Radiology <ul style="list-style-type: none">Hospital	Deductible, 90%	Deductible, 70% Fee Schedule	Deductible, 50% of Allowable Charges
<ul style="list-style-type: none">Physician's Office	\$20 PCP/ \$70 Specialist	\$20 PCP/ Deductible, 70% Specialist	Deductible, 50% of Allowable Charges
<ul style="list-style-type: none">Free Standing Facility	Deductible, 90%	Deductible, 70% Fee Schedule	Deductible, 50% of Allowable Charges
Pre-admission Testing	Deductible, 90%	Deductible, 70% Fee Schedule	Deductible, 50% of Allowable Charges
CT Scans / CTA <ul style="list-style-type: none">Hospital	Deductible, 90%	Deductible, 70% Fee Schedule	Deductible, 50% of Allowable Charges
<ul style="list-style-type: none">Free Standing Facility	Deductible, 90%	Deductible, 70% Fee Schedule	Deductible, 50% of Allowable Charges
Pet Scans <ul style="list-style-type: none">Hospital	Deductible, 90%	Deductible, 70% Fee Schedule	Deductible, 50% of Allowable Charges
<ul style="list-style-type: none">Free Standing Facility	Deductible, 90%	Deductible, 70% Fee Schedule	Deductible, 50% of Allowable Charges
MRI / MRA <ul style="list-style-type: none">Hospital	Deductible, 90%	Deductible, 70% Fee Schedule	Deductible, 50% of Allowable Charges
<ul style="list-style-type: none">Free Standing Facility	Deductible, 90%	Deductible, 70% Fee Schedule	Deductible, 50% of Allowable Charges

- (1) Pre-authorization: Certain services require Pre-authorization. See Medical Management section for the Pre-Authorization list.
- (2) Reimbursement to all providers is based on the "Plan Allowable Charges". Any Tier 3 provider can balance bill the patient for any amounts in excess of the Plan Allowable Charges. This excess amount is considered a non-covered amount and does not accrue towards the Out-of-Pocket maximum.

Nuclear Cardiac Studies			
• Hospital	Deductible, 90%	Deductible, 70% Fee Schedule	Deductible, 50% of Allowable Charges
• Free Standing Facility	Deductible, 90%	Deductible, 70% Fee Schedule	Deductible, 50% of Allowable Charges
Elective Stress Echocardiograms & Diagnostic Catheterizations			
• Hospital	Deductible, 90%	Deductible, 70% Fee Schedule	Deductible, 50% of Allowable Charges
• Free Standing Facility	Deductible, 90%	Deductible, 70% Fee Schedule	Deductible, 50% of Allowable Charges
Dexa / Bone Density			
• Hospital	Deductible, 90%	Deductible, 70% Fee Schedule	Deductible, 50% of Allowable Charges
• Free Standing Facility	Deductible, 90%	Deductible, 70% Fee Schedule	Deductible, 50% of Allowable Charges
Therapy Services			
Cardiac / Respiratory Rehab ⁽¹⁾			
• In-patient	Refer to In-Patient Admissions	Refer to In-Patient Admissions	Refer to In-Patient Admissions
• Out-patient Hospital	\$20 Copay	\$20 Copay	Deductible, 50% of Allowable Charges
• Office / Other Facility	\$20 Copay	\$20 Copay	Deductible, 50% of Allowable Charges
Radiation / Chemotherapy			
• In-patient	Refer to In-Patient Admissions	Refer to In-Patient Admissions	Refer to In-Patient Admissions
• Out-patient Hospital	Deductible, 90%	Deductible, 70% Fee Schedule	Deductible, 50% of Allowable Charges
• Office / Other Facility	Deductible, 90%	Deductible, 70% Fee Schedule	Deductible, 50% of Allowable Charges

(1) Pre-authorization: Certain services require Pre-authorization. See Medical Management section for the Pre-Authorization list.
(2) Reimbursement to all providers is based on the "Plan Allowable Charges". Any Tier 3 provider can balance bill the patient for any amounts in excess of the Plan Allowable Charges. This excess amount is considered a non-covered amount and does not accrue towards the Out-of-Pocket maximum.

Dialysis			
• In-patient	Refer to In-Patient Admissions	Refer to In-Patient Admissions	Refer to In-Patient Admissions
• Out-patient Hospital	Deductible, 90%	Deductible, 70% Fee Schedule	Deductible, 50% of Allowable Charges
• Other Facility	N/A	Deductible, 70% Fee Schedule	Deductible, 50% of Allowable Charges
Infusion Therapy ⁽¹⁾			
• In-patient	Refer to In-Patient Admissions	Refer to In-Patient Admissions	Refer to In-Patient Admissions Charges
• Out-patient Hospital	Deductible, 90%	Deductible, 70% Fee Schedule	Deductible, 50% of Allowable Charges
• Physician's Office	Deductible, 90%	Deductible, 70% Fee Schedule	Deductible, 50% of Allowable Charges
• Home Based	N/A	Deductible, 70% Fee Schedule	Deductible, 50% of Allowable Charges
Cognitive Therapy ⁽¹⁾			
• In-patient	Refer to In-Patient Admissions	Refer to In-Patient Admissions	Refer to In-Patient Admissions
• Out-patient Hospital	\$20 Copay	\$20 Copay	Deductible, 50% of Allowable Charges
• Office / Other Facility	\$20 Copay	\$20 Copay	Deductible, 50% of Allowable Charges
Occupational Therapy ⁽¹⁾			
• In-patient	Refer to In-Patient Admissions	Refer to In-Patient Admissions	Refer to In-Patient Admissions
• Out-patient Hospital	\$20 Copay	\$20 Copay	Deductible, 50% of Allowable Charges
• Office / Other Facility	\$20 Copay	\$20 Copay	Deductible, 50% of Allowable Charges
Physical Therapy ⁽¹⁾			
• In-patient	Refer to In-Patient Admissions	Refer to In-Patient Admissions	Refer to In-Patient Admissions
• Out-patient Hospital	\$20 Copay	\$20 Copay	Deductible, 50% of Allowable Charges
• Office / Other Facility	\$20 Copay	\$20 Copay	Deductible, 50% of Allowable Charges
60 visits per year for PT and OT combined			

(1) Pre-authorization: Certain services require Pre-authorization. See Medical Management section for the Pre-Authorization list.

(2) Reimbursement to all providers is based on the "Plan Allowable Charges". Any Tier 3 provider can balance bill the patient for any amounts in excess of the Plan Allowable Charges. This excess amount is considered a non-covered amount and does not accrue towards the Out-of-Pocket maximum.

Habilitative Services	Services are intended to enhance ability to function, including OT, PT, & speech therapy for the treatment of a child with a congenital or genetic birth defect such as: Autism or an autism spectrum disorder; Cerebral palsy; Intellectual disability; Down syndrome; Spina bifida; Hydroencephalocele; Congenital or genetic developmental disabilities. Coverage is not required for services delivered through early intervention or school service.		
Speech Therapy ⁽¹⁾ • Out-patient Hospital	\$20 Copay	\$20 Copay	Deductible, 50% of Allowable Charges
• Office / Other Facility	\$20 Copay	\$20 Copay	Deductible, 50% of Allowable Charges
26 visits per year			
Acupuncture 10 visits per year	N/A	Deductible, 70% Fee Schedule	Deductible, 50% of Allowable Charges
Pain Management ⁽¹⁾ • Out-patient Hospital	Deductible, 90%	Deductible, 70% Fee Schedule	Deductible, 50% of Allowable Charges
• Free Standing Surgery Center	Deductible, 90%	Deductible, 70% Fee Schedule	Deductible, 50% of Allowable Charges
• Physician's Office	\$70 Copay	Deductible, 70% Fee Schedule	Deductible, 50% Allowable Charges
Covered if deemed Medically Necessary			
Other Covered Services			
Hospice ⁽¹⁾	N/A	Deductible, 70% Fee Schedule	Deductible, 50% of Allowable Charges
Bereavement Counseling	N/A	\$70 Copay	Deductible, 50% of Allowable Charges
Home Health Care ⁽¹⁾ 100 days calendar year limit	Deductible, 90% where available	Deductible, 70% Fee Schedule	Deductible, 50% of Allowable Charges
Private Duty Nursing	N/A	Deductible, 70% Fee Schedule	Deductible, 50% of Allowable Charges
Durable Medical Equipment ⁽¹⁾	Deductible, 90%	Deductible, 90% Fee Schedule Subject to Tier 1 benefit	Deductible, 50% of Allowable Charges
Durable Medical Equipment ⁽¹⁾ Repairs	Deductible, 90%	Deductible, 90% Fee Schedule Subject to Tier 1 benefit	Deductible, 50% of Allowable Charges
Breast Pump & Supplies Hospital grade requires pre-authorization	100%	100%	100%
Lactation Consultant Up to 3 visits per calendar year – within one year of birth	100%	100%	100%
Diabetic DME Supplies	Covered under DME	Covered under DME	Covered under DME

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Diabetic Counseling No visit limit	100%	Deductible, 70% Fee Schedule	Deductible, 50% of Allowable Charges
Nutritional Counseling 3 visits per calendar year	100%	Deductible, 70% Fee Schedule	Deductible, 50% of Allowable Charges
Ambulance Transportation <ul style="list-style-type: none"> • Emergent Subject to Tier 1 benefit	Deductible, 90%	Deductible, 90% Fee Schedule	Deductible, 90% of Allowable Charges
<ul style="list-style-type: none"> • Hospital To Hospital ⁽¹⁾ 	Deductible, 90%	Deductible, 70% Fee Schedule	Deductible, 50% of Allowable Charges
<ul style="list-style-type: none"> • Acute to Rehab ⁽¹⁾ 	Deductible, 90%	Deductible, 70% Fee Schedule	Deductible, 50% of Allowable Charges
	Covered if deemed Medically Necessary		
Prosthesis ⁽¹⁾	Deductible, 90%	Deductible, 70% Fee Schedule	Deductible, 50% of Allowable Charges
Orthotics ⁽¹⁾ Braces custom fitted (support of body part)	Deductible, 90%	Deductible, 70% Fee Schedule	Deductible, 50% of Allowable Charges
Foot Orthotics ⁽¹⁾ \$300 calendar year max	Deductible, 90%	Deductible, 70% Fee Schedule	Deductible, 50% of Allowable Charges
	Covered if deemed medically Necessary		
IUD <ul style="list-style-type: none"> • Insertion 	100%	100%	Not Covered
<ul style="list-style-type: none"> • Removal 	100%	100%	Not Covered
<ul style="list-style-type: none"> • Device 	100%	100%	Not Covered
Mid-Wives	Deductible, 90%	Deductible, 70% Fee Schedule	Deductible, 50% of Allowable Charges
Birthing Centers	N/A	Deductible, 70% Fee Schedule	Deductible, 50% of Allowable Charges
Abortion <ul style="list-style-type: none"> • Elective 	Not Covered	Not Covered	Not Covered
<ul style="list-style-type: none"> • Non-Elective 	Deductible, 90%	Deductible, 70% Fee Schedule	Deductible, 50% of Allowable Charges
Sterilization / Reversal <ul style="list-style-type: none"> • Sterilization 	Deductible, 90%	Deductible, 70% Fee Schedule	Deductible, 50% of Allowable Charges
<ul style="list-style-type: none"> • Reversal of Sterilization 	Not Covered	Not Covered	Not Covered
Bariatric Surgery	Deductible, 90%	Not Covered	Not Covered
	Performed at Piedmont Hospitals only ***Subject to medical necessity and clinical guidelines; \$20,000 lifetime max – Service requirement 2 years employed***		
Wigs after Chemo	\$300 max per lifetime – covered at 100%		

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Sleep Study / Disorder • Facility	Deductible, 90%	Deductible, 70% Fee Schedule	Deductible, 50% of Allowable Charges
• Physicians	Deductible, 90%	Deductible, 70% Fee Schedule	Deductible, 50% of Allowable Charges
Covered if deemed medically Necessary			
Infertility Services Precertification is Required			
Infertility Testing - Coverage for the treatment of underlying condition to the point an infertility condition is diagnosed.	Deductible, 90%	Deductible, 70% Fee Schedule	Deductible, 50% of Allowable Charges
Diagnostic testing to determine infertility prior to any treatment Diagnostic Work up Only			
Infertility Treatment	Not Covered	Not Covered	Not Covered
Mental Health/Substance Use Disorder Services			
In-patient ⁽¹⁾ • Hospital / Facility	N/A	Deductible, 90% Fee Schedule	Refer to In-Patient Admissions
• Physician Charges	N/A	Deductible, 90% Fee Schedule	Deductible, 50% of Allowable Charges
	Services Not Available at Piedmont. Tier 2 Inpatient Mental Health and Substance Use Disorder Facility & Physician Services to be paid at Tier 1 benefit.		
Residential Treatment	N/A	Deductible, 90% Fee Schedule	Deductible, 50% of Allowable Charges
Partial Hospitalization (PHP) ⁽¹⁾	Refer to Out-patient Mental Health/ Substance Use Disorder Benefit Above		
Intensive Out-patient (IOP) ⁽¹⁾	Refer to Out-patient Mental Health/ Substance Use Disorder Benefit Above		
Out-patient • Hospital / Facility	N/A	\$20 Copay	Deductible, 50% of Allowable Charges
• Physician Office	N/A	\$20 Copay	Deductible, 50% of Allowable Charges
Biofeedback	See Out-patient Benefits Above		
Marriage Counseling	Not Covered		

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Hearing Services			
Hearing Exam <ul style="list-style-type: none">Pediatric Wellness	100%	100%	Deductible, 50% of Allowable Charges
<ul style="list-style-type: none">Routine	Not Covered	Not Covered	Not Covered
<ul style="list-style-type: none">Non – Routine	\$70 Copay	Deductible, 70% Fee Schedule	Deductible, 50% of Allowable Charges
Hearing Aid – Over 18	Not Covered	Not Covered	Not Covered
Hearing Aid – Under 18	Deductible, 90%	Deductible, 70% Fee Schedule	Deductible, 50% of Allowable Charges
	Hearing aids, examinations for the prescription or fitting of hearing aids, and batteries for hearing aids are NOT COVERED, except for hearing aids and examinations as provided for children <i>under 18 years of age</i> .		
Hearing Aid Repair – Under 18	Deductible, 90%	Deductible, 70% Fee Schedule	Deductible, 50% of Allowable Charges
Vision Services			
Eye Exam <ul style="list-style-type: none">Routine	Not Covered	Not Covered	Not Covered
<ul style="list-style-type: none">Non – Routine	\$70 Copay	Deductible, 70% Fee Schedule	Deductible, 50% of Allowable Charges
Optical benefit (Hardware)	Covered through Vision Vendor		
Glasses after Cataract Surgery	Deductible, 90%	Deductible, 70% Fee Schedule	Deductible, 50% of Allowable Charges
	Glasses & Contact lenses – only covered for first pair of contact lenses for treatment of keratoconus, aphakia, or post-cataract surgery		
Dental Services			
General Dental Services	Services provided by Dental Plan		
Oral Surgery **Note: Only covered if related to an accident and/or damage to healthy teeth within first 72 hours following accidental injury	N/A	Deductible, 70% Fee Schedule	Deductible, 50% of Allowable Charges
	Covered if deemed medically Necessary		
Full / Partial Bony Impacted Wisdom teeth	Deductible, 90%	Deductible, 70% Fee Schedule	Deductible, 50% of Allowable Charges

- (1) Pre-authorization: Certain services require Pre-authorization. See Medical Management section for the Pre-Authorization list.
- (2) Reimbursement to all providers is based on the “Plan Allowable Charges”. Any Tier 3 provider can balance bill the patient for any amounts in excess of the Plan Allowable Charges. This excess amount is considered a non-covered amount and does not accrue towards the Out-of-Pocket maximum.

TMJ			
• Surgical	Deductible, 90%	Deductible, 70% Fee Schedule	Deductible, 50% of Allowable Charges
• Non – Surgical	Not Covered	Not Covered	Not Covered
	Excludes appliances and orthodontic treatment – covered per state mandate & medical policy		

- (1) Pre-authorization: Certain services require Pre-authorization. See Medical Management section for the Pre-Authorization list.
- (2) Reimbursement to all providers is based on the “Plan Allowable Charges”. Any Tier 3 provider can balance bill the patient for any amounts in excess of the Plan Allowable Charges. This excess amount is considered a non-covered amount and does not accrue towards the Out-of-Pocket maximum.

Pharmacy Benefits

* You must meet a \$150 (per member) annual deductible for brand-name prescriptions (preferred and non-preferred) before benefits begin. This is a separate deductible from the medical plan deductible. Keep in mind, you will not have to meet this deductible for generic prescriptions.

Prescription Drugs	Generic Copays		Brand-Name* Copays		Specialty Copays
	**Preventive Generic Copay	Generic Copay	Preferred	Non-Preferred	
Mail-Order Prescriptions – Up to 90-day supply <u>(You are encouraged to use mail order or the Cigna 90 Now retail network to save on maintenance medications)</u>	\$0	\$25	\$100	\$200	\$150 (30-day only)
Retail Prescriptions – Up to a 30 day supply <i>(Visit any retail pharmacy in Cigna's broad network)</i>	\$0	\$10	\$40	\$80	\$150 (30-day only) only via Piedmont Specialty pharmacies including Athens Regional and Cigna Home Delivery
Maintenance Medication Program - Piedmont Athens Regional, Oconee Drugs, Walgreens, Kroger and Walmart Pharmacies <i>(30-day or 90-day supply)</i>	\$0 (30-day) \$0 (90-day)	\$10 (30-day) \$20 (90-day)	\$40 (30-day) \$80 (90-day)	\$80 (30-day) \$160 (90-day)	N/A

** Specific preventive Generic medication list as posted on www.myhealth360piedmont.com

Preventive drugs at no cost: To help you maintain a steady treatment regimen, certain preventive generic medications are paid at 100% with no deductible when you visit an in-network pharmacy. This includes many diabetes, cholesterol, blood pressure and other select medication categories.

ROUTINE WELLNESS SCHEDULE - ALL AGES *(Including Immunizations)*

Not Covered Out-of-Network

Table 1. Ages at Which Childhood Health Supervision Visits Are Covered

Age at time of Screening
Newborn
First week of life
1 month
2 months
4 months
6 months
9 months
12 months
15 months
18 months
2 years
2 ½ years
Annually from age 3 years through age 21 years

Table 2. Covered Childhood Vaccinations

Vaccine	Doses in Series	Primary Age Range	Catch Up Range
Hepatitis B	3	Birth – 18 months	19 months – 21 years
Rotavirus	3	6 weeks – 32 weeks	None
DtaP*	5	2 months – 6 months	4 – 6 years
Tdap	1	10 years	Through age 21 years And postpartum
Haemophilus influenza b (Hib)*	4	2 months – 15 months	18 Months – 6 years
Pneumococcal conjugate	4	2 months – 6 years	None
Pneumococcal polysaccharide	1	None	7 – 21 years if medically necessary
Inactivated Polio**	4	2 months – 6 years	Through age 21 years
Influenza	Annual	6 months – 21 years	Not Applicable
Measles**	2	12 – 15 months	Through age 21 years
Mumps**	2	12 – 15 months	Through age 21 years
Rubella**	2	12 – 15 months	Through age 21 years
Varicella**	2	12 months – 6 years	Through age 21 years
Hepatitis A	2	12 – 18 months	Through age 21 years
Meningococcal	1 – 2	2 years	Through age 21 years
Human papilloma virus (HPV) (Cervical cancer vaccine)	3	9 – 12 years	Through age 21 years

Vaccines marked with single asterisk () are covered whether given singly or in combination with each other.

Vaccines marked with double asterisk () are covered whether given singly or in combination with each other.

Table 3. Tests or Interventions Covered in Addition to Childhood Health Supervision Visit

I Age/Age Range	Test or Intervention
Newborn – 2 months	Vision Screen (Visual Evoked Potential) Hearing Screen (Auditory Evoked Potential)
Newborn – 2 months	Hemoglobin and Metabolic Screening (PKU, Hypothyroidism)
9 months, 18 months, 30 months	Autism Screening
12 months (earlier and more often if indicated by history)	Hemoglobin
12 months and 24 months	Lead screening
At any visit after 1 month, if indicated by history	Tuberculin Skin Test
3 – 5 years	Baseline Urinalysis
11 – 18 years	One dipstick urinalysis annually for male and female adolescents who are sexually active
18 – 21 years (earlier if indicated by history and/or physical examination)	Dyslipidemia Screening (cholesterol, lipid panel)
11 years – 21 years (if indicated by history and/or physical examination)	Sexually Transmitted Infection Screening (e.g., Cervical or Urethral Culture)
11 years – 21 years (if indicated by history and/or physical examination)	Cervical Dysplasia Screening (e.g. Pap Smear)

Table 4. Covered Adult Wellness Evaluations or Interventions

Age/Age Range	Frequency	Evaluation or Intervention
From age 22	Annually	History and Physical Examination
From age 22 years	Annually	Multiphasic chemistry screening, to include cholesterol and high-density lipoprotein (HDL) level (or lipid panel, if indicated by history)
From age 22 years	Annually	Hemoglobin
From age 22 years	Annually	Urinalysis
From age 22 years	Annually	Screen for cervical dysplasia (Pap Smear)
From age 22 years	Annually	Electrocardiogram
Women between age 35 years and 39 years (if indicated by family history)	Once	Baseline Mammogram
Women from age 40 years	Annually	Mammogram
From age 45 years	Annually	Stool Examination for Presence of Blood
From age 50 years (for average risk individual)	Every 10 years	Colonoscopy
Males from age 50 years (from age 40 years if in a high-risk category such as African-American or with family history of prostate cancer) through age 75 years	Annually	Prostate-Specific Antigen (PSA)
From age 35 years	Every 2 years	Intraocular Pressure (Glaucoma) Test
Women within 3 – 5 years after menopause or age 65 years or older (if never screened)	Once	Bone Densitometry (Osteoporosis Screening)
Men age 70 years or older	Once	Bone Densitometry (Osteoporosis Screening)
From age 22 years	Annually	Influenza vaccine
Women between age 22 years and 26 years (if not yet immunized)	Once	Three-dose series of human papilloma virus (HPV [cervical cancer]) vaccine
From age 22 years (if not immune or previously immunized)	Once	One- to two-dose series of varicella (chickenpox) vaccine
From age 22 years (if not immune or previously immunized)	Once	Two-dose series of measles-mumps-rubella vaccine
From age 22 years (but not prior to 10 years since last tetanus booster)	Once	Td or TdaP, influenza, pneumococcal, meningococcal (as per ACIP recommendations); childhood diseases (e.g., MMR, varicella) if susceptible; others (e.g., hepatitis B, human papilloma virus [HPV], zoster) if indicated (See individual policies for HPV vaccine and zoster vaccine .)

Preventive Services Provided at No-Cost to Covered Employees and their Dependents

In addition to any other preventive services provided at no cost as described in this Plan, the following Preventive Services shall be provided with no copayment, coinsurance or deductible **when provided In-Network** under any of the Plans discussed below pursuant to ACA and its implementing regulations:

1. **Evidence-based items or services, including various types of screenings**, with a rating of "A" or "B" under current recommendations from the US Preventive Services Task Force (USPSTF) with respect to the individual involved, including but not limited to:

- Screenings for diabetes, high cholesterol, high blood pressure, depression; and
- Screening and counseling related to tobacco use, alcohol use and obesity.

2. **Routine immunizations for Children, Adolescents and Adults** 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, including but not limited to:

- Influenza
- Meningitis
- Tetanus
- HPV
- Hepatitis A and B
- Measles
- Mumps
- Rubella
- Rotavirus
- Varicella

3. **Preventive care and screenings for infants and children through age 21** provided for in comprehensive guidelines supported by the Health Resources and Services Administration, including but not limited to:

- regular pediatrician visits
- vision, hearing and oral health exams
- developmental assessments
- immunizations
- iron and fluoride supplements
- screening for autism
- screening for lipid disorders, tuberculosis, and certain genetic diseases

4. **Evidence-informed preventive care and screenings for women** (including pregnant women) to the extent not described in section 1 above, provided for in binding comprehensive health plan coverage guidelines supported by the Health Resources and Services Administration, including but not limited to:

- FDA-approved contraceptives and contraceptive counseling (see Schedule of Benefits for more details)
- Well-woman visits, including preconception and prenatal care (including Dependents)
- Gestational diabetes screening
- Human papillomavirus (HPV) DNA testing for women age 30 and older
- Sexually transmitted infection counseling
- HIV screening and counseling
- Breastfeeding support, supplies and counseling
- Domestic violence screening and counseling

Preventive benefits shall be provided at no cost consistent with any updates to benefits in the above categories provided by U.S. Department Health and Human Services. For more information regarding preventive services and whether a particular preventive service is covered at no cost, visit U.S. Department Health and Human Services website at <https://www.healthcare.gov/coverage/preventive-care-benefits/> or contact your Claims Administrator. Note that this list is subject to change based on updates by the U.S. Department Health and Human Services.

MEDICAL BENEFITS

Medical Benefits apply when covered charges are incurred by a Covered Person for care of an Injury or Sickness and while the person is covered for these benefits under the Plan.

DEDUCTIBLE AND COPAYMENTS

Deductible /Copayments are payable by Covered Persons

Deductibles/Copayments are dollar amounts that the Covered Person must pay before the Plan pays.

A deductible is an amount of money that is paid once a Calendar Year before benefit payments begin. Typically, there is one deductible amount and it must be paid before any money is paid by the Plan for any covered services. Deductibles accrue toward the maximum out-of-pocket payment.

A copayment is a smaller amount of money that is paid each time a particular service is used. Typically, there may be copayments on some services and other services will not have any copayments. Copayments accrue toward the maximum out-of-pocket payment. You do not have to satisfy the deductible for services in which a copayment applies.

Family Unit Limit. The family deductible shown in the **Schedule of Benefits** by aggregating all family member out of pocket costs.

BENEFIT PAYMENT

Each Calendar Year the plan will pay the eligible charges of a Covered Person that are in excess of the deductible and any copayments. Payment will be made at the rate shown under Reimbursement rate in the **Schedule of Benefits**. No benefits will be paid in excess of the Maximum Benefit Amount or any listed limit of the Plan.

OUT-OF-POCKET LIMIT

Covered Charges are payable at the percentages shown each Calendar Year until the out-of-pocket limit shown in the **Schedule of Benefits** is reached. Then, Covered Charges incurred by a Covered Person will be payable at 100% (except for the charges excluded) for the rest of the Calendar Year.

When a Family Unit reaches the out-of-pocket limit, Covered Charges for that Family Unit will be payable at 100% (except for the charges excluded) for the remainder of the Calendar Year.

MAXIMUM BENEFIT AMOUNT

The Maximum Benefit Amount is shown in the **Schedule of Benefits**. It is the total amount of benefits that will be paid under the Plan for all covered charges incurred by a Covered Person.

COVERED SERVICES

COVERED CHARGES FOR THE FOLLOWING

The following Covered Charges are reimbursed based on the "Plan's Allowable Charges" and may be subject to determination of Medical Necessity, Plan Deductibles, Coinsurance, Copayment, or day/visit limitation. Please refer to the **Schedule of Benefits** for more information.

NOTE: Please see the sections entitled "How to Submit / File a Claim" and "Appeal/Grievance Procedure" for important information about how to make a claim for benefits and file an appeal, and the section entitled "Deadlines for Claims Submissions and Applicable Statutes of Limitation" for important information about timeframes for submitting a benefit claim and applicable deadlines for filing a lawsuit.

- (1) **Hospital Care.** The medical services and supplies furnished by a Hospital or Ambulatory Surgical Center. Covered charges for room and board will be payable as shown in the **Schedule of Benefits**. After 23 observation hours, a confinement will be considered an inpatient confinement.
- (2) **Organ transplant limits.** Charges otherwise covered under the Plan that are incurred for the care and treatment due to an organ or tissue transplant are subject to these limits:

The transplant must be performed to replace an organ or tissue;

If the Covered Person is an organ or tissue donor or recipient, then charges are covered under the Plan (subject to the provisions and benefits of the Plan);

If the organ or tissue donor is not a Covered Person, then, the Plan will cover donor organ or tissue charges for;

evaluating the organ or tissue;

removing the organ or tissue from the donor; and

transportation of the organ or tissue from within the United States and Canada to the place where the transplant is to take place.

When the donor has other medical coverage, his or her other plan will pay first. If the donor does not have medical coverage for organ transplants, the Plan will pay for the donor charges as identified above.

- (3) **Pre-admission testing,** provided the tests are performed on an outpatient basis within seven days of the planned admission and surgery, as shown in the **Schedule of Benefits**.
- (4) **Skilled Nursing Facility Care.** The room and board and nursing care furnished by a Skilled Nursing Facility will be payable if and when:
 - (i) the patient is confined as a bed patient in the facility;
 - (ii) the confinement starts within 14 days of a Hospital confinement of at least 3 days;
 - (iii) the attending Physician certifies that the confinement is needed for further care of the condition that caused the Hospital confinement; and
 - (iv) the attending Physician completes a treatment plan which includes a diagnosis, the proposed course of treatment and the projected date of discharge from the Skilled Nursing Facility.

Covered charges for a Covered Person's care in these facilities is shown in the **Schedule of Benefits**.

OUTPATIENT/PHYSICIAN COVERED SERVICES

- 1) **Acupuncture:** covered as stated within the Summary of Benefits section and rendered by a Licensed Anesthesiologist or Licensed Medical Doctor, if Medically Necessary.
- 2) **Allergy Testing and Treatment:** covered charges for allergy testing and treatment, including routine allergy injections and immunizations. Not covered for the purpose of travel or as a requirement of a Covered Person's employment.
- 3) **Ambulance:** Local Medically Necessary professional land or air ambulance service. A charge for this item will be a Covered Charge only if the service is to the nearest Hospital or Skilled Nursing Facility where necessary treatment can be provided.
- 4) **Anesthetic:** Administration of these items is covered under the Plan.
- 5) **Coverage of Pregnancy.** Group health plans generally may not, under Federal law, restrict benefits for any hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a vaginal delivery, or less than 96 hours following a cesarean section. However, Federal law generally does not prohibit the mother's or newborn's attending provider, after consulting with the mother, from discharging the mother or her newborn earlier than 48 hours (or 96 hours as applicable). In any case, plans and issuers may not, under Federal law, require that a provider obtain authorization from the plan or the issuer for prescribing a length of stay not in excess of 48 hours (or 96 hours).
- 6) **Preventive services related to a Dependent Child's pregnancy** as required by the ACA.
- 7) **Drugs,** medications, and biologicals when prescribed as part of a covered admission in a hospital/facility.
- 8) **Hearing Exam:** hearing exams rendered by a physician or a licensed audiologist, when services are determined to be Medically Necessary and Appropriate are covered, only as stated in the Schedule of Benefits.
- 9) ****Home Health Care Services and Supplies.** Charges for home health care services and supplies are covered only for care and treatment of an Injury or Sickness when Hospital or Skilled Nursing Facility confinement would otherwise be required. The diagnosis, care and treatment must be certified by the attending Physician and be contained in a Home Health Care Plan.

Benefit payment for nursing, home health aide and therapy services is subject to the Home Health Care limit shown in the **Schedule of Benefits**.

A home health care visit will be considered a periodic visit by either a nurse or therapist, as the case may be, or four hours of home health aide services.

****All Treatment is subject to the Benefit Payment maximums or limitations shown in the Schedule of Benefits.**

- 10) ****Hospice Care Services and Supplies.** Charges for hospice care services and supplies are covered only when the attending Physician has diagnosed the Covered Person's condition as being terminal, determined that the person is not expected to live more than six months and placed the person under a Hospice Care Plan.

****All Treatment is subject to the Benefit Payment maximums or limitations shown in the Schedule of Benefits.**

- 11) **Infusion Therapy.**
- 12) **Laboratory Services.**

- 13) **Mammography:** Plan Covers charges for Mammography: See Covered Adult Wellness Evaluations or Interventions.
- 14) ****Outpatient Surgery:** covers charges performed in a Hospital Outpatient department, Physician's office or an Ambulatory Surgical Center in connection with covered surgery.

****All Treatment is subject to the Benefit Payment maximums or limitations shown in the Schedule of Benefits.**

- 15) **Physician Care.** The professional services of a Physician for surgical or medical services.

- (i) Charges for **multiple surgical procedures** will be a covered expense subject to the following provisions:
 - (a) If bilateral or multiple surgical procedures are performed by one (1) surgeon, benefits will be determined based on the Plan Allowable Charge that is allowed for the primary procedures; 50% of the Plan Allowable Charge will be allowed for each additional procedure performed through the same incision. Any procedure that would not be an integral part of the primary procedure or is unrelated to the diagnosis will be considered "incidental" and no benefits will be provided for such procedures;
 - (b) If multiple unrelated surgical procedures are performed by two (2) or more surgeons on separate operative fields, benefits will be based on the Plan Allowable Charge for each surgeon's primary procedure. If two (2) or more surgeons perform a procedure that is normally performed by one (1) surgeon, benefits for all surgeons will not exceed the Plan Allowable Charge allowed for that procedure; and
 - (c) If an assistant surgeon is required, the assistant surgeon's covered charge will not exceed 20% of the Plan's Allowable Charges.

- 16) **Routine Preventive Care.** Covered charges under Medical Benefits are payable for routine Preventive Care as described in the Schedule of Benefits. See also Section entitled Preventive Services Provided at No-Cost for list of services provided without copayments, coinsurance or deductibles. There is no benefit, however, if service is provided by an out of network provider.

Charges for Routine Well Adult Care. Routine well adult care is care by a Physician that is not for an Injury or Sickness.

Charges for Routine Well Child Care. Routine well child care is routine care by a Physician that is not for an Injury or Sickness. Routine well-child care covered through Age 18.

Flu vaccinations are to be covered at 100% not subject to deductible or co-pay.

- 17) **Reconstructive Surgery.** Correction of abnormal congenital conditions and reconstructive mammoplasties will be considered covered charges.

This mammoplasty coverage will include reimbursement for:

- (i) reconstruction of the breast on which a mastectomy has been performed;
- (ii) surgery and reconstruction of the other breast to produce a symmetrical appearance; and
- (iii) coverage of prostheses and physical complications during all stages of mastectomy, including lymphedemas and two (2) post mastectomy bras per year, in a manner determined in consultation with the attending Physician and the patient.

- 18) **Surgical dressings,** splints, casts and other devices used in the reduction of fractures and dislocations.

20) Well Newborn Nursery/Physician Care

Charges for Routine Nursery Care. Routine well newborn nursery care is room, board and other normal care for which a Hospital makes a charge.

This coverage is only provided if a parent is a Covered Person who was covered under the Plan at the time of the birth and the newborn child is an eligible Dependent and is neither injured nor ill.

The benefit is limited to Plan Allowable Charges for nursery care for the newborn child while Hospital confined as a result of the child's birth.

Charges for covered routine nursery care will be applied toward the Plan of the mother.

Group health plans generally may not, under Federal law, restrict benefits for any hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a vaginal delivery, or less than 96 hours following a cesarean section. However, Federal law generally does not prohibit the mother's or newborn's attending provider, after consulting with the mother, from discharging the mother or her newborn earlier than 48 hours (or 96 hours as applicable). In any case, plans and issuers may not, under Federal law, require that a provider obtain authorization from the plan or the issuer for prescribing a length of stay not in excess of 48 hours (or 96 hours).

Charges for Routine Physician Care. The benefit is limited to the Plan Allowable Charges made by a Physician for the newborn child while Hospital confined as a result of the child's birth.

Charges for covered routine Physician care will be applied toward the Plan of the mother.

21) Sterilization procedures.

22) Charges associated with the initial purchase of a **wig after chemotherapy**, up to a \$300 maximum.

23) Wilm's Tumor: Covered charges for treatment of Wilm's tumor the same way it covers charges for any other illness. Treatment can include, but is not limited to, autologous bone marrow transplants when standard Chemotherapy treatment is unsuccessful. Coverage is available for this treatment even if deemed Experimental or Investigational.

24) Diagnostic **x-rays**, including CAT scans, but not dental x-rays unless related to covered services. Diagnostic testing including Magnetic Resonary Imaging (MRI).

25) Certified Nurse Midwife: Deliveries performed by a Certified Nurse Midwife are covered under the Pre-certification is needed and benefits will be payable as shown in the Schedule of Benefits.

Emergency Care & Urgent Care

Do not delay getting medical care in the event of an emergency. If a hospital admission and/or surgery is required due to a life-threatening illness or injury, get the immediate care you need. Then, you or your physician must call the Plan at 1-877-601-3835 within 2 business days, or as soon as possible after the admission occurs. In addition, you or your doctor must request a continued stay review for any emergency admission.

Definition You Need to Know

Medical Emergency — the manifestation of acute symptoms of sufficient severity (including severe pain) which a prudent layperson, who possesses an average knowledge of health and medicine, reasonably expects in the absence of immediate medical attention will result in placing the health of the individual (or, with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy; serious impairment to bodily functions; or serious dysfunction of any bodily organ or part).

Coverage if You Are Out of Town

If you require medical attention while you are traveling out of area or out of country or your covered Dependent Child requires care while away at school, the Plan will pay benefits as follows:

- *Emergency and urgent care* will be reimbursed at the Tier 1 network level where the care resulted from a Medical Emergency as defined above.

Care Not Available Within Network

The Plan has a special feature for those rare instances in which you need care that is not available within the Piedmont Healthcare Network or Cigna Open Access Provider Network. This feature permits you to get specialized care for certain procedures from Tier 3 / out-of-network providers and receive the Tier 2 network level of benefits. Any physician charges provided during an inpatient/outpatient stay must be medically necessary as determined by the Plan. Please note, you will still be responsible for the applicable office visit copay. **You must obtain approval from the Plan prior to receiving services and treatment in order to receive the Tier 2 network level of benefits through this special feature.** The plan hotline number: 1-877-601-3835

DENTAL SERVICES

Services rendered as a result of Injury to **mouth, teeth and gums**. Charges for injury to or care of the mouth, teeth, gums and alveolar processes will be covered charges under Medical Benefits only if that care is for the following oral surgical procedures:

Excision of tumors and cysts of the jaws, cheeks, lips, tongue, roof and floor of the mouth;

Surgery needed to correct accidental injuries to the jaws, cheeks, lips, tongue, floor and roof of the mouth;

Excision of benign bony growths of the jaw and hard palate;

External incision and drainage of cellulitis;

Incision of sensory sinuses, salivary glands or ducts;

Removal of bony impacted teeth; and

Charges for Surgical treatment of temporo-mandibular joint dysfunction syndrome (TMJ).

No charge will be covered under Medical Benefits for dental and oral surgical procedures involving orthodontic care of the teeth, periodontal disease, preparing the mouth for the fitting of or continued use of dentures, crowns and/or routine dental care.

DURABLE MEDICAL EQUIPMENT

- (1) **Rental of **durable medical or surgical equipment** if deemed Medically Necessary. These items may be bought rather than rented, with the cost not to exceed the fair market value of the equipment at the time of purchase, but only if agreed to in advance by the Claims Administrator.

****All Treatment is subject to the Benefit Payment maximums/limitations shown in the Schedule of Benefits.**

- (2) **The initial purchase, fitting and repair of **orthotic appliances** such as braces, splints or other appliances which are required for support for an injured or deformed part of the body as a result of a disabling congenital condition or an Injury or Sickness, unless there is sufficient change in the Covered Person's physical condition to make the original device no longer functional.

****All Treatment is subject to the Benefit Payment maximums/limitations shown in the Schedule of Benefits.**

- (3) **Foot Orthotics- Covered if Deemed Medically Necessary and subject to Plan approval.

****All Treatment is subject to the Benefit Payment maximums/limitations shown in the Schedule of Benefits.**

- (4) **The initial purchase, fitting and repair of fitted **prosthetic devices** which replace body parts, unless there is sufficient change in the Covered Person's physical condition to make the original device no longer functional.

****All Treatment is subject to the Benefit Payment maximums/limitations shown in the Schedule of Benefits.**

- (5) The Plan does not cover the following regarding Durable Medical Equipment:
- any purchases without advance written approval from the Plan;
 - replacements or repairs that are not pre-approved;
 - the rental or purchase of items such as, but not limited to, air conditioners, exercise equipment, saunas or air humidifiers that do not fully meet the definition of durable medical equipment; or
 - adjustable and/or supportive chairs or orthopedic mattresses.

The Plan does not provide for replacements (unless medically necessary and appropriate) or repairs. However, the Plan will cover certain medically necessary replacements if there is a sufficient change in a Covered Person's physical condition to make the original devices no longer functional.

MENTAL HEALTH AND SUBSTANCE USE DISORDERS

Treatment of **Mental Disorders and Substance Use Disorders**. Covered charges for care, supplies and treatment of Mental Disorders and Substance Use Disorders will be limited as follows:

- Physician's visits are limited to one treatment per day.
- Psychiatrists (M.D.), psychologists (Ph.D.) or counselors (Ph.D.) may bill the Plan directly. Other licensed mental health practitioners must be under the direction of and must bill the Plan through these professionals.

****All treatment is subject to the benefit payment shown in the Schedule of Benefits.**

SPINAL MANIPULATION/CHIROPRACTIC THERAPY SERVICES

****Spinal Manipulation/Chiropractic services** by a licensed M.D., D.O. or D.C.

****All Treatment is subject to the Benefit Payment maximums/limitations shown in the Schedule of Benefits.**

THERAPY SERVICES

- (1) ****Cardiac rehabilitation** as deemed Medically Necessary provided services are rendered (a) under the supervision of a Physician; (b) in connection with a myocardial infarction, coronary occlusion or coronary bypass surgery; (c) initiated within 12 weeks after other treatment for the medical condition ends; and (d) in a Medical Care Facility as defined by this Plan.

****All Treatment is subject to the Benefit Payment maximums/limitations shown in the Schedule of Benefits.**

- (2) ****Radiation or chemotherapy** and treatment with radioactive substances. The materials and services of technicians are included.

****All Treatment is subject to the Benefit Payment maximums/limitations shown in the Schedule of Benefits.**

- (3) ****Cognitive Therapy** by a licensed psychologist. Therapy must be in accordance with a physician's exact orders as to type, frequency, and duration to improve cognitive skills.

****All Treatment is subject to the Benefit Payment maximums/limitations shown in the Schedule of Benefits.**

- (4) ****Occupational therapy** by a licensed occupational therapist. Therapy must be ordered by a Physician, result from an Injury or Sickness and improve a body function. Covered expenses do not include recreational programs, maintenance therapy or supplies used in occupational therapy.

****All Treatment is subject to the Benefit Payment maximums/limitations shown in the Schedule of Benefits.**

- (5) ****Physical therapy** by a licensed physical therapist. The therapy must be in accord with a Physician's exact orders as to type, frequency and duration and to improve a body function.

****All Treatment is subject to the Benefit Payment maximums/limitations shown in the Schedule of Benefits.**

- (6) ****Speech therapy** by a licensed speech therapist. Therapy must be ordered by a Physician and follow either: (i) surgery for correction of a congenital condition of the oral cavity, throat or nasal complex (other than a frenectomy) of a person; (ii) an Injury; or (iii) a Sickness or Mental Disorder, or habilitative services for children under age 19 as shown in the schedule.

****All Treatment is subject to the Benefit Payment maximums/limitations shown in the Schedule of Benefits.**

VISION SERVICES

Glasses & Contact lenses – only covered for first pair of contact lenses for treatment of keratoconus, aphakia, or post-cataract surgery.

CARE MANAGEMENT SERVICES

(This service provided by QualCare, Inc., a Cigna Company)

CARE MANAGEMENT SERVICES PHONE NUMBER: 1-877-601-3835

The patient, a family member or a provider must call this number to receive certification for certain services that are outlined on the Pre-Certification Requirement List on page 42. This call must be made five (5) days before an elective pre-certifiable service is rendered or within 2 business days for an urgent or emergent admission.

MEDICAL NECESSITY

The Plan provides payment for benefits when services are:

- performed or prescribed by a physician; and
- provided at the proper level of care (inpatient, outpatient or outside of the hospital).

In addition, the Plan only covers services or supplies that are *medically necessary* for the treatment or diagnosis of a sickness or injury, and meet the nationally recognized guidelines established to determine medical necessity.

The Plan uses specific medical guidelines to make a determination on care that is provided in either an inpatient or outpatient setting. This means that even though a physician may prescribe a service or supply, the Plan may not consider that service or supply as medically necessary for the treatment or diagnosis of a sickness or injury based on specific medical guidelines. If the Plan determines that an eligible service can be provided in an alternate setting that is medically acceptable, then the Plan reserves the right to provide benefits for such services when performed in that alternative setting.

PRE- CERTIFICATION

The Medical Management Committee of the Plan has established guidelines for participating network providers outlining the requirements regarding Pre-certification. To find out if a service requires Pre-certification, just call the Plan hotline at: **1-877-601-3835**

Definition You Need to Know

Pre-Certification: Before a Covered Person enters the Hospital on a non-emergency basis, the care review administrator will, in conjunction with the attending Physician, certify the care. A non-emergency Hospitalization is one that can be scheduled in advance. The purpose of the program is to determine what is payable by the Plan. This program is not designed to be the practice of medicine or to be a substitute for the medical judgment of the attending Physician or other health care provider. Emergency admissions require pre-certification within 2 business days.

In order to qualify for Tier 2 coverage when Piedmont Healthcare does not provide the service, you must get authorization from Care Management Department. Failure to follow this process may result in coverage of services at the Tier 3 level of benefits, or denial of services.

MyHealth360 Medical Benefit Program

Pre-Certification List As of January 1, 2016

The following is the list of Pre-Certification Requirements under your MyHealth360 Medical Benefit Program, effective 1/1/2016. **Note however that this list is subject to change and therefore Covered Persons should be sure to call 1-877-601-3835 prior to the receipt of the service to confirm whether pre-authorization is required.** Pre-Authorization is a partnership between the Covered person, the Covered Person's Physician and Care Management Staff, to ensure that your health care services are properly coordinated and the Covered Person receives the most appropriate care. It is the Covered Person's responsibility to ensure that Pre-Certification is coordinated with the Pre-Certification Department.

1. All inpatient admissions including:

- Acute Care
- Subacute Care
- Skilled Nursing
- Rehabilitation
- Hospice
- Mental Health and Substance Use Disorders
- Partial Hospital Stay for Behavioral Health

Note: Elective inpatient admissions require preauthorization at least five (5) days before the admission. Urgent or emergency admissions require notification within two (2) business days of admission.

2. Outpatient and ambulatory surgery, regardless of the location, for only the procedures listed below:

- Blepharoplasty (eyelid surgery)
- Dialysis
- Keloid revisions (removal of scar tissue)
- Foot Surgery using CPT Codes 28285 through 28299 (Hammertoe, correction of bunion)
- Mammoplasty, reduction (breast reduction)
- Mastopexy (surgical revision of a breast or other breast surgery, whether female or male)
- Gynecomastia Surgical Procedures (removal of excess tissue from the male breast)
- Otoplasty (external ear surgery)
- Rhinoplasty (plastic surgery of the nose)
- Septoplasty (reconstruction of the partition between the nasal cavities)
- Spinal Surgical Procedure (i.e: Microdiscectomy, Percutaneous Discectomy, Laminectomy)
- Turbinectomy (removal of nasal walls)
- Uvuloplasty (surgery of the soft palate of mouth)

3. Pain Management Programs/Treatment including:

- Epidurals (anesthesia into the spinal canal for pain relief)
- Cryodenervation (freezing of nerves for pain relief)
- Facet Injections (injections into a spinal joint)
- Radiofrequency denervation (procedure to destroy a nerve for relief of pain)
- Sacroiliac joint injections (injection into lower back for pain relief)
- Intrathecal (spinal canal) Pumps
- Spinal cord stimulators

4. Other outpatient services:

- Ankle Foot Orthotics, Custom fitted (those custom braces made for support above the foot)
- Autologous chondrocyte implantation, Carticel®
- Braces, Custom fitted (support of a body part)
- Durable Medical Equipment (purchases greater than \$500)
- Durable Medical Equipment All Rentals
- Homecare, Hospice, Home Infusion
- Hyperbaric Oxygen Therapy
- Infertility (treatment for those that are unable to conceive, must have coverage under the Plan Benefits)

- Investigational/Experimental Services
- Obstetrical Ultrasounds greater than three (3) per pregnancy (test to visualize a fetus in the uterus)
- Outpatient Infusion therapy, excluding Cancer Chemotherapy (medicine or fluids into veins)
- Polysomnography (attended sleep Lab studies)
- Prosthetics (artificial body parts)
- Proton Beam Radiotherapy
- Rehabilitation (cardiac, cognitive, occupational, physical, pulmonary, speech therapy)
- Transplant evaluations
- Transportation Elective (non-emergency only) by fixed wing aircraft

For Precertification Call:

1-877-601-3835

If Hospitalization or Surgery Is Recommended

All non-emergency Hospital admissions must be reviewed by the Plan before the patient is admitted. This procedure must be followed whether you use the network or out-of-network portion of the Plan. You or your doctor must call for pre-certification and request a pre-Hospital review at least five business days before the admission is scheduled (or as soon as possible).

You are also required to obtain a pre-surgical review for any non-emergency procedure that is listed on the pre-certification list performed outside of a physician's office. The review must be requested at least five days before the surgery is scheduled. If the surgery is being performed in a Hospital on an inpatient basis, the pre-surgical review request should be made at the same time as the request for a pre-Hospital review.

Here's how the program works.

Pre-Certification. Before a Covered Person enters a Medical Care Facility on a non-emergency basis or receives other listed medical services, the Care Management administrator will, in conjunction with the attending Physician, certify the care as appropriate for Plan reimbursement. A non-emergency stay in a Medical Care Facility is one that can be scheduled in advance.

The Care Management program is set in motion by a telephone call from the Covered Person. Contact the Care Management administrator at the telephone number on your ID card **at least 5 days before** services are scheduled to be rendered with the following information:

- The name of the patient and relationship to the covered Employee;
- The name, identification number and address of the covered Employee;
- The name of the Employer;
- The name and telephone number of the attending Physician;
- The name of the Medical Care Facility, proposed date of admission, and proposed length of stay;
- The diagnosis and/or type of surgery; and
- The proposed medical services.

If there is an **emergency** or urgent care admission to the Medical Care Facility, the patient, patient's family member, Medical Care Facility or attending Physician must contact the Care Management administrator **within 2 business days** of the first business day after the admission.

The Care Management administrator will determine the number of days of Medical Care Facility confinement or use of other listed medical services authorized for payment. **Failure to follow this procedure may reduce reimbursement received from the Plan.**

If the Covered Person does not receive authorization as explained in this section, payment may be reduced/ or a penalty applied according to the "Schedule of Benefits".

Concurrent review, discharge planning. Concurrent review of a course of treatment and discharge planning from a Medical Care Facility are parts of the Care Management program. The Care Management administrator will monitor the Covered Person's Medical Care Facility stay or use of other medical services and coordinate with the attending Physician, Medical Care Facilities and Covered Person either the scheduled release or an extension of the Medical Care Facility stay or extension or cessation of the use of other medical services.

If the attending Physician feels that it is Medically Necessary for a Covered Person to receive additional services or to stay in the Medical Care Facility for a greater length of time than has been precertified, the attending Physician must request the additional services or days.

SECOND AND/OR THIRD OPINION PROGRAM

Certain surgical procedures are performed either inappropriately or unnecessarily. In some cases, surgery is only one of several treatment options. In other cases, surgery will not help the condition.

In order to prevent unnecessary or potentially harmful surgical treatments, the second and/or third opinion program fulfills the dual purpose of protecting the health of the Plan's Covered Persons and protecting the financial integrity of the Plan.

Benefits will be provided for a second (and third, if necessary) opinion consultation to determine the Medical Necessity of an elective surgical procedure. An elective surgical procedure is one that can be scheduled in advance; that is, it is not an emergency or of a life-threatening nature.

The patient may choose any board-certified specialist who is not an associate of the attending Physician and who is affiliated in the appropriate specialty.

While any surgical treatment is allowed a second opinion, the following procedures are ones for which surgery is often performed when other treatments are available.

Cataract surgery	Hernia surgery	Spinal surgery
Cholecystectomy (gall bladder removal)	Hysterectomy	Surgery to knee, shoulder, elbow or toe
Deviated septum (nose surgery)	Mastectomy surgery	Tonsillectomy and adenoidectomy
Hemorrhoidectomy	Prostate surgery	Tympanotomy (inner ear)
	Salpingo-oophorectomy (removal of tubes/ovaries)	Varicose vein ligation

PREADMISSION TESTING SERVICE

Preadmission testing as set forth above will be reimbursed according to the **Schedule of Benefits**.

- (1) performed on an outpatient basis within seven days before a Hospital confinement;
- (2) related to the condition which causes the confinement; and
- (3) performed in place of tests while Hospital confined.

Covered charges for this testing will be payable according to the schedule of benefits even if tests show the condition requires medical treatment prior to Hospital confinement or the Hospital confinement is not required.

CASE MANAGEMENT

When a catastrophic condition, such as a spinal cord Injury, cancer, AIDS or a premature birth occurs, a person may require long-term, perhaps lifetime care. After the person's condition is diagnosed, he or she might need extensive services or might be able to be moved into another type of care setting--even to his or her home.

Case Management is a program whereby a case manager monitors these patients and explores, discusses and recommends coordinated and/or alternate types of appropriate Medically Necessary Care. The case manager consults with the patient, the family and the attending Physician in order to develop a plan of care for approval by the patient's attending Physician and the patient. This plan of care may include some or all of the following:

- personal support to the patient;
- contacting the family to offer assistance and support;
- monitoring Hospital or Skilled Nursing Facility;
- determining alternative care options; and
- assisting in obtaining any necessary equipment and services.

Case Management occurs when this will be beneficial to both the patient and the Plan.

The case manager will coordinate and implement the Case Management program by providing guidance and information on available resources and suggesting the most appropriate treatment plan. The Plan Administrator, attending Physician, patient and patient's family must all agree to the alternate treatment plan.

Once agreement has been reached, the Plan Administrator will direct the Plan to reimburse for Medically Necessary expenses as stated in the treatment plan, even if these expenses normally would not be paid by the Plan.

Note: Case Management is a voluntary service. There are no reductions of benefits or penalties if the patient and family choose not to participate.

Each treatment plan is individually tailored to a specific patient and should not be seen as appropriate or recommended for any other patient, even one with the same diagnosis.

DEFINED TERMS

The following terms have special meanings and when used in this Plan will be bolded.

Ambulance is a certified transportation vehicle for transporting ill or injured people that contains all life-saving equipment and staff as required by applicable state and local law.

Ambulatory Surgical Center is a licensed facility that is used mainly for performing outpatient surgery, has a staff of Physicians, has continuous Physician and nursing care by registered nurses (R.N.s) and does not provide for overnight stays.

Baseline shall mean the initial test results to which the results in future years will be compared in order to detect abnormalities.

Benefit Plan Year begins January 1st and ends December 31st.

Birthing Center means any freestanding health facility, place, professional office or institution which is not a Hospital or in a Hospital, where births occur in a home-like atmosphere. This facility must be licensed and operated in accordance with the laws pertaining to Birthing Centers in the jurisdiction where the facility is located.

The Birthing Center must provide facilities for obstetrical delivery and short-term recovery after delivery; provide care under the full-time supervision of a Physician and either a registered nurse (R.N.) or a licensed nurse-midwife; and have a written agreement with a Hospital in the same locality for immediate acceptance of patients who develop complications or require pre- or post-delivery confinement.

Calendar Year means January 1 through December 31 of the same year.

COBRA means the Consolidated Omnibus Budget Reconciliation Act of 1985, as amended.

Cosmetic surgery or procedure is any surgery or procedure which involves physical appearance, but which does not correct or materially improve a physiological function and is not Medically Necessary and Appropriate.

Covered Person is an Eligible Employee or Dependent who is covered under this Plan.

Custodial Care is care (including room and board needed to provide that care) that is given principally for personal hygiene or for assistance in daily activities and can, according to generally accepted medical standards, be performed by persons who have no medical training. Examples of Custodial Care are help in walking and getting out of bed; assistance in bathing, dressing, feeding; or supervision over medication which could normally be self-administered.

Dependent. Refer to Eligible Classes of Dependent section.

Diabetes drugs and supplies mean test strips for glucose monitors and visual reading and urine test strips; insulin; injection aids; cartridges for the legally blind; syringes; insulin infusion devices; and oral agents for controlling blood sugar.

Diagnostic Services means procedures ordered by a recognized provider because of specific symptoms to diagnose a specific condition or disease. Some examples are: a) radiology, ultrasound and nuclear medicine; b) laboratory and pathology; c) EKGs, EEGs and other electronic diagnostic tests.

Discretion means the employer has the sole right to make a decision or determination.

Durable Medical Equipment means equipment which (a) can withstand repeated use, (b) is primarily and customarily used to serve a medical purpose, (c) generally is not useful to a person in the absence of an Illness or Injury and (d) is appropriate for use in the home.

Effective Date is the date on which coverage begins for a Covered Person.

Employee means a person who is a common law employee of the Employer.

Employer is Piedmont Healthcare, Inc.

Enrollment Date is the first day of coverage after the Waiting Period.

ERISA is the Employee Retirement Income Security Act of 1974, as amended.

Experimental and/or Investigational means services, supplies, care and treatment which does not constitute accepted medical practice properly within the range of appropriate medical practice under the standards of the case and by the standards of a reasonably substantial, qualified, responsible, relevant segment of the medical community or government oversight agencies at the time services were rendered.

The Plan Administrator must make an independent evaluation of the experimental/non-experimental standings of specific technologies. The Plan Administrator shall be guided by a reasonable interpretation of Plan provisions. The decisions shall be made in good faith and rendered following a detailed factual background investigation of the claim and the proposed treatment. The decision of the Plan Administrator will be final and binding on the Plan. The Plan Administrator will be guided by the following principles:

- (1) if the drug or device cannot be lawfully marketed without approval of the U.S. Food and Drug Administration and approval for marketing has not been given at the time the drug or device is furnished; or
- (2) if the drug, device, medical treatment or procedure, or the patient informed consent document utilized with the drug, device, treatment or procedure, was reviewed and approved by the treating facility's Institutional Review Board or other body serving a similar function, or if federal law requires such review or approval; or
- (3) if reliable evidence shows that the drug, device, medical treatment or procedure is the subject of on-going phase I or phase II clinical trials, is the research, experimental, study or Investigational arm of on-going phase III clinical trials, or is otherwise under study to determine its maximum tolerated dose, its toxicity, its safety, its efficacy or its efficacy as compared with a standard means of treatment or diagnosis; or
- (4) if reliable evidence shows that the prevailing opinion among experts regarding the drug, device, medical treatment or procedure is that further studies or clinical trials are necessary to determine its maximum tolerated dose, its toxicity, its safety, its efficacy or its efficacy as compared with a standard means of treatment or diagnosis.

Drugs are considered Experimental if they are not commercially available for purchase and/or they are not approved by the Food and Drug Administration for general use.

Extended Care Center or Facility. See Skilled Nursing Facility definition.

Family Unit is the covered Employee and the Employee's family members who are covered as Dependents under the Plan.

Generic Drug means a Prescription Drug which has the equivalency of the brand name drug with the same use and metabolic disintegration. This Plan will consider as a Generic Drug any Food and Drug Administration approved generic pharmaceutical dispensed according to the professional standards of a licensed pharmacist and clearly designated by the pharmacist as being generic.

Home Health Care Agency is an organization that meets all of these tests: its main function is to provide Home Health Care Services and Supplies; it is federally certified as a Home Health Care Agency; and it is licensed by the state in which it is located, if licensing is required.

Home Health Care Plan must meet these tests: it must be a formal written plan made by the patient's attending Physician which is reviewed at least every 30 days; it must state the diagnosis; it must certify that the Home Health Care is in place of Hospital confinement; and it must specify the type and extent of Home Health Care required for the treatment of the patient.

Home Health Care Services and Supplies include: part-time or intermittent nursing care by or under the supervision of a registered nurse (R.N.); part-time or intermittent home health aide services provided through a Home Health Care Agency (this does not include general housekeeping services); physical, occupational and speech therapy; medical supplies; and laboratory services by or on behalf of the Hospital.

Hospice means a provider of palliative and supportive care for terminally ill or terminally injured people who are medically certified to have less than six (6) months to live. The Plan will recognize it if it carries out its stated purpose under all relevant state and local laws, and is either:

- a) approved for its stated purpose by Medicare; or
- b) accredited for its stated purpose by an appropriate accrediting entity.

Hospice Agency is an organization where its main function is to provide Hospice Care Services and Supplies and it is licensed by the state in which it is located, if licensing is required.

Hospice Care Plan is a plan of terminal patient care that is established and conducted by a Hospice Agency and supervised by a Physician.

Hospice Care Services and Supplies are those provided through a Hospice Agency and under a Hospice Care Plan and include inpatient care in a Hospice, Hospice Unit or other licensed facility, home care, and family counseling during the bereavement period.

Hospice Unit is a facility or separate Hospital Unit that provides treatment under a Hospice Care Plan and admits at least two unrelated persons who are expected to die within six months.

Hospital is an institution which is engaged primarily in providing medical care and treatment of sick and injured persons on an inpatient basis at the patient's expense and which fully meets these tests: it is accredited as a Hospital by the Joint Commission on Accreditation of Healthcare Organizations or Det Norske Veritas Healthcare, Inc.; it is approved by Medicare as a Hospital; it maintains diagnostic and therapeutic facilities on the premises for surgical and medical diagnosis and treatment of sick and injured persons by or under the supervision of a staff of Physicians; it continuously provides on the premises 24-hour-a-day nursing services by or under the supervision of registered nurses (R.N.s); and it is operated continuously with organized facilities for operative surgery on the premises.

The definition of "Hospital" shall be expanded to include the following:

- A facility operating legally as a psychiatric Hospital or residential treatment facility for mental health and licensed as such by the state in which the facility operates; and
- A facility operating primarily for the treatment of Substance Use Disorders if it meets these tests: maintains permanent and full-time facilities for bed care and full-time confinement of at least 15 resident patients; has a Physician in regular attendance; continuously provides 24-hour a day nursing service by a registered nurse (R.N.); has a full-time psychiatrist or psychologist on the staff; and is primarily engaged in providing diagnostic and therapeutic services and facilities for treatment of Substance Use Disorders.

Illness means a bodily disorder, disease, physical sickness or Mental Disorder. Illness includes Pregnancy, childbirth, miscarriage or Complications of Pregnancy.

Infertility means a condition that results in the abnormal function of the reproductive system such that a person is unable to:

- a. impregnate another person;
- b. conceive after unprotected intercourse; or
- c. carry a pregnancy to live birth.

Injury means an accidental physical Injury to the body caused by unexpected external means.

Intensive Care Unit is defined as a separate, clearly designated service area which is maintained within a Hospital solely for the care and treatment of patients who are critically ill. This also includes what is referred to as a "coronary care unit" or an "acute care unit." It has: facilities for special nursing care not available in regular rooms and wards of the Hospital; special lifesaving equipment which is immediately available at all times; at least two beds for the accommodation of the critically ill; and at least one registered nurse (R.N.) in continuous and constant attendance 24 hours a day.

Late Enrollee means an Eligible Employee or the Eligible Employee's Dependent who enrolls under the Plan other than during the first 31-day period in which the individual is eligible to enroll under the Plan or during a Special Enrollment Period.

Legal Guardian means a person recognized by a court of law as having the duty of taking care of the person and managing the property and rights of a minor child.

Lifetime is a word that appears in this Plan in reference to benefit maximums and limitations. Lifetime is understood to mean while covered under this Plan. Under no circumstances does Lifetime mean during the lifetime of the Covered Person.

Medical Care Facility means a Hospital, a facility that treats one or more specific ailments or any type of Skilled Nursing Facility.

Medical Emergency is the manifestation of acute symptoms of sufficient severity (including severe pain) which a prudent layperson, who possesses an average knowledge of health and medicine, reasonably expects the in the absence of immediate medical attention will result in placing the health of the individual (or, with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy; serious impairment to bodily functions; or serious dysfunction of any bodily organ or part).

Medically Necessary Care is care or treatment recommended or approved by a Physician; is consistent with the patient's condition or accepted standards of good medical practice; is medically proven to be effective treatment of the condition; is not performed mainly for the convenience of the patient or provider of medical services; is not conducted for research purposes; and is the most appropriate level of services which can be safely provided to the patient.

All of these criteria must be met; merely because a Physician recommends or approves certain care does not mean that it is Medically Necessary. The Claims Administrator has the discretionary authority to decide whether care or treatment is Medically Necessary.

Medicaid is Title XIX (grants to states for medical assistance programs) of the United States Social Security Act, as amended.

Medicare is the Health Insurance For The Aged and Disabled program under Title XVIII of the Social Security Act, as amended.

Mental Disorder means any disease or condition, regardless of whether the cause is organic, that is classified as a Mental Disorder in the current edition of International Classification of Diseases, published by the U.S. Department of Health and Human Services or is listed in the current edition of Diagnostic and Statistical Manual of Mental Disorders, published by the American Psychiatric Association.

Morbid Obesity is a diagnosed condition in which the body weight exceeds the medically recommended weight by either 100 pounds or is twice the medically recommended weight in the most recent Metropolitan Life

Insurance Co. tables (or similar actuarial tables) for a person of the same height, age and mobility as the Covered Person.

No-Fault Auto Insurance is the basic reparations provision of a law providing for payments without determining fault in connection with automobile accidents.

Nurse means a registered nurse or licensed practical nurse, including a nurse specialist such as a nurse anesthetist, who: a) is properly licensed or certified to provide medical care under the laws of the state where he/she practices; and b) provides medical services which are within the scope of his or her license or certificate and are covered by this Plan.

Open Enrollment is the period prior to the Plan's Calendar Year effective date during which eligible Employee's and their Dependent may enroll for the first time and Covered Persons and their Dependents will have the opportunity to change their level of coverage or choose between plans offered. Benefit elections made during Open Enrollment will become effective on January 1st and remain in effect for 12 months unless there is a Qualifying Event, as set-forth under a family or job status change, as noted in the enrollment section of this document.

Outpatient Care is treatment including services, supplies and medicines provided and used at a Hospital under the direction of a Physician to a person not admitted as a registered bed patient; or services rendered in a Physician's office, laboratory or X-ray facility, an Ambulatory Surgical Center, or the patient's home.

Pharmacy means a licensed establishment where covered Prescription Drugs are filled and dispensed by a pharmacist licensed under the laws of the state where he or she practices.

Physician means a Doctor of Medicine (M.D.), Doctor of Osteopathy (D.O.), Doctor of Dental Surgery (D.D.S.), Doctor of Podiatry (D.P.M.), Doctor of Chiropractic (D.C.), Audiologist, Certified Nurse Anesthetist, Licensed Professional Counselor, Licensed Professional Physical Therapist, Midwife, Occupational Therapist, Optometrist (O.D.), Physiotherapist, Psychiatrist, Psychologist (Ph.D.), Speech Language Pathologist and any other practitioner of the healing arts who is licensed and regulated by a state or federal agency and is acting within the scope of his or her license.

Plan means Piedmont Healthcare, Inc. MyHealth360 Medical Benefit Program offered under the Piedmont Healthcare, Inc. Comprehensive Health and Welfare Benefits Plan.

Plan Allowable Charges are charges that do not exceed the maximum dollar amount the Plan will recognize for a covered service, procedure or supply by network providers of similar profession. Charges in excess of the *Plan's Allowable Charges* are not considered covered charges under the Plan and do not accrue towards your maximum out-of-pocket allowance.

Plan Participant is any Employee or Dependent who is covered under this Plan.

Pre-Certification. Before a Covered Person enters the Hospital on a non-emergency basis, the Care Management administrator will, in conjunction with the attending Physician, certify the care. A non-emergency Hospitalization is one that can be scheduled in advance. This program is not designed to be the practice of medicine or to be a substitute for the medical judgment of the attending Physician or other health care providers. Emergency admissions require pre-certification within 2 business days. If the Covered Person does not receive authorization as explained under the section Care Management Services, payment may be reduced/ or a penalty applied according to the "Schedule of Benefits".

Pregnancy is childbirth and conditions associated with Pregnancy, including complications.

Prescription Drug means any of the following: a Food and Drug Administration-approved drug or medicine which, under federal law, is required to bear the legend: "Caution: federal law prohibits dispensing without prescription"; injectable insulin; hypodermic needles or syringes, but only when dispensed upon a written prescription of a licensed Physician. Such drug must be Medically Necessary in the treatment of a Sickness or Injury.

Preventive Care means services and supplies in accordance with the Affordable Care Act, including but not limited to, routine physical examinations, including laboratory tests and x-rays, immunizations and vaccines, well baby care, pap smears, mammography, and screening tests.

Sickness is a person's illness, disease or pregnancy (including complications).

Skilled Nursing Facility is a facility that fully meets all of these tests:

- (1) It is licensed to provide professional nursing services on an inpatient basis to persons convalescing from Injury or Sickness. The service must be rendered by a registered nurse (R.N.) or by a licensed practical nurse (L.P.N.) under the direction of a registered nurse. Services to help restore patients to self-care in essential daily living activities must be provided;
- (2) Its services are provided for compensation and under the full-time supervision of a Physician;
- (3) It provides 24 hour per day nursing services by licensed nurses, under the direction of a full-time registered nurse;
- (4) It maintains a complete medical record on each patient;
- (5) It has an effective Care Management plan;
- (6) It is not, other than incidentally, a place for rest, the aged, drug addicts, alcoholics, mental retardates, Custodial or educational care or care of Mental Disorders; and
- (7) It is approved and licensed by Medicare.

This term also applies to charges incurred in a facility referring to itself as an extended care facility, convalescent nursing home, rehabilitation hospital or any other similar nomenclature.

Spinal Manipulation/Chiropractic Care means skeletal adjustments, manipulation or other treatment in connection with the detection and correction by manual or mechanical means of structural imbalance or subluxation in the human body. Such treatment is done by a Physician to remove nerve interference resulting from, or related to, distortion, misalignment or subluxation of, or in, the vertebral column.

Substance Use Disorder is a condition in which the use of one or more substances leads to a clinically significant impairment or distress affecting the individual's physical or mental health. Such substances include alcoholic beverages, controlled substances (whether by prescription or not), and tobacco products (other than for religious or ceremonial use) used on average four or more times per week within no longer than the past six months. This does not include dependence on ordinary caffeine-containing drinks.

Total Disability (Totally Disabled) means: Children who are Totally Disabled, incapable of self-sustaining employment by reason of mental or physical handicap, primarily dependent upon the covered Employee for support and maintenance and are unmarried.

Usual and Reasonable Charge is a charge which is not higher than the usual charge made by the provider of the care or supply and does not exceed the usual charge made by most providers of like service in the same area. This test will consider the nature and severity of the condition being treated. It will also consider medical complications or unusual circumstances that require more time, skill or experience.

PLAN EXCLUSIONS

Not all healthcare services are covered services. The following is a list of services that are not covered under the Plan. If you are not sure if a service is covered, call Member Services to find out if that service is covered.

(1) **Alternative Medicine:** Acupressure, aromatherapy, ayurvedic medicine, guided imagery, herbal medicine, homeopathy, massage therapy, naturopathy, relaxation therapy, transcendental meditation, or yoga.

(2) **Behavioral Health Services.** The following behavioral health services are not covered under the Plan:

- Any psychotherapy, psychiatric care, or treatment services for mental health or substance use which are court-ordered, unless such services are medically necessary;
- Treatment for personality disorders where that is the primary diagnosis;
- Any treatment/services related to personal or professional growth/development, educational or professional training or certification, or treatment services required for investigative purposes related to employment;
- Any services necessary to obtain or maintain employment or insurance or for judicial or administrative proceedings, including, but not limited to, adjudication of marital, child support, or custody cases;
- Methadone maintenance for the treatment of chemical dependency;
- Treatment for chronic behavioral conditions, once you have been restored to the pre-crisis level of function;
- Marriage or family counseling, except when rendered in connection with services provided for a treatable mental disorder;
- Chronic maintenance therapy, except in the case of serious mental illness;
- Aversion therapy, bioenergetics therapy, carbon dioxide therapy, confrontation therapy, crystal healing therapy, cult deprogramming, electrical aversion therapy for alcoholism, narcotherapy, orthomolecular therapy, primal therapy, expressive therapies, such as art or psychodrama, and hyperbaric or other therapy;
- Sex therapy without a diagnosis as defined by the most current version of the Diagnostic and Statistical Manual of Mental Disorders (DSM);
- Sedative action electrostimulation therapy;
- Sensitivity training;
- 12-step model programs as sole therapy for conditions, including, but not limited to, eating disorders or addictive gambling;
- Treatment or consultation provided by the members' parents, siblings, children, current or former spouse or domiciliary partner;
- Truancy or disciplinary problems not associated with a treatable mental disorder;
- Psychoanalysis or other therapies which are not short-term or crisis-oriented;
- Psychological and neuropsychological testing for learning disabilities or problems, other school-related issues, to obtain or maintain employment, to submit a disability application for a mental or emotional condition, and any other testing that does not require administration by a behavioral health professional, including self-test reports;
- Intensive health coaching services, resource coordination activity, behavioral health rehabilitation services for children and adolescents, and summer camp programs;
- Respite services;
- Educational services and treatment of behavioral disorders, and services for remedial education or childhood autism, except what is covered for neurological disorders and behavioral issues; and
- Hyperkinetic syndromes.

Eligibility for and maintenance of Social Security disability benefits does not determine whether the Plan will cover specific behavioral health or Substance Use Disorder treatment services. Medical necessity criteria will be used to determine whether specific treatment services are covered.

(3) **Blood.** Non-purchased blood or blood products, including autologous donations are not covered.

(4) Corrective Appliances.

Corrective appliances primarily intended for athletic purposes or related to a sports medicine treatment plan and other appliances or devices, or any related services, including, but not limited to, children's corrective shoes, arch supports, special clothing or bandages of any type, back braces, lumbar corsets, hand splints, shoe inserts, or orthopedic shoes, unless otherwise set forth herein.

(5) Cosmetic Surgery. Surgical or other services for cosmetic purposes performed to repair or reshape a body structure for the improvement of the person's appearance or for psychological or emotional reasons and from which no improvement in physiological function can be expected, except as such surgery or services are required to be covered by law. Excluded services include, but are not limited to, port wine stains, augmentation procedures, reduction procedures, and scar revisions.

(6) Court Ordered Services. Court-ordered services when your physician or other professional provider determines that those services are not medically necessary.

(7) Custodial Care. Custodial care, domiciliary care, or protective and supportive care, including, but not limited to, respite care, rest cures, educational services, convalescent care, dietary services, homemaker services, maintenance therapy, and food or home-delivered meals.

(8) Dental Care. Except as otherwise set forth in this document, services directly related to care, treatment, removal, or replacement of teeth, the treatment of injuries to or diseases of the teeth, gums, or structures directly supporting or attached to the teeth, including, but not limited to, treatment of dental abscesses or granuloma, treatment of gingival tissues (other than for tumors), and dental examinations.

(9) Employment Related or Employer Sponsored Services. The following employment related or employer sponsored services are not covered:

- For any illness or bodily injury that occurs in the course of employment, if benefits or compensation is available in whole or in part, pursuant to any federal, state, or local government's workers' compensation, or occupational disease, or similar type of legislation. This exclusion applies whether or not you claim those benefits or compensation; and
- Services that you receive from a dental or medical department, operated in whole or in part by, or on behalf of, an employer, mutual benefit association, labor union, trust, or similar entity.

(10) Experimental/Investigational. Services that are experimental/investigational in nature as determined by the claims administrator are not covered.

(11) Food Supplements/Vitamins. Food, food supplements, vitamins, and other nutritional and over-the-counter electrolyte supplements, except otherwise set forth herein.

(12) Foot Care Services. Palliative or cosmetic foot care services are not covered, including, but not limited to:

- Treatment of weak, strained, flat, unstable, or unbalanced feet;
- Metatarsalgia or bunions (except open cutting procedures);
- Treatment of corns, calluses, or toenails (except removal of nail roots if determined to be medically necessary by the claims administrator); and
- Supportive orthotic devices for the foot are covered with a calendar year max of \$300.

(13) Genetic Counseling and Testing. Genetic counseling and testing not medically necessary for treatment of a defined medical condition, except when such coverage is required by the Affordable Care Act.

(14) Growth Hormones. Growth hormone therapy unless prescribed for Classic Growth Hormone Deficiency, Turner syndrome, or certain other diagnoses as determined by the claims administrator and authorized in accordance with applicable policy and procedure.

(15) Hearing Aids. Hearing aids, examinations for the prescription or fitting of hearing aids, and batteries for hearing aids, except for hearing aids and examinations as provided for children under 18 years of age.

(16) Hearing Examinations. Hearing examinations and related services, except when such coverage is required

by the Affordable Care Act.

(17) **Home Care.** Home care for chronic conditions such as permanent, irreversible disease, injuries, or congenital conditions requiring long periods of care or observation are not covered.

(18) **Home Medical Equipment.** Comfort or convenience items, for you or your caretaker, including, but not limited to, fitness club memberships, air conditioners, televisions, telephones, dehumidifiers, air purifiers, food blenders, exercise equipment, orthopedic mattresses, home or automobile modifications, whirlpools, barber or beauty service, guest service or similar items, even if recommended by a professional provider. Medical equipment and supplies that are expendable in nature (i.e., disposable items such as incontinent pads, catheters, irrigation kits, disposable electrodes, ace bandages, and dressings) and primarily used for non-medical purposes are not covered, regardless of whether recommended by a professional provider.

(19) **Immunizations and Drugs.** Physical examinations and immunizations required by foreign travel, school, or employment, except as required by the Affordable Care Act.

(20) **Infertility Services.** Except to diagnosis the condition.

(21) **Inpatient/Outpatient Healthcare Provider Services.** The following services are not covered:

- Medical care for inpatient stays primarily for diagnostic services or observation (Observation is only covered at the observation rate);
- Medical care for inpatient stays that are primarily for rehabilitation services, except inpatient comprehensive physical rehabilitation services; and
- A private room, when the hospital has a semi-private room available (Payment will be based on the average semi-private room rate).

(22) **Medical/Dental Services not Identified as “Covered” in this document.** Any other medical or dental service or treatment, except as provided in this document or as mandated by law are not covered.

(23) **Medical Devices and Supplies.** Durable medical equipment or supplies associated or used in conjunction with non-covered items or services are not covered.

(24) **Medically Unnecessary Services.** Services that are not medically necessary as determined by the claims administrator are not covered.

(25) **Medicare.** Services for which or to the extent that payment has been made pursuant to Medicare coverage, when Medicare coverage is primary; however, this exclusion does not apply when your employer or group plan sponsor is required to offer you all of the benefits set forth in this document by law and you elect this coverage as your primary coverage.

(27) **Mental Health and Substance Use Disorder.** Services, including behavioral health treatment, that include

- Marital counseling;
- Wilderness programs; and
- Boarding schools.

(28) **Military Service.** The following military services are not covered:

- Care for military service-connected disabilities and conditions for which you are legally entitled to services and for which facilities are reasonably accessible to you; and
- Services that are provided to members of the armed forces and the National Health Service or to individuals in Veterans Administration facilities for military service-related illness or injury, unless you have a legal obligation to pay.

(29) **Miscellaneous.** Any services, supplies, or treatments not specifically listed in this document as covered benefits or preventive care services are not covered, such as:

- Services and supplies that are not provided or arranged by a participating provider and/or authorized for payment in accordance with Medical Management Department policies and process;
- Any services related to or necessitated by an excluded item or non-covered service;

- Services provided by a non-licensed practitioner or practitioner not recognized by the Plan;
- Services which are primarily educational in nature, including, but not limited to, vocational rehabilitation or recreational or educational therapy;
- Services rendered prior to the effective date of your coverage or incurred after the date of termination of your coverage, except as provided elsewhere in this document;
- Services for which you otherwise would have no legal obligation to pay;
- Charges for failure to keep a scheduled appointment;
- Concierge fees or boutique medical practice membership fees;
- Educational therapies intended to improve academic performance;
- Financial/legal services;
- Services performed by a professional provider enrolled in an education or training program when such services are related to the education or training program;
- Charges for completion of any insurance form or copying of medical records Personal comfort items, including when used in an inpatient hospital setting, including telephones, televisions, laundry charges or guest trays;
- Services rendered by a professional provider who is a member of your immediate family, defined as the member's spouse, child, stepchild, parent, sibling, son-in-law, daughter-in-law, mother-in-law, father-in-law, sister-in-law, brother-in-law, or grandparent;
- Services that are submitted by two different professional providers for the same services performed on the same date for the same individual;
- Services for, or related to, any illness or injury suffered after the effective date of your coverage that is the result of any act of war; and
- Vocational rehabilitation and employment counseling.

(30) **Motor Vehicle Accident/Workers' Compensation.** Treatment or services for injuries resulting from the maintenance or use of a motor vehicle if such treatment or service is paid or payable under a motor vehicle insurance policy, including, but not limited to, a qualified plan of self-insurance, or any fund or program for the payment of extraordinary medical benefits established by law, including medical benefits payment in any manner under applicable state law. Claims related to on the job injury or illness are not payable.

(31) **Non-Medical Items.** Health club memberships, air conditioners, televisions, telephones, dehumidifiers, air purifiers, food blenders, exercise equipment, orthopedic mattresses, home or automobile modifications, whirlpools, barber or beauty service, guest service or similar items, even if recommended by a physician.

(32) **Nutritional Supplements.** The following nutritional supplements are not covered:

- Blended food, baby food, or regular shelf food when used with an enteral system;
- Milk- or soy-based infant formula with intact proteins;
- Any formula, when used for the convenience of you or your family members;
- Nutritional supplements or any other substance utilized for the sole purpose of weight loss or gain, or for caloric supplementation, limitation, or maintenance;
- Oral semisynthetic intact protein/protein isolates, natural intact protein/protein isolates, and intact protein/protein isolates; and
- Food additives, including, but not limited to, thickeners, vitamins, fiber supplements, calorie or protein supplements and lactose digestion products, and normal food products used in the dietary management of rare hereditary genetic metabolic disorders.

(33) **Oral Surgery.** Services, including or related to oral surgery, except as otherwise outlined in this document. Exclusions include, but are not limited to:

- Services that are part of an orthodontic treatment program;
- Services required for correction of an occlusal defect;
- Services encompassing orthognathic or prognathic surgical procedures;
- Treatment of temporomandibular joint syndrome or temporomandibular joint disorders, except as set forth in this document under the covered benefits section;
- Removal of asymptomatic, non-impacted third molars; and
- Orthodontia and related services.

(34) **Transplant Services.** The following transplant services are not covered under this plan:

- Services for or related to any organ transplant except those deemed medically necessary and non-experimental/investigational by the Plan;
- Any organ transplant or procurement done outside of the continental U.S.;
- An organ transplant relating to a condition arising from employment;
- Organ and tissue transplant covered services, if there are research funds available to pay for the services; and
- Expenses incurred while searching for a suitable donor.

(35) **Over-The-Counter Drugs.** Food, food supplements, vitamins, and other nutritional and over-the-counter electrolyte supplements, except otherwise outlined in this document.

(36) **Physical Examinations.** Physical examinations, immunizations, or behavioral health services obtained for the completion of forms and preparation of specialized reports solely for insurance, licensing, employment, or other non-preventive or non-medically necessary purposes, including, but not limited to, premarital examinations, physicals for employment, school, camp, and participation in sports or travel, except as otherwise outlined in this document or when such coverage is required by the Affordable Care Act.

(37) **Reversal of Voluntary Sterilization Procedures.** Services to reverse sterilization are not covered.

(38) **Surrogate Motherhood.** Services and supplies associated with surrogate motherhood, including, but not limited to, all services and supplies relating to conception, prenatal care, delivery, and postnatal care of a member acting as a surrogate mother are not covered.

(39) **Temporomandibular Joint Syndrome.** Treatment of temporomandibular joint syndrome or temporomandibular joint disorders, regardless of the nature of the problem, except as set forth in this document and MyHealth360 Medical Benefit Program are not covered.

(40) **Transportation.** Non-emergent transportation, by any means, including via ambulance provider is not covered, unless such transportation is pre-authorized by the Medical Management Department.

(41) **Treatment Outside the U.S.** Treatment for non-emergent or non-urgent services received outside the U.S. is not covered.

(42) **Vision.** The following vision services are not covered under this plan:

- Eyeglasses and contact lenses and vision examinations, including those for prescribing or fitting eyeglasses or contact lenses (except where you have cataracts, keratoconus, or aphakic);
- Services for the correction of myopia, hyperopia, or astigmatism, including, but not limited to, radial keratotomy;
- Vision training; and
- Orthoptics.

(43) **Weight Reduction Services.** Weight reduction programs, including all related diagnostic testing and other services are not covered, except as outlined in this document for morbid obesity or when coverage is required by the Affordable Care Act. Antiobesity medication, including, but not limited to, appetite suppressants and lipase inhibitors are not covered under this plan.

HOW TO SUBMIT/FILE A CLAIM

HOW TO FILE A CLAIM

Be sure to refer to the following procedures when you need to file a claim.

When you use a Tier 1 or Tier 2 network provider, **you will not have to complete any claim forms**. If you use a Tier 3 out-of-network provider, however, you and the provider will have to complete the appropriate claim forms and submit them to the address below. Claim forms can be obtained by contacting the Claims Administrator.

Mail Claims to:
Piedmont Healthcare P.O. Box 1000 Piscataway, NJ 08855-1000
Plan Hotline: <u>1-877-601-3835</u>

If you have a question about a claim, please call the Plan hotline at 1-877-601-3835. A representative will help you resolve your question, including verifying that your claim is for a covered treatment.

CLAIMING YOUR BENEFITS (FILING A CLAIM)

The Plan Administrator has delegated to the Claims Administrator the authority to make all initial claim determinations.

Forms for filing claims may be obtained from the Claims Administrator. Complete and return them as directed by Claims Administrator within the applicable timeframes described below. When filing your claim, you must submit proof of each charge. It is extremely important that you secure copies of bills for all charges. All bills should be itemized.

Complete claims forms must be furnished to the Claims Administrator within 90 days following the date service, treatment or supply was provided. However, if through no fault of your own, you are unable to submit a claim within 90 days, your untimely claim may still be considered so long a completed claims form is submitted as soon as reasonably possible, but in no event shall the claim be submitted later than 365 days from the original date the service, treatment or supply was provided.

All benefits provided by the Plan will be paid as soon as possible upon receipt of proof of claim.

IF YOUR CLAIM IS DENIED

If your health benefits claim is denied in whole or in part, the Claims Administrator will notify you in writing or electronically of its determination within the time frames written below. The Claims Administrator may determine that more time is needed, but will notify you in writing if that is the case before the end of the respective claim period. If your claim is not filed properly, you or your authorized representatives will be notified of that fact and of the procedures to be followed to properly file a claim.

CLAIM NOTIFICATION TIME-FRAMES

When you file a claim, the Claims Administrator reviews the claim and makes the initial decision to either approve or deny the claim, according to the following time limits:

Urgent care claims (adverse or not) will be decided as soon as possible, but in no event later than 72 hours from receipt of the claim. If the claim is incomplete, so that a determination cannot be made of whether benefits are covered or payable under the Plan, the Claims Administrator will notify you within 24 hours of receipt of the claim of the information needed to complete the claim. You then have 48 hours to provide the information. Once the additional information is received by the Claims Administrator, the claim will be decided within 48 hours of the earlier of:

- (1) the Claim Administrator's receipt of the specified information; or
- (2) the end of the period afforded to you to provide the specified additional information.

Concurrent care decisions to reduce or terminate ongoing treatment will be communicated in writing or electronically to you far enough in advance to give you time to appeal and obtain a determination on review before the benefit is reduced. Any request that you may make to extend the treatment beyond the Plan-specified time or number of treatments will be decided within 24 hours of receipt of your request by the Claims Administrator. However, you must make the request to extend treatment at least 24 hours before the scheduled termination or reduction in treatment. Any decision by the Claims Administrator will be conveyed to you either in writing or electronically.

Pre-service claims (adverse or not) will be decided within 15 days of receipt. This determination period may be extended one time for 15 days for reasons beyond the Plan's control, but the Claims Administrator will notify you in writing or electronically of the circumstances causing the delay and the date a determination is expected. If the extension is due to a faulty claim, the notice of extension will describe the needed information and provide you at least 45 days from receipt of the notice to provide the necessary information.

Post-service claims denials will be decided and communicated to you in writing or electronically within 30 days of receipt of the claim. This determination period may be extended one time for 15 days for reasons beyond the Plan's control, in which case the Claims Administrator will notify you in writing or electronically within the first 30-day period of the circumstances requiring an extension and the expected date of a decision. If the extension is due to a faulty claim, the notice of extension will describe the needed information and provide you at least 45 days from receipt of the notice to provide the necessary information.

NOTICE OF INITIAL ADVERSE DETERMINATIONS

You will be given written or electronic notice of any adverse benefit determination on your claim. The notice will set forth:

- the specific reasons for denial;
- reference to the specific plan provisions on which the decision is based;
- a description of any additional material or information needed for you to perfect the claim and an explanation of why the material or information is needed;
- a description of the Plan's review procedures and the applicable time limits, as well as a statement of your right to sue;
- any specific rule, guideline, protocol or other similar criterion the decision-maker relied upon in making the adverse determination, and that a copy of the rule, guideline, etc., will be provided free, if you request a copy;
- if the decision is based on a medical necessity or experimental treatment or similar exclusion or limitation, an explanation of the scientific or clinical judgment, or a statement that the explanation will be provided free, if you request a copy; and
- if the request involves an urgent care decision, a description of the applicable expedited review process.

When an urgent care decision is involved, information may be provided orally initially, but will be provided in writing or electronically within three days of the oral notice.

APPEALS/GRIEVANCE PROCEDURES

For the purposes of this section, any reference to "you" or "your" also refers to a representative designated by you to act on your behalf; unless otherwise noted.

"Physician Reviewers" are licensed Physicians depending on the care, service or treatment under review.

We want you to be completely satisfied with the care you receive. That is why we have established a process for addressing your concerns and solving your problems.

Start With Customer Service

We are here to listen and help. If you have a concern regarding a person, a service, the quality of care, contractual benefits, or a rescission of coverage, you may call the toll-free number on your ID card, explanation of benefits, or claim form and explain your concern to one of our Customer Service representatives. You may also express that concern in writing.

We will do our best to resolve the matter on your initial contact. If we need more time to review or investigate your concern, we will get back to you as soon as possible, but in any case within 30 days. If you are not satisfied with the results of a coverage decision, you may start the appeals procedure.

Appeals Procedure

The Plan has a two-step appeals procedure for coverage decisions. To initiate an appeal, you must submit a request for an appeal in writing to the Claims Administrator's Appeals Department within 180 days of receipt of a denial notice. You should state the reason why you feel your appeal should be approved and include any information supporting your appeal. If you are unable or choose not to write, you may ask the Claims Administrator to register your appeal by telephone. Call or write us at the toll-free number on your ID card, explanation of benefits, or claim form.

Level-One Appeal

Your appeal will be reviewed and the decision made by someone not involved in the initial decision. Appeals involving Medical Necessity or clinical appropriateness will be considered by a health care professional.

For level-one appeals, we will respond in writing with a decision within 15 calendar days after we receive an appeal for a required preservice or concurrent care coverage determination, and within 30 calendar days after we receive an appeal for a postservice coverage determination. If more time or information is needed to make the determination, we will notify you in writing to request an extension of up to 15 calendar days and to specify any additional information needed to complete the review.

You may request that the appeal process be expedited if, (a) the time frames under this process would seriously jeopardize your life, health or ability to regain maximum functionality or in the opinion of your Physician would cause you severe pain which cannot be managed without the requested services; or (b) your appeal involved nonauthorization of an admission or continuing inpatient Hospital stay.

If you request that your appeal be expedited based on (a) above, you may also ask for an expedited external Independent Review at the same time, if the time to complete an expedited level-one appeal would be detrimental to your medical condition.

The Claims Administrator's Physician Reviewer, in consultation with the treating Physician, will decide if an expedited appeal is necessary. When an appeal is expedited, the Claims Administrator will respond orally with a decision within 72 hours, followed up in writing.

Level-Two Appeal

If you are dissatisfied with our level-one appeal decision, you may request a second review. To initiate a level-two appeal, follow the same process required for a level-one appeal.

Requests for a level-two appeal regarding the Medical Necessity or clinical appropriateness of your issue will be conducted by a Committee, which consists of one or more people not previously involved in the prior decision. The Committee will consult with at least one Physician in the same or similar specialty as the care under consideration, as determined by the Claims Administrator's Physician Reviewer. You may present your situation to the Committee by conference call.

For required preservice and concurrent care coverage determinations the Committee review will be completed within 15 calendar days and for post service claims, the Committee review will be completed within 30 calendar days. If more time or information is needed to make the determination, we will notify you in writing to request an extension of up to 15 calendar days and to specify any additional information needed by the Committee to complete the review.

In the event any new or additional information (evidence) is considered, relied upon or generated by the Claims Administrator in connection with the level-two appeal, the Claims Administrator will provide this information to you as soon as possible and sufficiently in advance of the Committee's decision, so that you will have an opportunity to respond. Also, if any new or additional rationale is considered by the Claims Administrator, the Claims Administrator will provide the rationale to you as soon as possible and sufficiently in advance of the Committee's decision so that you will have an opportunity to respond.

You will be notified in writing of the Committee's decision within 5 business days after the Committee meeting, and within the Committee review time frames above if the Committee does not approve the requested coverage.

You may request that the appeal process be expedited if the time frames under this process would seriously jeopardize your life, health or ability to regain maximum functionality or in the opinion of your Physician, would cause you severe pain which cannot be managed without the requested services; or your appeal involves nonauthorization of an admission or continuing inpatient Hospital stay. The Claims Administrator's Physician Reviewer, in consultation with the treating Physician, will decide if an expedited appeal is necessary. When an appeal is expedited the Claims Administrator will respond orally with a decision within 72 hours, followed up in writing.

Independent Review Procedure / External Review

If you are not fully satisfied with the decision of the Claims Administrator level-two appeal review and the appeal involves a medical judgement or a rescission of coverage, you may request that your appeal be referred to an Independent Review Organization. The Independent Review Organization is composed of persons who are not employed by the Claims Administrator or any of its affiliates. A decision to request an appeal to an Independent Review Organization will not affect the claimant's rights to any other benefits under the plan.

There is no charge for you to initiate this Independent Review Process, but there may be an application fee based on your state guidelines. The Claims Administrator will abide by the decision of the Independent Review Organization.

To request an independent review, you must notify the Appeals Coordinator within 180 days of your receipt of the Claims Administrator level-two appeal review denial. The Claims Administrator will then forward the file to the Independent Review Organization. The Independent Review Organization will render an opinion within 45 days.

When requested, and if a delay would be detrimental to your medical condition, as determined by the Claims Administrator's Physician Reviewer, or if your appeal concerns an admission, availability of care, continued stay, or health care item or service for which you received emergency services, but you have not yet been discharged from a facility, the review shall be completed within 72 hours.

Notice of Benefit Determination on Appeal

Every notice of a determination on appeal will be provided in writing or electronically and, if an adverse determination, will include: information sufficient to identify the claim; the specific reason or reasons for the adverse determination; reference to the specific plan provisions on which the determination is based; a statement that the claimant is entitled to receive, upon request and free of charge, reasonable access to and copies of all documents, records, and other Relevant Information as defined (below); a statement describing any voluntary appeal procedures offered by the plan and the claimant's right to bring an action under ERISA section 502(a); upon request and free of charge, a copy of any internal rule, guideline, protocol or other similar criterion that was relied upon in making the adverse determination regarding your appeal, and an explanation of the scientific or clinical judgment for a determination that is based on Medical Necessity, experimental treatment or other similar exclusion or limit; and information about any office of health insurance consumer assistance or ombudsman available to assist you in the appeal process. A final notice of an adverse determination will include a discussion of the decision.

You also have the right to bring a civil action under section 502(a) of ERISA, after you have exhausted all required levels of appeal, if you are not satisfied with the final adverse benefit decision on review. You or your plan may have other voluntary alternative dispute resolution options such as Mediation. One way to find out what may be available is to contact your local U.S. Department of Labor office and your State insurance regulatory agency. You may also contact the Plan Administrator.

Relevant Information

Relevant Information is any document, record or other information which: was relied upon in making the benefit determination; was submitted, considered or generated in the course of making the benefit determination, without regard to whether such document, record, or other information was relied upon in making the benefit determination; demonstrates compliance with the administrative processes and safeguards required by federal law in making the benefit determination; or constitutes a statement of policy or guidance with respect to the plan concerning the denied treatment option or benefit for the claimant's diagnosis, without regard to whether such advice or statement was relied upon in making the benefit determination.

Administrative (Non-Benefit) Appeals

The plan also has a procedure for resolving disputes between you and the Plan regarding administrative (i.e., non-benefit- related) matters. An example of such matters is eligibility determinations.

There are two (2) levels of appeal under this Plan for such administrative matters. Both levels are mandatory and must be exhausted prior to bringing civil action under section 502(a) of ERISA.

Stage 1 Administrative Appeal

Direct your initial inquiry to the Claim's Administrator. If you are dissatisfied with the response to your inquiry, you may appeal in writing to the Claim's Administrator's Appeals Department for an initial Administrative Appeal review. Presentation of a complaint should be in writing and may include written information from you or any other party in interest. This should be done as soon as possible but in no event later than 180 days from the date of the inquiry.

A Plan representative will review your appeal/grievance and respond in writing within 30 days. If you wish to appeal that decision, you will be given specific instructions and forms to complete a Stage 2 appeal. You may do so by submitting your Stage 2 Appeal in writing to the Claim's Administrator's Appeals Department within 30 days of the Plan's initial written denial.

Stage 2 Administrative Appeal

The Plan's Benefits Review Committee for Stage 2 Appeals will review the initial decision and will respond to you in writing within 30 days of receipt of your inquiry. If you wish to appeal that decision, you will be given specific

instructions and forms to complete a Stage 2 Appeal. You may do so by submitting your Stage 2 Appeal in writing to the Plan's Administrator's Appeals Department within 30 days from receiving the Plan's Stage 1 written denial. The decision of the Plan's Benefits Review Committee for Stage 2 Appeals will be binding. No external review process is available in the case of administrative (i.e. non-benefit-related) claims.

Requirement that You Follow the Plan's Claims Procedures

All decisions following a review by the Claims Administrator are final and binding for purposes of the Plan's internal claims and appeal procedures. If no appeal is sought, the initial decision of the Claims Administrator is final and binding upon expiration of the time period for seeking an internal appeal.

Neither you, your beneficiary, nor any legal representative may bring any legal action (i) to recover benefits under the Plan, (ii) to enforce or clarify any rights under the Plan (including any rights under Section 502 or Section 510 of ERISA), or (iii) under any other provision of law, whether or not statutory, until the Plan's claim and appeals procedures explained in the above sections have been timely exhausted in their entirety. If you do not follow and complete the required internal claims and appeals procedures, your civil action will be subject to dismissal for failure to exhaust administrative remedies under this Plan.

For purposes of this section requiring that you follow the Plan's claims procedures prior to filing a lawsuit "you" and "your" does not refer to a healthcare provider or hospital or other facility designated by you to act on your behalf during the administrative claims process. As set forth more fully herein, the Plan expressly prohibits the assignment, transfer, pledge, sale or alienation, by operation of law or otherwise, any rights, benefits, or interest under this Plan to any third party, including any healthcare provider, hospital or other facility. No healthcare provider, hospital, or other facility may bring any legal action on your behalf. The payment of benefits directly to a provider or hospital or other facility, if any, will be done as a convenience and will not constitute an assignment of rights, benefits, or any other interest under this Plan or a waiver of the Plan's anti-assignment provisions.

Deadline for Claims Submissions and Applicable Statutes of Limitations

Deadline for Claims Submissions

You must submit a claim within 90 days after the date the service, treatment or supply was provided. If, through no fault of your own, you are unable to submit a claim within 90 days, your untimely claim may still be considered so long as it is submitted as soon as reasonably possible, but in no event shall the claim be submitted later than 365 days after the original date the service, treatment or supply was provided.

The failure to timely complete and submit a claim will result in the denial of your claim.

Statute of Limitations for Filing Legal Actions

Any legal action filed in court must be filed on or before the later of:

- One year from the date a final adverse benefit determination is made under the Plan or should have been made in accordance with the Plan's claims appeal/review procedures;
- One year from the date on which you shall be deemed to have exhausted the Plan's internal appeal/review procedures under applicable federal law; or
- One year from the date the service or treatment was provided or the date the claim arose, whichever is earlier.

The failure to file a legal action in court before expiration of these deadlines will bar any lawsuit.

COORDINATION OF BENEFITS

Coordination of the benefit plans. This Plan was developed to provide necessary care for our employees and their dependents. Some of our employees, and/or their eligible dependents may be covered by the Plan and another group health care plan. In this case, the Plan may pay only a portion of the expense. This is commonly referred to as Coordination of Benefits. Coordination of Benefits refers to the set of rules when two or more plans cover charges incurred by a Covered Person. To be sure that all Plans covering you and your dependents are considered, please make sure to contact the plan's Customer Service Department when there is a change in your personal information.

When this Plan is Primary, benefits will be determined without regard to what any other plan covering you, or your dependent, will pay.

When this Plan is the secondary payor, it will consider the difference between the actual eligible charge (less any provider discount or contracted amount*) and what the primary plan pays. However, the amount this Plan will pay as a secondary payor will never be more than it would pay if it were the primary payor. The combination of benefits paid by all of the plans covering any one person will not be more than the actual charge.

*In the case of a Managed Care Plan (HMO, PPO, POS, etc.), this Plan will not consider any charges in excess of what the contracted participating provider has agreed to accept as payment in full for either the primary or secondary plans.

Coordination of Benefits	
If...	Then...
You are the patient	This Plan is Primary
Your child is the patient	The birthday rule is used. This means the plan of the parent with the earlier birthday in the calendar year (month and date) is considered primary
Your spouse's plan does not have a coordination of benefits provision	Your spouse's plan will be considered primary for all family members except you
You are covered by this Plan and your spouse or Domestic Partner does not have other coverage	This Plan is primary

Benefit plan. This provision will coordinate the medical benefits of a benefit plan. The term benefit plan means this Plan or any one of the following plans:

- (1) Group or group-type plans, including franchise or blanket benefit plans;
- (2) Blue Cross and Blue Shield group plans;
- (3) Group practice and other group prepayment plans;
- (4) Federal government plans or programs. This includes Medicare;
- (5) Other plans required or provided by law. This does not include Medicaid or any benefit plan like it that, by its terms, does not allow coordination; and
- (6) No Fault Auto Insurance, by whatever name it is called, when not prohibited by law.

Allowable charge. For a charge to be allowable it must be a Plan Allowable Charge and at least part of it must be covered under this Plan.

In the case of HMO (Health Maintenance Organization) or other in-network only plans: This Plan will not consider any charges in excess of what an HMO or network provider has agreed to accept as payment in full. Also, when an HMO or network plan is primary and the Covered Person does not use an HMO or network provider, this Plan will not consider as an allowable charge any charge that would have been covered by the HMO or network plan had the Covered Person used the services of an HMO or network provider.

In the case of service type plans where services are provided as benefits, the reasonable cash value of each service will be the allowable charge.

Automobile limitations. When medical payments are available under vehicle insurance, the Plan shall pay excess benefits only, without reimbursement for vehicle plan deductibles, coinsurance, or copayments. This Plan shall always be considered the secondary carrier regardless of the individual's election under PIP (personal injury protection) coverage with the auto carrier. This Plan will not pay more as the secondary carrier than it would have paid as the primary plan. Plan payments as the secondary carrier are subject to the rules and limitations for all benefits as described in this booklet.

Benefit plan payment order. When two or more plans provide benefits for the same allowable charge, benefit payment will follow these rules.

- (1) Plans that do not have a coordination provision, or one like it, will pay first. Plans with such a provision will be considered after those without one.
- (2) Plans with a coordination provision will pay their benefits up to the Allowable Charge:
 - (a) The benefits of the plan which covers the person directly (that is, as an employee, member or subscriber) ("Plan A") are determined before those of the plan which covers the person as a dependent ("Plan B").
 - (b) The benefits of a benefit plan which covers a person as an Employee who is neither laid off nor retired are determined before those of a benefit plan which covers that person as a laid-off or Retired Employee. The benefits of a benefit plan which covers a person as a Dependent of an Employee who is neither laid off nor retired are determined before those of a benefit plan which covers a person as a Dependent of a laid off or Retired Employee. If the other benefit plan does not have this rule, and if, as a result, the plans do not agree on the order of benefits, this rule does not apply.
 - (c) The benefits of a benefit plan which covers a person as an Employee who is neither laid off nor retired or a Dependent of an Employee who is neither laid off nor retired are determined before those of a plan which covers the person as a COBRA beneficiary.
 - (d) When a child is covered as a Dependent and the parents are not separated or divorced, these rules will apply:
 - (i) The benefits of the benefit plan of the parent whose birthday falls earlier in a year are determined before those of the benefit plan of the parent whose birthday falls later in that year; and
 - (ii) If both parents have the same birthday, the benefits of the benefit plan which has covered the parent for the longer time are determined before those of the benefit plan which covers the other parent.
 - (e) When a child's parents are divorced or legally separated, these rules will apply:
 - (i) This rule applies when the parent with custody of the child has not remarried. The benefit plan of the parent with custody will be considered before the benefit plan of the parent without custody;

- (ii) This rule applies when the parent with custody of the child has remarried. The benefit plan of the parent with custody will be considered first. The benefit plan of the stepparent that covers the child as a Dependent will be considered next. The benefit plan of the parent without custody will be considered last;
 - (iii) This rule will be in place of items (i) and (ii) above when it applies. A court decree may state which parent is financially responsible for medical and dental benefits of the child. In this case, the benefit plan of that parent will be considered before other plans that cover the child as a Dependent; and
 - (iv) If the specific terms of the court decree state that the parents shall share joint custody, without stating that one of the parents is responsible for the health care expenses of the child, the plans covering the child shall follow the order of benefit determination rules outlined above when a child is covered as a Dependent and the parents are not separated or divorced.
- (f) If there is still a conflict after these rules have been applied, the benefit plan which has covered the patient for the longer time will be considered first. When there is a conflict in coordination of benefit rules, the Plan will never pay more than 50% of allowable charges when paying secondary.
- (3) Medicare will pay primary, secondary or last to the extent stated in federal law. When Medicare is to be the primary payer, this Plan will base its payment upon benefits that would have been paid by Medicare under Parts A and B, regardless of whether or not the person was enrolled under both of these parts.

Medicare is always primary for domestic partners who are eligible for Medicare, even if the domestic partner is not enrolled in Medicare. Piedmont benefits are considered secondary. The secondary plan will make payments that are due up to the amount it would have paid, but not greater than the balance due.

- (4) If a Plan Participant is under a disability extension from a previous benefit plan, that benefit plan will pay first and this Plan will pay second.

Claims determination period. Benefits will be coordinated on a Calendar Year basis. This is called the claims determination period.

Right to receive or release necessary information. To make this provision work, this Plan may give or obtain needed information from another insurer or any other organization or person. This information may be given or obtained without the consent of or notice to any other person. A Covered Person will give this Plan the information it asks for about other plans and their payment of allowable charges.

Facility of payment. This Plan may repay other plans for benefits paid that the Claims Administrator determines it should have paid. That repayment will count as a valid payment under this Plan.

Right of recovery. This Plan may pay benefits that should be paid by another benefit plan. In this case this Plan may recover the amount paid from the other benefit plan or the Covered Person. That repayment will count as a valid payment under the other benefit plan.

Further, this Plan may pay benefits that are later found to be greater than the allowable charge. In this case, this Plan may recover the amount of the overpayment from the source to which it was paid.

THIRD PARTY RECOVERY PROVISION

RIGHT OF SUBROGATION AND REFUND

By enrolling in the Plan and applying for benefits from the Plan, the Covered Person is subject to, and agrees to be bound by, the following terms and conditions.

The term “Covered Person” as used herein includes the Covered Person’s dependents, including any minor dependents.

When this provision applies. The Plan has no obligation to pay expenses that may be, or may become, the responsibility of another person or entity. If a Covered Person is involved in an accident (automobile or otherwise), or suffers an illness, injury or other condition that entitles the Covered Person to recover from a third party or some other source (e.g., an insurance company, a group health plan or an individual), and the Covered Person obtains such recovery, the Plan is entitled to obtain reimbursement from the Covered Person for any benefit payments the Plan has made on the Covered Person’s behalf.

A Covered Person also may have a claim against a third party or some other source for expenses incurred as a result of an accident, illness, injury or other condition. In such circumstances, as described more fully below, the Plan has the authority to pursue any such claim and recover all amounts paid by the Plan on behalf of the Covered Person.

The Plan may, in its sole discretion, require a Covered Person to review and execute an acknowledgement, in a form satisfactory to the Plan, acknowledging the Plan’s subrogation and reimbursement rights as well as the Covered Person’s responsibilities and obligations hereunder.

No application of “make whole,” “double recovery,” and “common fund” rules. The Plan’s provisions concerning subrogation, reimbursement, refund and recovery rights, equitable liens and other equitable remedies (outlined more fully below) supersede the applicability of the federal common law and equitable doctrines commonly referred to as the “make whole” rule, the “double-recovery” rule and the “common fund” rule. These doctrines have no applicability to the Plan’s right of subrogation, reimbursement and recovery hereunder.

Right to Reimbursement. A Covered Person is required to reimburse the Plan (and the Plan is entitled to recover), 100% of all amounts paid by the Plan on the Covered Person’s behalf from any and all recoveries obtained by the Covered Person from any third party or other source (including but not limited to another group health plan, an insurer or an individual), whether by lawsuit, mediation, arbitration, settlement, award, judgment, order, insurance or otherwise) (the “Recovered Funds”).

A Covered Person is required to reimburse the Plan on a first-dollar basis (which means that the Plan will have a first priority claim to any Recovered Funds), regardless of whether the Recovered Funds amount to full or partial recovery. Further, the Plan is entitled to recovery and reimbursement regardless of how the Recovered Funds are characterized (e.g., pain and suffering, punitive damages, benefits, lost wages, loss of future earnings, medical expenses, costs and/or expenses, attorneys’ fees) and regardless of whether the recovery is designated as payment for medical and/or dental services or expenses. The Plan’s share of recovery will not be reduced because the Covered Person has not received the full damages claimed, unless the Plan agrees in writing to a reduction. Any reduction to the required reimbursement amount is subject to prior written approval by the Plan.

If the Covered Person (and not the Plan) pursues and obtains any Recovered Funds, the Covered Person shall be responsible for all expenses involved in obtaining that recovery (whether obtained by lawsuit, mediation, arbitration, settlement, award, judgment, order, insurance or otherwise), including but not limited to, all attorney’s fees, costs and expenses; which fees, costs, and expenses shall not reduce the amount that the Covered Person is required to reimburse the Plan.

For purposes of clarity, the Plan’s right to reimbursement operates on every dollar received from a third party or other source, even those covering the Covered Person’s litigation costs and expenses and attorneys’ fees.

Assignment of rights (subrogation). Accepting benefits under this Plan for incurred expenses automatically assigns to the Plan any rights the Covered Person may have to recover payments from a third party or other source, including but not limited to, another group health plan, insurer or individual. This subrogation right allows the Plan to pursue any claim the Covered Person has or may have against any third party or other source, including but not limited to, another group health plan, an insurer, or individual, whether or not the Covered Person chooses to pursue that claim.

In the event the Covered Person elects not to pursue a claim(s) against a third party or other source, the Plan shall be equitably subrogated to the Covered Person's right of recovery.

This assignment also grants the Plan the ability and right to recover from any no-fault auto insurance carrier in the event no third party may be liable, and from any uninsured or underinsured motorist coverage.

Equitable Lien and other Equitable Remedies. By accepting benefits under this Plan, the Covered Person agrees that the Plan has established an equitable lien against any Recovered Fund the Covered Person (or any individual or entity acting on the Covered Person's behalf such as a legal representative or agent) recovers from any third party or other source, including but not limited to, an insurer, another group health plan or another individual, sufficient to reimburse the Plan in full for any benefits or expenses advanced. This equitable lien also attaches to any payment received from workers' compensation, whether by judgment, award, settlement or otherwise, where the Plan has paid benefits prior to a determination that the covered expenses arose out of and in the course of employment. Payment by workers' compensation insurers will be deemed to mean that such a determination has been made.

The Covered Person further agrees to hold any Recovered Funds recovered by the Covered Person (or any Covered Person's legal representative or agent) in trust and on behalf of the Plan to cover all benefits and expenses paid by the Plan.

The Plan reserves all rights to seek enforcement of its rights hereunder, including but not limited to, the right to file a lawsuit against the Covered person or any other party possessing or controlling any Recovered Funds, and the right to recoup amounts owed to the Plan in any other manner prescribed by law.

Obligation to Assist the Plan. When a right of recovery exists, the Covered Person will execute and deliver all required instruments and papers as well as doing whatever else is needed to secure the Plan's right of subrogation as a condition to having the Plan make payments. In addition, the Covered Person will do nothing to prejudice the right of the Plan to subrogate and/or obtain reimbursement for expenses paid (such as settling a claim against another party without notifying the Plan or by not including the Plan as a co-payee).

As part of this obligation, the Covered Person is also required to provide the Plan with any information concerning any other applicable insurance coverage that may be available (including, but not limited to, automobile, home, and other liability insurance coverage, and coverage under another group health plan), and the identity of any other person or entity, and their insurers (if known), that may be obligated to provide payments or benefits on account of the same illness, injury or other condition for which the Plan made payments.

The term "information" here includes any documents, insurance policies, and police or other investigative reports, as well as any other facts that may reasonably be requested to help the Plan enforce its rights.

Failure by the Covered Person to cooperate with the Plan in the exercise of its subrogation and reimbursement rights may result, at the discretion of the Plan Administrator, in a reduction of future benefit payments available to the Covered Person under the Plan by an amount, up to the aggregate amount paid by the Plan that was subject to the Plan's equitable lien, but for which the Plan was not reimbursed.

Recovery from another plan under which the Covered Person is covered. This right of refund and reimbursement described herein also applies when a Covered Person recovers under an uninsured or underinsured motorist plan, homeowner's plan, renter's plan, medical malpractice plan or any liability plan.

COBRA CONTINUATION OPTIONS

CONTINUATION COVERAGE RIGHTS UNDER COBRA

Under federal law, the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA), certain Employees and their eligible dependents covered under the Piedmont Healthcare MyHealth 360 Medical Benefit Program (the "Plan") will be entitled to the opportunity to elect a temporary extension of health coverage (called "COBRA continuation coverage") where coverage under the Plan would otherwise end. This notice is intended to inform Plan Participants and beneficiaries, in summary fashion, of their rights and obligations under the continuation coverage provisions of COBRA, as amended and reflected in final and proposed regulations published by the Department of the Treasury. This notice is intended to reflect the law and does not grant or take away any rights under the law.

COBRA continuation coverage for the Plan is administered by Allegiance COBRA Services (the "COBRA Administrator"). Complete instructions on COBRA, as well as election forms and other information, will be provided to Plan Participants who become Qualified Beneficiaries under COBRA.

What is COBRA continuation coverage? COBRA continuation coverage is the temporary extension of group health plan coverage that must be offered to certain Plan Participants and their eligible dependents who are covered under the Plan (called "Qualified Beneficiaries") at group rates. The right to COBRA continuation coverage is triggered by the occurrence of a life event that results in the loss of coverage under the terms of the Plan (the "Qualifying Event"). The coverage must be identical to the Plan coverage that the Qualified Beneficiary had immediately before the Qualifying Event, or if the coverage has been changed, the coverage must be identical to the coverage provided to similarly situated Employees who have not experienced a Qualifying Event (in other words, similarly situated non-COBRA beneficiaries).

Who can become a Qualified Beneficiary? In general, a Qualified Beneficiary can be:

- (i) Any individual who, on the day before a Qualifying Event, is covered under a Plan by virtue of being on that day either a covered Employee, the Spouse or Domestic Partner of a covered Employee, or a Dependent child of a covered Employee. If, however, an individual is denied or not offered coverage under the Plan under circumstances in which the denial or failure to offer constitutes a violation of applicable law, then the individual will be considered to have had the Plan coverage and will be considered a Qualified Beneficiary if that individual experiences a Qualifying Event.
- (ii) Any child who is born to or placed for adoption with a covered Employee during a period of COBRA continuation coverage, and any individual who is covered by the Plan as an alternate recipient under a qualified medical support order. If, however, an individual is denied or not offered coverage under the Plan under circumstances in which the denial or failure to offer constitutes a violation of applicable law, then the individual will be considered to have had the Plan coverage and will be considered a Qualified Beneficiary if that individual experiences a Qualifying Event.

An individual is not a Qualified Beneficiary if the individual's status as a covered Employee is attributable to a period in which the individual was a nonresident alien who received from the individual's Employer no earned income that constituted income from sources within the United States. If, on account of the preceding reason, an individual is not a Qualified Beneficiary, then a Spouse or Dependent child of the individual will also not be considered a Qualified Beneficiary by virtue of the relationship to the individual.

Each Qualified Beneficiary (including a child who is born to or placed for adoption with a covered Employee during a period of COBRA continuation coverage) must be offered the opportunity to make an independent election to receive COBRA continuation coverage.

What is a Qualifying Event? A Qualifying Event is any of the following if the Plan provided that the Plan participant would lose coverage (i.e., cease to be covered under the same terms and conditions as in effect immediately before the Qualifying Event) in the absence of COBRA continuation coverage:

- (i) The death of a covered Employee;
- (ii) The termination (other than by reason of the Employee's gross misconduct), or reduction of hours, of a covered Employee's employment;
- (iii) The divorce or legal separation of a covered Employee from the Employee's Spouse;
- (iv) A covered Employee's enrollment in any part of the Medicare program; and.
- (v) A Dependent child's ceasing to satisfy the Plan's requirements for a Dependent child (for example, attainment of the maximum age for dependency under the Plan).

If the Qualifying Event causes the covered Employee, or the covered Spouse or a Dependent child of the covered Employee, to cease to be covered under the Plan under the same terms and conditions as in effect immediately before the Qualifying Event (or in the case of the bankruptcy of the Employer, any substantial elimination of coverage under the Plan occurring within 12-months before or after the date the bankruptcy proceeding commences), the persons losing such coverage become Qualified Beneficiaries under COBRA if all the other conditions of the COBRA are also met. For example, any increase in contribution that must be paid by a covered Employee, or the Spouse, or a Dependent child of the covered Employee, for coverage under the Plan that results from the occurrence of one of the events listed above is a loss of coverage.

The taking of leave under the Family and Medical Leave Act of 1993 ("FMLA") does not constitute a Qualifying Event. A Qualifying Event will occur, however, if an Employee does not return to employment at the end of the FMLA leave and all other COBRA continuation coverage conditions are present. If a Qualifying Event occurs, it occurs on the last day of FMLA leave and the applicable maximum coverage period is measured from this date (unless coverage is lost at a later date and the Plan provides for the extension of the required periods, in which case the maximum coverage date is measured from the date when the coverage is lost). Note: that the covered Employee and family members will be eligible for COBRA continuation coverage even if they failed to pay the Employee portion of premiums for coverage under the Plan during the FMLA leave.

What is the requirement for obtaining COBRA continuation coverage? The Plan has conditioned the availability of COBRA continuation coverage upon the timely election of such coverage. An election is timely if it is made during the election period.

What is the election period and how long must it last? The election period is the time period within which the Qualified Beneficiary can elect COBRA continuation coverage under the Plan. The election period must begin not later than the date the Qualified Beneficiary would lose coverage on account of the Qualifying Event and must not end before the date that is 60 days after the later of the date the Qualified Beneficiary would lose coverage on account of the Qualifying Event or the date notice is provided to the Qualified Beneficiary of her or his right to elect COBRA continuation coverage.

Note: If a covered Employee who has been terminated or experienced a reduction of hours qualifies for a trade readjustment allowance or alternative trade adjustment assistance under a federal law called the Trade Act of 2002, and the Employee and his or her covered dependents have not elected COBRA coverage within the normal election period, a second opportunity to elect COBRA coverage will be made available for themselves and certain family members, but only within a limited period of 60 days or less and only during the six months immediately after their group health plan coverage ended. Any person who qualifies or thinks that he and/or his family members may qualify for assistance under this special provision should contact the COBRA Administrator for further information.

Is a covered Employee or Qualified Beneficiary responsible for informing the Plan Administrator of the occurrence of a Qualifying Event?

The Plan will offer COBRA continuation coverage to qualified beneficiaries only after the Plan Administrator or its designee has been timely notified that a Qualifying Event has occurred. The employer will notify the COBRA Administrator of the Qualifying Event within 30 days following the date coverage ends when the Qualifying Event is, for example:

- the end of employment or reduction of hours of employment;
- death of the Employee;
- commencement of a proceeding in bankruptcy with respect to the employer, or

IMPORTANT:

For the other Qualifying Events (divorce or legal separation of the Employee and spouse or a dependent child's losing eligibility for coverage as a dependent child), you or someone on your behalf must notify the Plan Administrator or its designee in writing within 60 days after the Qualifying Event occurs, using the procedures specified below. If these procedures are not followed or if the notice is not provided in writing to the Plan Administrator (as noted in the box below) or its designee during the 60-day notice period, any spouse or dependent child who loses coverage will not be offered the option to elect continuation coverage. You must send this notice to Piedmont Healthcare at the address shown in the box below.

NOTICE PROCEDURES:

Any notice that you provide must be in writing. Oral notice, including notice by telephone, is not acceptable. You must mail, fax or hand-deliver your notice to the person, department or firm listed below, at the following address:

**Piedmont Healthcare
Human Resources Department
2727 Paces Ferry Road
Building Two, Suite 900
Atlanta, GA 30339
(678) 503-1900**

If mailed, your notice must be postmarked no later than the last day of the required notice period. Any notice you provide must state:

- the ***name of the plan or plans*** under which you lost or are losing coverage;
- the ***name and address of the Employee*** covered under the plan;
- the ***name(s) and address(es) of the qualified beneficiary(ies)***; and
- the ***qualifying event*** and the ***date*** it happened.

If the qualifying event is a ***divorce or legal separation***, your notice must include ***a copy of the divorce decree or the legal separation agreement***. There are other notice requirements in other contexts. See, for example, the discussion below under the heading entitled, ***“How does a Qualified Beneficiary become entitled to a disability extension?”*** That explanation describes other situations where notice from you or the qualified beneficiary is required in order to gain the right to COBRA coverage.

Once the Plan Administrator or its designee receives timely notice that a Qualifying Event has occurred, COBRA continuation coverage will be offered to each of the qualified beneficiaries. Each Qualified Beneficiary will have an independent right to elect COBRA continuation coverage. Covered Employees may elect COBRA continuation coverage for their spouses, and parents may elect COBRA continuation coverage on behalf of their children. For each Qualified Beneficiary who elects COBRA continuation coverage, COBRA continuation coverage will begin on the date that plan coverage would otherwise have been lost. If you or your spouse or dependent children do not elect continuation coverage within the 60-day election period described above, the right to elect continuation coverage will be lost.

Is a waiver before the end of the election period effective to end a Qualified Beneficiary's election rights?

If, during the election period, a Qualified Beneficiary waives COBRA continuation coverage, the waiver can be revoked at any time before the end of the election period. Revocation of the waiver is an election of COBRA continuation coverage. However, if a waiver is later revoked, coverage need not be provided retroactively (that is, from the date of the loss of coverage until the waiver is revoked). Waivers and revocations of waivers are considered made on the date they are sent to the Plan Administrator or its designee, as applicable.

When may a Qualified Beneficiary's COBRA continuation coverage be terminated? During the election period, a Qualified Beneficiary may waive COBRA continuation coverage. Except for an interruption of coverage in connection with a waiver, COBRA continuation coverage that has been elected for a Qualified Beneficiary must extend for at least the period beginning on the date of the Qualifying Event and ending not before the earliest of the following dates:

- (i) The last day of the applicable maximum coverage period;
- (ii) The first day for which Timely Payment is not made to the Plan with respect to the Qualified Beneficiary;
- (iii) The date upon which the Employer ceases to provide any group health plan (including a successor plan) to any Employee;
- (iv) The date, after the date of the election, that the Qualified Beneficiary first becomes covered under any other Plan that does not contain any exclusion or limitation with respect to any pre-existing condition, other than such an exclusion or limitation that does not apply to, or is satisfied by, the Qualified Beneficiary;
- (v) The date, after the date of the election that the Qualified Beneficiary first enrolls in the Medicare program (either part A or part B, whichever occurs earlier); and
- (vi) In the case of a Qualified Beneficiary eligible for a disability extension, the later of:
 - (a) 29-months after the date of the Qualifying Event, or (ii) the first day of the month that is more than 30 days after the date of a final determination under Title II or XVI of the Social Security Act that the disabled Qualified Beneficiary whose disability resulted in the Qualified Beneficiary's entitlement to the disability extension is no longer disabled, whichever is earlier; or
 - (b) the end of the maximum coverage period that applies to the Qualified Beneficiary without regard to the disability extension.

The Plan can terminate for cause the coverage of a Qualified Beneficiary on the same basis that the Plan terminates for cause the coverage of similarly situated non-COBRA beneficiaries, for example, for the submission of a fraudulent claim.

In the case of an individual who is not a Qualified Beneficiary and who is receiving coverage under the Plan solely because of the individual's relationship to a Qualified Beneficiary, if the Plan's obligation to make COBRA continuation coverage available to the Qualified Beneficiary ceases, the Plan is not obligated to make coverage available to the individual who is not a Qualified Beneficiary.

What are the maximum coverage periods for COBRA continuation coverage? The maximum coverage periods are based on the type of the Qualifying Event and the status of the Qualified Beneficiary, as shown below.

- (i) In the case of a Qualifying Event that is a termination of employment or reduction of hours of employment, the maximum coverage period ends 18-months after the Qualifying Event, if there is not a disability extension, and 29-months after the Qualifying Event, if there is a disability extension.
- (ii) In the case of a covered Employee's enrollment in the Medicare program before experiencing a Qualifying Event that is a termination of employment or reduction of hours of employment, the maximum coverage period for Qualified Beneficiaries other than the covered Employee ends on the later of:
 - (a) 36-months after the date the covered Employee becomes enrolled in the Medicare program; or
 - (b) 18-months (or 29-months, if there is a disability extension) after the date of the covered Employee's termination of employment or reduction of hours of employment.
- (iii) In the case of a Qualified Beneficiary who is a child born to or placed for adoption with a covered Employee during a period of COBRA continuation coverage, the maximum coverage period is the maximum coverage period applicable to the Qualifying Event giving rise to the period of COBRA continuation coverage during which the child was born or placed for adoption.
- (iv) In the case of any other Qualifying Event than that described above, the maximum coverage period ends 36-months after the Qualifying Event.

Under what circumstances can the maximum coverage period be expanded? If a Qualifying Event that gives rise to an 18-month or 29-month maximum coverage period is followed, within that 18- or 29-month period, by a second Qualifying Event that gives rise to a 36-months maximum coverage period, the original period is expanded to 36-months, but only for individuals who are Qualified Beneficiaries at the time of both Qualifying Events. In no circumstance can the COBRA maximum coverage period be expanded to more than 36-months after the date of the first Qualifying Event. The Plan Administrator must be notified of the second Qualifying Event within 60 days of the second Qualifying Event. This notice must be sent to: **Allegiance COBRA Services, P.O. Box 2097, Missoula, MT 59806**

How does a Qualified Beneficiary become eligible for a disability extension? A disability extension will be granted if an individual (whether or not the covered Employee) who is a Qualified Beneficiary in connection with the Qualifying Event that is a termination or reduction of hours of a covered Employee's employment, is determined under Title II or XVI of the Social Security Act to have been disabled at any time during the first 60 days of COBRA continuation coverage. To qualify for the disability extension, the Qualified Beneficiary must also provide the Plan Administrator with notice of the disability determination on a date that is both within 60 days after the date of the determination and before the end of the original 18-month maximum coverage. This notice should be sent to, COBRA Administrator. **Allegiance COBRA Services, P.O. Box 2097, Missoula, MT 59806**

Does the Plan require payment for COBRA continuation coverage? For any period of COBRA continuation coverage under the Plan, qualified beneficiaries who elect COBRA continuation coverage must pay for COBRA continuation coverage. Qualified beneficiaries will pay up to 102% of the applicable premium and up to 150% of the applicable premium for any expanded period of COBRA continuation coverage covering a disabled Qualified Beneficiary due to a disability extension. The Plan will terminate a Qualified Beneficiary's COBRA continuation coverage as of the first day of any period for which timely payment is not made.

Must the Plan allow payment for COBRA continuation coverage to be made in monthly installments? Yes. The Plan is also permitted to allow for payment at other intervals.

What is Timely Payment for payment for COBRA continuation coverage? Timely Payment means a payment made no later than 30 days after the first day of the coverage period. Payment that is made to the Plan by a later date is also considered Timely Payment if either under the terms of the Plan, covered Employees or Qualified Beneficiaries are allowed until that later date to pay for their coverage for the period or under the terms of an arrangement between the Employer and the entity that provides Plan benefits on the Employer's behalf, the

Employer is allowed until that later date to pay for coverage of similarly situated non-COBRA beneficiaries for the period.

Notwithstanding the above paragraph, the Plan does not require payment for any period of COBRA continuation coverage for a Qualified Beneficiary earlier than 45 days after the date on which the election of COBRA continuation coverage is made for that Qualified Beneficiary. Payment is considered made on the date on which it is postmarked to the Plan.

If Timely Payment is made to the Plan in an amount that is not significantly less than the amount the Plan requires to be paid for a period of coverage, then the amount paid will be deemed to satisfy the Plan's requirement for the amount to be paid, unless the Plan notifies the Qualified Beneficiary of the amount of the deficiency and grants a reasonable period of time for payment of the deficiency to be made. A "reasonable period of time" is 30 days after the notice is provided. A shortfall in a Timely Payment is not significant if it is no greater than the lesser of \$50 or 10% of the required amount.

Must a Qualified Beneficiary be given the right to enroll in a conversion health plan at the end of the maximum coverage period for COBRA continuation coverage? If a Qualified Beneficiary's COBRA continuation coverage under a group health plan ends as a result of the expiration of the applicable maximum coverage period, the Plan will, during the 180- day period that ends on that expiration date, provide the Qualified Beneficiary with the option of enrolling under a conversion health plan if such an option is otherwise generally available to similarly situated non-COBRA beneficiaries under the Plan. If such a conversion option is not otherwise generally available, it need not be made available to Qualified Beneficiaries.

IF YOU HAVE QUESTIONS

If you have questions about your COBRA continuation coverage, you should contact,(800) 259-2738. COBRA Administrator or you may contact the nearest Regional or District Office of the U.S. Department of Labor's Employee Benefits Security Administration (EBSA). Addresses and phone numbers of Regional and District EBSA Offices are available through EBSA's Web site at www.dol.gov/ebsa.

KEEP YOUR PLAN ADMINISTRATOR INFORMED OF ADDRESS CHANGES

In order to protect your family's rights, you should keep the Plan Administrator informed of any changes in the addresses of family members. You should also keep a copy, for your records, of any notices you send to the Plan Administrator.

RESPONSIBILITIES FOR PLAN ADMINISTRATION

PLAN ADMINISTRATOR. Piedmont Healthcare, Inc. the Plan Administrator. The Plan will be administered by the Plan Administrator in accordance with the provisions of ERISA. An individual may be appointed by Piedmont Healthcare, Inc. to be Plan Administrator and serve at the convenience of the Employer. If the Plan Administrator resigns, dies or is otherwise removed from the position, Piedmont Healthcare, Inc. shall appoint a new Plan Administrator as soon as reasonably possible.

PLAN ADMINISTRATOR DISCRETION. The Plan Administrator shall administer this Plan in accordance with its terms and establish its policies, interpretations, practices, and procedures. It is the express intent of this Plan that the Plan Administrator shall have maximum legal discretionary authority to: construe and interpret the terms and provisions of the Plan; resolve and clarify inconsistencies, ambiguities and/or omissions in the Plan; make determinations regarding eligibility and entitlement to benefits; determine benefit amounts; make decisions regarding questions of coverage; employ, appoint or designate persons to help or advise in connection with the performance of any administrative function; decide disputes which may arise relative to a Plan Participant's rights under the Plan; decide questions of Plan interpretation and those of fact relating to the Plan; and exercise all other power and authority contemplated by ERISA with respect to the Plan. The decisions of the Plan Administrator will be final and legally binding on all parties.

Any interpretation, determination or other action of the Plan Administrator shall be given deference in the event the determination is subject to judicial review and shall be overturned by a court of law only if it is arbitrary and capricious or otherwise an abuse of discretion. Any review by a court of a final decision or action of the Plan Administrator shall be based only on such evidence presented to or considered by the Plan Administrator at the time it made the decision that is the subject of the court's review. Accepting any benefits or making any claim for benefits under this Plan constitutes agreement to the limited and deferential scope of review described herein.

The Plan Administrator shall also have sole discretionary authority to prescribe procedures for filing a claim for benefits.

The Plan Administrator may delegate any of its duties and responsibilities to one or more persons or entities. Such delegation of authority must be in writing, and must identify the delegate and the scope of the delegated responsibilities.

The Plan Administrator has delegated its fiduciary duties with respect to claims determinations under the Piedmont Healthcare MyHealth 360 Medical Benefit Program (which is described in this SPD), including final claims determinations, to the Claims Administrator. The Claims Administrator has the full extent of the Plan Administrator's authorities and duties with respect to those responsibilities delegated to it.

Service of legal process may be made upon the Plan Administrator.

PLAN ADMINISTRATOR COMPENSATION. The Plan Administrator serves **without** compensation; however, all expenses for claims administration, including compensation for hired services, will be paid by the Plan.

FUNDING THE PLAN AND PAYMENT OF BENEFITS

This is not an insured benefit Plan. The benefits provided under the Plan will be paid, to the extent permitted under ERISA, from the general assets of the Employer and Covered Employee contributions. Nothing in this Plan will be construed to require the Employer to maintain any fund for its own contributions or segregate any amount which it is obligated to contribute for the benefit of any Plan Participant, and no Plan Participant or other person will have any claim against, right to, or security or other interest in, any fund, account or asset of the Employer from which any payment under the Plan may be made.

The level of any Employee contributions will be set by the Plan Administrator. These Employee contributions will be used in funding the cost of the Plan as soon as practicable after they have been received from the Employee or withheld from the Employee's pay through payroll deduction.

Benefits are paid directly from the Plan through the Claims Administrator.

PLAN IS NOT AN EMPLOYMENT CONTRACT

The Plan is not to be construed as a contract for or of employment.

CLERICAL ERROR

Any clerical error by the Plan Administrator or an agent of the Plan Administrator in keeping pertinent records or a delay in making any changes will not invalidate coverage otherwise validly in force or continue coverage validly terminated. An equitable adjustment of contributions will be made when the error or delay is discovered.

If, due to a clerical error, an overpayment occurs in a Plan reimbursement amount, the Plan retains a contractual right to recoup the overpayment. The person or institution receiving the overpayment will be required to return the incorrect amount of money. In the case of a Covered Member, if it is requested, the amount of overpayment will be deducted from future benefits payable.

AMENDING AND TERMINATING THE PLAN

If the Plan is terminated, the rights of the Covered Members are limited to expenses incurred before termination.

The Employer reserves the right, at any time, to amend, suspend or terminate the Plan in whole or in part, in its sole discretion, at any time. This includes amending the benefits offered or made available under the Plan and modifying the Plan to provide different cost sharing between the Employer and covered Employees. The terms of this Plan may also be amended from time to time based on applicable law.

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STATEMENT OF ERISA RIGHTS

As a participant in the Benefit Plan of Piedmont Healthcare, Inc., you are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974 (ERISA). ERISA provides that all Plan participants shall be entitled to:

- (1) Examine, without charge, at the Plan Administrator's office and at other specified locations, such as worksites and union halls, all documents governing the Plan, including insurance contracts, if any, and collective bargaining agreements, if any, and a copy of the latest annual report (Form 5500 Series) filed by the Plan with the U.S. Department of Labor and available at the Public Disclosure Room of the Pension and Welfare Benefit Administration;
- (2) Obtain, upon written request to the Plan Administrator, copies of documents governing the operation of the Plan, including insurance contracts, if any, and collective bargaining agreements, if any, and copies of the latest annual report (Form 5500 Series) and updated Summary Plan Description. The Plan Administrator may make a reasonable charge for the copies;
- (3) Receive a summary of the Plan's annual financial report. The Plan Administrator is required by law to furnish each participant with a copy of this summary annual report; and
- (4) Continued health care coverage ("COBRA") for yourself, your spouse or dependents if there is a loss of coverage under the Plan as a result of a Qualifying Event. You or your dependents may have to pay for such coverage. Review this summary plan description and the documents governing the Plan on the rules governing your COBRA continuation coverage rights.

In addition to creating rights for Plan participants, ERISA imposes duties upon the people who are responsible for the operation of the employee benefit plan. The people who operate your Plan, called "fiduciaries" of the Plan, have a duty to do so prudently and in the interest of you and other Plan participants and beneficiaries. No one, including your Employer, your union, if any, or any other person, may fire you or otherwise discriminate against you in any way to prevent you from obtaining a welfare benefit or exercising your rights under ERISA.

If your claim for a welfare benefit is denied or ignored, in whole or in part, you have a right to know why this was done, to obtain copies of documents relating to the decision without charge, and to appeal any denial, all within certain time schedules.

Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request a copy of plan documents or the latest annual report from the Plan and do not receive them within 30 days, you may file suit in a federal court. In such a case, the court may require the Plan Administrator to provide the materials and pay you up to \$110 a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the Plan Administrator.

If you have a claim for benefits which is denied or ignored, in whole or in part, you may file a suit in a state or federal court, but only after you have exhausted the Plan's claims and appeals procedures.

In addition, if you disagree with the Plan's decision or lack thereof concerning the qualified status of a domestic relations order or a medical child support order (QMCSO), you may file suit in federal court.

If it should happen that Plan fiduciaries misuse the Plan's money, or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor, or you may file suit in a federal court.

If you file a suit against the Plan, the court will decide who should pay court costs and legal fees. If you are successful, the court may order the person you have sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees, for example, if it finds your claim is frivolous. However, as set forth above, no legal action may be commenced or maintained against the Plan prior to your exhaustion of the Plan's claims and appeals procedures described in this SPD.

If you have any questions about the Plan, you should contact the Plan Administrator. If you have any questions about this statement or about your rights under ERISA, or if you need assistance in obtaining documents from the

Plan Administrator, you should contact the nearest office of the Employee Benefits Security Administration, U.S. Department of Labor, listed in your telephone directory or:

The Division of Technical Assistance and Inquiries
Employee Benefits Security Administration
U.S. Department of Labor
200 Constitution Avenue, N.W.
Washington, DC 20210

You may also obtain certain publications about your rights and responsibilities under ERISA by calling the publications hotline of the Employee Benefits Security Administration.

NOTICE OF FEDERAL REQUIREMENTS

The Woman's Health Care And Cancer Rights Act Of 1998

The Women's Health and Cancer Rights Act of 1998 requires group health plans like this Plan to provide benefits for mastectomy-related services including reconstruction and surgery to achieve symmetry between breasts, prostheses, and complications resulting from a mastectomy (including lymphedema). These benefits will be provided subject to the same deductibles and coinsurance applicable to other medical and surgical benefits provided under this Plan. You may contact your Plan Administrator for more information.

The Newborn's And Mother's Health And Protection Act

Group health plans and health insurance issuers generally may not, under the Newborn's And Mother's Health And Protection Act, restrict benefits for any Hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a vaginal delivery, or less than 96 hours following a cesarean section. However, Federal law generally does not prohibit the mothers or newborns attending provider, after consulting with the mother, from discharging the mother or her newborn earlier than 48 hours (or 96 hours as applicable). In any case, plans and issuers may not, under Federal law, require that a provider obtain authorization from the plan or the insurance issuer for prescribing a length of stay not in excess of 48 hours (or 96 hours). Please review the Schedule of Benefits in this Plan for further details on specific coverage under each of the Plan options.

Notice Regarding Provider Directories and Provider Networks

If your Plan uses a network of Providers, you will automatically and without charge, receive a separate listing of Participating Providers.

Your Participating Provider network consists of a group of local medical practitioners, including Hospitals, of varied specialties as well as general practice, who are employed by or contracted with Piedmont Healthcare, Inc. or Cigna Open Access Plus.

Uniformed Services Employment and Re-Employment Rights Act of 1994 (USERRA)

Uniformed Services Employment and Re- Employment Rights Act of 1994 (USERRA)

The Uniformed Services Employment and Re-employment Rights Act of 1994 (USERRA) sets requirements for continuation of health coverage and re-employment in regard to an Employee's military leave of absence. These requirements apply to medical and dental coverage for you and your Dependents. They do not apply to any Life, Short- term or Long-term Disability or Accidental Death & Dismemberment coverage you may have.

Continuation of Coverage

For leaves of less than 31 days, coverage will continue as described in the Termination section regarding Leave of Absence.

For leaves of 31 days or more, you may continue coverage for yourself and your Dependents as follows:

You may continue benefits by paying the required premium to your Employer, until the earliest of the following:

- 24 months from the last day of employment with the Employer;
- the day after you fail to return to work; and
- the date the plan cancels.

Your Employer may charge you and your Dependents up to 102% of the total premium.

Following continuation of health coverage per USERRA requirements, you may convert to a plan of individual coverage according to any "Conversion Privilege" shown in your booklet.

Reinstatement of Benefits (applicable to all coverages)

If your coverage ends during the leave of absence because you do not elect USERRA or an available conversion plan at the expiration of USERRA and you are reemployed by your current Employer, coverage for you and your Dependents may be reinstated if you gave your Employer advance written or verbal notice of your military service leave, and the duration of all military leaves while you are employed with your current Employer does not exceed 5 years.

You and your Dependents will be subject to only the balance of a waiting period that was not yet satisfied before the leave began. However, if an Injury or Sickness occurs or is aggravated during the military leave, full Plan limitations will apply.

If your coverage under this plan terminates as a result of your eligibility for military medical and dental coverage and your order to active duty is canceled before your active duty service commences, these reinstatement rights will continue to apply.

Qualified Medical Child Support Orders

The Plan Administrator shall honor an order that is a Qualified Medical Child Support Order, including a National Medical Support Notice Order within the meaning of ERISA Section 609(a)(2)(A) ("QMCSO"). The Plan Administrator has full discretionary authority to determine whether a medical child support order is qualified within the meaning of ERISA Section 609(a)(2)(A), and reserves the right, waivable at its discretion, to seek clarification with respect to the order from the court or administrative agency that issues the order, up to and including the right to seek a hearing before the court or agency.

Piedmont Healthcare Non-Discrimination Statement for its Employee Health Benefit Programs

Piedmont Healthcare complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex in its provision and administration of its employee health benefit programs ("Health Programs"). The Health Programs do not exclude people or treat them differently because of race, color, national origin, age, disability, or sex.
Piedmont Healthcare:

- Provides free aids and services to people with disabilities to communicate effectively with us about the Health Programs, such as: Qualified sign language interpreters and written information in other formats (large print, audio, accessible electronic formats, other formats)
- Provides free language services to people whose primary language is not English to help them access the Health Programs, such as: Qualified interpreters and information written in other languages

If you need these services for the Health Programs, contact the HR Service Center at 678-503-1900.

If you believe that the Health Programs 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: Compliance Department, 1800 Howell Mill Rd., Ste. 350, Atlanta, GA 30318, Phone: 404-425-7350, Fax: 770-916-7647, compliance@piedmont.org. You can file a grievance related to the Health Programs in person or by mail, fax, or email. If you need help filing a grievance, the Compliance Department is available to help you.

If you believe Piedmont Healthcare has not complied with this statement in its provision or administration of the Health Programs, 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, 1-800-868-1019, 800-537-7697 (TDD).

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

CONFIDENTIALITY

FEDERAL PRIVACY REQUIREMENTS

A federal law, the Health Insurance Portability and Accountability Act of 1996 (HIPAA), requires that health plans protect the confidentiality of your private health information. A complete description of your rights under HIPAA can be found in the Plan's privacy notice, a copy of which is given to you upon enrollment in the Plan and which is available from your Employer's Human Resources Department.

This Plan, and the Plan Administrator, will not use or further disclose information that is protected by HIPAA (protected health information) except as necessary for treatment, payment, health plan operations and administration, or as otherwise permitted or required by law. By law, the Plan has required all of its business associates (like QualCare, Inc., a Cigna Company the Claims Administrator) to also observe HIPAA's privacy requirements. In particular, the Plan will not, without authorization, use or disclose protected health information for employment-related actions or decisions or in connection with any other benefit or employee benefit plan of the Plan Administrator or your Employer.

For purposes of HIPAA, determining the Employee's eligibility for the Plan or enrolling Employees in the Plan is an enrollment function performed by the Employer. Employee and dependent eligibility and enrollment information is the Employer's information and not the Plan's information while it is held and transmitted by the Employer.

Under HIPAA, you have certain rights with respect to your protected health information, including certain rights to see and copy information, receive an accounting of certain disclosures of the information and, under certain circumstances, amend the information. You also have the right to file a complaint with the Plan or with the Secretary of the U.S. Department of Health and Human Services, if you believe your rights under HIPAA have been violated.

As mentioned, the Plan has a privacy notice that provides a complete description of your rights under HIPAA's privacy rules. For a copy of that notice or if you have questions about the privacy of your health information, please contact your Employer's Privacy Officer. If you wish to file a complaint under HIPAA, please contact your Employer's Privacy Officer.

GENERAL PLAN INFORMATION

PLAN NAME

Piedmont Healthcare, Inc. Comprehensive Health and Welfare Benefits Plan. The MyHealth360 Medical Benefit Program is a benefit program provided under the Piedmont Healthcare, Inc. Comprehensive Health and Welfare Benefit Plan.

TAX ID NUMBER: 58-0566213

PLAN YEAR: January 1 – December 31

PLAN NUMBER: 503

PLAN YEAR ENDS: December 31

EMPLOYER / PLAN SPONSOR INFORMATION

Piedmont Healthcare, Inc.
2727 Paces Ferry Road
Building Two, Suite 900
Atlanta, GA 30339

PLAN ADMINISTRATOR

Piedmont Healthcare, Inc.
2727 Paces Ferry Road
Building Two, Suite 900
Atlanta, GA 30339

NAMED FIDUCIARY

The Plan Administrator is the named fiduciary of the Plan

AGENT FOR SERVICE OF LEGAL PROCESS

Piedmont Healthcare, Inc.
c/o CSC of Cobb County, Inc.
192 Anderson Street SE
Suite 125
Marietta, GA 30060

CLAIMS ADMINISTRATOR – Medical

QualCare, Inc., a Cigna Company
30 Knightsbridge Road
Piscataway, New Jersey 08854
1-877-601-3835

COBRA ADMINISTRATOR

Allegiance COBRA Services
P.O. Box 2097
Missoula, MT 59806
(800) 259-2738

TYPE OF PLAN

The Piedmont Healthcare, Inc. Comprehensive Health and Welfare Benefits Plan is a welfare benefits plan. The MyHealth 360 Medical Benefit Program is a medical benefit offered under the Piedmont Healthcare, Inc. Comprehensive Health and Welfare Benefits Plan.

PLAN ADMINISTRATION/FUNDING

The MyHealth360 Medical Benefit Program is a self-insured medical benefit program. The administration of the MyHealth360 Medical Benefit Program is provided through a third party Claims Administrator. The funding of the benefits provided under the MyHealth360 Medical Benefit Program is derived from the funds of the Employer and contributions made by covered Employees. The MyHealth360 Medical Benefit Program is not insured.