



**REQUEST FOR PROPOSALS TITLE PAGE**  
**Include This Page as the First Page in Your Proposal Response**



**Proposal Title: Medical Plan**

This is the City of Lynchburg’s Request for Proposals (RFP) No. 17-004 issued June 8, 2016, for the administration and reinsurance of the medical program for employees of the City of Lynchburg (City) and Lynchburg City Schools (Schools). Direct inquires for information in writing to: Stephanie Suter, [stephanie.suter@lynchburgva.gov](mailto:stephanie.suter@lynchburgva.gov).

Sealed Proposals will be accepted prior to 4:00 PM Local Prevailing Time, June 30, 2016. All Proposals will be publicly opened and the Offerors’ names read. Proposals received after the stated due date and time shall not be considered.

Submit Proposals in a sealed, opaque envelope, and place the RFP number, title, due date, and time on the lower left front. Offerors are responsible for assuring the Proposal is submitted to the Procurement Division before the deadline indicated above and should include all addenda issued.

Acknowledge receipt of addenda here: No. \_\_\_\_\_ Date: \_\_\_\_\_ No. \_\_\_\_\_ Date: \_\_\_\_\_

Submit Proposals: BY MAIL, GROUND DELIVERY, OR HAND DELIVER TO:  
Procurement Division  
Third Floor City Hall  
900 Church Street  
Lynchburg, Virginia 24504

**Information the Offeror deems Proprietary is included in the proposal response in section(s):** \_\_\_\_\_  
See Paragraph B. on page 2 for guidelines on submitting proprietary information.

In compliance with this Request for Proposals and all the conditions imposed therein, the undersigned offers and agrees to furnish the services in accordance with the attached proposal or as mutually agreed by subsequent negotiations. By my signature below, I certify that I am authorized to bind the Offeror in any and all negotiations and/or contractual matters relating to this Request for Proposals. Sign in ink and type or print requested information.

Full Legal Name of Offeror: \_\_\_\_\_

Fed ID OR SOC. SEC. NO.: \_\_\_\_\_ Date: \_\_\_\_\_

Representative Signature: \_\_\_\_\_ Print: \_\_\_\_\_

Title: \_\_\_\_\_

Address: \_\_\_\_\_ Phone: ( ) \_\_\_\_\_

\_\_\_\_\_ Fax: ( ) \_\_\_\_\_

\_\_\_\_\_  
City Procurement Manager’s Signature

## I. SUBMISSION OF PROPOSALS

- A. **An original, so marked, and seven (7) copies, so marked, for a total of eight (8)** copies of the Proposal document are required. In addition, one (1) copy of the Proposal in an electronic format, either floppy disk or CD in Microsoft Word format or PDF file must accompany the Proposal. The City will not assume responsibility for reproduction where an insufficient number of copies have been supplied. In any such case, the City will notify the Offeror of the deficiency and request that the appropriate number of copies be delivered within 24 hours. Failure to comply with this or other requirements of this RFP shall be grounds for the City to reject such Proposals. Telegraphic or facsimile submission of Proposals will not be considered. Nothing herein is intended to exclude any responsible company or in any way restrain or restrict competition. All responsible Offerors are encouraged to submit Proposals. The content of the RFP and the successful Offeror's Proposal will become an integral part of the Contract, but may be modified by provision of the Contract. Offerors must be amenable to inclusion in a Contract any information, exclusive of that which is determined to be proprietary, provided either in response to this RFP or subsequently discussed and agreed upon during the selection/negotiation process. The information received will be considered contractual in nature, and will be used in validation and evaluation of Proposals, and in subsequent actions related to Contract execution and performance of responsibilities.
- B. Any changes, amendments, or modifications of proposals prior to the deadline for receipt of proposals must be in writing and submitted in the same manner as the original proposal, but conspicuously labeled as a change, amendment, or modification of the previously submitted proposal. Changes, amendments, or modifications of proposals will not be considered after the deadline for receipt of proposals.
- C. **Submission of Proprietary Information**  
Trade secrets or proprietary information submitted by an Offeror in connection with the submittal shall not be subject to public disclosure under the Virginia Freedom of Information Act. However, the Offeror must invoke the protection of this Section prior to or upon submission of the data or the materials, and must identify the data or the materials to be protected and state the reason why protection is necessary (Section 2.2-4342 of the Code of Virginia). **Offerors shall submit, in a separate section of the Proposal, any information that is considered proprietary and copyrighted material, and clearly identify the information as proprietary and/or copyrighted information. Offerors may not declare the entire Proposal proprietary nor may the Offeror declare proposed pricing as proprietary.** All information contained within the body of the Proposal and not in the separate section labeled proprietary shall be considered public information.
- D. Proposals having any erasures or corrections must be initialed in ink by the Offeror.
- E. The City reserves the right to accept or reject any or all Proposals, to waive informalities, and to reissue any RFP and to award a Contract in the City's (Schools) best interest. The City (Schools) reserves the right to contract with firms not party to the resultant Contract if determined to be in the City's (Schools) best interest.
- F. By submitting a Proposal response, the Offeror agrees that the **Proposal response will not be withdrawn for a period of one hundred fifty (150) days** following the due date for Proposal responses.
- G. By submitting a Proposal response, the Offeror certifies not to have conspired or agreed to intentionally alter or otherwise manipulate the Proposal response for the purpose of allocating purchases or sales to or among persons, raising or otherwise fixing the prices of the goods or services, or excluding other persons from conducting business with Schools.
- H. By submitting a Proposal response, the Offeror certifies the Proposal is made without collusion or fraud and the Offeror has not offered or received any kickbacks or inducements from any other Offeror, supplier, manufacturer or subcontractor in connection with the Proposal, and the Offeror has not conferred with any public employee having official responsibility for this procurement transaction, any payment, loan, subscription, advance, deposit of money, services or anything of more than nominal value, present or promised.
- I. The City will not be responsible for any expense incurred by any Offeror in preparing and submitting a Proposal response. All Proposals submitted will become the property of the City and Schools.

## **II. GENERAL INFORMATION**

The City and Schools currently have separate Health Benefit Plans. This RFP seeks proposals for current benefits as well as for a combined plan with the City benefits. The goal is to provide a cost-effective (administrative expenses, reinsurance premiums, and network discounts) high quality benefit plan with the following: effective disease management and cost containment programs, an extensive provider and facility network, on demand information systems, and dedicated customer and administrative services. In addition, both groups have made substantial investments in the onsite clinic, as such we are also looking for a comprehensive clinic and related wellness services. The ability to coordinate with and maximize the benefits and cost savings of this program is an important additional goal.

## **III. SCOPE OF SERVICES**

Offerors shall submit multiple proposals in their response with a financial proposal for each of the following benefit designs:

1. Schools Current Plan - standalone
2. City Current Plan – standalone
3. Combined – City Plan

Multiple proposals for each design may be submitted provided the alternative proposals contain significant and cost-effective variations from the Offeror's other proposals. Each alternative proposal should be submitted as a separate individual proposal.

Any changes, amendments, or modifications of proposals prior to the deadline for receipt of proposals must be in writing and submitted in the same manner as the original proposal, but conspicuously labeled as a change, amendment, or modification of the previously submitted proposal. Changes, amendments, or modifications of proposals will not be considered after the deadline for receipt of proposals.

The terms, conditions, and rates in the proposal will be valid from the proposal return date to the implementation date. The implementation date will be January 1, 2017. By mutual agreement of the City, Schools, and the Offeror awarded the contract, the terms, conditions and rates in the proposal may be valid beyond January 1, 2017, if the beginning date is delayed due to unanticipated events.

No proposals will be considered that includes commissions and/or service fees for an agent or broker.

## **IV. STATEMENTS NOT WARRANTIES AND REPRESENTATIONS**

The statements contained herein, particularly in the experience and census data sections, are made for the purpose of informing and assisting prospective Offerors in preparing bids. None of the statements contained herein shall be construed to be a warranty or representation and the City and Schools, its officials, employees, agents, and consultants shall not be liable to any persons for any statement contained herein.

## **V. PROPOSAL PREPARATION AND SUBMISSION REQUIREMENTS**

- A. **General Requirements:** Proposals should be thorough and detailed providing all relevant information that may be required in order for the City and Schools to properly evaluate the services offered.
- B. **Specific Requirements:** Offers are required to submit the following items as part of the complete proposal:
  1. Resumes of staff personnel to be assigned to this contract, including their specific responsibility within the potential contract.
  2. Completion of the proposed plans, questionnaire, and fee schedule.

Offerors are encouraged to provide additional information not specifically identified as a requirement if that additional information enables the proposal to better suit the needs of the City and Schools.

In order to procure the program that best suits the needs of the City and Schools, the review process and evaluation criteria consider factors in addition to cost.

**VI. CRITERIA FOR PROPOSAL EVALUATION AND METHOD OF AWARD**

A. **Evaluation Criteria** –An evaluation committee composed of representatives from the City and Schools and its consultant, Corporate Benefit Consultants, will evaluate proposals received.

Proposals will be evaluated on the basis of the Offeror's ability to provide a Health Plan and related services for the City and Schools. Proposal information relating to: claims processing capabilities, ability to serve subscribers, ability to contain Health care costs, network discounts, ability to administer other aspects of the program as outlined in the RFP, and financial stability of the company will be considered. Program costs and fee schedules will be considered, but shall not be the sole factor determining the contract award.

The City and Schools reserves the right to request verification, validation, or clarification of any information contained in proposals submitted.

Only information, which is received in response to this RFP, will be evaluated; reference to information previously submitted will not be considered.

**B. Method of Award**

Following individual evaluation of the submitted proposals by each evaluation committee member, selection shall be made of two or more Offerors deemed to be fully qualified and best suited among those submitting proposals, on the basis of the evaluation criteria. Negotiations will be conducted with the Offerors so selected, at the conclusion of which the City and Schools may select the proposal(s), as negotiated, which in the sole opinion of the City and Schools is (are) deemed to be in the best interest of the City and Schools. In such negotiations, the City and Schools reserves the right to request proposal amendments or modifications, which it deems to be in their best interest. If the City and Schools determines, after evaluating all proposals submitted for the program, that only one Offeror is fully qualified, or that one Offeror is clearly more qualified than others, the City and Schools may negotiate and award a contract to such Offeror.

The City of Lynchburg & Lynchburg City Schools anticipates that the award of the contract will be made around August 1, 2016.

**VII. CONTRACT TERM AND RENEWAL**

The contract will begin January 1, 2017, and continue through December 31, 2017, with the option to renew annually pending acceptable renewal rates.

It is understood and agreed between the parties to any agreement resulting from this proposal that if first year premiums only are quoted, the premiums may be adjusted at renewal, but the City and Schools reserve the right to cancel the contract at renewal date upon notification of premium adjustments deemed unacceptable.

**VIII. GENERAL TERMS AND CONDITIONS**

A. Advertising: It is understood and agreed that, in the event a contract is awarded for the service to the City and/or Schools, it shall not be used in any way in product literature or advertising without prior written approval.

- B. **Applicable Laws and Courts:** Any contract resulting from this solicitation shall be governed in all respects by the laws of the Commonwealth of Virginia and any litigation with respect thereto shall be brought in the courts of the City of Lynchburg. The Offeror shall comply with applicable federal, state and local laws and regulations.
- C. **Assignment of Contract:** A contract shall not be assignable by the Offeror in whole or in part without the written consent of the City and/or Schools.
- D. **Audit and Records Retention:** The successful Offeror hereby agrees to retain all books, records, and other documents relative to this contract for five (5) years after final payment, or until audited by the Commonwealth of Virginia whichever is sooner. Such records shall include, but not be limited to all paid vouchers including those for out-of-pocket expenses; other reimbursements supported by invoices, including Offeror's copies of periodic estimates for partial payment; ledgers; cancelled checks; deposit slips; bank statements; journals; contract amendments and change orders; insurance documents; payroll documents; timesheets; memoranda; and correspondence. The City and/or Schools, its authorized agents, or State auditors shall have full access to and the right to examine any of said material during said period. Records will be available on demand and without notice during normal working hours.
- E. **Availability of Funds:** It is understood and agreed between the parties herein that the City and/or Schools shall be bound hereunder only to the extent of the funds available or which may hereafter become available for the purpose of this agreement.
- F. **Cancellation of Contract:** The City and Schools reserve the right to cancel and terminate any resulting contract, in part or in whole, without penalty, upon 30 days written notice to the successful Offeror. Any contract cancellation notice shall not relieve the successful Offeror of the obligation to deliver or perform on all outstanding obligations prior to the effective date of cancellation.
- G. **Clarification of Terms:** If any prospective Offeror has questions about the specifications or other solicitation documents, the prospective Offeror shall contact the individual whose name appears on the face of the solicitation, not later than seven days prior to the due date. Any revisions to the solicitation will be made only by addendum issued by the Procurement Division. Any addendum officially amends the RRP and may be used to modify, correct or add to the information contained herein. It is the responsibility of each Offeror to ensure receipt of all addenda by viewing the City's Current Solicitation's website.
- H. **Collusion:** By submitting a proposal, the Offeror represents that in the preparation and submission of this proposal, said Offeror did not, either directly or indirectly, enter into any combination or arrangement with any person, firm or corporation or enter into any agreement, participate in any collusion, or otherwise take any action in the restraint of free, competitive bidding in violation of the Sherman Act (15 U.S.C. Sec. 1) or Section 59.1-9.1 through 59.1-9.17 or Sections 59.1-68.6 through 59.1-68.8 of the Code of Virginia.
- I. **Compensation:** The successful Offeror shall be required to submit a complete itemized invoice on each delivery or service, which it may perform under the contract. Payment shall be rendered to the successful Offeror for satisfactory compliance with the contract within thirty (30) days after the receipt of the proper invoice.
- J. **Conflict of Interest:** By submitting a proposal, the Offeror certifies that no member of the governing body, officer, or employee of the City or Schools during his/her tenure, or for one year thereafter shall have any interest, direct or indirect, in this contract or the proceeds thereof in violation of the Code of Virginia, Section 2.1-636.6 through 2.1-639.7.
- K. **Contract Documents:** The contract entered into by the parties shall consist of the Request for Proposal, the signed proposal submitted by the offeror, the Notice of Award, or Purchase Order/Contract, the General and Special Conditions, and the Scope of Work. All time limits stated in the contract document are of the essence of the contract.
- L. **Contractual Disputes:** Any dispute concerning a question of fact including claims for money or other relief as a result of a contract which is not disposed of by agreement shall be decided by the Contract Administrator, who shall reduce a decision to writing and mail or otherwise forward a copy thereof to the contractor within ten (10) days. The decision of the Contract Administrator shall be final and conclusive unless the contractor appeals in writing, a formal protest within ten (10) days after award. Contractual claims, whether for money or other relief, shall be submitted in writing no later than sixty (60) days after final payment; however, written

notice of Contractor's intention to file such a claim shall have been given at the time of the occurrence or beginning of the work upon which the claim is based. Pending claims shall not delay payment of amounts agreed due in the final payment.

- M. Drug Free: During the performance of any contract exceeding \$10,000.00 the Offeror agrees to provide a drug-free workplace for the Offeror's employees; post in conspicuous places, available to employees and applications for employment, a statement notifying employees that the unlawful manufacture, sale, distribution, dispensation, possession, or use of a controlled substance or marijuana is prohibited in the Offeror's workplace and specifying the actions that will be taken against employees for violations of such prohibition; state in all solicitations or advertisements for employees placed by or on behalf of the Offeror that the Offeror maintains a drug-free workplace.
- N. Debarment Status: By submitting a proposal, Offeror certifies it is not currently debarred from submitting proposals on contracts by any agency of the Commonwealth of Virginia nor is it an agent of any person or entity that is currently debarred from submitting proposals on contracts by any agency of the Commonwealth of Virginia.
- O. Nondiscrimination: If the Contract exceeds \$10,000, during the performance of the Contract, the Contractor agrees to conform to the provisions of the Federal Civil Rights Act of 1964, as amended, as well as the Virginia Fair Employment Contracting Act of 1975, as amended, where applicable, the Virginians with Disabilities Act, the Americans with Disabilities Act, Sec. 2.2-4311 of the Virginia Public Procurement Act, and the Lynchburg Public Procurement Ordinance.
1. The Contractor will not discriminate against any employee or applicant for employment because of race, religion, color, sex, national origin, age, disability or other basis prohibited by state law relating to discrimination in employment, except where there is a bona fide occupational qualification reasonably necessary to the normal operation of the Contractor. The Contractor agrees to post in conspicuous places, available to employees and applicants for employment, notices setting forth the provisions of this nondiscrimination clause.
  2. The Contractor, in all solicitations or advertisements for employees placed by or on behalf of the Contractor, will state that such Contractor is an equal opportunity employer.
  3. Notices, advertisements and solicitations placed in accordance with federal law, rule or regulation shall be deemed sufficient for the purpose of meeting the requirements of this Section.
  4. The Contractor will include the provisions outlined in this RFP, Section N Paragraphs 1, 2, and 3 in every subcontract or purchase orders over \$10,000, so that the provisions will be binding upon each subcontractor or vendor.
- P. Ethics in Public Contracting: By submitting a proposal, the Offeror certifies that the proposal is made without collusion or fraud and that it has not offered or received any kickbacks or inducements from any other Offeror, supplier, manufacturer, or subcontractor in connection with their proposal, and that they have not conferred on any public employee having official responsibility for this procurement transaction any payment, loan, subscription, advance, deposit of money, services, or anything of more than nominal value.
- Q. Immigration Act: By signature on this solicitation, Offeror certifies that they do not and will not during the performance of the contract employ illegal alien workers or otherwise violate the provisions of the Federal Immigration Reform and Control Act of 1986.
- R. Inconsistencies in Conditions: In the event there are inconsistencies between the General Terms and Conditions and the Special Terms and Conditions, and/or other schedules contained herein, the latter two shall take precedence.
- S. Indemnification: To the fullest extent permitted by law, the Contractor, for itself, heirs, representatives, successors, and assigns agrees to save, defend, keep harmless, and indemnify the City and the Schools and all of their officials, agents and employees from and against any and all claims, loss, damage, injury, costs (including court costs and attorney's fees), charges, liability or exposure, however caused, resulting from, arising out of or in any way connected with the Contractor's performance (or nonperformance) of the Contract terms or its obligations under this Contract. The City can not, by Virginia Law, either hold harmless or indemnify the Contractor.

- T. Insurance: The Contractor shall be required to maintain in force the following insurance policies and coverage limits for the duration of the Contract: General Liability Insurance \$1,000,000; Automobile Liability Insurance \$1,000,000; Workers Compensation Insurance in Statutory Amounts; Errors and Omissions Insurance \$1,000,000, which will protect the Contractor and the City from claims which may arise out of or result from the execution of the work, whether such execution be by the Contractor, the Contractor's employees, agents, subcontractors or by anyone for whose acts any of them may be liable. The General Liability policy shall include the following: premises/operations, independent contractors, products and completed operations, contractual liability and personal injury liability. The Contractor is required to provide evidence of an Employee Dishonesty Bond in the minimum amount of \$1,000,000. Contractors authorized to conduct business in the Commonwealth of Virginia shall provide all insurance. The Contractor shall furnish the City with an original Certificate of Insurance. The Certificate should name Lynchburg City Schools, its officers and employees as an additional insured. The Contractor shall notify the Schools at least thirty (30) days prior to policy cancellation or non-renewal or reduction of coverage.
- U. Method of Payment: The Contractor shall be paid on the basis of invoices submitted, to be paid net thirty (30) days from receipt and approval by an authorized City and/or Schools official, upon completion of services. Payment shall be made after satisfactory performance of the contract in accordance with all of the provisions thereof and upon receipt of a properly completed invoice. The School Board reserves the right to withhold any or all payments or portions thereof for contractor's failure to perform in accordance with the provisions of the contract or any modifications thereto.
- V. Notice of Award: Notice of Award shall be posted to the City of Lynchburg's Procurement website, Notice of Awards: <http://www.lyncburgva.gov/current-solicitations>. The City will notify successful Offeror of award by written notice.
- W. Ownership of Material: Ownership of all data, material and documentation originated and prepared for the City and Schools pursuant to the RFP shall belong exclusively to the City and Schools and shall be subject to public inspection in accordance with the Virginia Freedom of Information Act. Trade secrets or proprietary information submitted by an Offeror shall not be subject to public disclosure under the Virginia Freedom of Information Act.
- X. Obligation of Offeror: By submitting a proposal, the Offeror covenants and agrees that it has satisfied itself, from its own investigation of the conditions to be met that it fully understands the obligation and that it will not make any claim for, or have right to cancellation or relief from the contract because of any misunderstanding or lack of information.
- Y. Prime Contractor Responsibilities: The Contractor shall be responsible for completely supervising and directing the work under this contract and all subcontractors that they may utilize, using their best skill and attention. Subcontractors who perform work under this contract shall be responsible to the prime Contractor. The Contractor agrees to be fully responsible for the acts and omissions of their subcontractors and of persons employed by them as they are for the acts and omissions of their own employees.
- Z. Qualifications of Offerors: The City and Schools may make such reasonable investigations as deemed proper and necessary to determine the ability of the Offeror to perform the work and the Offeror shall furnish all such information and data for this purpose as may be requested. The City and Schools further reserve the right to reject any proposal if the evidence submitted by or investigations of such Offeror fails to satisfy that such Offeror is properly qualified to carry out the obligations of the contract and to complete the work contemplated herein.
- AA. Smoke-free environment. Smoking is not permitted on any Lynchburg City School site (including both in buildings and on school grounds).
- BB. Termination for Cause/Default: In case of failure to deliver goods or provide services in accordance with the contract terms and conditions, the City and/or Schools, after due oral or written notice, may procure them from other sources and hold the vendor responsible for any resulting additional purchase and administrative costs. If, through any cause, the successful Offeror shall fail to fulfill in a timely and proper manner their obligations under this contract, or if the successful Offeror shall violate any of the covenants, agreements, or stipulations of this contract, the City and/or Schools shall thereupon have the right to terminate, specifying the effective date thereof, at least five (5) days before the effective date of such termination.

CC. Termination for Convenience: The City and Schools reserve the right to cancel and terminate any resulting contract, in part or in whole, without penalty, whenever the contract administrator determines that such a termination is in the best interest of the City and/or Schools. Any such termination shall be effected by delivery to the successful Offeror, at least ten (10) working days prior to the termination date. A Notice of Termination specifies the extent to which performance shall be terminated and date upon which such termination becomes effective. After receipt of notice of termination, the successful Offeror must stop all work or deliveries under the purchase order and/or contract on the date and to the extent specified; however, any contract termination notice shall not relieve the successful Offeror of the obligation to deliver and/or perform on all outstanding orders issued prior to the effective date of termination.

**THE CITY OF LYNCHBURG & LYNCHBURG CITY SCHOOLS**

**EXPERIENCE HISTORY**

Attached:

**City Experience and Enrollment (Excel file on website)**  
**Schools Experience and Enrollment (Excel file on website)**  
**City Top Providers Facilities**  
**Schools Top Providers Facilities**

**BENEFIT DESIGN HISTORY**

Attached:

**City SPD 2013.2014.2015**  
**City SBC 2016**  
**School SPD 2013.2014.2015**  
**School SBC 2016 (Schools added annual wellness physicals for all)**

**CENSUS**

Attached:

**City Census 5.26.2016 (Excel file on website)**  
**City Location Codes**  
**Schools Census 5.26.2016 (Excel file on website)**  
**Schools Location Codes**  
**EE: Employee only**  
**E1: Employee/child**  
**EC: Employee/children**  
**ES: Employee/spouse**  
**FM: Family**

**CLINIC INFORMATION ATTACHED**

**Role of On-Site HealthCare Provider**  
**Clinic FAQs**  
**Basic Lab Test Clinic**

**THE CITY OF LYNCHBURG & LYNCHBURG CITY SCHOOLS**

**PREMIUMS AND FUNDING**

**FUNDING**

Please quote the following funding arrangements for each option requested:

1. Health Plan: Self-Insured Funding – Quote should include a 24/12 and a 12/15 contract, with a specific stop loss of \$300,000 with a \$50,000 deductible and a 110% and 120% aggregate cap. No reinsurance is requested for Carve-outs.

Please include expected and maximum rates by tier.

Attached Contributions Medical & Rx:

City Contributions

Schools Contributions

**NOTE: Please use the May 2016 enrollment by tiers for all exhibits.**

# THE CITY OF LYNCHBURG & LYNCHBURG CITY SCHOOLS

## GENERAL INFORMATION

### MEDICAL

#### QUESTIONS TO BE ANSWERED

##### A. Medical

1. Have you followed specifications and quoted these coverages as requested? If not, specifically outline your deviations.
2. What medical trend factors are being used in this proposal? Please provide your medical trends for the last five years.
3. What is your allowable charge and frequency for the procedures in the attached spreadsheet (Appendix A) for your primary network (Lynchburg, Charlottesville, and Roanoke; separately if different, if there are differences by site of care please note), wrap network (if applicable) and out-of-network, if different.

##### B. Claims Administration/Customer Service

1. What office will be responsible for claims payment?
2. What local assistance is available for employees regarding their coverage? Will you provide a dedicated customer service contact?
3. Outline the key elements of your "direct" claims system. (Include specimen copies of claim forms, EOB, etc.)
4. What percentage of claims require no additional information?
5. Please indicate your average claim turnaround on time on:
  - a) "Clean Claims"
  - b) Claims that required additional information
6. Please describe in detail all Web based apps available to members.
7. Please provide details on your average call response time.
8. Please describe in detail how claims are adjudicated for out of area dependents and retirees.
9. Please describe in detail the process for members to access care outside of your primary network.

##### C. Policy Administration

1. Where is your servicing office that will be responsible for this account?
2. Please describe in detail the initial and ongoing enrollment process.
3. Please describe in detail the assistance that you will provide installing the case. Include a proposed timeline with tasks and responsibilities.
4. Please include specimen copies of all your standard reports.

5. What other management reports do you have available and recommend? Briefly outline each of these reports and indicate what additional charge, if any, would be made (include specimen copies of your standard reports). Describe how these reports will be used to contain HealthCare costs.
6. What employee education (wellness) programs will you make available. Specify goals of each program and its cost, if any. Specify how the program would be implemented and by who.
7. Will a service representative be available at the various work sites on a regular basis if needed?
8. Please provide detailed information on assistance and reports available for all level of compliance (Federal (ACA, HIPPA, etc.), State, Local, etc.)

#### D. Networks/Discounts

1. For all Managed Care Options please provide a network match based on two primary care physicians, pediatricians, Ob/GYNs and all other specialist in 10 and 20 mile standards.
2. For the categories in #1, please provide the number for each zip code.
3. For the categories in #1, please provide number of board certified/eligible for each zip code.
4. Please provide a list of all hospitals in network in Virginia, Maryland, & North Carolina.
5. Provide a complete description of your credentialing of providers under contract and ongoing quality assurance procedures.
6. Please explain in detail your hospital discount arrangement and average network percentage savings off of total allowable billed charges (net of COB) for all proposed networks for Lynchburg, Charlottesville, and Roanoke separately, if different, for the last three years. When is the next anticipated change in your fee schedule?
7. Please explain in detail your provider discount arrangement and average network percentage savings off of total allowable billed charges (net of COB) for all proposed networks for Lynchburg, Charlottesville, and Roanoke separately, if different, for the last three years. Please note Primary care and specialist separately. When is the next anticipated change in your fee schedule?

#### F. Cost Containment

1. How do you envision your firm partnering with the City and Schools to implement comprehensive ways to reduce HealthCare related expenses?
2. Please provide recommendations for providing essential healthcare for our employees and dependents that optimizes patient outcomes while reducing unnecessary medical procedures.
3. How does your risk management strategy reduce healthcare and worker compensation costs?

#### G. Clinic

1. Please provide a comprehensive proposal to provide clinic/wellness services coordinated with the medical program (see attachments).

#### H. Guarantees

1. Please provide a specific guarantee for Network savings (by network) based on the percentage of savings to the total allowable billed charges (net of COB).

2. Please provide a set of performance standards that you will be willing to offer.
3. Please provide second and third year guarantees/caps for administrative charges, network access fees, reinsurance charges, and the maximum claim liability.

I. Financials

1. Please provide your current financial ratings from the following:
  - a. S&P
  - b. Moodys
  - c. Duff & Phelps
  - d. AM Best

Also provide for your proposed reinsurance company, if different.

TO BE RETURNED WITH PROPOSALS

THE CITY OF LYNCHBURG & LYNCHBURG CITY SCHOOLS

HEALTH PLAN PROPOSALS

The undersigned is familiar with the specifications and other information as supplied in this invitation to present proposals and understands that The City of Lynchburg & Lynchburg City Schools will not be responsible for any errors or omissions on the part of the undersigned in making up the proposal. Any deviations or exceptions must be fully explained in writing by the undersigned.

It is understood that The City of Lynchburg & Lynchburg City Schools reserves the right to reject any or all proposals or any part thereof, or to accept any proposal or any part thereof, and to waive any informalities in any proposal deemed to be for the best interest of The City of Lynchburg & Lynchburg City Schools. The undersigned agrees that the proposal submitted shall remain open and available to contract by The City of Lynchburg & Lynchburg City Schools for 90 days after the opening.

The undersigned also agrees and understands that his request is for "proposals" and is to be willing to discuss all proposals with The City of Lynchburg & Lynchburg City Schools' Insurance Consultant and be willing to negotiate with the Consultant as so required.

BY

\_\_\_\_\_  
Signed Authorized Representative

\_\_\_\_\_  
Authorized Representative (Typed)

\_\_\_\_\_  
Name of Firm

\_\_\_\_\_  
Address

\_\_\_\_\_  
Phone Number - Include Area Code



**THE CITY OF LYNCHBURG**  
**Top 25 Providers**  
**Calendar Year 2015<sup>(1)</sup>**

Provider Name	Specialty	Type	Medical Paid
JUSTIN MUTCH MD	PEDIATRICS	PHYSICIAN	\$ 37,045.48
ROBERT SULLIVAN JR. MD	PEDIATRICS	PHYSICIAN	30,681.37
MATTHEW TATOM DO	INTERNAL MEDICINE	PHYSICIAN	25,762.55
EDWARD LEWIS MD	SPORTS MEDICINE	PHYSICIAN	19,969.91
ROBERT RICHARDS MD	GASTROENTEROLOGY	PHYSICIAN	19,508.24
KENNETH MUSANA HUDSON MD	GASTROENTEROLOGY	PHYSICIAN	18,622.64
KRISTI LYNN KIDD MD	OBSTETRICS GYNECOLOGY	PHYSICIAN	17,133.20
RACHEL GAGEN MD	PEDIATRICS	PHYSICIAN	17,087.01
ROBERT MCCURLEY MD	PEDIATRICS	PHYSICIAN	16,610.57
GAUTHAM GONDI MD	ORTHOPEDECS	PHYSICIAN	16,403.51
DAVID CRESSON MD	PATHOLOGY	PHYSICIAN	15,464.56
CHRISTINE MARRACCINI MD	OBSTETRICS GYNECOLOGY	PHYSICIAN	14,701.50
WADE NEIMAN MD	OBSTETRICS GYNECOLOGY	PHYSICIAN	14,543.09
STEPHANIE SULLIVAN MD	PEDIATRICS	PHYSICIAN	14,379.57
MATTHEW TOMPKINS MD	OBSTETRICS GYNECOLOGY	PHYSICIAN	13,958.57
WILLIAM BAKER MD	OBSTETRICS GYNECOLOGY	PHYSICIAN	13,513.88
CHRISTOPHER VON ELTEN MD	FAMILY MEDICAL PRACTICE	PHYSICIAN	13,471.99
MICHAEL PADILLA MD	PEDIATRICS	PHYSICIAN	13,365.04
KIMBERLY COMBS MD	FAMILY MEDICAL PRACTICE	PHYSICIAN	13,279.14
LORETTA MAFFEI SMITH MD	GASTROENTEROLOGY	PHYSICIAN	13,142.32
LOAN KLINE MD	PEDIATRICS	PHYSICIAN	12,779.11
LARRY CLARK JR MD	GASTROENTEROLOGY	PHYSICIAN	12,604.79
LEWIS DABNEY MW	OBSTETRICS GYNECOLOGY	PHYSICIAN	12,591.80
KEITH PITZER MD	PLASTIC/RECONSTRUCTIVE SURGE	PHYSICIAN	12,199.52
MICHAEL ROWLAND MD	FAMILY MEDICAL PRACTICE	PHYSICIAN	12,123.31
			\$ 420,942.67

<sup>(1)</sup>Claims Incurred January 1, 2015 through December 31, 2015  
 Claims Paid January 1, 2015 through March 31, 2016



PIEDMONT COMMUNITY HEALTH PLAN  
Community Partners for Quality Healthcare

**THE CITY OF LYNCHBURG**

Top 25 Facilities  
Calendar Year 2015<sup>(1)</sup>

Provider Name	Specialty	Type	Medical Paid
LYNCHBURG GENERAL HOSPITAL	HOSPITAL	HOSPITAL	\$ 2,463,398.70
UVA HEALTH SCIENCES CENTER	HOSPITAL	HOSPITAL	967,092.50
VIRGINIA BAPTIST HOSPITAL	REHABILITATION HOSPITAL	HOSPITAL	479,644.60
VIRGINIA BAPTIST HOSPITAL	HOSPITAL	HOSPITAL	400,573.38
VCU HEALTH SYSTEM	HOSPITAL	HOSPITAL	97,492.37
CHIPPENHAM J. W. HOSPITAL	HOSPITAL	HOSPITAL	89,993.10
CARILION ROANOKE MEMORIAL HOSPITAL	HOSPITAL	HOSPITAL	75,867.40
SURGERY CENTER OF LYNCHBURG	SURGERY CENTER	ANCILLARY	74,771.80
DUKE UNIVERSITY HOSPITAL	HOSPITAL	HOSPITAL	73,885.00
SALEM VAMC	VA HOSPITAL	HOSPITAL	41,388.13
CENTRA LAB	LABORATORY	ANCILLARY	37,462.44
INTRAVENE LLC	HOME INFUSION IV THERAPY	ANCILLARY	36,165.27
BEDFORD MEMORIAL HOSPITAL	HOSPITAL	HOSPITAL	32,957.54
TIMBERLAKE MAMMOGRAPHY CENTER	BREAST CENTER	ANCILLARY	29,994.62
LEWIS-GALE MEDICAL CENTER	HOSPITAL	HOSPITAL	29,982.97
UVA DIALYSIS CENTER	DIALYSIS CENTER	ANCILLARY	28,553.93
CENTRA SPECIALTY HOSPITAL	LONG TERM CARE FACILITY	HOSPITAL	26,250.00
LABCORP BURLINGTON	LABORATORY	ANCILLARY	22,530.27
PIEDMONT STONE CENTER PLLC	SURGERY CENTER	ANCILLARY	18,692.38
ROBERTS HOME MEDICAL INC	DURABLE MEDICAL EQUIPMENT	ANCILLARY	18,471.24
LINCARE INC	DURABLE MEDICAL EQUIPMENT	ANCILLARY	16,882.27
BAYFRONT HEALTH PUNTA GOR	HOSPITAL	HOSPITAL	14,990.35
WESTMINSTER CENTERBURY LYNCHB	HOSPITAL	HOSPITAL	11,682.56
HEALTH PARK MEDICAL CENTER	HOSPITAL	HOSPITAL	11,295.06
CENTRA HOME HEALTH LYNCHBURG	HOME HEALTH CARE	ANCILLARY	11,121.88
			\$5,111,139.76

<sup>(1)</sup>Claims Incurred January 1, 2015 through December 31, 2015  
Claims Paid January 1, 2015 through March 31, 2016

**LYNCHBURG CITY SCHOOLS**  
**Top 25 Providers**  
**Calendar Year 2015 <sup>(1)</sup>**

Provider Name	Specialty	Type	Medical Paid
CHRISTINE MARRACCINI MD	OBSTETRICS GYNECOLOGY	PHYSICIAN	\$23,434.55
ROBERT MCCURLEY MD	PEDIATRICS	PHYSICIAN	\$21,636.41
MATTHEW TATOM DO	INTERNAL MEDICINE	PHYSICIAN	\$21,012.33
LARRY CLARK JR MD	GASTROENTEROLOGY	PHYSICIAN	\$20,957.98
JUSTIN MUTCH MD	PEDIATRICS	PHYSICIAN	\$20,450.40
STEPHANIE SULLIVAN MD	PEDIATRICS	PHYSICIAN	\$20,052.48
KIMBERLY COMBS MD	FAMILY MEDICAL PRACTICE	PHYSICIAN	\$18,031.96
CHRISTOPHER VON ELTEN MD	FAMILY MEDICAL PRACTICE	PHYSICIAN	\$17,910.47
ROBERT SULLIVAN JR. MD	PEDIATRICS	PHYSICIAN	\$17,883.76
MATTHEW TOMPKINS MD	OBSTETRICS GYNECOLOGY	PHYSICIAN	\$17,656.46
DAVID PHEMISTER MD	OBSTETRICS GYNECOLOGY	PHYSICIAN	\$16,508.26
WEI HOU MD	GASTROENTEROLOGY	PHYSICIAN	\$16,047.70
RALPH WISNIEWSKI MD	GASTROENTEROLOGY	PHYSICIAN	\$15,727.84
ROBERT RICHARDS MD	GASTROENTEROLOGY	PHYSICIAN	\$15,585.86
DAVID CRESSON MD	PATHOLOGY	PHYSICIAN	\$15,505.77
WADE NEIMAN MD	OBSTETRICS GYNECOLOGY	PHYSICIAN	\$15,414.15
PATRICIA RICHARDSON MD	FAMILY MEDICAL PRACTICE	PHYSICIAN	\$14,901.31
KENNETH MUSANA HUDSON MD	GASTROENTEROLOGY	PHYSICIAN	\$13,757.48
MICHAEL ROWLAND MD	FAMILY MEDICAL PRACTICE	PHYSICIAN	\$13,748.08
LORETTA MAFFEI SMITH MD	GASTROENTEROLOGY	PHYSICIAN	\$13,666.61
LOUIS GRAHAM MD	FAMILY MEDICAL PRACTICE	PHYSICIAN	\$13,115.28
JOHN WILLIAMS MD	FAMILY MEDICAL PRACTICE	PHYSICIAN	\$13,027.22
CATHERINE SCHULLER MD	OBSTETRICS GYNECOLOGY	PHYSICIAN	\$12,353.52
HARRY ESCHENROEDER JR. MD	ORTHOPEDICS	PHYSICIAN	12,088.05
LYNNETT SCHINDLER MD	OBSTETRICS GYNECOLOGY	PHYSICIAN	11,925.62
			\$412,399.55

<sup>(1)</sup>Claims Incurred January 1, 2015 through December 31, 2015  
Claims Paid January 1, 2015 through March 31, 2016

**LYNCHBURG CITY SCHOOLS**  
Top 25 Facilities  
Calendar Year 2015 <sup>(1)</sup>

Facility Name	Specialty	Type	Medical Paid
LYNCHBURG GENERAL HOSPITAL	HOSPITAL	HOSPITAL	\$2,124,655.15
VIRGINIA BAPTIST HOSPITAL	HOSPITAL	HOSPITAL	\$483,734.28
UVA HEALTH SCIENCES CENTER	HOSPITAL	HOSPITAL	\$473,027.85
VIRGINIA BAPTIST HOSPITAL	REHABILITATION HOSPITAL	HOSPITAL	\$252,674.91
TEMPLE UNIVERSITY HOSPITAL	HOSPITAL	HOSPITAL	\$84,455.70
CONTINUUM HOME HEALTH/UNIV OF VA	HOME HEALTH CARE	ANCILLARY	\$72,212.03
DUKE UNIVERSITY HOSPITAL	HOSPITAL	HOSPITAL	\$55,377.22
SURGERY CENTER OF LYNCHBURG	SURGERY CENTER	ANCILLARY	\$51,454.87
TIMBERLAKE MAMMOGRAPHY CENTER	BREAST CENTER	ANCILLARY	\$51,312.50
MYRIAD GENETIC LABORATORIES INC	LABORATORY	ANCILLARY	\$44,004.00
JOHN RANDOLPH MEDICAL CENTER	PSYCHIATRIC HOSPITAL	HOSPITAL	\$42,952.71
INTRAVENE LLC	HOME INFUSION IV THERAPY	ANCILLARY	\$41,015.27
CENTRA LAB	LABORATORY	ANCILLARY	\$31,568.14
VIRGINIA PSYCHIATRIC CO DOMINION HO	HOSPITAL	HOSPITAL	\$27,106.03
NORTH CAROLINA BAPTIST	LABORATORY	ANCILLARY	\$26,730.48
BEDFORD MEMORIAL HOSPITAL	HOSPITAL	HOSPITAL	\$21,443.04
CARILION ROANOKE MEMORIAL HOSPITAL	HOSPITAL	HOSPITAL	\$21,372.20
LABCORP BURLINGTON	LABORATORY	ANCILLARY	\$20,725.69
HANGER PROSTHETICS & ORTHOTICS	ORTHOTICS/PROSTHETICS	ANCILLARY	\$15,375.84
PHYSICIAN CHOICE LABORATORY SE	LABORATORY	ANCILLARY	\$13,347.80
ROANOKE AMBULATORY SURGERY CENTER	SURGERY CENTER	ANCILLARY	\$12,947.25
GUGGENHEIMER	SKILLED NURSING FACILITY	ANCILLARY	\$12,906.73
LINCARE INC	DURABLE MEDICAL EQUIPMENT	ANCILLARY	\$12,343.79
CENTRA HOME HEALTH LYNCHBURG	HOME HEALTH CARE	ANCILLARY	\$12,190.50
TATE SPRINGS MAMMOGRAPHY CENTER	BREAST CENTER	ANCILLARY	\$11,010.00
			\$4,015,943.98

<sup>(1)</sup>Claims Incurred January 1, 2015 through December 31, 2015  
Claims Paid January 1, 2015 through March 31, 2016



**Plan Document  
&  
Summary Plan  
Description**

**The City of Lynchburg**

**Health Care Plan**

Effective January 1, 2015

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## INTRODUCTION

This document is a description of The City Of Lynchburg Employee Health Care Benefit Plan (the Plan), as amended and restated effective October 1, 2012, and replaces and supersedes all previous Plan documents. No oral interpretations can change this Plan.

This plan is a “grandfathered health plan” under the Patient Protection and Affordable Care Act. As permitted by the Affordable Care Act, a grandfathered health plan can preserve certain basic health coverage that was already in effect when the law was enacted. Being a grandfathered health plan means that your plan may not include certain consumer protections of the Affordable Care Act that apply to other plans, for example, the requirement for the provision of preventive health services without any cost share. However, grandfathered health plans must comply with certain other consumer protections in the Affordable Care Act, for example, the elimination of lifetime limits on benefits.

Questions regarding which protections apply and which protections do not apply to a grandfathered health plan and what might cause a plan to change from grandfathered health plan status can be directed to the plan administrator at (434)522-3700. Covered Persons may also contact the Employee Benefits Security Administration, U.S. Department of Labor at 1-866-444-3272 or [www.dol.gov/ebsa/healthreform](http://www.dol.gov/ebsa/healthreform). This website has a table summarizing which protections do and do not apply to grandfathered health plans.

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

Failure to follow the eligibility or enrollment requirements of this Plan may result in delay of coverage or no coverage at all. Reimbursement from the Plan can be reduced or denied because of certain provisions in the Plan, such as coordination of benefits, subrogation, exclusions, timeliness of COBRA elections, utilization review or other cost management requirements, lack of Medical Necessity, lack of timely filing of claims or lack of coverage. These provisions are explained in summary fashion in this document; additional information is available from the Plan Administrator at no extra cost.

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 the expenses incurred while this coverage is in effect. No benefits are payable for expenses incurred before coverage began or after coverage terminated. An expense for a service or supply is incurred on the date the service or supply is furnished.

The Employer fully intends to maintain this Plan indefinitely. However, it reserves the right to terminate, suspend, discontinue or amend the Plan at any time. If the Plan is terminated, amended, or benefits are eliminated, the rights of Covered Persons are limited to covered charges incurred before termination, amendment, or elimination.

The Plan is a cost sharing mechanism for certain health care services and supplies used by a Covered Person. The Plan is not responsible for the efficiency and integrity of the health care providers delivering such health care services and supplies. The Plan is not liable in any way for the effect of delivery of such health care services and supplies or the results of action taken as a result of a health care service or supply being limited or not covered by the Plan.

This document summarizes the Plan rights and benefits for covered Employees and their Dependents and should be read carefully since each Participant is required to take action to assure that the maximum payment levels under the Plan are paid. This document is divided into the following parts:

**Eligibility, Funding, Effective Date and Termination.** Explains eligibility for coverage under the Plan, funding of the Plan and when the coverage takes effect and terminates.

**Schedule of Benefits.** Provides an outline of the Plan reimbursement formulas as well as payment limits on certain services.

**Benefit Descriptions.** Explains when the benefit applies and the types of charges covered.

**Medical Management Services.** Explains the methods used to curb unnecessary and excessive charges.

**Defined Terms.** Defines those Plan terms that have a specific meaning. If a word or a phrase has a specific meaning, it starts with a capital letter and is either defined in the Defined Terms section or in the text of this document where it occurs.

**Plan Exclusions.** Shows what charges are **not** covered.

**Claim Provisions.** Explains the rules for filing claims and the claim appeal process.

**Coordination of Benefits.** Shows the Plan payment order when a person is covered under more than one plan.

**Third Party Recovery Provision.** Explains the Plan's rights to recover payment of charges when a Covered Person has a claim against another person because of injuries sustained.

**COBRA Continuation Options.** Explains when a person's coverage under the Plan ceases and the continuation options which are available.

## **ELIGIBILITY, FUNDING, EFFECTIVE DATE AND TERMINATION PROVISIONS**

### **ELIGIBILITY**

#### **Eligible Classes of Employees.**

All Eligible and Retired Employees of the Employer.

**Eligibility Requirements for Employee Coverage.** A person is eligible for Employee coverage from the first day that he or she:

- (1) is a Full-Time, Active Employee of the Employer. An Employee is considered to be Full-Time if he or she normally works at least 40 hours per week and is on the regular payroll of the Employer for that work, or
- (2) is a Retired Employee of the Employer, and
- (3) is in a class eligible for coverage.

Coverage will be effective on the first day of the month after the employee satisfies his or her eligibility requirements and the Plan Administrator receives the completed enrollment application.

Employees who were previously covered by the Plan and lost coverage because they no longer met the eligibility requirements (i.e., works less than full-time), but who are still employed by the Employer, will be eligible for coverage under the Plan again if they subsequently regain eligibility. These Employees must enroll for coverage as instructed in the ENROLLMENT section of this document.

#### **Coverage for Retirees**

Retirees are eligible for coverage must enroll for coverage as instructed in the Enrollment section of this document. This plan will be the primary coverage until the retiree enrolls under Medicare. Generally, retirees become eligible for Medicare at age 65. A person may become eligible for Medicare if under the age of 65 and disabled. The person must enroll in Medicare when they turn 65, it is not automatic. The person must carry coverage for Part A and Part B under Medicare in order to be covered under this plan. After enrolling with Medicare, coverage will be coordinated with this Plan. Medicare will be primary and this plan secondary. This Plan will be a duplicating plan to Medicare Part A and a non-duplicating plan to Medicare Part B. This means that under Part A, this Plan will pay part or all of the Medicare Part A deductible depending on the amount that this Plan would have paid on the claim had it been primary.

Under Part B, this Plan will only pay after the Medicare Part B deductible and if this Plan would have paid more on the claim than Medicare had it been primary. Payments made by this Plan under Part B are subject to the Plans deductible, co-payments and out of pocket maximums.

Once a retiree or a retiree's dependent is eligible for Medicare, they will no longer be eligible for prescription drug coverage under the City's Plan. Instead, Medicare Part D provides options for prescription drug coverage.

There is no "open enrollment" for retirees.

## **Examples of claims paying as secondary:**

### **Eligible Classes of Dependents.**

A Dependent is any one of the following persons:

- (1) A covered Employee's Spouse.

The term "Spouse" shall mean the person recognized as the covered Employee's husband or wife under the laws of the state where the covered Employee lives or was married, and shall not include common law marriages. The term "Spouse" shall not include partners of the same sex who were legally married under the laws of the State in which they were married. The Plan Administrator may require documentation proving a legal marital relationship.

- (2) A covered Employee's Child(ren).

An Employee's "Child" includes his natural child, stepchild, adopted child, or a child placed with the Employee for adoption. An Employee's Child will be an eligible Dependent until reaching the limiting age of 26, without regard to student status, marital status, financial dependency or residency status with the Employee or any other person. When the child reaches the applicable limiting age, coverage will end on the child's birthday. However, for Plan Years beginning before January 1, 2014, an Employee's Child is not an eligible Child if the Child is eligible to enroll in an employer-sponsored health plan other than the group health plan of a parent of the Child.

The phrase "child placed with the Employee for adoption" refers to a child whom a person intends to adopt, whether or not the adoption has become final, who has not attained the age of 18 as of the date of such placement for adoption. The term "placed" means the assumption and retention by such person 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.

- (3) A covered Employee's Qualified Dependents.

The term "Qualified Dependents" shall include children for whom the Employee is a Legal Guardian.

To be eligible for Dependent coverage under the Plan, a Qualified Dependent must be unmarried, under the limiting age of 19 years, living with the Employee and primarily dependent upon the covered Employee for support and maintenance. Coverage will end on the date in which the Qualified Dependent ceases to meet the applicable eligibility requirements.

The Dependent may only be added to the Subscriber's policy within 31 days of the Subscriber's assuming legal guardianship for the individual.

Any child of a Plan Participant 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 Plan Administrator may require documentation proving dependency, including birth certificates, tax records or initiation of legal proceedings severing parental rights.

- (4) A eligible Dependent Child or Qualified Dependent who reaches the limiting age and is 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 unmarried. The Plan Administrator may require, at reasonable intervals, continuing proof of the Total Disability and dependency.

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.

These persons are excluded as Dependents: other individuals living in the covered Employee's home, but who are not eligible as defined; the legally separated or divorced former Spouse of the Employee; any person who is on active duty in any military service of any country; or any person who is covered under the Plan as an Employee.

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.

If both mother and father are Employees, their children will be covered as Dependents of the mother or father, but not of both.

**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 may require proof that a Spouse, Qualified Dependent, or a Child qualifies or continues to qualify as a Dependent as defined by this Plan.

## **FUNDING**

### **Cost of the Plan.**

The City of Lynchburg shares the cost of Employee and Dependent coverage under this Plan with the covered Employees. The enrollment application for coverage will include a payroll deduction authorization. This authorization must be filled out, signed and returned with the enrollment application.

The level of any Employee contributions is set by the Plan Administrator. The Plan Administrator reserves the right to change the level of Employee contributions.

## **ENROLLMENT**

**Enrollment Requirements.** An Employee must enroll for coverage by filling out and signing an enrollment application.

### **Enrollment Requirements for Newborn Children.**

For newborns enrolled in the Plan, charges for inpatient hospital services, physician care while in the hospital will be applied toward the Plan of the covered parent. For newborns enrolled in the Plan, coverage of Sickness or Injury, including Medically Necessary care and treatment of congenital defects, birth abnormalities, or complications resulting from prematurity will be applied toward the Plan of the newborn child.

## **TIMELY ENROLLMENT**

**Timely Enrollment** - The enrollment will be "timely" if the 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. This also applies to newborns.

If two Employees (the mother and father of the child(ren)) 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 and the covered Employee enrolls the Dependent children within 31 days of the children's loss of coverage.

## **SPECIAL ENROLLMENT RIGHTS**

Federal law provides Special Enrollment provisions under some circumstances. If an Employee is declining enrollment for himself/herself or his/her dependents (including his/her spouse) because of other health insurance or group health plan coverage, there may be a right to enroll in this Plan if there is a loss of eligibility for that other coverage (or if the employer stops contributing towards the other coverage). However, a request for enrollment must be made within 31 days after the coverage ends (or after the employer stops contributing towards the other coverage).

There may be a right to enroll in this Plan if (a) an Employee or Dependent loses eligibility for coverage under Medicaid or a State child health plan or (b) if the Employee or Dependent becomes eligible for assistance under such Medicaid plan or State child health plan. However, the Employee must request enrollment within 60 days after (a) the date the Medicaid or State child health plan coverage ends or (b) the date the employee or dependent is determined to be eligible for such assistance, as applicable.

In addition, in the case of a birth, marriage, adoption or placement for adoption, there may be a right to enroll in this Plan. However, a request for enrollment must be made within 31 days after the birth, marriage, adoption or placement for adoption.

The Special Enrollment rules are described in more detail below. To request Special Enrollment or obtain more detailed information of these portability provisions, contact the Plan Administrator.

## **SPECIAL ENROLLMENT PERIODS**

The Enrollment Date for anyone who enrolls under a Special Enrollment Period is the first date of coverage. Thus, the time between the date a special enrollee first becomes eligible for enrollment under the Plan and the first day of coverage is not treated as a Waiting Period.

- (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 (i) the coverage was terminated as a result of loss of eligibility for the coverage (including as a result of legal separation, divorce, cessation of dependent status (such as attaining the maximum age to be eligible as a dependent child under the plan), death, termination of employment or reduction in the number of hours of employment, or the Plan ceasing to provide benefits to a class of similarly-situated individuals), or (ii) employer contributions towards the coverage were terminated. The Employee or Dependent also has a loss of eligibility when coverage is offered through an HMO, or other arrangement, in the individual or group market that does not provide benefits to individuals who no longer reside, live or work in a service area, (whether or not within the choice of the individual), and, in the case of the group market, no other benefit package is available to the individual.
  - (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 is incurred).

**Coverage obtained due to this Special Enrollment event will begin on the first day of the first calendar month following the date the other coverage ends**

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 or an intentional misrepresentation of a material fact in connection with the plan), that individual does not have a Special Enrollment right.

- (2) Individuals losing Medicaid coverage or State Child Health Insurance Plan (CHIP) coverage.** An Employee or Dependent who is eligible, but not enrolled in this Plan, may enroll if each of the following conditions is met. However, if a Dependent becomes eligible to enroll under this provision and the Employee is not then enrolled, the Employee must enroll in order for the Dependent to enroll.
  - (a)** The Employee or Dependent is covered under a Medicaid plan under title XIX of the Social Security Act or under a State child health plan under title XXI of such Act and coverage of the Employee or Dependent under such a plan is

terminated as a result of loss of eligibility for such coverage.

- (b) The Employee or Dependent requests enrollment in this Plan not later than 60 days after the date of termination of the Medicaid or State child health plan coverage. Coverage obtained due to loss of Medicaid or CHIP coverage will be effective on the first day of the first calendar month following the date the Plan Administrator receives the completed enrollment request.
- (3) **Individuals becoming eligible for employment assistance under Medicaid coverage or CHIP coverage.** An Employee or Dependent who is eligible, but not enrolled in this Plan, may enroll if each of the following conditions is met. However, if a Dependent becomes eligible to enroll under this provision and the Employee is not then enrolled, the Employee must enroll in order for the Dependent to enroll.

  - (a) The Employee or Dependent becomes eligible for assistance, with respect to coverage under this Plan, under a Medicaid plan or State child health plan.
  - (b) The Employee or Dependent requests enrollment in this Plan not later than 60 days after the date the Employee or Dependent is determined to be eligible for such assistance. Coverage obtained due to assistance eligibility will be effective on the first day of the first calendar month following the date the Plan Administrator receives the completed enrollment request.

(4) **Dependent beneficiaries. If:**

- (a) 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 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:

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

## EFFECTIVE DATE

**Effective Date of Employee Coverage.** Except as required for a Special Enrollment, an Employee will be covered under this Plan as of the first day of the calendar month following the date that the Employee satisfies all of the following:

- (1) The Eligibility Requirement.
- (2) The Active Employee Requirement.
- (3) The Enrollment Requirements of the Plan.

### **Active Employee Requirement.**

An Employee must be an Active Employee (as defined by this Plan) for this coverage to take effect. An absence of work that is due to a Health Factor is not considered an absence for purposes of measuring the Waiting Period or determining if the Employee is an Active Employee.

**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 coverage under this Plan stops, Plan Participants can receive a certificate that will show the period of coverage under this Plan. Please contact the Plan Administrator for further details.**

**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 first of the month following the day the covered Employee ceases to be in one of the Eligible Classes. This includes death or termination of Active Employment of the covered Employee. (See the COBRA Continuation Options.) It also includes an Employee on disability, layoff or leave of absence, unless the Plan specifically provides for continuation during these periods.
- (3) The end of the period for which the required contribution has been paid if the charge for the next period is not paid when due.
- (4) If an Employee commits fraud or makes a material misrepresentation in applying for or obtaining coverage, or obtaining benefits under the Plan, or fails to notify the Plan Administrator that he or she has become ineligible for coverage, then the Employer or Plan may either void coverage for the employee and covered Dependents for the period of time coverage was in effect, may terminate coverage as of a date to be determined at the Plan's discretion, or may immediately terminate coverage. If coverage is to be terminated or voided retroactively for fraud or misrepresentation, the Plan will provide at least 30 days' advance written notice of such action. **The employer will refund all contributions paid for any coverage rescinded;**

**however, claims paid will be offset from this amount. The employer reserves the right to collect additional monies if claims are paid in excess of the Employee's and/or Dependent's paid contributions.**

**Continuation During Periods of Employer-Certified Disability, Leave of Absence or Layoff.** A person may remain eligible for a limited time if Active, full-time work ceases due to disability, leave of absence or layoff. This continuance will end as of the date the employer decides:

**For disability leave only:** the date the Employer ends the continuance.

**For leave of absence or layoff only:** the date the Employer ends the continuance.

While continued, coverage will be that which was in force on the last day worked as an Active Employee. 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.

**Rehiring a Terminated Employee.** A terminated Employee who is rehired 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.

**Reinstated Employee.** A reinstated Employee will be eligible for coverage without any lapse of coverage.

**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 24 month 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.

If the Employee wishes to elect this coverage or obtain more detailed information, contact the Plan Administrator. The Employee may also have continuation rights under COBRA. In general, the Employee must meet the same requirements for electing USERRA coverage as are required under COBRA continuation coverage requirements. Coverage elected under these circumstances is concurrent not cumulative. The Employee may elect USERRA continuation coverage for the Employee and their Dependents. Only the Employee has election rights. Dependents do not have any independent right to elect USERRA health plan continuation.

**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):

- (1) The date the Plan or Dependent coverage under the Plan is terminated.
- (2) The date that the Employee's coverage under the Plan terminates for any reason including death. (See the COBRA Continuation Options.)
- (3) The date a covered Spouse loses coverage due to loss of eligibility status. The employee must notify the plan within 30 days when a qualified dependent becomes ineligible for coverage. They would be eligible for COBRA coverage. (See the COBRA Continuation Options.)
- (4) On the first date that a Dependent child fails to meet the applicable eligibility requirements. (See the COBRA Continuation Options.)
- (5) The end of the period for which the required contribution has been paid if the charge for the next period is not paid when due.
- (6) If a Dependent commits fraud or makes a material misrepresentation in applying for or obtaining coverage, or obtaining benefits under the Plan, or fails to notify the Plan Administrator that he or she has become ineligible for coverage, then the Employer or Plan may either void coverage for the Dependent for the period of time coverage was in effect, may terminate coverage as of a date to be determined at the Plan's discretion, or may immediately terminate coverage. If coverage is to be terminated or voided retroactively for fraud or misrepresentation, the Plan will provide at least 30 days' advance written notice of such action.

## **OPEN ENROLLMENT**

During the annual open enrollment period, covered Employees and their covered Dependents will be able to change some of their benefit decisions based on which benefits and coverages are right for them.

Benefit choices made during the open enrollment period will become effective at the beginning of the plan year and remain in effect throughout the plan year unless there is a change in family status during the year (birth, death, marriage, divorce, adoption) or loss of coverage due to loss of a Spouse's employment. To the extent previously satisfied, coverage Waiting Periods and Pre-Existing Conditions Limits will be considered satisfied when changing from one plan to another plan.

A Plan Participant who fails to make an election during open enrollment will automatically retain his or her present coverages.

Plan Participants will receive detailed information regarding open enrollment from their Employer.

**THE CITY OF LYNCHBURG  
SCHEDULE OF BENEFITS**

<b>Benefits</b>	<b>In-Plan</b>	<b>Out-of-Plan</b>
<b>Annual Deductible</b> Individual Family	\$500 \$1000	\$600 \$1,200
<b>Annual Out-of-Pocket Maximum</b> Individual	\$2,000	\$4,000
<b>Coinsurance</b>	80%	60%
<b>Physician Services</b> Office Visits  Allergy Injections  Lab work/Pathology in the Office  Other services performed in the Office  Inpatient Surgical	100% after \$20 copayment – Family Practice and Pediatrics, \$30 copayment for Specialist  100% after \$5 copayment  100% after office visit copayment  80% after deductible  80% after deductible 80% after deductible	60% after deductible  60% after deductible  60% after deductible  60% after deductible 60% after deductible
<b>Preventive Care</b> Routine physical Exams – Adult (\$300 Calendar Year maximum allowed)  Pediatric Wellness Exams	After \$20 copayment, \$300 annual maximum; charges exceeding the \$300 benefit subject to deductible & coinsurance  100% after \$20 copayment	60% after deductible  60% after deductible
<b>Emergency Room Services</b>  <b>Non-Emergency Room Services</b>	100% after \$50 copayment (waived if admitted)  80% after deductible	100% after \$50 copayment (waived if admitted)  60% after deductible
<b>Hospital Expenses</b> (Inpatient and outpatient)	80% after deductible	60% after deductible
<b>Intensive Care Unit</b>	80% after deductible	60% after deductible
<b>Durable Medical Equipment and Diabetic Supplies</b>	80% after deductible	60% after deductible
<b>Prosthetics</b>	80% after deductible	60% after deductible
<b>Orthotics</b>	80% after deductible	60% after deductible

Benefits	In-Plan	Out-of-Plan
<b>Chiropractic Services</b> (20 visits per Calendar Year)	100% after \$30 copayment	60% after deductible
<b>Physical/Occupational Therapy</b> (30 visits combined per Calendar Year)		
In office	100% after \$30 copayment	60% after deductible
Outpatient	80% after deductible	60% after deductible
<b>Speech Therapy</b> (30 visits per Calendar Year)		
In office	100% after \$30 copayment	60% after deductible
Outpatient	80% after deductible	60% after deductible
<b>Wig after Chemotherapy</b>	80% after deductible	60% after deductible
<b>Ambulance</b>	80% after deductible	60% after deductible
<b>Skilled Nursing Facility Care</b> 30 day limit	80% after deductible	60% after deductible
<b>Home Health Care</b> (100 visits Calendar Year maximum combined)	80% after deductible	60% after deductible
<b>Hospice</b>	80% after deductible	60% after deductible
<b>Organ Transplants</b>	80% after deductible	60% after deductible
<b>Pregnancy</b> Inpatient (includes delivery)	80% after deductible	60% after deductible
In doctor's office	First visit \$100 copayment then 100% thereafter	60% after deductible
<b>* Prescription Drugs</b>		
Retail 30 day supply	Coinsurance: Generic 40% Brand 40%	Coinsurance: Generic 40% Brand 40%
Mail Order 90 day supply	Coinsurance: Generic 40% Brand 40%	Coinsurance: Generic 40% Brand 40%
	<ul style="list-style-type: none"> <li>• Mandatory Generic</li> <li>• Mandatory Mail Order for Maintenance Prescriptions</li> </ul>	<ul style="list-style-type: none"> <li>• Mandatory Generic</li> <li>• Mandatory Mail Order for Maintenance Prescriptions</li> </ul>

Benefits	In-Plan	Out-of-Plan
Prescription drug charges do not accrue toward Medical Plan deductible and out of pocket maximum.		

\* Prescription Drug Benefits are not administered by PCHP, please direct any questions about prescription drugs to Script Care, LTD at 1-866-807-0072.

**NOTE:** Out-of-plan services subject to Maximum Plan Allowance.

## SCHEDULE OF BENEFITS

### Participating Provider Plan

The Medical Plan is a Preferred Provider Organization (PPO) Plan. Preferred Providers are members of Piedmont's network of Participating Providers. Generally, a higher level of benefits is paid for services rendered by a Participating Provider.

Piedmont 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 payment from the Plan than when a non-participating Provider is used, except that the higher payment will also be made for a non-participating provider if the covered person resides outside the area served by the Piedmont network, or if the services are for a Medical Emergency. It is the Covered Person's choice as to which Provider to use.

Additional information and a list of Participating Providers will be given to covered Employees and updated as needed.

### MEDICAL BENEFITS

All benefits described in this Schedule 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 Usual and Reasonable; 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.

**NOTE: Medical Services received in the event of a Medical Emergency do not require precertification. Otherwise, the following services must be precertified or reimbursement from the Plan may be reduced.**

#### Hospitalizations

**MRI/PET scans**

**Skilled Nursing Facility stays**

**Home Health Care**

**Hospice Care**

**Durable Medical Equipment**

**Physical, speech and/or occupational therapy (Evaluation visit does not require referral)**

**Cardiac rehabilitation therapy**

**Outpatient surgical procedures**

**Selected out of network services**

The attending Physician does not have to obtain pre-certification from the Plan for prescribing a Hospital length of stay in connection with childbirth for the mother or her newborn child that is 48 hours or less following a vaginal delivery or 96 hours or less following a cesarean delivery.

Obstetric hospitalizations that exceed the 48 or 96 hour time periods and any services that are not associated with the delivery must be pre-certified as set forth in this document.

**NOTE:** When the delivery occurs outside a Hospital, the Hospital length of stay begins at the time the mother or newborn is admitted as a Hospital inpatient in connection with childbirth. The attending Physician will determine whether the admission is in connection with childbirth.

**Please see the Medical Management section in this booklet for details.**

### **Deductibles/Copayments payable by Plan Participants**

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 per Covered Person. Typically, there is one deductible amount per Plan and it must be paid before any money is paid by the Plan for any covered services. Each January 1<sup>st</sup>, a new deductible amount is required. Deductibles do not accrue toward the 100% 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 do not accrue toward the 100% maximum out-of-pocket payment or toward the deductible.

### **Physician visit copayment**

In-Plan Services Family Practice .....	\$20
In-Plan Services Specialist .....	\$30
Allergy Injection.....	\$5
Out-of-Plan Services .....	60% after Deductible

**Lab and pathology services provided in the office are covered under the office visit copayment. All other services performed in the office are subject to the deductible and coinsurance. Exceptions are prenatal services and allergy injections.**

### **Emergency room copayment**

In-Plan Services .....	\$50
Out-of-Plan Services .....	60% after Deductible

This copayment will be waived if the Covered Person is admitted directly from the emergency room to the Hospital because of a Medical Emergency.

### **Non-Emergency room**

In-Plan Services .....	80% after Deductible
Out-of-Plan Services .....	60% after Deductible

### **Deductibles, per Calendar Year**

Per Covered Person, In-Plan Services .....	\$500
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Per Covered Person, Out-of-Plan Services ..... \$600

Per Family Unit, In-Plan Services ..... \$1000

Per Family Unit, Out-of-Plan Services ..... \$1200

\*\*At least two members of the family must satisfy the \$500 deductible before family deductible is met.

**Maximum out-of-pocket payments, per Calendar Year**

The Plan will pay the percentage of covered charges designated until the following amounts of out-of pocket payments are reached in total, by two members, at which time the Plan will pay 100% of the remainder of covered charges for the rest of the Calendar Year unless stated otherwise.

Per Covered Person, In-Plan Services ..... \$2,000

Per Covered Person, Out-of-Plan Services ..... \$4,000

The charges for the following do not apply to the 100% benefit limit and are never paid at 100%.

(1) Deductible(s)

(2) Copayments

**NOTE:** The maximums listed below are the total for In-Plan and Out-of-Plan expenses. For example, if a maximum of 60 days is listed twice under a service, the Calendar Year maximum is 60 days total, which may be split between In-Plan and Out-of-Plan providers.

Following are other maximums on individual benefits.

**Hospital Room and Board –**

Daily limit.....the average semi-private room rate when applicable

Reimbursement rate

In-Plan Services ..... 80% after Deductible

Out-of-Plan Services ..... 60% after Deductible

**Intensive Care Unit –**

Daily limit.....same as semi-private room rate

Reimbursement rate

In-Plan Services ..... 80% after Deductible

Out-of-Plan Services ..... 60% after Deductible

**Skilled Nursing Facility –**

Daily limit.....the facility’s average semi-private room rate

Reimbursement rate

In-Plan Services .....80% after Deductible

Out-of-Plan Services .....60% after Deductible

**Skilled nursing is limited to 30 days per calendar year. For Medicare participants, this is in addition to the Medicare day limit.**

**Home Health Care –**

Reimbursement rate

In-Plan Services .....80% after Deductible

Out-of-Plan Services .....60% after Deductible

Calendar Year maximum

In-Plan/Out-of-Plan Services ..... 100 visits combined

**Physician Services –**

**Inpatient**

Reimbursement rate

In-Plan Services .....80% after Deductible

Out-of-Plan Services .....60% after Deductible

**Office visit**

Reimbursement rate

In-Plan Services Family Practice ..... 100% after \$20 Copayment

In-Plan Services Specialist Practice ..... 100% after \$30 Copayment

Out-of-Plan Services .....60% after Deductible

**Lab and pathology services provided in the office are covered under the office visit copayment. All other services performed in the office are subject to the deductible and coinsurance. Exceptions are prenatal services and allergy injections.**

**Surgical services (outpatient) –**

Reimbursement rate

In-Plan Services ..... 80% after Deductible

Out-of-Plan Services ..... 60% after Deductible

**Hospice Care –**

Reimbursement rate

In-Plan Services ..... 80% after Deductible

Out-of-Plan Services ..... 60% after Deductible

**Ambulance Service –**

Reimbursement rate

In-Plan Services ..... 80% after Deductible

Out-of-Plan Services ..... 60% after Deductible

**Jaw Joint/TMJ –**

Reimbursement rate

In-Plan Services ..... 100% after \$30 Copayment

Out-of-Plan Services ..... 60% after Deductible

**Wig after chemotherapy –**

Reimbursement rate

In-Plan Services ..... 80% after Deductible

Out-of-Plan Services ..... 60% after Deductible

**Occupational / Physical Therapy –**

Reimbursement rate (outpatient)

In-Plan Services ..... 80% after Deductible

Out-of-Plan Services ..... 60% after Deductible

Reimbursement rate (in office)

In-Plan Services ..... 100% after \$30 Copayment  
Out-of-Plan Services ..... 60% after Deductible  
Calendar Year maximum ..... 30 visits (combined)

**Speech Therapy –**

Reimbursement rate

In-Plan Services ..... 80% after Deductible  
Out-of-Plan Services ..... 60% after Deductible

Reimbursement rate (in office)

In-Plan Services ..... 100% after \$30 Copayment  
Out-of-Plan Services ..... 60% after Deductible  
Calendar Year maximum ..... 30 visits

**Durable Medical Equipment –**

Reimbursement rate

In-Plan Services ..... 80% after Deductible  
Out-of-Plan Services ..... 60% after Deductible

**Prosthetics –**

Reimbursement rate

In-Plan Services ..... 80% after Deductible  
Out-of-Plan Services ..... 60% after Deductible

**Orthotics --**

Reimbursement rate

In-Plan Services ..... 80% after Deductible  
Out-of-Plan Services ..... 60% after Deductible

**Mental Disorders Treatment –**

Reimbursement rate (inpatient)

In-Plan Services ..... 80% after Deductible

Out-of-Plan Services ..... 60% after Deductible

Reimbursement rate (outpatient)

In-Plan Services ..... 80% after Deductible

Out-of-Plan Services ..... 60% after Deductible

Reimbursement rate (in office)

In-Plan Services ..... 100% after \$20 Copayment

Out-of-Plan Services ..... 60% after Deductible

**Substance Abuse Treatment –**

Reimbursement rate (inpatient)

In-Plan Services ..... 80% after Deductible

Out-of-Plan Services ..... 60% after Deductible

Reimbursement rate (outpatient)

In-Plan Services ..... 80% after Deductible

Out-of-Plan Services ..... 60% after Deductible

Reimbursement rate (in office)

In-Plan Services ..... 100% after \$20 Copayment

Out-of-Plan Services ..... 60% after Deductible

**Chiropractic Services –**

Reimbursement rate

In-Plan Services ..... 100% after \$30 Copayment

Out-of-Plan Services ..... 60% after Deductible

Calendar Year maximum ..... 20 visits

**Organ Transplant Coverage –**

Covered Transplant Procedures:

Organ and tissue transplants are covered except those which are classified as “Experimental and/or Investigational.”

Reimbursement rate

In-Plan Services ..... 80% after Deductible

Out-of-Plan Services ..... 60% after Deductible

**Pregnancy Benefits –**

Reimbursement rate

In-Plan Services (office visits)..... \$100 Copayment for first office visit then payable at 100%

In-Plan Services (other than office visits)..... 80% after Deductible

Out-of-Plan Services ..... 60% after Deductible

Covered Child

No coverage for Pregnancy or any Complication of Pregnancy

**Nursery/Physician**

**Well Newborn Care In-Patient –**

Reimbursement rate

In-Plan Services ..... 80% after Deductible

Out-of-Pan Services ..... 60% after Deductible

**Preventive Care**

**Routine Well Adult Care –**

Reimbursement rate

In-Plan Services Family Practice ..... 100% after \$20 Copayment

Out-of-Plan Services ..... 60% after Deductible

Coverage includes reimbursement for the following routine services: office visits, pap smear, mammogram, prostate screening, gynecological examination, routine physical examination, x-rays and laboratory blood tests.

Frequency limits for mammogram

Ages 35 through 39 ..... Single Baseline mammogram

Age 40 and over ..... annually

Frequency limits for Screening Colonoscopies

Age 55 and over..... One every 5 to 10 years

**NOTE: Preventive Adult Care - \$300 annual maximum; charges exceeding the \$300 benefit subject to deductible & coinsurance**

**Routine Well Child Care –**

Reimbursement rate

In-Plan Services Family Practice ..... 100% after \$20 Copayment

Out-of-Plan Services ..... 60% after Deductible

The charges for well child care made by a Physician will be considered covered charges through age 6.

Coverage includes reimbursement for the following routine services: office visits, routine physical examination, laboratory blood tests, x-rays and immunizations.

**PIEDMONT COMMUNITY HEALTH PLAN  
PREVENTIVE HEALTH CARE SCHEDULE**

<b>Age of Covered Person</b>	<b>In-Plan Covered Services</b>
<b>0 to 12 months</b>	6 checkups, including routine immunizations
<b>13 to 24 months</b>	3 checkups, including routine immunizations and tuberculin test
<b>2 to 19 years</b>	1 checkup/physical exam, including routine immunizations every year up to age 6; every 12 months ages 7 to 19. Annual pap smear for females beginning at age 13.*
<b>20 to 39 years</b>	1 physical exam every 12 months, including pap and physician breast exam for women (gyn care may be done annually if needed). Tetanus-diphtheria booster every 10 years; hepatitis B vaccine, pneumovax vaccine, chicken pox vaccine, influenza vaccine if needed. Fasting serum glucose and cholesterol checked every two to five years. Hematocrit and urinalysis to be checked with gyn exam. 1 baseline mammography screening between ages 35 to 39.
<b>40 to 49 years</b>	1 physical exam every 12 months, including pap and physician breast exam for women (gyn care may be done annually if needed). Digital prostate exam to be done with male exam. Tetanus-diphtheria booster every ten years, hepatitis B vaccine, pneumovax vaccine, chicken pox vaccine, influenza vaccine if needed. Fasting serum glucose and cholesterol checked every two to five years. Hematocrit and urinalysis to be checked with gyn exam. Screening mammography annually.
<b>50 years and older</b>	1 physical exam every 12 months, including pap and physician breast exam for women, digital prostate exam for men. Tetanus-diphtheria booster every 10 years, hepatitis B vaccine, pneumovax vaccine, chicken pox vaccine, influenza vaccine if needed. Hemocrit and urinalysis to be checked with gyn exam. Fasting serum glucose and cholesterol checked every two to five years. Annual screening mammography for women. Annual occult blood test. Flexible sigmoidoscopy every three to five years. One baseline EKG. Annual PSA.
<b>55 year and older</b>	Screening Colonoscopy- one every 5 to 10 years

\*Pap smears and mammograms may be covered at an earlier age or more frequently if recommended by a physician.

## PRESCRIPTION DRUG BENEFIT

Once a retiree, or a retiree's dependent, is eligible for Medicare, they will no longer be eligible for prescription drug coverage under this Plan. Instead, Medicare Part D provides options for prescription drug coverage.

**Pharmacy Option** (30 day supply) Minimum of \$20 per script and Maximum of \$100 per script

Coinsurance, per Prescription

For name brands.....40%

For Generic drugs .....40%

**Mail Order Prescription Drug Option** (90 day supply)

Minimum of \$60 per script and Maximum of \$300 per script

Copayment, per Prescription

For name brands.....40%

For Generic drugs .....40%

### Prescription Drug Benefit

**40% Coinsurance for each 30 day supply** – If the prescription cost for a 30 day supply is \$50 or less, you will pay the lesser of \$20 or the cost of the drug. If the cost of 30 day supply is greater than \$50, you will pay 40% of the cost up to a maximum of \$100.

**Mandatory Generic** – When a generic drug is available, the plan benefit is based on the cost of the generic. If you request or require a brand name drug, then you must pay the difference between the cost of the generic drug and the brand name drug in addition to your coinsurance.

**Mandatory Mail Order** – You can fill an initial prescription for a 30-day supply at the pharmacy and receive up to three 30 day supply refills at the pharmacy. After that, the prescription must be filled through the mail order benefit. You will still be required to use generic drugs and you will still be required to pay 40% of the prescription cost. If the cost of the 90 -day supply is \$150 or less, you will pay \$60 or the actual cost of the drug, whichever is less. If the cost of the 90-day supply is greater than \$150, you will pay 40% of the cost to a maximum of \$300 per 90 day supply.

**NOTE:** Pharmacy benefits are not administered by Piedmont, please direct any questions about prescriptions drugs to Prescription Solutions by Script Care, LTD at 1-866-807-0072.

## MEDICAL MANAGEMENT SERVICES

### Medical Management Services Phone Number

Piedmont Community Health Plan  
1-800-400-7247

The provider, patient, or family member must call this number to receive certification of certain Services. This call must be made at least 72 hours in advance of services being rendered.

### UTILIZATION REVIEW

Utilization review is a program designed to help ensure that all Covered Persons receive necessary and appropriate health care while avoiding unnecessary expenses.

The program consists of:

- (a) Precertification of the Medical Necessity for the following non-emergency services before Medical and/or Surgical services are provided:

- Cardiac rehabilitation therapy**
  - Durable Medical Equipment over \$200**
  - Home Health Care**
  - Hospice Care**
  - Hospitalizations**
  - MRI/PET scans**
  - Outpatient surgical procedures**
  - Physical, speech and occupational therapy after evaluation visit**
  - Skilled Nursing Facility stays**
  - Substance Abuse/Mental Disorder treatments**

The attending Physician does not have to obtain pre-certification from the Plan for prescribing a Hospital length of stay in connection with childbirth for the mother or her newborn child that is 48 hours or less following a vaginal delivery or 96 hours or less following a cesarean delivery.

Obstetric hospitalizations that exceed the 48 or 96 hour time periods and any services that are not associated with the delivery must be pre-certified as set forth in this document.

**NOTE:** When the delivery occurs outside a Hospital, the Hospital length of stay begins at the time the mother or newborn is admitted as a Hospital inpatient in connection with childbirth. The attending Physician will determine whether the admission is in connection with childbirth.

- (b) Retrospective review of the Medical Necessity of the listed services provided on an emergency basis;
- (c) Concurrent review, based on the admitting diagnosis, of the listed services requested by the attending Physician; and

- (d) Certification of services and planning for discharge from a Medical Care Facility or cessation of medical treatment.

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.

Prior authorization (pre-certification of services) is not a guarantee of coverage. The utilization management program is designed only to determine whether or not a proposed setting and course of treatment is Medically Necessary and appropriate. Benefits under the Plan will depend upon the person's eligibility for coverage and the Plan's limitations and exclusions. Nothing in the utilization management program will increase benefits to cover any confinement or service which is not Medically Necessary or which is otherwise not covered under the Plan.

If a particular course of treatment or medical service is not certified, it means that the Plan will not consider that course of treatment as appropriate for the maximum reimbursement under the Plan.

In order to maximize Plan reimbursements, please read the following provisions carefully.

### **How the program works.**

**Precertification.** Before a Covered Person enters a Medical Care Facility on a non-emergency basis or receives other listed medical services, the utilization review 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 utilization review program is set in motion by a telephone call from, or on behalf of, the Covered Person. Contact the utilization review administrator at Piedmont Community Health Plan 800-400-7247 **at least 72 hours before** services are scheduled to be rendered with the following information:

- The name of the patient and relationship to the covered Employee
- The name, Employee 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
- The proposed rendering of listed medical services

If there is an **emergency** admission to the Medical Care Facility, the patient, patient's family member, Medical Care Facility or attending Physician must contact Piedmont Community Health Plan **within 48 hours** of the first business day after the admission.

The utilization review 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.**

**The Covered Person is ultimately responsible for obtaining required authorization for services.** To minimize the risk of reduced benefits, the Covered Person should contact the utilization management administrator to make certain that the facility or attending Physician has initiated the necessary pre-certification process. If the Covered Person does not receive authorization as explained in this section, the benefit will be reduced to the out of network benefit level.

**Concurrent review, discharge planning.** Concurrent review of a course of treatment and discharge planning from a Medical Care Facility are parts of the utilization review program. The utilization review 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. Pre-authorization is not required for a second opinion by an in-network provider. 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.

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

## **PREAMISSION TESTING SERVICE**

The Medical Benefits percentage payable will be 100% for diagnostic lab tests and x-ray exams when:

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

## **PRECERTIFICATION FOR HOSPITAL ADMISSIONS**

### **Purpose**

Precertification reviews the necessity and length of your recommended medical hospital stay and identifies and informs you of alternatives to inpatient hospitalization when appropriate.

- In an emergency, you, a family member or your doctor must call your primary physician or PCHP (1-800-400-7247) within 48 hours.
- To precertify a non-emergency admission, call your primary care physician before admission.
- Failure to precertify will reduce covered hospital charges to, reimbursed at 60% after the annual deductible of (\$600).

### **Tertiary Providers/Out of Network Providers**

For services that cannot be provided in the Piedmont network you must contact Piedmont's Medical Management or have your physician send in documentation when referred to a Tertiary Provider or an out of network provider.

## **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 alternate benefit 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 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.**

#### **Emergencies Outside The Service Area**

Emergency and urgent care is covered whether the member is in or out of the services area including out of the United States. As long as it is an emergency, care received from non-network facilities will be treated as in-plan. The member should contact PCHP within 48 hours to receive the proper authorization for in-plan benefits. Routine care must be received from network providers in order to be covered in-plan.

## MEDICAL BENEFITS/DEFINED TERMS

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. The Defined Terms when used in this Plan will be capitalized.

**Active Employee** is an Employee who is on the regular payroll of the Employer and who is scheduled to perform the duties of his or her job with the Employer on a full-time basis.

**Allowable Charge** is the amount of a Provider's billed charges used by the Plan to determine the benefits that are payable for a Plan Participant. For Network Providers, the Allowable Charge is the charge agreed upon in the PPO contract. For Non-Network Providers, the Allowable Charge is the Usual and Reasonable Charge based on the area services are received. Usual and Reasonable Charges does not apply towards the deductible or out-of-pocket maximum.

**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.

**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 1st through December 31st of the same year.

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

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

**Creditable Coverage** includes most health coverage, such as coverage under a group health plan (including COBRA continuation coverage), HMO membership, an individual health insurance policy, Medicaid or Medicare, a State health benefit risk pool, a public health plan (including plans established or maintained by a foreign country), or the State Children's Health Insurance Program.

Creditable Coverage does not include coverage consisting solely of dental or vision benefits. Creditable Coverage does not include coverage that was in place before a significant break of coverage of more than 63 days.

**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.

**Deductible Amount.** This is an amount of covered charges for which no benefits will be paid. Before benefits can be paid in a Calendar Year a Covered Person must meet the deductible shown in the Schedule of Benefits. Services which are subject to a copayment rather than a coinsurance will not be subject to the deductible.

This amount will not accrue toward the 100% out-of-pocket maximum.

**Durable Medical Equipment** means equipment which meets the following: (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. (e) diabetic supplies are products used for diabetes self-management and includes: blood glucose monitors, glucose test strips, lancet, control solutions, batteries, and insulin pump (needs authorization for medical necessity).

**Employee** means a person who is an Active, regular Employee of the Employer, regularly scheduled to work for the Employer in an Employee/Employer relationship. The following persons are not eligible for coverage under this Plan: (i) leased employees as defined in Internal Revenue Code section 414(n); (ii) individuals classified by the Employer as temporary employees or part time employees; (iii) individuals classified by the Employer as independent contractors or leased employees (including those who are at any time reclassified as employees by the Internal Revenue Service or a court of competent jurisdiction).

**Employer** is The City of Lynchburg.

**Enrollment Date** is the first day of coverage.

**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 or nonexperimental 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 ongoing phase I or phase II clinical trials, is the research, experimental, study or Investigational arm of ongoing 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.

Reliable evidence shall mean only published reports and articles in the authoritative medical and scientific literature; the written protocol or protocols used by the treating facility or the protocol(s) of another facility studying substantially the same drug, device, medical treatment or procedure; or the written informed consent used by the treating facility or by another facility studying substantially the same drug, device, medical treatment, or procedure.

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.

**Family Unit** is the covered Employee and the family members who are covered as Dependents under the Plan. When the dollar amount shown in the Schedule of Benefits has been incurred by two members of a Family Unit toward their Calendar Year deductibles, the deductibles of all members of that Family Unit will be considered satisfied for that year.

**Foster Child** means a child temporarily living in the covered Employee's home; one placed in the covered Employee's home by a social service agency which retains control of the child; or whose natural parent(s) may exercise or share parental responsibility and control. A Foster Child is not an eligible dependent.

**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.

**Genetic Information** means information about the genetic tests of an individual or his family members, and information about the manifestations of disease or disorder in family members of the individual. A "genetic test" means an analysis of human DNA, RNA, chromosomes, proteins or metabolites, which detects genotypes, mutations or chromosomal changes. It does not mean an analysis of proteins or metabolites that is directly related to a manifested disease, disorder or pathological condition that could reasonably be detected by a health care professional with appropriate training and expertise in the field of medicine involved. Genetic information does not include information about the age or gender of an individual.

**Health Factor** means, in relation to an individual, any of the following health status-related factors: (i) health status; (ii) medical condition; (iii) claims experience; (iv) receipt of health care; (v) medical history; (vi) genetic information; (vii) evidence of insurability (including conditions arising out of domestic violence); or (viii) disability.

## **BENEFIT PAYMENT**

Each Calendar Year, benefits will be paid for the covered charges of a Covered Person that are in excess of the deductible and any copayments. Payment will be made at the rate shown under Percentage Payable in the Schedule of Benefits.

## **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.

## **COVERED CHARGES**

Covered charges are the Usual and Reasonable Charges that are incurred for the following items of service and supply. These charges are subject to the benefit limits, exclusions and other provisions of this Plan. A charge is incurred on the date that the service or supply is performed or furnished.

- (1) Hospital Care.** The medical services and supplies furnished by a Hospital or Ambulatory Surgical Center or a Birthing 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.

**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; 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.
- A facility operating primarily for the treatment of Substance Abuse 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 Abuse.

**(2) Skilled Nursing Facility Care.** The room and board and nursing care furnished by a Skilled Nursing Facility will be payable if and when:

- (a) the patient is confined as a bed patient in the facility;
- (b) the confinement starts immediately following a Hospital confinement or a period of Home Health Care Utilization;
- (c) the attending Physician certifies that the confinement is needed for further care of the condition that caused the Hospital confinement; and
- (d) 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.
- (e) the Claim Administrator authorizes the service provided.

**Skilled nursing is limited to 30 days per Calendar Year. For Medicare participants, this is in addition to the Medicare limits.**

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

- (a) 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.
- (b) Its services are provided for compensation and under the full-time supervision of a Physician.
- (c) It provides 24 hour per day nursing services by licensed nurses, under the direction of a full-time registered nurse.
- (d) It maintains a complete medical record on each patient.
- (e) It has an effective utilization review plan.
- (f) 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.
- (g) 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.

**(3) Physician Care.** The professional services of a Physician for surgical or medical services.

**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.

- (a) Charges for **multiple surgical procedures** will be a covered expense subject to the following provisions:
  - (i) If bilateral or multiple surgical procedures are performed by one (1) surgeon, benefits will be determined based on the Allowable Charge that is allowed for the primary procedures; 50% of the Allowable Charge will be allowed for each additional procedure performed during the same operative session. 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;
  - (ii) If multiple unrelated surgical procedures are performed by two (2) or more surgeons on separate operative fields, benefits will be based on the 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 Allowable Charge allowed for that procedure; and
  - (iii) If an assistant surgeon is required, the assistant surgeon's covered charge will not exceed 20% of the surgeon's Allowable Charge.
  - (iv) If a Certified Registered Nurse Anesthetist (CRNA) is required, the CRNA's covered charge will not exceed 80% of the Anesthesiologist's Allowable Charge. The total amount payable to the CRNA and Anesthesiologist will not exceed the Anesthesiologist's Allowable Charge (i.e., the Anesthesiologist's reimbursement shall also be 80% of the Anesthesiologist's Usual and Reasonable Charge).
  
- (4) **Private Duty Nursing Care.** The private duty nursing care by a licensed nurse (R.N., L.P.N. or L.V.N.). Covered charges for this service will be included to this extent:
  - (a) **Inpatient Nursing Care.** Charges are covered only when care is Medically Necessary or not Custodial in nature and the Hospital's Intensive Care Unit is filled or the Hospital has no Intensive Care Unit.
  - (b) **Outpatient Nursing Care.** Charges are covered only when care is Medically Necessary and not Custodial in nature. The only charges covered for Outpatient nursing care are those shown below, under Home Health Care Services and Supplies. Outpatient private duty nursing care on a 24-hour-shift basis is not covered.
  
- (5) **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.

**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.

- (6) **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.

Covered charges for Hospice Care Services and Supplies are payable as described in the Schedule of Benefits.

**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 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.

- (7) **Other Medical Services and Supplies.** These services and supplies not otherwise included in the items above are covered as follows: **Illness** means a bodily disorder, disease, physical sickness or mental disorder. Illness includes pregnancy, childbirth, miscarriage or complications of pregnancy.

**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.

**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 Condition** means any condition, whether physical or mental, including, but not limited to, any condition resulting from Illness, Injury (whether or not the Injury is accidental), Pregnancy, or congenital malformation. However, Genetic Information is not a Medical Condition.

**Medical Emergency** means a sudden onset of a condition with acute symptoms requiring immediate medical care and includes such conditions as heart attacks, cardiovascular accidents, poisonings, loss of consciousness or respiration, convulsions or other such acute medical conditions.

**Medically Necessary** care and treatment is 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 Plan Administrator has the discretionary authority to decide whether care or treatment is Medically Necessary.

**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.

**(8) Other medical Services and Supplies.** These services and supplies not otherwise included in the items above are covered as follows:

- (a)** Medically Necessary professional land or air **ambulance** service. A charge for this item will be a Covered Charge
- (b)** **Anesthetic**; oxygen; blood and blood derivatives that are not donated or replaced; intravenous injections and solutions. Administration of these items is included.
- (c)** **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.
- (d)** Radiation or **chemotherapy** and treatment with radioactive substances. The materials and services of technicians are included.
- (e)** Initial **contact lenses** or glasses required following cataract surgery.
- (f)** 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 Plan Administrator. NOTE: Benefits for rental charges of durable medical or surgical equipment are limited to the Allowable Charge for the purchase price of the equipment.
- (g)** Medically Necessary services for care and treatment of **jaw joint conditions, including Temporomandibular Joint syndrome.**
- (h)** **Laboratory studies.**
- (i)** **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.
- (j)** 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.

- (k) **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.
- (l) **Prescription Drugs** (as defined).
- (m) The initial purchase, fitting and repair of fitted **prosthetic devices** which replace body parts.
- (n) **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,

In a manner determined in consultation with the attending Physician and the patient.

- (o) **Speech therapy** by a licensed speech therapist. Therapy must be ordered by a Physician to restore speech to a member who lost existing speech function (the ability to express thoughts, speak words and form sentences) as a result of disease or injury.
- (p) **Spinal Manipulation/Chiropractic services** by a licensed M.D., D.O. or D.C.

**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.

- (q) **Sterilization** procedures.
- (r) **Surgical dressings**, splints, casts and other devices used in the reduction of fractures and dislocations.
- (s) Charges associated with the initial purchase of a **wig after chemotherapy**.
- (t) Diagnostic **X-rays**.

## INJURY TO OR CARE OF 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:

- (1) Excision of tumors and cysts of the jaws, cheeks, lips, tongue, roof and floor of the mouth.
- (2) Emergency repair due to injury to sound natural teeth. This repair must be made within 12 months from the date of an accident.
- (3) Surgery needed to correct accidental injuries to the jaws, cheeks, lips, tongue, floor and roof of the mouth.
- (4) Excision of benign bony growths of the jaw and hard palate.
- (5) External incision and drainage of cellulitis.
- (6) Incision of sensory sinuses, salivary glands or ducts.
- (7) Surgical removal of impacted teeth.

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

**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.

**Partial Hospitalization** is an outpatient program specifically designed for the diagnosis or active treatment of a Mental Disorder or Substance Abuse when there is reasonable expectation for improvement or when it is necessary to maintain a patient's functional level and prevent relapse; this program shall be administered in a psychiatric facility which is accredited by the Joint Commission on Accreditation of Health Care Organizations and shall be licensed to provide partial hospitalization services, if required, by the state in which the facility is providing these services. Treatment lasts less than 24 hours, but more than four hours, a day and no charge is made for room and board.

**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.

**Plan** means The City of Lynchburg Health Care Plan, which is a benefits plan for certain employees of The City of Lynchburg and is described in this document.

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

**Plan Year** is the 12-month period beginning on either the effective date of the Plan or on the day following the end of the first Plan Year which is a short Plan Year.

**Pre-Existing Condition** is a condition for which medical advice, diagnosis, care or treatment was recommended or received within six months of the person's Enrollment Date under this Plan. Genetic Information is not a condition. Treatment includes receiving services and supplies, consultations, diagnostic tests or prescribed medicines. In order to be taken into account, the medical advice, diagnosis, care or treatment must have been recommended by, or received from, a Physician.

The Pre-Existing Condition does not apply to pregnancy, and Covered Persons up to the age of 19

**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.

**Retired Employee** is a former Active Employee of the Employer who was retired while employed by the Employer under the formal written plan of the Employer and elects to contribute to the Plan the contribution required from the Retired Employee.

**Substance Abuse** is the condition caused by regular excessive compulsive drinking of alcohol and/or physical habitual dependence on drugs that results in a chronic disorder affecting physical health and/or personal or social functioning. This does not include dependence on tobacco and ordinary caffeine-containing drinks.

**Temporomandibular Joint (TMJ)** syndrome is the treatment of jaw joint disorders including conditions of structures linking the jaw bone and skull and the complex of muscles, nerves and other tissues related to the temporomandibular joint. Care and treatment shall include, but are not limited to orthodontics, crowns, inlays, physical therapy and any appliance that is attached to or rests on the teeth.

**Total Disability (Totally Disabled)** means: In the case of a Dependent Child, the complete inability as a result of Injury or Sickness to perform the normal activities of a person of like age and sex in good health.

**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.

The Plan will reimburse the actual charge billed if it is lesser than the Usual and Reasonable Charge.

The Plan Administrator has the discretionary authority to decide whether a charge is Usual and Reasonable.

## **ORGAN TRANSPLANT COVERAGE 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:

- (1) The transplant must be performed to replace an organ or tissue of the Covered Person.
- (2) Charges for obtaining donor organs are covered charges under the Plan when the recipient is a Covered Person. When the donor has medical coverage, his or her plan will pay first. The benefits under this Plan will be reduced by those payable under the donor's plan. Donor charges include those for:
  - (a) evaluating the organ;

- (b)** removing the organ from the donor; and
- (c)** transportation of the organ from within the United States and Canada to the place where the transplant is to take place.

## **ROUTINE PREVENTIVE CARE**

Covered charges under Medical Benefits are payable for routine Preventive Care as described in the Schedule of Benefits.

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

**Charges for Routine Well Child Care.** Routine well child care includes routine pediatric care and immunizations by a Physician that is not for an Injury or Sickness.

In addition to appropriate immunizations, these services of the Physician are included for each visit: (1) physical exam; (2) lab tests; (3) patient history; (4) development assessment; (5) anticipatory guidance.

## **COVERAGE OF 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.

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

Coverage for a Hospital stay following a normal vaginal delivery may not be limited to less than 48 hours for both the mother (if a Covered Person) and the newborn child. Coverage for a Hospital stay in connection with childbirth following a Cesarean section may not be limited to less than 96 hours for both mother (if a Covered Person) and the newborn child. However, the mother's or the newborn child's attending provider, after consulting with the mother, may discharge the mother or newborn child earlier than the minimum 48 hour period (or 96 hour, if applicable).

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

**Charges for Routine Physician Care.** The benefit is limited to the Usual and Reasonable Charges made by a Physician for the first pediatric visit to the newborn child after birth while Hospital confined.

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

## **COVERAGE OF PREGNANCY**

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

The Usual and Reasonable Charges for the care and treatment of Pregnancy are covered the same as any other Sickness for a covered Employee or covered Spouse.

Coverage for a Hospital stay following a normal vaginal delivery may not be limited to less than 48 hours for both the mother (if a Covered Person) and the newborn child. Coverage for a Hospital stay in connection with childbirth following a Cesarean section may not be limited to

less than 96 hours for both mother (if a Covered Person) and the newborn child. However, the mother's or the newborn child's attending provider, after consulting with the mother, may discharge the mother or newborn child earlier than the minimum 48 hour period (or 96 hour, if applicable).

There is no coverage of Pregnancy for a Dependent child.

**Waiting Period** is the time period that must pass before coverage becomes effective for an Employee who is otherwise eligible to enroll under the terms of the Plan. The Waiting Period is counted in the Pre-Existing Conditions exclusion time.

## PLAN EXCLUSIONS

**NOTE:** All exclusions related to Prescription Drugs are shown in the Prescription Drug Plan.

For all Medical Benefits shown in the Schedule of Benefits, a charge for the following is not covered:

- (1) **Abortion.** Services, supplies, care or treatment in connection with an abortion unless the life of the mother is endangered.
- (2) **Acupuncture.** Services for acupuncture.
- (3) **Alcohol.** Services, supplies, care or treatment to a Covered Person for an Injury or Sickness which occurred as a result of that Covered Person's illegal use of alcohol. The arresting officer's determination of inebriation will be sufficient for this exclusion. Expenses will be covered for Injured Covered Persons other than the person illegally using alcohol and expenses will be covered for Substance Abuse treatment as specified in this Plan. This exclusion does not apply if the injury resulted from an act of domestic violence or a Medical Condition.
- (4) **Complications of non-covered treatments.** Care, services or treatment required as a result of complications from a treatment not covered under the Plan. However, complications from a non-covered abortion are covered.
- (5) **Cosmetic Services.** Abdominoplasty, penniculectomy, abdominal sculpture, tummy tucks, abdominodermatolipectomy, and liposuction are not covered. Breast Reductions unless related to surgical interventions following a mastectomy are not covered.
- (6) **Custodial care.** Services or supplies provided mainly as a rest cure, maintenance or Custodial Care.
- (7) **Dental care or treatment** except as needed for treatment of accidental injury, removal of impacted wisdom teeth or medically diagnosed cleft lip, cleft palate or ectodermal dysplasia.
- (8) **Educational or vocational testing.** Services for educational or vocational testing or training.
- (9) **Excess charges.** The part of an expense for care and treatment of an Injury or Sickness that is in excess of the Usual and Reasonable Charge.
- (10) **Exercise programs.** Exercise programs for treatment of any condition, except for Physician-supervised cardiac rehabilitation, occupational or physical therapy covered by this Plan.
- (11) **Experimental or not Medically Necessary.** Care and treatment that is either Experimental/Investigational or not Medically Necessary.
- (12) **Eye care.** Radial keratotomy, Lasik or other eye surgery to correct near-sightedness. Also, routine eye examinations, including refractions, lenses for the eyes and exams

- for their fitting. This exclusion does not apply to aphakic patients and soft lenses or sclera shells intended for use as corneal bandages.
- (13) **Foot care.** Treatment of weak, strained, flat, unstable or unbalanced feet, metatarsalgia or bunions (except open cutting operations), and treatment of corns, calluses or toenails (unless needed in treatment of a metabolic or peripheral-vascular disease).
  - (14) **Foreign travel.** Care, treatment or supplies out of the U.S. if travel is for the sole purpose of obtaining medical services.
  - (15) **Government coverage.** Care, treatment or supplies furnished by a program or agency funded by any government. This does not apply to Medicaid or when otherwise prohibited by law.
  - (16) **Hair loss.** Care and treatment for hair loss including wigs, hair transplants or any drug that promises hair growth, whether or not prescribed by a Physician, except for wigs after chemotherapy up to the limit shown in the Schedule of Benefits.
  - (17) **Hearing aids and exams.** Charges for services or supplies in connection with hearing aids or exams for their fitting. Cochlear implants or any treatment, or follow-up for this procedure.
  - (18) **Hospital employees.** Professional services billed by a Physician or nurse who is an employee of a Hospital or Skilled Nursing Facility and paid by the Hospital or facility for the service.
  - (19) **Illegal acts.** Charges for services received as a result of Injury or Sickness caused by or contributed to by engaging in an illegal act or occupation; by committing or attempting to commit any crime, criminal act, assault or other felonious behavior; or by participating in a riot or public disturbance. This exclusion does not apply if the injury resulted from an act of domestic violence or a Medical Condition.
  - (20) **Illegal drugs or medications.** Services, supplies, care or treatment to a Covered Person for Injury or Sickness resulting from that Covered Person's voluntary taking of or being under the influence of any controlled substance, drug, hallucinogen or narcotic not administered on the advice of a Physician. Expenses will be covered for Injured Covered Persons other than the person using controlled substances and expenses will be covered for Substance Abuse treatment as specified in this Plan. This exclusion does not apply if the injury resulted from an act of domestic violence or a Medical Condition.
  - (21) **Infertility.** Care and treatment for infertility, artificial insemination or in vitro fertilization.
  - (22) **No charge.** Care and treatment for which there would not have been a charge if no coverage had been in force.
  - (23) **Non-emergency Hospital admissions.** Care and treatment billed by a Hospital for non-Medical Emergency admissions on a Friday or a Saturday. This does not apply if surgery is performed within 24 hours of admission.

- (24) **No obligation to pay.** Charges incurred for which the Plan has no legal obligation to pay.
- (25) **No Physician recommendation.** Care, treatment, services or supplies not recommended and approved by a Physician; or treatment, services or supplies when the Covered Person is not under the regular care of a Physician. Regular care means ongoing medical supervision or treatment which is appropriate care for the Injury or Sickness.
- (26) **Not specified as covered.** Non-traditional services, treatments and supplies which are not specified as covered under this Plan.
- (27) **Obesity.** Care and treatment of obesity, weight loss or dietary control whether or not it is, in any case, a part of the treatment plan for another Sickness. Services for weight loss or weight control and related services including but not limited to gastric bypass surgery or services for complications resulting from gastric bypass surgery.
- (28) **Occupational.** Care and treatment of an Injury or Sickness that is occupational -- that is, arises from work for wage or profit including self-employment.
- (29) **Personal comfort items.** Personal comfort items or other equipment, such as, but not limited to, air conditioners, air-purification units, humidifiers, electric heating units, orthopedic mattresses, blood pressure instruments, scales, elastic bandages or stockings, nonprescription drugs and medicines, and first-aid supplies and nonhospital adjustable beds.
- (30) **Plan design excludes.** Charges excluded by the Plan design as mentioned in this document.
- (31) **Pregnancy of daughter.** Care and treatment of Pregnancy and Complications of Pregnancy for a dependent daughter only.
- (32) **Relative giving services.** Professional services performed by a person who ordinarily resides in the Covered Person's home or is related to the Covered Person as a Spouse, parent, child, brother or sister, whether the relationship is by blood or exists in law.
- (33) **Replacement braces.** Replacement of braces of the leg, arm, back, neck, or artificial arms or legs, unless there is sufficient change in the Covered Person's physical condition to make the original device no longer functional.
- (34) **Routine care.** Charges for routine or periodic examinations, screening examinations, evaluation procedures, preventive medical care, or treatment or services not directly related to the diagnosis or treatment of a specific Injury, Sickness or pregnancy-related condition which is known or reasonably suspected, unless such care is specifically covered in the Schedule of Benefits.
- (35) **Self-Inflicted.** Any loss due to an intentionally self-inflicted Injury, while sane or insane. This exclusion does not apply if the Injury resulted from an act of domestic violence or a Medical Condition.
- (36) **Services before or after coverage.** Care, treatment or supplies for which a charge was incurred before a person was Covered under this Plan or after coverage ceased under this Plan.

- (37) **Sexual Dysfunction** – Charges for the treatment of sexual dysfunction not related to organic disease.
- (38) **Sex changes.** Care, services or treatment for non-congenital transsexualism, gender dysphoria or sexual reassignment or change. This exclusion includes medications, implants, hormone therapy, surgery, medical or psychiatric treatment.
- (39) **Smoking cessation.** Care and treatment for smoking cessation programs, including smoking deterrent products.
- (40) **Speech therapy** for developmental delay.
- (41) **Surgical sterilization reversal.** Care and treatment for reversal of surgical sterilization.
- (42) **Travel or accommodations.** Charges for travel or accommodations, whether or not recommended by a Physician, except for ambulance charges as defined as a covered expense.
- (43) **War.** Any loss that is due to a declared or undeclared act of war.
- (44) Services, treatment, education testing or training related to learning disabilities or developmental delays.
- (45) Primal therapy, psychodrama, megavitamin therapy, bioenergetic therapy.
- (46) Counseling for sexual dysfunction and sexual deviation.
- (47) Services in connection with career, social adjustment, pastoral or financial counseling.
- (48) Charges incurred at a residential care facility or halfway house.
- (49) Completion of claim forms or preparation of medical reports; for missed appointments; for telephone consultations; or for consultations, medical record reviews, medical opinions, or similar services provided via the Internet, other electronic means, or by any method in which the Covered Person is not seen in person by the Physician or other health care provider.
- (50) Family/marital counseling or for hospitalization for environmental change.
- (51) Charges for inpatient treatment of eating disorders.
- (52) Charges for outpatient treatment of eating disorders.
- (53) Charges for court-ordered services unless approved as Medically Necessary by the Claims Administrator.
- (54) Activities therapy.
- (55) Recreational therapy, i.e. play, sleep, dance, art, crafts.
- (56) Behavioral problems (except for hyperkinetic syndrome of childhood or adulthood ADD).

- (57)** Treatment for certain personality disorders, including anti-social personality and inadequate personality.
- (58)** Group delinquent reaction of childhood.
- (59)** Hypnotherapy, biofeedback.
- (60)** Physical Therapy/Chiropractic services. Any physical therapy or chiropractic services that are not considered treatment following an acute condition, which do not restore bodily function or prevent disability following Injury or Sickness, or which are provided as maintenance services for a chronic condition.
- (61)** Non-compliance. All charges in connection with treatments or medications where the patient either is in non-compliance with or is discharged from a Hospital or Skilled Nursing Facility against medical advice.

## **PRESCRIPTION DRUG BENEFITS**

Prescription Drugs Benefits are not administered by Piedmont Community Health Plan, please direct any questions about prescription drugs to Script Care.

### **PHARMACY DRUG CHARGE**

Participating pharmacies have contracted with the Plan to charge Covered Persons reduced fees for covered Prescription Drugs. A pharmacy benefits management organization will administer the pharmacy drug plan.

### **COINSURANCE**

The coinsurance is applied to each covered pharmacy drug charge and is shown in the Schedule of Benefits. The coinsurance amount is not a covered charge under the Medical Plan. Any one prescription is limited to a 30 day supply.

If a drug is purchased from a non-participating pharmacy, or a participating pharmacy when the Covered Person's ID card is not used, the amount payable in excess of the coinsurance will be the ingredient cost and dispensing fee.

### **MANDATORY GENERIC**

If no generic is available, reimbursement will be based on the cost of the drug.

### **MAIL ORDER DRUG BENEFIT OPTION**

The mail order drug benefit is mandatory for maintenance medications (those that are taken for long periods of time, such as drugs sometimes prescribed for heart disease, high blood pressure, asthma, etc.). After an initial 30 day supply and three 30-day supply refills the medication is considered maintenance and can only be reimbursed by the Plan by mail order. Because of volume buying, mail order pharmacy is able to offer Covered Persons significant savings on their prescriptions.

The following drugs are exempt from the mandatory mail order requirement:

Prednisolone	Amlodipine	Azithromycin
Adderall	Omeprazole	Accutane
Simvastatin	Lisinipril	Metformin
Fluoxetine		

All controlled substances  
All anti-infectives

### **COINSURANCE**

The coinsurance is applied to each covered mail order prescription charge and is shown in the Schedule of Benefits. It is not a covered charge under the Medical Plan. Any one prescription is limited to the 90-day supply.

## COVERED PRESCRIPTION DRUGS

- (1) All drugs, prescribed by a Physician that require a prescription either by federal or state law, except injectibles (other than insulin) or any other drugs not covered under this Plan.
- (2) All compounded prescriptions containing at least one prescription ingredient in a therapeutic quantity.
- (3) Insulin when prescribed by a Physician.

## LIMITS TO THIS BENEFIT

This benefit applies only when a Covered Person incurs a covered Prescription Drug charge. The covered drug charge for any one prescription will be limited to:

- (1) Refills only up to the number of times specified by a Physician.
- (2) Refills up to one year from the date of order by a Physician.

## EXPENSES NOT COVERED

This benefit will not cover a charge for any of the following:

- (1) **Administration.** Any charge for the administration of a covered Prescription Drug.
- (2) **Appetite suppressants.** A charge for appetite suppressants, dietary supplements or vitamin supplements, except for prenatal vitamins requiring a prescription or prescription vitamin supplements containing fluoride.
- (3) **Consumed on premises.** Any drug or medicine that is consumed or administered at the place where it is dispensed.
- (4) **Devices.** Devices of any type, even though such devices may require a prescription. These include (but are not limited to) therapeutic devices, artificial appliances, braces, support garments, or any similar device.
- (5) **Drugs used for cosmetic purposes.** Charges for drugs used for cosmetic purposes, such as anabolic steroids, Retin A or medications for hair growth or removal.
- (6) **Experimental.** Experimental drugs and medicines, even though a charge is made to the Covered Person.
- (7) **FDA.** Any drug not approved by the Food and Drug Administration.
- (8) **Growth hormones.** Charges for drugs to enhance physical growth or athletic performance or appearance.
- (9) **Immunization.** Immunization agents or biological sera.

- (10) **Injectibles.** A charge for hypodermic syringes and/or needles, injectibles or any prescription directing administration by injection (other than insulin) unless prior authorization has been obtained.
- (11) **Inpatient medication.** A drug or medicine that is to be taken by the Covered Person, in whole or in part, while Hospital confined or take home medical care devices. This includes being confined in any institution that has a facility for the dispensing of drugs and medicines on its premises.
- (12) **Investigational.** A drug or medicine labeled: "Caution - limited by federal law to investigational use".
- (13) **Medical exclusions.** A charge excluded under Medical Plan Exclusions.
- (14) **No charge.** A charge for Prescription Drugs which may be properly received without charge under local, state or federal programs.
- (15) **No prescription.** A drug or medicine that can legally be bought without a written prescription. This does not apply to injectible insulin.
- (16) **Off-label drugs.** A charge for FDA-approved drugs that are prescribed for non-FDA-approved uses.
- (17) Ostomy supplies.
- (18) Prescription Products that have Over-the-Counter equivalents.
- (19) **Refills.** Any refill that is requested more than one year after the prescription was written or any refill that is more than the number of refills ordered by the Physician.
- (20) **Smoking cessation.** A charge for Prescription Drugs for smoking cessation (i.e., nicotine gum).
- (21) **Smoking deterrent products.** A charge for smoking deterrent products.
- (22) Vitamins, nutrients, food supplements, dietary drugs/aids, weight reduction drugs/aids, or body building drugs.
- (23) Chemstrips, lancets, and glucose monitors are not covered under the prescription drug benefit. They are covered under medical service – Durable Medical Equipment and Diabetic Supplies – and are subject to the deductible.

### **Drugs Requiring Prior Authorization**

This Plan requires prior review of selected drugs before payment is authorized. The following are examples of drugs requiring prior authorization:

- Amphetamines (Dexedrine, Desoxyn, Adderall)
- Interferon Beta (Betaseron, Avonex, Copaxone)
- Accutane
- Growth Hormones
- Gonadotropins (Clomid, Pergonal, Metrodin, HCG, Humegon, Fertinex, Crinone)
- Injectables

- Interferon Alpha (Roferon-A, Alferon N, Intron A)
- Interferon Gamma (Actimmune)
- Luteinizing Hormone Releasing Hormones (Zoladex, Lupron, Lupron Depot, Synarel)
- Pulmozyme
- Retin-A (older than 35)
- Tobi
- Viagra (prior authorization must be obtained from a urologist)
- Viagra is available for men, age 19 or older with a documented diagnosis of erectile dysfunction (documentation would consist of reviewing the patient's history for other causes of impotence such as adverse effects of medication, for example)

The following drugs have quantity limitations. Exception requests will be required if quantities greater than the plan limits are requested.

**Sporanox** – a quantity limitation of 2800 mg in tablet form (does not affect liquid) per rolling 21 days; maximum of 8400 mg per rolling 365 days.

**Imitrex** – following limitations per rolling 30 days  
 18-25 mg tablets; or  
 9-50 mg tablets; or  
 2 injections kits (4 injections total); or  
 A combination of one injection kit (2 injections) and 9-25 mg tablets; or  
 6-5 mg bottles of nasal spray; or  
 6-20 mg bottles of nasal spray.

**Zomig** – (effective 5-1-98) following limitations per rolling 30 days  
 12-2.5 mg tablets; or  
 6-5 mg tablets or any combination not to exceed 30 mg maximum

**Amerge** – (effective 6-1-98) following limitations per rolling 30 days  
 20-1.0 mg tablets; or  
 8-2.5 mg tablets

**Stadol** – 4 canisters per calendar month

**Viagra** – (effective 5-1-98) eight tablets per month deemed medically necessary

## HOW TO SUBMIT A CLAIM

When a Covered Person has a claim to submit for payment that person must:

- (1) For Plan reimbursements ALL BILLS MUST SHOW:
  - Name of Plan
  - Employee's name
  - Name of patient
  - Name, address, telephone number of the provider of care
  - Diagnosis
  - Type of services rendered, with diagnosis and/or procedure codes
  - Date of services
  - Charges
  
- (2) Send the above to the Claims Administrator at this address:

**Piedmont Community Health Plan  
P.O. Box 14408  
Cincinnati, Ohio 45250  
(800) 400-7247**

## CLAIMS REVIEW/APPEALS PROCESS

### WHEN CLAIMS SHOULD BE FILED

Claims should be filed with the Claims Administrator within 365 days of the date charges for the service were incurred. Claims filed later than that date will be declined. Benefits are based on the Plan's provisions at the time the charges were incurred. Network providers cannot balance bill the member if claim is received after the 365 days.

Any corrections to a claim previously submitted must also be filed with the Claims Administrator within 365 days of the date charges for the service were incurred.

The Claims Administrator will determine if enough information has been submitted to enable proper consideration of the claim. If not, the claim will be denied. Any information requested by the Claims Administrator to process the claim must be submitted to the Claims Administrator within one year after the date the services were rendered. Claims will be denied if requested information is not received within one year after the date the services were rendered.

## CLAIMS PROCEDURE

Following is a description of how the Plan processes Claims for benefits. A Claim is defined as any request for a Plan benefit, made by a claimant or by a representative of a claimant, that complies with the Plan's reasonable procedure for making benefit Claims. A claimant is a Plan participant or beneficiary. Providers of medical service are not claimants unless specifically appointed in writing as the claimant's representative. However, the Plan will reply to requests for reconsideration from medical providers that are made in a timely manner (see Provider Reconsideration Requests under Claims Procedure below).

**NOTE:** A second or subsequent submission of a claim that is for the same services to the same Plan participant provided by the same medical care provider on the same date of service as a claim submitted previously is not considered a new claim. Therefore, these claims will be processed as duplicate claims and will not entitle the claimant or provider to new or additional appeal rights.

The times listed are maximum times only. A period of time begins at the time the Claim is filed. Decisions will be made within a reasonable period of time appropriate to the circumstances. "Days" means calendar days.

There are different kinds of Claims and each one has a specific timetable for either approval, payment, request for further information, or denial of the Claim. If you have any questions regarding this procedure, please contact the Plan Administrator.

The definitions of the types of Claims are:

### **Urgent Care Claim**

A Claim involving Urgent Care is any Claim for medical care or treatment where using the timetable for a non-urgent care determination could seriously jeopardize the life or health of the claimant; or the ability of the claimant to regain maximum function; or in the opinion of the attending or consulting Physician, would subject the claimant to severe pain that could not be adequately managed without the care or treatment that is the subject of the Claim.

A Physician with knowledge of the claimant's medical condition may determine if a Claim is one involving Urgent Care. If there is no such Physician, an individual acting on behalf of the Plan applying the judgment of a prudent layperson who possesses an average knowledge of health and medicine may make the determination.

In the case of a Claim involving Urgent Care, the following timetable applies:

<b>Notification to claimant of benefit determination</b>	<b>72 hours</b>
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**Insufficient information on the Claim, or failure to follow the Plan's procedure for filing a Claim:**

<b>Notification to claimant, orally or in writing</b>	<b>24 hours</b>
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<b>Response by claimant, orally or in writing</b>	<b>48 hours</b>
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<b>Benefit determination, orally or in writing</b>	<b>48 hours after the earlier of the receipt of information or the end of the claimant's response period.</b>
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**Ongoing courses of treatment, notification of:**

<b>Reduction or termination before the end of treatment</b>	<b>72 hours</b>
<b>Determination as to extending course of treatment</b>	<b>24 hours</b>
<b>Review of adverse benefit determination</b>	<b>72 hours</b>

If there is an adverse benefit determination on a Claim involving Urgent Care, a request for an expedited appeal may be submitted orally or in writing by the claimant. All necessary information, including the Plan's benefit determination on review, may be transmitted between the Plan and the claimant by telephone, facsimile, or other similarly expeditious method.

**Pre-Service Claim**

A Pre-Service Claim means any Claim for a benefit under this Plan where the Plan conditions receipt of the benefit, in whole or in part, on approval in advance of obtaining medical care. These are, for example, Claims subject to pre-certification. Please see the Utilization management section of this booklet for further information about Pre-Service Claims.

In the case of a Pre-Service Claim, the following timetable applies:

<b>Notification to claimant of benefit determination</b>	<b>15 days</b>
<b>Extension due to matters beyond the control of the Plan</b>	<b>15 days</b>
<b>Insufficient information on the Claim:</b>	
<b>Notification of</b>	<b>15 days</b>
<b>Response by claimant</b>	<b>45 days</b>
<b>Notification, orally or in writing, of failure to follow the Plan's procedures for filing a Claim</b>	<b>5 days</b>

**Ongoing courses of treatment:**

<b>Reduction or termination before the end of the treatment</b>	<b>15 days</b>
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**Request to extend course of treatment**

**15 days**

**Review of adverse benefit determination**

**30 days**

### **Post-Service Claim**

A Post-Service Claim means any Claim for a Plan benefit that is not a Claim involving Urgent Care or a Pre-Service Claim; in other words, a Claim that is a request for payment under the Plan for covered medical services already received by the claimant.

**In the case of a Post-Service Claim, the following timetable applies:**

**Notification to claimant of benefit determination**

**30 days**

**Extension due to matters beyond the control of the Plan**

**15 days**

**Insufficient information on the Claim:**

**Notification of**

**15 days**

**Response by claimant**

**45 days**

**Review of adverse benefit determination**

**60 days**

### **Notice to claimant of adverse benefit determinations**

Except with Urgent Care Claims, when the notification may be oral followed by written or electronic notification within three days of the oral notification, the Claims Administrator shall provide written or electronic notification of any adverse benefit determination. The notice will state, in a manner calculated to be understood by the claimant:

- (1) The specific reason or reasons for the adverse determination.
- (2) Reference to the specific Plan provisions on which the determination was based.
- (3) A description of any additional material or information necessary for the claimant to perfect the Claim and an explanation of why such material or information is necessary.
- (4) 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 information relevant to the Claim.
- (5) If the adverse benefit determination was based on an internal rule, guideline, protocol, or other similar criterion, the specific rule, guideline, protocol, or criterion will be provided free of charge. If this is not practical, a statement will be included that such a rule, guideline, protocol, or criterion was relied upon in making the adverse benefit determination and a copy will be provided free of charge to the claimant upon request.

- (6) If the adverse benefit determination is based on the Medical Necessity or Experimental or Investigational treatment or similar exclusion or limit, an explanation of the scientific or clinical judgment for the determination, applying the terms of the Plan to the claimant's medical circumstances, will be provided. If this is not practical, a statement will be included that such explanation will be provided free of charge, upon request.

### **Provider Reconsideration Requests**

When a provider of medical service receives a copy of the adverse benefit determination, the provider may request a reconsideration of the decision. The request must be in writing and must be sent to the Claims Administrator (attention Appeals Unit) within 180 days after the date of the determination. The request must include the claim number, the reason for the request (i.e., an explanation of why the provider thinks the claim was processed incorrectly), and supporting documentation that was not included with the initial claim submission. Provider reconsideration requests sent later than 180 days after the date of the determination will not be considered. A Provider does not have the same rights as a Claimant.

**NOTE:** A second or subsequent submission of a claim that is for the same services to the same Plan participant provided by the same medical care provider on the same date of service as a claim submitted previously is not considered a new claim. Therefore, these claims will be processed as duplicate claims and will not entitle the provider to new or additional appeal rights.

### **Claimant Appeals**

When a claimant receives an adverse benefit determination, the claimant has 180 days following receipt of the notification in which to appeal the decision. Except in the case of urgent care claim appeals, the appeal must be in writing and be sent to the Claims Administrator, attention Appeals Unit. A claimant may submit written comments, documents, records, and other information relating to the Claim. If the claimant so requests, he or she will be provided, free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to the Claim.

The period of time within which a benefit determination on review is required to be made shall begin at the time an appeal is filed in accordance with the procedures of the Plan. This timing is without regard to whether all the necessary information accompanies the filing.

**NOTE:** A second or subsequent submission of a claim that is for the same services to the same Plan participant provided by the same medical care provider on the same date of service as a claim submitted previously is not considered a new claim. Therefore, these claims will be processed as duplicate claims and will not entitle the claimant to new or additional appeal rights.

A document, record, or other information shall be considered relevant to a Claim if it:

- (1) was relied upon in making the benefit determination;
- (2) was submitted, considered, or generated in the course of making the benefit determination, without regard to whether it was relied upon in making the benefit determination;
- (3) demonstrated compliance with the administrative processes and safeguards

designed to ensure and to verify that benefit determinations are made in accordance with Plan documents and Plan provisions have been applied consistently with respect to all claimants; or

- (4) constituted a statement of policy or guidance with respect to the Plan concerning the denied treatment option or benefit.

The review shall take into account all comments, documents, records, and other information submitted by the claimant relating to the Claim, without regard to whether such information was submitted or considered in the initial benefit determination. The review will not afford deference to the initial adverse benefit determination and will be conducted by a fiduciary of the Plan who is neither the individual who made the adverse determination nor a subordinate of that individual.

If the determination was based on a medical judgment, including determinations with regard to whether a particular treatment, drug, or other item is Experimental, Investigational, or not Medically Necessary or appropriate, the fiduciary shall consult with a health care professional who was not involved in the original benefit determination. This health care professional will have appropriate training and experience in the field of medicine involved in the medical judgment. Additionally, medical or vocational experts whose advice was obtained on behalf of the Plan in connection with the initial determination will be identified.

If the decision on review affirms the initial denial of the claim, the claimant will be furnished with a notice of adverse benefit determination on review setting forth:

- the specific reason(s) for the decision on review,
- the specific Plan provision(s) on which the decision is based,
- a statement of the claimant's right to review (on request and at no charge) relevant documents and other information,
- if an internal rule, guideline, protocol, or other similar criterion is relied on in making the decision on review, a description of the specific rule, guideline, protocol, or other similar criterion or a statement that such a rule, guideline, protocol, or other similar criterion was relied on and that a copy of such rule, guideline, protocol, or other criterion will be provided free of charge to the claimant upon request,
- an explanation of the scientific or clinical judgment for the determination if the adverse benefit determination is based on the Medical Necessity or Experimental or Investigational treatment or similar exclusion or limit, or a statement that such explanation will be provided free of charge, upon request, and

Any suit for benefits must be brought within one year after the date the Plan Administrator (or his or her designee) has made a final denial (or deemed denial) of the claim. Notwithstanding any other provision herein, any suit for benefits must be brought within two years after the date the service or treatment was rendered.

**NOTE:** A second or subsequent submission of a claim that is for the same services to the same Plan participant provided by the same medical care provider on the same date of service as a claim submitted previously is not considered a new claim. Therefore, these claims will be processed as duplicate claims and will not entitle the claimant or provider to new or additional appeal rights.

The Claims Administrator may be reached at the following address and telephone number:

**Piedmont Community Health Plan, Inc.**  
**2316 Atherholt Road**  
**Lynchburg, VA 24501**

**Telephone Number: 800-400-7247**

## COORDINATION OF BENEFITS

Coordination of benefits between health plans is necessary when you have more than one insurance, so that the combined payments of all of the plans do not exceed the amount of the expense. When two group health plans cover, the plan that pays benefits first is called the primary plan and the other plan is called the secondary plan.

In general, the following rules apply:

- If your spouse is covered by another group health plan as an employee or retiree and is a dependent on your City plan, the City's plan coverage is secondary for your spouse.
- If this plan and another group plan covers your dependent children, a "birthday rule" determines which plan is primary. Children's benefits are paid first by the plan of the parent whose birthday (month and day) falls earlier in the calendar year.

### Non-Duplication

The City of Lynchburg Health Care Plan follows non-duplication of benefits when coordinating payments with other plans. The City plan does not duplicate benefits payable under other group health plans, or Medicare part B.

When the City plan is secondary (that is, another health plan pays benefits on a claim first), your City plan payments are offset by the other plan's benefits. As a result, for each secondary claim received:

- If the primary plan paid the same (or more than) the amount payable under the City plan, the entire City benefit is offset and no additional payment is made by the City plan, and
- If the primary plan paid less than the amount payable under this plan, the City plan pays the difference between its usual benefit payment and the amount paid by the primary plan.
- If the primary plan is Medicare, under Part B, the Medicare Part B deductible will always be the member's responsibility; the City will coordinate benefits minus the Medicare Part B deductible.
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### Duplication

The City of Lynchburg's Health Care Plan follows duplication of benefits when coordinating payments with Medicare Part A. The Plan will pay 100% of the original Medicare Inpatient deductible only.

Once a retiree or a retiree's dependent is eligible for Medicare, they will no longer be eligible for prescription drug coverage under the City's Plan. Medicare Part D provides options for prescription drug coverage.

**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 Plan 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.

## **COBRA CONTINUATION OPTIONS**

Under federal law, the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA), certain Employees and their families covered under the The City of Lynchburg Health Care Plan(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.

The Plan Administrator is the City of Lynchburg Medical Plan, P.O. Box 60, Lynchburg, Virginia 24505, telephone (434) 455-4205. COBRA continuation coverage for the Plan is administered by the City of Lynchburg Medical Plan, P.O. Box 60, Lynchburg, Virginia 24505, telephone (434) 455-4205. Complete instructions on COBRA, as well as election forms and other information, will be provided by the Plan Administrator 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 family members (called "Qualified Beneficiaries") at group rates for up to a statutory-mandated maximum period of time or until they become ineligible for COBRA continuation coverage, whichever occurs first. The right to COBRA continuation coverage is triggered by the occurrence of one of certain events that result 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 active 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:

- (1) 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 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.
- (2) 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. ***The Employee must enroll the child in the Plan by submitting an Enrollment Form (available from the COBRA or Plan Administrator) to the COBRA Administrator within thirty days after the birth or adoption.*** 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.

- (3) A covered Employee who retired on or before the date of substantial elimination of Plan coverage which is the result of a bankruptcy proceeding under Title 11 of the U.S. Code with respect to the Employer, as is the Spouse, surviving Spouse or Dependent child of such a covered Employee if, on the day before the bankruptcy Qualifying Event, the Spouse, surviving Spouse or Dependent child was a beneficiary under the Plan.

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. A domestic partner is not a Qualified Beneficiary.

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:

- (1) The death of a covered Employee.
- (2) The termination (other than by reason of the Employee's gross misconduct), or reduction of hours, of a covered Employee's employment.
- (3) The divorce or legal separation of a covered Employee from the Employee's Spouse. If the Employee reduces or eliminates the Employee's Spouse's Plan coverage in anticipation of a divorce or legal separation, and a divorce or legal separation later occurs, then the divorce or legal separation may be considered a Qualifying Event even though the Spouse's coverage was reduced or eliminated before the divorce or legal separation.
- (4) A covered Employee's enrollment in any part of the Medicare program.
- (5) 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).
- (6) A proceeding in bankruptcy under Title 11 of the U.S. Code with respect to an Employer from whose employment a covered Employee retired at any time.

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 entitled to COBRA continuation coverage even if they failed to pay the employee portion of premiums for coverage under the Plan during the FMLA leave.

**What factors should be considered when determining to elect COBRA continuation coverage?** You should take into account that a failure to continue your group health coverage will affect your rights under federal law. First, you can lose the right to avoid having pre-existing condition exclusions applied by other group health plans if there is more than a 63-day gap in health coverage and election of COBRA continuation coverage may help you avoid such a gap. Second, if you do not elect COBRA continuation coverage and pay the appropriate premiums for the maximum time available to you, you will lose the right to convert to an individual health insurance policy, which does not impose such pre-existing condition exclusions. Finally, you should take into account that you have special enrollment rights under federal law (HIPAA). You have the right to request special enrollment in another group health plan for which you are otherwise eligible (such as a plan sponsored by your Spouse's employer) within 30 days after Plan coverage ends due to a Qualifying Event listed above. You will also have the same special right at the end of COBRA continuation coverage if you get COBRA continuation coverage for the maximum time available to you.

**What is the procedure 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 no 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. If coverage is not elected within the 60 day period, all rights to elect COBRA continuation coverage are forfeited.

**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 Plan 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 (if the employer is not the Plan Administrator) will notify the Plan Administrator of the Qualifying Event within 30 days following the date coverage ends when the Qualifying Event is:

- (1) the end of employment or reduction of hours of employment,
- (2) death of the employee,
- (3) 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), the Qualified Beneficiary must notify the Plan Administrator or its designee in writing within 60 days after the later of the date the Qualifying Event occurs or the date the Qualified Beneficiary would lose coverage on account of the Qualifying Event, using the procedures specified below. If these procedures are not followed or if the notice is not provided in writing to the Plan Administrator 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.**

**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:

The City of Lynchburg  
c/o Human Resource Department  
Third Floor City Hall  
900 Church Street  
Lynchburg, Virginia 24504

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) and Plan identification numbers 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**.

Be aware that there are other notice requirements in other contexts, for example, in order to qualify for a disability extension.

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 the qualified beneficiaries 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 day after the date coverage is lost due to a Qualifying Event and ending not before the earliest of the following dates:

- (1) The last day of the applicable maximum coverage period.
- (2) The first day for which Timely Payment is not made to the Plan with respect to the Qualified Beneficiary.
- (3) The date upon which the Employer ceases to provide any group health plan (including a successor plan) to any employee.
- (4) 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.
- (5) 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).
- (6) In the case of a Qualified Beneficiary entitled to a disability extension, the later of:
  - (a) (i) 29 months after the date coverage is lost due to 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 Qualified Beneficiary must notify the COBRA Administrator in writing within 30 days after

the Qualified Beneficiary becomes covered by another group health plan or entitled to Medicare. The Qualified Beneficiary must also notify the COBRA Administrator in writing within 30 days after the date of the final determination by the Social Security Administration that the Qualified Beneficiary is no longer disabled. This written notice must include the names and Plan identification numbers of the Qualified Beneficiaries and the date on which the other coverage (or Medicare) became effective, or the date of the non-disability determination (as applicable).

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.

- (1) 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 date coverage is lost due to a Qualifying Event if there is not a disability extension and 29 months after the date coverage is lost due to a Qualifying Event if there is a disability extension.
- (2) 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 loss of coverage due to termination of employment or reduction of hours of employment.
- (3) In the case of a bankruptcy Qualifying Event, the maximum coverage period for a Qualified Beneficiary who is the covered retiree ends on the date of the retiree's death. The maximum coverage period for a Qualified Beneficiary who is the covered Spouse, surviving Spouse or Dependent child of the retiree ends on the earlier of the Qualified Beneficiary's death or 36 months after the death of the retiree.
- (4) 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.
- (5) In the case of any other Qualifying Event than that described above, the maximum coverage period ends 36 months after the date coverage is lost due to 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 and with respect to both Qualifying Events. Also, these events can be a second Qualifying Event only if they would have caused the Qualified Beneficiary to lose coverage under the Plan if the first Qualifying Event had not occurred. For example, in most cases a former employee's entitlement to Medicare will not extend the 18-month COBRA continuation coverage period for the employee's spouse and dependents. This is because if the employee had not terminated employment or reduced working hours (i.e., if the first qualifying event had not occurred), entitlement to Medicare would not result in a loss of family coverage under the Plan. By contrast, the divorce of the employee and spouse after the first qualifying event generally will extend the COBRA continuation coverage period for the spouse. If the employee had not terminated employment or reduced working hours (i.e., if the first qualifying event had not occurred), the divorce would result in a loss of coverage for the spouse.

In no circumstance can the COBRA maximum coverage period be expanded to more than 36 months after the date coverage is lost due to the first Qualifying Event. ***The Qualified Beneficiary must send written notice of the second Qualifying Event to the COBRA Administrator within 60 days after the later of the date of the Qualifying Event or the date coverage would be lost due to the Qualifying Event. This written notice must include the names and Plan identification numbers of the Qualified Beneficiaries, the type of Qualifying Event, and the date on which the Qualifying Event occurred.***

**How does a Qualified Beneficiary become entitled to 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 before the 60th day of COBRA continuation coverage. **To qualify for the disability extension, the Qualified Beneficiary must also provide the COBRA Administrator with written notice of the disability determination (including a copy of the determination) on a date that is both within 60 days after the later of the date of the determination or the date coverage is lost due to the Qualifying Event, and before the end of the original 18-month maximum coverage.**

**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.

Individuals are required by law to notify the Plan Administrator in writing if they become eligible for coverage under another group health plan or Medicare. If an individual does not provide this written notice, the individual will subject to a penalty of 110% of the premium reduction provided after termination of eligibility.

**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 the 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 website at [www.dol.gov/ebsa](http://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 or COBRA Administrator.

## PRIVACY AND SECURITY OF MEDICAL INFORMATION

**COMPLIANCE WITH HIPAA PRIVACY STANDARDS.** Certain members of the Employer's workforce perform services in connection with administration of the Plan. In order to perform these services, it is necessary for these employees from time to time to have access to Protected Health Information (as defined below).

Under the Standards for Privacy of Individually Identifiable Health Information (45 CFR Part 164, the "Privacy Standards"), these employees are permitted to have such access subject to the following:

- (1) **General.** The Plan shall not disclose Protected Health Information to any member of the Employer's workforce unless each of the conditions set out in this HIPAA Privacy section is met. "Protected Health Information" shall have the same definition as set out in the Privacy Standards but generally shall mean individually identifiable health information about the past, present or future physical or mental health or condition of an individual, including information about treatment or payment for treatment.
- (2) **Permitted Uses and Disclosures.** Protected Health Information disclosed to members of the Employer's workforce shall be used or disclosed by them only for purposes of Plan administrative functions. The Plan's administrative functions shall include all Plan payment and health care operations. The terms "payment" and "health care operations" shall have the same definitions as set out in the Privacy Standards, but the term "payment" generally shall mean activities taken with respect to payment of premiums or contributions, or to determine or fulfill Plan responsibilities with respect to coverage, provision of benefits, or reimbursement for health care. "Health care operations" generally shall mean activities on behalf of the Plan that are related to quality assessment; evaluation, training or accreditation of health care providers; underwriting, premium rating and other functions related to obtaining or renewing an insurance contract, including stop-loss insurance; medical review; legal services or auditing functions; or business planning, management and general administrative activities. Genetic information will not be used or disclosed for underwriting purposes.
- (3) **Authorized Employees.** The Plan shall disclose Protected Health Information only to members of the Employer's workforce who are designated and are authorized to receive such Protected Health Information, and only to the extent and in the minimum amount necessary for these persons to perform duties with respect to the Plan. For purposes of this HIPAA Privacy section, "members of the Employer's workforce" shall refer to all employees and other persons under the control of the Employer.
  - (a) **Updates Required.** The Employer shall amend the Plan promptly with respect to any changes in the members of its workforce who are authorized to receive Protected Health Information.
  - (b) **Use and Disclosure Restricted.** An authorized member of the Employer's workforce who receives Protected Health Information shall use or disclose the Protected Health Information only to the extent necessary to perform his or her duties with respect to the Plan.
  - (c) **Resolution of Issues of Noncompliance.** In the event that any member of the Employer's workforce uses or discloses Protected Health Information other than as permitted by the Privacy Standards, the incident shall be

reported to the privacy official. The privacy official shall take appropriate action, including:

- (i) Investigation of the incident to determine whether the breach occurred inadvertently, through negligence, or deliberately; whether there is a pattern of breaches; and the degree of harm caused by the breach;
- (ii) Applying appropriate sanctions against the persons causing the breach, which, depending upon the nature of the breach, may include, oral or written reprimand, additional training, or termination of employment;
- (iii) Mitigating any harm caused by the breach, to the extent practicable; and
- (iv) Documentation of the incident and all actions taken to resolve the issue and mitigate any damages.

**(4) Certification of Employer.** The Employer must provide certification to the Plan that it agrees to:

- (a) Not use or further disclose the Protected Health Information other than as permitted or required by the Plan documents or as required by law;
- (b) Ensure that any agent or subcontractor, to whom it provides Protected Health Information received from the Plan, agrees to the same restrictions and conditions that apply to the Employer with respect to such information;
- (c) Not use or disclose Protected Health Information for employment-related actions and decisions or in connection with any other benefit or employee benefit plan of the Employer;
- (d) Report to the Plan any use or disclosure of the Protected Health Information of which it becomes aware that is inconsistent with the uses or disclosures hereunder or required by law;
- (e) Make available Protected Health Information to individual Plan members in accordance with Section 164.524 of the Privacy Standards;
- (f) Make available Protected Health Information for amendment by individual Plan members and incorporate any amendments to Protected Health Information in accordance with Section 164.526 of the Privacy Standards;
- (g) Make available the Protected Health Information required to provide any accounting of disclosures to individual Plan members in accordance with Section 164.528 of the Privacy Standards;
- (h) Make its internal practices, books and records relating to the use and disclosure of Protected Health Information received from the Plan available to the Department of Health and Human Services for purposes of determining compliance by the Plan with the Privacy Standards;
- (i) If feasible, return or destroy all Protected Health Information received from the Plan that the Employer still maintains in any form, and retain no copies of such information when no longer needed for the purpose of which disclosure

was made, except that, if such return or destruction is not feasible, limit further uses and disclosures to those purposes that make the return or destruction of the information unfeasible; and

- (j) Ensure the adequate separation between the Plan and member of the Employer's workforce, as required by Section 164.504(f)(2)(iii) of the Privacy Standards.

The following members of the City of Lynchburg's workforce are designated as authorized to receive Protected Health Information from the City of Lynchburg Employee Health Care benefit Plan ("the Plan") in order to perform their duties with respect to the Plan: **Director of Human Resource, Benefits Manager, Human Resource Manager, Human Resource Technician.**

**COMPLIANCE WITH HIPAA ELECTRONIC SECURITY STANDARDS.** Under the Security Standards for the Protection of Electronic Protected Health Information (45 CFR Part 164.300 et. seq., the "Security Standards"), the Employer agrees to the following:

- (1) The Employer agrees to implement reasonable and appropriate administrative, physical and technical safeguards to protect the confidentiality, integrity and availability of Electronic Protected Health Information that the Employer creates, maintains or transmits on behalf of the Plan. "Electronic Protected Health Information" shall have the same definition as set out in the Security Standards, but generally shall mean Protected Health Information that is transmitted by or maintained in electronic media.
- (2) The Employer shall ensure that any agent or subcontractor to whom it provides Electronic Protected Health Information shall agree, in writing, to implement reasonable and appropriate security measures to protect the Electronic Protected Health Information.
- (3) The Employer shall ensure that reasonable and appropriate security measures are implemented to comply with the conditions and requirements set forth in Compliance With HIPAA Privacy Standards provisions (3) Authorized Employees and (4) Certification of Employers described above.

## **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 the overpayment. The person or institution receiving the overpayment will be required to return the incorrect amount of money. In the case of a Plan Participant, 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 Plan Participants are limited to expenses incurred before termination.

The Employer intends to maintain this Plan indefinitely; however, it reserves the right, at any time, to amend, suspend or terminate the Plan in whole or in part. This includes amending the benefits under the Plan or the Trust agreement (if any).

### **Right to make changes:**

From time to time, conditions or circumstances may require that The City of Lynchburg make changes, additions, or deletions in its health care coverage for both active employees and retirees as The City of Lynchburg determines are appropriate. This policy does not grant employees or retirees vested health coverage benefits, in other words, employees and retirees are not guaranteed current or future health coverage benefits.

## **GENERAL PLAN INFORMATION**

### **TYPE OF ADMINISTRATION**

The Plan is a self-funded health plan and the administration is provided through a third party Claims Administrator. The funding for the benefits is derived from the funds of the Employer and contributions made by covered Employees. The Plan is not insured.

### **PLAN NAME**

The City of Lynchburg Employee Health Care Benefit Plan

**PLAN EFFECTIVE DATE:** January 1st

**PLAN YEAR ENDS:** December 31st

### **EMPLOYER INFORMATION**

The City of Lynchburg  
900 Church Street  
Lynchburg, Virginia 24504  
(434) 455-4200

### **PLAN ADMINISTRATOR**

The City of Lynchburg  
900 Church Street  
Lynchburg, Virginia 24504  
(434) 455-4200

### **CLAIMS ADMINISTRATOR**

Piedmont Community Health Plan  
2316 Atherholt Road  
Lynchburg, Virginia 24501  
(434) 947-4463



**This is only a summary.** If you want more detail about your coverage and costs, you can get the complete terms in the policy or plan document at [www.pchp.net](http://www.pchp.net) or by calling 1-800-400-7247. Note: The Uniform Glossary can be accessed at [www.cciio.cms.gov](http://www.cciio.cms.gov)

Important Questions	Answers	Why this Matters:
What is the overall <u>deductible</u> ?	<b>\$650</b> individual / <b>\$1,300</b> family in-network <b>\$780</b> individual / <b>\$1,480</b> family out-of-network Does not apply to preventive care or to covered services subject to a copayment rather than coinsurance. Copayments do not count toward the <u>deductible</u> .	You must pay all the costs up to the <u>deductible</u> amount before this plan begins to pay for covered services you use. Check your policy or plan document to see when the <u>deductible</u> starts over (usually, but not always, January 1st). See the chart starting on page 2 for how much you pay for covered services after you meet the <u>deductible</u> .
Are there other <u>deductibles</u> for specific services?	No.	You don't have to meet <u>deductibles</u> for specific services, but see the chart starting on page 2 for other costs for services this plan covers.
Is there an <u>out-of-pocket limit</u> on my expenses?	Yes. <b>\$2,600</b> individual in-network <b>\$5,200</b> individual out-of-network (There is no family out-of-pocket maximum.)	The <u>out-of-pocket limit</u> is the most you could pay during a coverage period (usually one year) for your share of the cost of covered services. This limit helps you plan for health care expenses.
What is not included in the <u>out-of-pocket limit</u> ?	The <u>deductible</u> , copayments, premiums, balance-billed charges, prescription drugs, charges in excess of any benefit limitations, and health care this plan doesn't cover.	Even though you pay these expenses, they don't count toward the <u>out-of-pocket limit</u> .
Is there an overall annual limit on what the plan pays?	No.	The chart starting on page 2 describes any limits on what the plan will pay for <i>specific</i> covered services, such as office visits.
Does this plan use a <u>network of providers</u> ?	Yes. See <a href="http://www.pchp.net">www.pchp.net</a> or call 1-800-400-7247 for a list of in-network providers.	If you use an in-network doctor or other health care <u>provider</u> , this plan will pay some or all of the costs of covered services. Be aware, your in-network doctor or hospital may use an out-of-network <u>provider</u> for some services. Plans use the term in-network, <u>preferred</u> , or participating for <u>providers</u> in their <u>network</u> . See the chart starting on page 2 for how this plan pays different kinds of <u>providers</u> .

**Questions:** Call 1-800-400-7247 or visit us at [www.pchp.net](http://www.pchp.net).

If you aren't clear about any of the underlined terms used in this form, see the Glossary. You can view the Glossary at [www.cciio.cms.gov](http://www.cciio.cms.gov) or call 1-800-400-7247 to request a copy.

OMB Control Numbers 1545-2229,  
1210-0147, and 0938-1146

Released on Dec.1, 2015 (corrected)

Do I need a referral to see a <u>specialist</u> ?	No. You don't need a referral to see a <u>specialist</u> .	You can see the <u>specialist</u> you choose without permission from this plan.
Are there services this plan doesn't cover?	Yes.	Some of the services this plan doesn't cover are listed on page 5. See your policy or plan document for additional information about <u>excluded services</u> .

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- **Copayments** are fixed dollar amounts (for example, \$15) you pay for covered health care, usually when you receive the service.
  - **Coinsurance** is *your* share of the costs of a covered service, calculated as a percent of the **allowed amount** for the service. For example, if the plan's **allowed amount** for an overnight hospital stay is \$1,000, your **coinsurance** payment of 20% would be \$200. This may change if you haven't met your **deductible**.
  - The amount the plan pays for covered services is based on the **allowed amount**. If an out-of-network **provider** charges more than the **allowed amount**, you may have to pay the difference. For example, if an out-of-network hospital charges \$1,500 for an overnight stay and the **allowed amount** is \$1,000, you may have to pay the \$500 difference. (This is called **balance billing**.)
  - This plan may encourage you to use in-network **providers** by charging you lower **deductibles**, **copayments** and **coinsurance** amounts.

Common Medical Event	Services You May Need	Your Cost If You Use an In-Network Provider	Your Cost If You Use an Out-of-Network Provider	Limitations & Exceptions
If you visit a health care <u>provider's</u> office or clinic	Primary care visit to treat an injury or illness	\$25 copay/visit	40% coinsurance	Doctor office labs covered at No Charge after office visit copay.
	Specialist visit	\$37.50 copay/visit	40% coinsurance	Doctor office labs covered at No Charge after office visit copay.
	Other practitioner office visit	\$37.50 copay/visit	40% coinsurance	Spinal manipulation/chiropractic services limited to 20 visits/year total. Maintenance therapy is Not Covered. Acupuncture is Not Covered.
	Preventive care/screening/immunization	No charge	40% coinsurance	—————none—————
If you have a test	Diagnostic test (x-ray, blood work)	20% coinsurance	40% coinsurance	Labs billed as "facility" subject to deductible and coinsurance.
	Imaging (CT/PET scans, MRIs)	20% coinsurance	40% coinsurance	Pre-authorization required.

**Questions:** Call 1-800-400-7247 or visit us at [www.pchp.net](http://www.pchp.net).

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Common Medical Event	Services You May Need	Your Cost If You Use an In-Network Provider	Your Cost If You Use an Out-of-Network Provider	Limitations & Exceptions
<b>If you need drugs to treat your illness or condition</b>  More information about <u>prescription drug coverage</u> is available from Script Care at 1-888-810-9010.	Generic drugs (\$100 maximum coinsurance for retail) (\$300 maximum coinsurance for mail order)	40% coinsurance/ \$20 min. (retail) 40% coinsurance/ \$60 min. (mail order)	40% coinsurance/ \$20 min. (retail) 40% coinsurance/ \$60 min. (mail order)	Coinsurance is per prescription; any one prescription is limited to a 30 day or 90 day supply.
	Preferred brand drugs (\$100 maximum coinsurance for retail) (\$300 maximum coinsurance for mail order)	40% coinsurance/ \$20 min. (retail) 40% coinsurance/ \$60 min. (mail order)	40% coinsurance/ \$20 min. (retail) 40% coinsurance/ \$60 min. (mail order)	Mandatory mail-order after the initial retail fill plus three refills. Mandatory generic: When a generic drug is available, benefits are based on the cost of the generic drug. If you request or require a brand name drug, you pay the cost difference between the two in addition to coinsurance.
	Non-preferred brand drugs (\$100 maximum coinsurance for retail) (\$300 maximum coinsurance for mail order)	40% coinsurance/ \$20 min. (retail) 40% coinsurance/ \$60 min. (mail order)	40% coinsurance/ \$20 min. (retail) 40% coinsurance/ \$60 min. (mail order)	If a drug is purchased from an Out-of-Network Provider, the amount payable in excess of the coinsurance will be the ingredient cost and dispensing fee.
	Specialty drugs (\$100 maximum coinsurance for retail) (\$300 maximum coinsurance for mail order)	40% coinsurance/ \$20 min. (retail) 40% coinsurance/ \$60 min. (mail order)	40% coinsurance/ \$20 min. (retail) 40% coinsurance/ \$60 min. (mail order)	
<b>If you have outpatient surgery</b>	Facility fee (e.g., ambulatory surgery center)	20% coinsurance	40% coinsurance	Pre-authorization required. Covered as Out-of-Network without pre-auth.
	Physician/surgeon fees	20% coinsurance	40% coinsurance	
<b>If you need immediate medical attention</b>	Emergency room services	\$65 copay/visit	\$65 copay/visit	If not an actual emergency, covered at 40% coinsurance after deductible. ER copay waived if admitted; then subject to inpatient ded/coinsurance.
	Emergency medical transportation	20% coinsurance	20% coinsurance	
	Urgent care	\$37.50 copay/visit	\$37.50 copay/visit	
<b>If you have a hospital stay</b>	Facility fee (e.g., hospital room)	20% coinsurance	40% coinsurance	Pre-authorization required. Covered as Out-of-Network without pre-auth.
	Physician/surgeon fee	20% coinsurance	40% coinsurance	

**Questions:** Call 1-800-400-7247 or visit us at [www.pchp.net](http://www.pchp.net).

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Common Medical Event	Services You May Need	Your Cost If You Use an In-Network Provider	Your Cost If You Use an Out-of-Network Provider	Limitations & Exceptions
<b>If you have mental health, behavioral health, or substance abuse needs</b>	Mental/Behavioral health outpatient services	\$25 copay/office visit and 20% coinsurance other outpatient services	40% coinsurance	Doctor office labs covered at No Charge after office visit copay. Pre-authorization required for any inpatient or outpatient facility services. Pre-authorization required for any services and office visits from Out-of-Network providers. Covered as Out-of-Network without pre-authorization.
	Mental/Behavioral health inpatient services	20% coinsurance	40% coinsurance	
	Substance use disorder outpatient services	\$25 copay/office visit and 20% coinsurance other outpatient services	40% coinsurance	
	Substance use disorder inpatient services	20% coinsurance	40% coinsurance	
<b>If you are pregnant</b>	Prenatal and postnatal care	Initial \$100 copay	40% coinsurance	Routine labs covered at No Charge.
	Delivery and all inpatient services	20% coinsurance	40% coinsurance	Pregnancy for a dependent child is Not Covered.
<b>If you need help recovering or have other special health needs</b>	Home health care	20% coinsurance	40% coinsurance	Limited to 100 visits per year total. Pre-authorization required.
	Rehabilitation services	20% coinsurance	40% coinsurance	Pre-authorization required. Physical therapy limit is 30 visits/year; speech and occupational therapy limits are 30 visits/year combined.
	Habilitation services	Not Covered	Not Covered	Habilitation services are Not Covered.
	Skilled nursing care	20% coinsurance	40% coinsurance	Pre-authorization required. Limited to 30 days per calendar year.
	Durable medical equipment	20% coinsurance	40% coinsurance	Pre-authorization required.
	Hospice service	20% coinsurance	40% coinsurance	Pre-authorization required.
<b>If your child needs dental or eye care</b>	Eye exam	Not Covered	Not Covered	Routine eye exam is Not Covered for children.
	Glasses	Not Covered	Not Covered	Glasses and routine dental check-ups Not Covered for children.
	Dental check-up	Not Covered	Not Covered	

**Questions:** Call 1-800-400-7247 or visit us at [www.pchp.net](http://www.pchp.net).

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## Excluded Services & Other Covered Services:

### Services Your Plan Does NOT Cover (This isn't a complete list. Check your policy or plan document for other excluded services.)

- Acupuncture
- Bariatric surgery
- Cosmetic surgery
- Dental care (Adult) (except for accidental injury)
- Glasses
- Habilitation services
- Hearing aids
- Infertility treatment
- Long-term care
- Non-emergency care when traveling outside the U.S.
- Routine eye care (Adult)
- Routine foot care (unless you are under active treatment for a metabolic or peripheral vascular disease, such as diabetes)
- Weight loss programs

### Other Covered Services (This isn't a complete list. Check your policy or plan document for other covered services and your costs for these services.)

- Chiropractic care (total spinal manipulation/ chiropractic services limited to 20 visits per year; maintenance therapy services are Not Covered)
- Private-duty nursing

**Questions:** Call 1-800-400-7247 or visit us at [www.pchp.net](http://www.pchp.net).

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## Your Rights to Continue Coverage:

If you lose coverage under the plan, then, depending upon the circumstances, Federal and State laws may provide protections that allow you to keep health coverage. Any such rights may be limited in duration and will require you to pay a **premium**, which may be significantly higher than the premium you pay while covered under the plan. Other limitations on your rights to continue coverage may also apply.

For more information on your rights to continue coverage, contact the plan at 1-800-400-7247. You may also contact your state insurance department, the U.S. Department of Labor, Employee Benefits Security Administration at 1-866-444-3272 or [www.dol.gov/ebsa](http://www.dol.gov/ebsa), or the U.S. Department of Health and Human Services at 1-877-267-2323 x61565 or [www.cciio.cms.gov](http://www.cciio.cms.gov).

## Your Grievance and Appeals Rights:

If you have a complaint or are dissatisfied with a denial of coverage for claims under your plan, you may be able to **appeal** or file a **grievance**. For questions about your rights, this notice, or assistance, you can contact Piedmont Community Health Plan at 1-800-400-7247 (434-947-4463 if local) or visit [www.pchp.net](http://www.pchp.net). You may also contact the U.S. Department of Labor, Employee Benefits Security Administration at 1-866-444-3272 or visit [www.dol.gov/ebsa/healthreform](http://www.dol.gov/ebsa/healthreform). For prescription drug information, contact Script Care at 1-888-810-9010 or visit [www.scriptcare.com](http://www.scriptcare.com).

## Does this Coverage Provide Minimum Essential Coverage?

The Affordable Care Act requires most people to have health care coverage that qualifies as “minimum essential coverage”. **This plan or policy does provide minimum essential coverage.**

## Does this Coverage Meet the Minimum Value Standard?

The Affordable Care Act establishes a minimum value standard of benefits of a health plan. The minimum value standard is 60% (actuarial value). **This health coverage does meet the minimum value standard for the benefits it provides.**

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*To see examples of how this plan might cover costs for a sample medical situation, see the next page.*

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**Questions:** Call 1-800-400-7247 or visit us at [www.pchp.net](http://www.pchp.net).

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## About these Coverage Examples:

These examples show how this plan might cover medical care in given situations. Use these examples to see, in general, how much financial protection a sample patient might get if they are covered under different plans. These examples were completed using the cost sharing for the Employee Only (Individual) coverage tier.



**This is not a cost estimator.**

Don't use these examples to estimate your actual costs under this plan. The actual care you receive will be different from these examples, and the cost of that care will also be different.

See the next page for important information about these examples.

### Having a baby (normal delivery)

- **Amount owed to providers: \$7,540**
- **Plan pays \$5,790**
- **Patient pays \$1,750**

**Sample care costs:**

Hospital charges (mother)	\$2,700
Routine obstetric care	\$2,100
Hospital charges (baby)	\$900
Anesthesia	\$900
Laboratory tests	\$500
Prescriptions	\$200
Radiology	\$200
Vaccines, other preventive	\$40
<b>Total</b>	<b>\$7,540</b>

**Patient pays:**

Deductibles	\$650
Copays	\$100
Coinsurance	\$800
Limits or exclusions	\$200
<b>Total</b>	<b>\$1,750</b>

### Managing type 2 diabetes (routine maintenance of a well-controlled condition)

- **Amount owed to providers: \$5,400**
- **Plan pays \$2,670**
- **Patient pays \$2,730**

**Sample care costs:**

Prescriptions	\$2,900
Medical Equipment and Supplies	\$1,300
Office Visits and Procedures	\$700
Education	\$300
Laboratory tests	\$100
Vaccines, other preventive	\$100
<b>Total</b>	<b>\$5,400</b>

**Patient pays:**

Deductibles	\$650
Copays	\$1,500
Coinsurance	\$500
Limits or exclusions	\$80
<b>Total</b>	<b>\$2,730</b>

**Questions:** Call 1-800-400-7247 or visit us at [www.pchp.net](http://www.pchp.net).

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## Questions and answers about the Coverage Examples:

### What are some of the assumptions behind the Coverage Examples?

- Costs don't include **premiums**.
- Sample care costs are based on national averages supplied by the U.S. Department of Health and Human Services, and aren't specific to a particular geographic area or health plan.
- The patient's condition was not an excluded or preexisting condition.
- All services and treatments started and ended in the same coverage period.
- There are no other medical expenses for any member covered under this plan.
- Out-of-pocket expenses are based only on treating the condition in the example.
- The patient received all care from in-network **providers**. If the patient had received care from out-of-network **providers**, costs would have been higher.

### What does a Coverage Example show?

For each treatment situation, the Coverage Example helps you see how **deductibles**, **copayments**, and **coinsurance** can add up. It also helps you see what expenses might be left up to you to pay because the service or treatment isn't covered or payment is limited.

### Does the Coverage Example predict my own care needs?

- ✗ **No.** Treatments shown are just examples. The care you would receive for this condition could be different based on your doctor's advice, your age, how serious your condition is, and many other factors.

### Does the Coverage Example predict my future expenses?

- ✗ **No.** Coverage Examples are **not** cost estimators. You can't use the examples to estimate costs for an actual condition. They are for comparative purposes only. Your own costs will be different depending on the care you receive, the prices your **providers** charge, and the reimbursement your health plan allows.

### Can I use Coverage Examples to compare plans?

- ✓ **Yes.** When you look at the Summary of Benefits and Coverage for other plans, you'll find the same Coverage Examples. When you compare plans, check the "Patient Pays" box in each example. The smaller that number, the more coverage the plan provides.

### Are there other costs I should consider when comparing plans?

- ✓ **Yes.** An important cost is the **premium** you pay. Generally, the lower your **premium**, the more you'll pay in out-of-pocket costs, such as **copayments**, **deductibles**, and **coinsurance**. You should also consider contributions to accounts such as health savings accounts (HSAs), flexible spending arrangements (FSAs) or health reimbursement accounts (HRAs) that help you pay out-of-pocket expenses.

**Questions:** Call 1-800-400-7247 or visit us at [www.pchp.net](http://www.pchp.net).

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**Plan Document and Summary Plan Description for  
Lynchburg City Schools  
Employee Health Care Benefit Plan**

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A TRADITION OF EXCELLENCE FOR ALL



LYNCHBURG CITY SCHOOLS



PIEDMONT COMMUNITY HEALTH PLAN

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## INTRODUCTION

This document is a description of the health benefits coverage offered to eligible Employees and eligible Retired Employees of Lynchburg City Schools Employee Health Care Benefit Plan (the Plan). No oral interpretation can change this Plan. The Plan described is designed to protect Plan Participants against certain health expenses.

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

Failure to follow the eligibility or enrollment requirements of this Plan may result in delay of coverage or no coverage at all. Reimbursement from the Plan can be reduced or denied because of certain provisions in the Plan, such as coordination of benefits, subrogation, exclusions, and timeliness of COBRA elections, utilization review or other cost management requirements, lack of Medical Necessity, lack of timely filing of claims or lack of coverage. These provisions are explained in summary fashion in this document; additional information is available from the Plan Administrator at no extra cost.

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 the expenses incurred while this coverage is in effect. No benefits are payable for expenses incurred before coverage began or after coverage terminated. An expense for a service or supply is incurred on the date the service or supply is furnished.

The Employer fully intends to maintain this Plan indefinitely. However, it reserves the right to terminate, suspend, discontinue or amend the Plan. If the Plan is terminated, the rights of Covered Persons are limited to covered charges incurred before termination.

This document summarizes the Plan rights and benefits for covered Employees and their Dependents and should be read carefully since each Participant is required to take action to assure that the maximum payment levels under the Plan are paid. This document is divided into the following parts:

**Eligibility, Funding, Effective Date and Termination.** Explains eligibility for coverage under the Plan, funding of the Plan and when the coverage takes effect and terminates.

**Schedule of Benefits.** Provides an outline of the Plan reimbursement formulas as well as payment limits on certain services.

**Benefit Descriptions.** Explains when the benefit applies and the types of charges covered.

**Cost Management Services.** Explains the methods used to curb unnecessary and excessive charges.

**Defined Terms.** Defines those Plan terms that have a specific meaning.

**Plan Exclusions.** Shows what charges are not covered.

**Claim Provisions.** Explains the rules for filing claims and the claim appeal process.

**Coordination of Benefits.** Shows the Plan payment order when a person is covered under more than one plan.

**Third Party Recovery Provision.** Explains the Plan's rights to recover payment of charges when a Covered Person has a claim against another person because of injuries sustained.

**COBRA Continuation Options.** Explains when a person's coverage under the Plan ceases and the continuation options which are available.

## ELIGIBILITY, FUNDING, EFFECTIVE DATE AND TERMINATION PROVISIONS

### ELIGIBILITY

#### Eligible Classes of Employees.

All Eligible and Retired Employees of the Employer.

**Eligibility Requirements for Employee Coverage.** A person is eligible for coverage who meets the criteria outlined in numbers 1, 2, and 3 below:

- (1) Is in a class eligible for coverage.
- (2) Completes the employment Waiting Period as of the date of hire as an Employee. However, an absence of work during the Waiting Period that is due to a Health Factor is not considered an absence for purposes of measuring the Waiting Period. A "Waiting Period" is the time period that must pass before coverage becomes effective for an Employee who is otherwise eligible to enroll under the terms of the Plan. The Waiting Period begins on the date of employment and ends on the first day of the month following the month in which the employee receives his/her initial compensation as an Employee.
- (3) (a) Is an Employee of the employer who normally works at least 30 hours and is on the regular payroll of the employer for that work or  
  
(b) Is an eligible retired Employee of the Employer and is not eligible or qualified for health care coverage under Medicare.

Employees who were previously covered by the Plan and lost coverage because they no longer met the eligibility requirements (i.e., works less than half-time), but who are still employed by the Employer, will be eligible for coverage under the Plan again if they subsequently regain eligibility. These Employees must enroll for coverage as instructed in the ENROLLMENT section of this document but do not have to satisfy the employment Waiting Period..

#### Eligible Classes of Dependents.

A Dependent is any one of the following persons:

- (1) A covered Employee's Spouse and children from birth to the limiting age of 26 years with coverage ending on the last day of the month in which the child reaches age 26.

The term "Spouse" shall mean the person recognized as the covered Employee's husband or wife under the laws of the state where the covered Employee lives. The Plan Administrator may require documentation proving a legal marital relationship.

The term "children" shall include natural children, adopted children or children placed with a covered Employee in anticipation of adoption. Step children or Foster Children who reside in the Employee's household may also be included.

If a covered employee is the Legal Guardian of an unmarried child or children, these children may be enrolled in the Plan as covered Dependents.

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.

Coverage of these pre-adoptive children is required by the federal Omnibus Budget Reconciliation Act of 1993. The child must be available for adoption and the legal process must have commenced.

The Plan Administrator may require documentation-proving dependency, including birth certificates or initiation of legal proceedings severing parental rights.

- (2) A covered Dependent child who is Totally Disabled, incapable of self-sustaining employment by reason of mental retardation or physical disability, primarily dependent upon the covered Employee for support and maintenance, unmarried and covered under the Plan when reaching the limiting age. The Plan Administrator may require, at reasonable intervals during the two years following the Dependent's reaching the limiting age, 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.

These persons are excluded as Dependents: other individuals living in the covered Employee's home, but who are not eligible as defined; the legally separated or divorced former Spouse of the Employee; any Spouse who is on active duty in any military service of any country; or any Spouse who is covered under the Plan as an Employee.

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.

If both mother and father are Employees, their children will be covered as Dependents of the mother or father, but not of both.

**\*\*\*The Employee is responsible for notifying the Employer of any status or Qualifying Event change when a dependent(s) becomes eligible or ineligible. If the Employee does not notify the Employer within 31 days of the status or qualifying event change, then the Employee will be responsible for any cost occurred.**

**Qualifying Change in Status events include, but are not limited to:**

- Events that change an Employee's legal marital status, including marriage, death of spouse, divorce, legal separation or annulment.
- Events that change an Employee's number of Dependents, including birth, death, adoption or placement for adoption.
- Events that change the employment status of the Employee, the Employee's Spouse, or the Employee's Dependent. Events include termination or commencement of employment, strike or lockout, commencement of or return from an unpaid leave of absence, change in worksite or change in the individual's employment when they cease to be eligible for the Program.
- Events that cause an Employee's Dependent to satisfy or cease to satisfy eligibility requirements for coverage based on age, student status, marital status or any similar circumstance.
- A change of residence for the Employee, Spouse or Dependent.

**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 may require proof that a Spouse or a child qualifies or continues to qualify as a Dependent as defined by this Plan.

## **FUNDING**

### **Cost of the Plan.**

Lynchburg City Schools shares the cost of Employee and Dependent coverage under this Plan with the covered Employees. The enrollment application for coverage will include a payroll deduction authorization. This enrollment application must be filled out, signed and returned to the Employer.

The level of any Employee contributions is set by the Plan Administrator. The Plan Administrator reserves the right to change the level of Employee contributions.

## **ENROLLMENT**

**Enrollment Requirements.** An Employee must enroll for coverage by filling out and signing an enrollment application. The Covered Employee may enroll for dependent coverage also. If the covered Employee already has Employee/Children or Family coverage, a newborn child will be automatically enrolled from birth (the Employee should still submit an enrollment application identifying this new Dependent); otherwise, a separate enrollment for a newborn child is required.

### **Enrollment Requirements for Newborn Children.**

A newborn child of a covered Employee who has Employee/Children or Family coverage is automatically eligible to be enrolled in this Plan. Charges for covered nursery care and covered routine physician care will be applied toward the Plan of the covered parent. If a separate enrollment application is required for the newborn child, but the newborn child is not enrolled in this Plan within 31 days of the child's birth, there will be no payment from the Plan and the covered parent will be responsible for all costs, including Medically Necessary care and treatment of congenital defects, birth abnormalities or complications resulting from prematurity.

If the children are required to be enrolled and are not enrolled within 31 days of birth, the enrollment will be considered a late enrollment.

## **TIMELY OR LATE ENROLLMENT**

- (1) Timely Enrollment** The enrollment will be "timely" if the 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 (husband and wife) 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** An enrollment is "late" if it is not made on a "timely basis" or during a Special Enrollment Period.

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.

The enrollment date for a Late Enrollee is the first date of coverage. Thus, the time between the dates a Late Enrollee first becomes eligible for enrollment under the Plan and the first day of coverage is not treated as a Waiting Period.

## **SPECIAL ENROLLMENT RIGHTS**

Federal law provides Special Enrollment provisions under some circumstances. If an Employee is declining enrollment for himself or his dependents (including their spouse) because of other health insurance or group health plan coverage, there may be a right to enroll in this Plan if there is a loss of eligibility for that other coverage (or if the employer stops contributing towards the other coverage). However, a request for enrollment must be made within 30 days after the coverage ends (or after the employer stops contributing towards the other coverage).

In addition, in the case of a birth, marriage, adoption or placement for adoption, there may be a right to enroll in this Plan. However, a request for enrollment must be made within 30 days after the birth, marriage, adoption or placement for adoption.

The Special Enrollment rules are described in more detail below. To request Special Enrollment or obtain more detailed information of these portability provisions, contact the Plan Administrator.

## **SPECIAL ENROLLMENT PERIODS**

The Enrollment Date for anyone who enrolls under a Special Enrollment Period is the first date of coverage. Thus, the time between the date a special enrollee first becomes eligible for enrollment under the Plan and the first day of coverage is not treated as a Waiting Period.

- (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 (i) the coverage was terminated as a result of loss of eligibility for the coverage (including as a result of legal separation, divorce, cessation of dependent status (such as attaining the maximum age to be eligible as a dependent child under the plan), death, termination of employment or reduction in the number of hours of employment, or the Plan ceasing to provide benefits to a class of similarly-situated individuals), or (ii) employer contributions towards the coverage were terminated. The Employee or Dependent also has a loss of eligibility when coverage is offered through an HMO, or other arrangement, in the individual or group market that does not provide benefits to individuals who no longer reside, live or work in a service area, (whether or not within the choice of the individual), and, in the case of the group market, no other benefit package is available to the individual.
  - (d)** The Employee or Dependent requests enrollment in this Plan not later than 30 days after the date of exhaustion of COBRA coverage or the termination of non-COBRA coverage due to loss of eligibility or employer contributions, described above.

Coverage will begin on the first day of the first calendar month following the date the Plan Administrator receives the completed enrollment form.

Coverage for retirees cannot extend beyond what is in effect at the time of retirement, unless a change of status occurs prior to retirement date and cannot be reinstated if dropped at retirement or at any point thereafter.

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 or an intentional misrepresentation of a material fact in connection with the plan), that individual does not have a Special Enrollment right.

**(2) Individuals losing Medicaid coverage or State Child Health Insurance Plan (CHIP) coverage.** An Employee or Dependent who is eligible, but not enrolled in this Plan, may enroll if each of the following conditions is met. However, if a Dependent becomes eligible to enroll under this provision and the Employee is not then enrolled, the Employee must enroll in order for the Dependent to enroll.

- (a) The Employee or Dependent is covered under a Medicaid plan under title XIX of the Social Security Act or under a State child health plan under title XXI of such Act and coverage of the Employee or Dependent under such a plan is terminated as a result of loss of eligibility for such coverage.
- (b) The Employee or Dependent requests enrollment in this Plan not later than 60 days after the date of termination of the Medicaid or State child health plan coverage.

**(3) Individuals becoming eligible for employment assistance under Medicaid coverage or CHIP coverage.** An Employee or Dependent who is eligible, but not enrolled in this Plan, may enroll if each of the following conditions is met. However, if a Dependent becomes eligible to enroll under this provision and the Employee is not then enrolled, the Employee must enroll in order for the Dependent to enroll.

- (a) The Employee or Dependent becomes eligible for assistance, with respect to coverage under this Plan, under a Medicaid plan or State child health plan.
- (b) The Employee or Dependent requests enrollment in this Plan not later than 60 days after the date the Employee or Dependent is determined to be eligible for such assistance.

**(4) Dependent beneficiaries.** The Dependent (and if not otherwise enrolled, the Employee) may be enrolled under this Plan as a covered Dependent of the covered Employee 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.

In the case of the birth or adoption of a child, the Spouse of the covered 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:

In the case of marriage, the first day of the first calendar month beginning after the date the Plan Administrator receives the completed request for enrollment;

In the case of a Dependent's birth, as of the date of birth; or

In the case of a Dependent's adoption or placement for adoption, the date of the adoption or placement for adoption.

## EFFECTIVE DATE

**Effective Date of Employee Coverage.** Except as required for a Special Enrollment, an Employee will be covered under this Plan as of the first day of the calendar month following the date that the Employee satisfies all of the following:

- (1) The Eligibility Requirement.
- (2) The Enrollment Requirements of the Plan.

**Effective Date of Dependent Coverage.** Except as required for a Special Enrollment, a Dependent's coverage will take effect on the day that the Eligibility Requirements is 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.

- (1) The date the Plan is terminated.
- (2) The last day of the calendar month after the month in which half of the Employee's monthly salary is received will be when the covered Employee ceases to be in one of the Eligible Classes. This includes death or termination of employment of the covered employee. (See the COBRA Continuation Options.)
- (3) The end of the period for which the required contribution has been paid if the charge for the next period is not paid when due.
- (4) When your employment terms prior to the 15<sup>th</sup> of the month your coverage will terminate at the end of the month. If your employment terms after the 15<sup>th</sup> of the month your coverage will terminate at the end of the following month.

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.

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

**For disability leave only:** the end of the 12 calendar month period that next follows the month in which the person last worked as an Employee.

While continued, coverage will be that which was in force on the last day worked as an Employee. 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 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. This Employee does not have to satisfy the employment Waiting Period.

**Employees on Military Leave.** Employees going into or returning from military service will have Plan rights mandated by the Uniformed Services Employment and Reemployment Rights Act. These rights include up to 24 months of extended health care coverage upon payment of the entire cost of coverage plus a reasonable administration fee (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) and immediate coverage with no preexisting conditions exclusions applied in the Plan upon return from service. These rights apply only to Employees and their Dependents covered under the Plan before leaving for military service.

Plan exclusion and Waiting Periods may be imposed for any Sickness or Injury determined by the Secretary of Veterans Affairs to have been incurred in, or aggravated during, military service.

**When Dependent Coverage Terminates.** A Dependent's coverage will terminate on the earliest of these dates:

- (1) The date the Plan is terminated.
- (2) The date that the Employee's coverage under the Plan terminates for any reason including death. (See the COBRA Continuation Options.)
- (3) The date Dependent coverage is terminated under the Plan.
- (4) The end of the period for which the required contribution has been paid if the charge for the next period is not paid when due.

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.

## **OPEN ENROLLMENT**

During the annual open enrollment period, covered Employees and the covered Dependents will be able to change some of their benefit decisions based on which benefits and coverages are right for them.

Benefit choices made during the open enrollment period will become effective January 1 and remain in effect until the next January 1 unless there is a change in family status during the year (birth, death, marriage, divorce, adoption) or loss of coverage due to loss of a Spouse's employment. Coverage Waiting Period Limits are waived during open enrollment for covered Employees and covered Dependents changing from one plan to another plan.

A Plan Participant who fails to make an election during open enrollment will automatically retain his or her present coverage.

Plan Participants will receive detailed information regarding open enrollment from their Employer.

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**PREFERRED PROVIDER ORGANIZATION PLAN**

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## SCHEDULE OF BENEFITS

The Medical Plan is a Preferred Provider Organization (PPO) Plan. Preferred Providers are members of Piedmont's network of Participating Providers. Generally, a higher level of benefits is paid for services rendered by a Participating Provider.

### MEDICAL BENEFITS

All benefits described in this Schedule 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 Usual and Reasonable; 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.

**NOTE: Medical services received in the event of a Medical Emergency do not require precertification. The following services must be precertified or reimbursement from the Plan will be reduced**

- **Cardiac rehabilitation therapy**
- **Durable Medical Equipment (over \$200)**
- **Home Health Care Hospice Care**
- **Hospice Care**
- **Hospitalizations**
- **MRI/PET Scan**
- **Outpatient surgical procedures**
- **Physical, speech and/or occupational therapy, Podiatry services**
- **Skilled Nursing Facility stays**
- **Substance Abuse/Mental Disorder treatments**

The attending Physician does not have to obtain pre-certification from the Plan for prescribing a Hospital length of stay in connection with childbirth for the mother or her newborn child that is 48 hours or less following a vaginal delivery or 96 hours or less following a cesarean delivery.

Obstetric hospitalizations that exceed the 48 or 96 hour time periods and any services that are not associated with the delivery must be pre-certified as set forth in this document.

**NOTE:** When the delivery occurs outside a Hospital, the Hospital length of stay begins at the time the mother or newborn is admitted as a Hospital inpatient in connection with childbirth. The attending Physician will determine whether the admission is in connection with childbirth.

**Please see the Medical Management section in this booklet for details.**

### **Deductibles/Copayments payable by Plan Participants.**

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 Plan Year per Covered Person. Typically, there is one deductible amount per Plan and it must be paid before any money is paid by the Plan for any covered services. Each October 1st, a new deductible amount is required.

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 do not accrue toward the 100% maximum out-of-pocket payment.

## BENEFITS 750 OPTION PPO

BENEFITS	IN-PLAN	OUT-OF-PLAN
<b>Annual Deductible</b>		
Individual	\$750	\$1,500
Family	\$1,500	\$3,000
<b>Annual Out of Pocket Maximum</b>	\$2,500	\$5,000
<b>Coinsurance</b>	80%	60%
<b>Physician Services</b>		
Office Visits - Family Practice	100% after \$25 copayment	60% after deductible
Office Visits - Specialist	100% after \$45 copayment	60% after deductible
Allergy Injections	100% after \$3 copayment	60% after deductible
Lab work/ office/reference lab	100%	60% after deductible
Other services performed in the Office	80% after deductible	60% after deductible
<b>Preventive Care</b>		
Routine physical exams—Adult	100%	60% after deductible
Pediatric wellness exams	100%	60% after deductible
Pediatric immunizations	100%	60% after deductible
<b>Emergency Room Services</b>	100% after \$200 copayment (waived if admitted)	60% after deductible
<b>Hospital Expenses</b> (inpatient and outpatient)	80% after deductible	60% after deductible
<b>Medical/Surgical Expenses</b> (except office visits)	80% after deductible	60% after deductible
<b>Durable Medical Equipment</b>	80% after deductible	60% after deductible
<b>Ambulance</b>	80% after deductible	60% after deductible
<b>Mental Health</b>		
Inpatient	80% after deductible	60% after deductible
Outpatient Facility	80% after deductible	60% after deductible
Outpatient Office Visit	100% after \$25 copayment	60% after deductible
<b>Substance Abuse</b>		
Inpatient	80% after deductible	60% after deductible
Outpatient Facility	80% after deductible	60% after deductible
Outpatient Office Visit	100% after \$25 copayment	60% after deductible
<b>Skilled Nursing Facility Care</b>	80% after deductible	60% after deductible
<b>Home Health Care</b> (100 visits per calendar year)	80% after deductible	60% after deductible
<b>Hospice</b>	80% after deductible	60% after deductible
<b>Private Duty Nursing</b>	80% after deductible	60% after deductible
<b>Early Intervention Services Maximum</b>	Up to age 3	

**Authorizations Required for PPO Plan for:** Inpatient Admission, Outpatient Surgery, and High Diagnostic Services

**MEDICAL BENEFITS 750 OPTION**

**Physician office visit copayment**

In Plan Services Family Practice .....	\$25
In Plan Services Specialist .....	\$45
Out of Plan Services .....	60% after deductible

**Lab services in the office/reference lab are covered at 100%. All other services performed in the office are subject to the deductible and coinsurance.**

**Exceptions are prenatal services, allergy injections, mental health services, physical therapy and speech therapy.**

**Emergency room copayment**

In Plan Services .....	\$200
Out of Plan Services .....	60% after deductible

This copayment will be waived if the Covered Person is admitted directly from the emergency room to the Hospital because of a Medical Emergency.

**Deductibles, per Plan Year**

Per Covered Person, In Plan Services .....	\$750
Per Covered Person, Out of Plan Services .....	\$1,500
Per Family Unit, In Plan Services .....	\$1,500
Per Family Unit, Out of Plan Services .....	\$3,000

**Maximum out of pocket payments, per Plan Year**

Per Covered Person, In Plan Services .....	\$2,500
Per Covered Person, Out of Plan Services .....	\$5,000
Per Family Unit, In Plan Services .....	\$5,000
Per Family Unit, Out of Plan Services .....	\$10,000

The charges for the following do not apply to the 100% benefit limit and are never paid at 100%.

- (1) Copayments

***THE FOLLOWING IS A LIST OF THE INDIVIDUAL BENEFITS:***

**Ambulance Service**

Reimbursement rate	
In Plan Services .....	80% after deductible
Out of Plan Services .....	60% after deductible

**Durable Medical Equipment**

Reimbursement rate	
In Plan Services .....	80% after deductible
Out of Plan Services .....	60% after deductible

**Home Health Care**

Reimbursement rate	
In Plan Services .....	80% after deductible
Out of Plan Services .....	60% after deductible
Plan Year maximum	
Combined in and out of plan service .....	100 visits

**Hospice Care**

Reimbursement rate	
In Plan Services .....	80% after deductible
Out of Plan Services .....	60% after deductible

**Intensive Care Unit**

Daily limit .....	Hospital's ICU Charge
Reimbursement rate	
In Plan Services .....	80% after deductible
Out of Plan Services .....	60% after deductible

**Mental Disorders Treatment**

Inpatient reimbursement rate	
In Plan Services .....	80% after deductible
Out of Plan Services .....	60% after deductible
Outpatient reimbursement rate	
In Plan Services (office visit) .....	100% after \$25 co-pay
In Plan Services (Outpatient Hospital/Facility) .....	80% after deductible
Out of Plan Services .....	60% after deductible

**Nursery/Physician - Well Newborn Care Limits**

Reimbursement rate	
In Plan Services .....	80% after deductible
Out of Plan Services .....	60% after deductible

**Occupational Therapy**

Reimbursement rate	
In Plan Services .....	100% after \$45 co-pay
Out of Plan Services .....	60% after deductible

**Organ Transplant Coverage Limits**

Covered Transplant Procedures:

Organ and tissue transplants are covered except those, which are classified as "Experimental and/or Investigational."

In Plan Services .....	80% after deductible
Out of Plan Services .....	60% after deductible
Donor coverage maximum	
In Plan/Out of Plan service .....	\$10,000 combined

Plan covers a Plan Participant's charges as a donor whether or not the recipient is a Covered Person. Plan also covers donor charges when the recipient is a Covered Person whether or not the donor is a Covered Person.

**Outpatient Private Duty Nursing**

Reimbursement rate	
In Plan Services .....	80% after deductible
Out of Plan Services .....	60% after deductible

**Physical Therapy**

Reimbursement rate	
In Plan Services .....	100% after \$45 co-pay
Out of Plan Services .....	60% after deductible

**Physician Services**

Inpatient Reimbursement rate	
In Plan Services .....	80% after deductible
Out of Plan Services .....	60% after deductible

Office visit only Family Practice

Reimbursement rate	
In Plan Services .....	100% after \$25 co-pay
Out of Plan Services .....	60% after deductible

Surgical services Family Practice

Reimbursement rate

In Plan Services (physician's office) .....	80% after deductible
In Plan Services (Inpatient or Outpatient Hospital) .....	80% after deductible
Out of Plan Services .....	60% after deductible

**Pregnancy Benefits**

In Plan Service (office visits) .....	\$45 co-payment for first office visit then payable at 100%
In Plan Services (Hospital and other services).....	80% after deductible
Out of Plan Services .....	60% after deductible

No coverage for Pregnancy or any Complication of Pregnancy for Dependent children

**Preventive Care - Routine Well Adult Care Limits**

Reimbursement rate

In Plan Services .....	100%
Out of Plan Services .....	60% after deductible

**NOTE: Coverage includes reimbursement for the following routine services: office visits, pap smear, mammogram, prostate screening, gynecological examination, routine physical examination, x-rays and laboratory blood tests.**

Frequency limits for mammogram

Ages 35 through 39 .....	one baseline mammogram
Ages 40 and over.....	one every 12 months

**NOTE: Diagnostic Mammograms received at a facility are covered under your Outpatient Hospital Services. Routine Screening Mammograms received at a facility are covered at 100%**

Frequency limits for Screening Colonoscopies

Ages 50 and over.....	one every 5 to 10 years
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Reimbursement rate:

In Plan Services.....	100%
Out of Plan Services .....	60% after deductible

**Preventive Care - Routine Well Child Care Limits**

Reimbursement rate

In Plan Services.....	100%
Out of Plan Services .....	60% after deductible

**Prosthetics/Orthotics**

Reimbursement rate

In Plan Services.....	80% after deductible
Out of Plan Services .....	60% after deductible

**Skilled Nursing Facility**

Daily limit .....	the facility's semi-private room rate
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Reimbursement rate

In Plan Services.....	80% after deductible
Out of Plan Services .....	60% after deductible

**Speech Therapy**

Reimbursement rate

In Plan Services.....	100% after \$45 co-pay
Out of Plan Services .....	60% after deductible

**Spinal Manipulation/Chiropractic Services**

Reimbursement rate

In Plan Services.....100% after \$45 co-pay  
Out of Plan Services .....60% after deductible

**Substance Abuse Treatment Limits**

Inpatient reimbursement rate

In Plan Services.....80% after deductible  
Out of Plan Services .....60% after deductible

Outpatient reimbursement rate

In Plan Services (office visit) .....100% after \$25 co-pay  
In Plan Services (Outpatient Hospital/Facility) .....80% after deductible  
Out of Plan Services .....60% after deductible

## BENEFITS 1500 OPTION PPO

BENEFITS	IN-PLAN	OUT-OF-PLAN
<b>Annual Deductible</b>		
Individual	\$1,500	\$2,500
Family	\$3,000	\$5,000
<b>Annual Out of Pocket Maximum</b>	\$2,500	\$5,000
<b>Coinsurance</b>	80%	60%
<b>Physician Services</b>		
Office Visits - Family Practice	100% after \$25 copayment	60% after deductible
Office Visits - Specialist	100% after \$45 copayment	60% after deductible
Allergy Injections	100% after \$3 copayment	60% after deductible
Lab work/ office/reference lab	100%	60% after deductible
Other services performed in the Office	80% after deductible	60% after deductible
<b>Preventive Care</b>		
Routine physical exams—Adult	100%	60% after deductible
Pediatric wellness exams	100%	60% after deductible
Pediatric immunizations	100%	
<b>Emergency Room Services</b>	100% after \$200 copayment (waived if admitted)	60% after deductible
<b>Hospital Expenses</b> (inpatient and outpatient)	80% after deductible	60% after deductible
<b>Medical/Surgical Expenses</b> (except office visits)	80% after deductible	60% after deductible
<b>Durable Medical Equipment</b>	80% after deductible	60% after deductible
<b>Ambulance</b>	80% after deductible	60% after deductible
<b>Mental Health</b>		
Inpatient	80% after deductible	60% after deductible
Outpatient Facility	80% after deductible	60% after deductible
Outpatient Office Visit	100% after \$25 copayment	60% after deductible
<b>Substance Abuse</b>		
Inpatient	80% after deductible	60% after deductible
Outpatient Facility	80% after deductible	60% after deductible
Outpatient Office Visit	100% after \$25 copayment	60% after deductible
<b>Skilled Nursing Facility Care</b>	80% after deductible	60% after deductible
<b>Home Health Care</b> (100 visits per calendar year)	80% after deductible	60% after deductible
<b>Hospice</b>	80% after deductible	60% after deductible
<b>Private Duty Nursing</b>	80% after deductible	60% after deductible
<b>Early Intervention Service Maximum</b>	Up to age 3	

**Authorizations Required for PPO Plan for:** Inpatient Admission, Outpatient Surgery, and High Diagnostic Services

**MEDICAL BENEFITS 1500 OPTION**

**Physician office visit copayment**

In Plan Services Family Practice .....	\$25
In Plan Services Specialist .....	\$45
Out of Plan Services .....	60% after deductible

**Lab services in the office/reference lab are covered at 100%. All other services performed in the office are subject to the deductible and coinsurance.**

**Exceptions are prenatal services, allergy injections, mental health services, physical therapy and speech therapy.**

**Emergency room copayment**

In Plan Services .....	\$200
Out of Plan Services .....	60% after deductible

This copayment will be waived if the Covered Person is admitted directly from the emergency room to the Hospital because of a Medical Emergency.

**Deductibles, per Plan Year**

Per Covered Person, In Plan Services .....	\$1,500
Per Covered Person, Out of Plan Services .....	\$2,500
Per Family Unit, In Plan Services .....	\$3,000
Per Family Unit, Out of Plan Services .....	\$5,000

**Maximum out of pocket payments, per Plan Year**

Per Covered Person, In Plan Services .....	\$2,500
Per Covered Person, Out of Plan Services .....	\$5,000
Per Family Unit, In Plan Services .....	\$5,000
Per Family Unit, Out of Plan Services .....	\$10,000

The charges for the following do not apply to the 100% benefit limit and are never paid at 100%.

- (1) Copayments

***THE FOLLOWING IS A LIST OF THE INDIVIDUAL BENEFITS:***

**Ambulance Service**

Reimbursement rate	
In Plan Services .....	80% after deductible
Out of Plan Services .....	60% after deductible

**Durable Medical Equipment**

Reimbursement rate	
In Plan Services .....	80% after deductible
Out of Plan Services .....	60% after deductible

**Home Health Care**

Reimbursement rate	
In Plan Services .....	80% after deductible
Out of Plan Services .....	60% after deductible
Plan Year maximum	
Combined in and out of plan service .....	100 visits

**Hospice Care**

Reimbursement rate	
In Plan Services .....	80% after deductible
Out of Plan Services .....	60% after deductible

**Intensive Care Unit**

Daily limit .....	Hospital's ICU Charge
Reimbursement rate	
In Plan Services .....	80% after deductible
Out of Plan Services .....	60% after deductible

**Mental Disorders Treatment**

Inpatient reimbursement rate	
In Plan Services .....	80% after deductible
Out of Plan Services .....	60% after deductible
Outpatient reimbursement rate	
In Plan Services (office visit) .....	100% after \$25 co-pay
In Plan Services (Outpatient Hospital/Facility) .....	80% after deductible
Out of Plan Services .....	60% after deductible

**Nursery/Physician - Well Newborn Care Limits**

Reimbursement rate	
In Plan Services .....	80% after deductible
Out of Plan Services .....	60% after deductible

**Occupational Therapy**

Reimbursement rate	
In Plan Services .....	100% after \$45 co-pay
Out of Plan Services .....	60% after deductible

**Organ Transplant Coverage Limits**

Covered Transplant Procedures:

Organ and tissue transplants are covered except those, which are classified as "Experimental and/or Investigational."

In Plan Services .....	80% after deductible
Out of Plan Services .....	60% after deductible

Donor coverage maximum

In Plan/Out of Plan service .....	\$10,000 combined
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Plan covers a Plan Participant's charges as a donor whether or not the recipient is a Covered Person. Plan also covers donor charges when the recipient is a Covered Person whether or not the donor is a Covered Person.

**Outpatient Private Duty Nursing**

Reimbursement rate	
In Plan Services .....	80% after deductible
Out of Plan Services .....	60% after deductible

**Physical Therapy**

Reimbursement rate	
In Plan Services .....	100% after \$45 co-pay
Out of Plan Services .....	60% after deductible

**Physician Services**

Inpatient Reimbursement rate	
In Plan Services .....	80% after deductible
Out of Plan Services .....	60% after deductible

Office visit only family practice

Reimbursement rate	
In Plan Services .....	100% after \$25 co-pay
Out of Plan Services .....	60% after deductible

Surgical services family practice

Reimbursement rate

In Plan Services (physician's office) .....	80% after deductible
In Plan Services (Inpatient or Outpatient Hospital) .....	80% after deductible
Out of Plan Services .....	60% after deductible

**Pregnancy Benefits**

In Plan Service (office visits) .....	\$45 co-payment for first office visit then payable at 100%
In Plan Services (Hospital and other services).....	80% after deductible
Out of Plan Services .....	60% after deductible

No coverage for Pregnancy or any Complication of Pregnancy for dependent children.

**Preventive Care - Routine Well Adult Care Limits**

Reimbursement rate

In Plan Services .....	100%
Out of Plan Services .....	60% after deductible

**NOTE: Coverage includes reimbursement for the following routine services: office visits, pap smear, mammogram, prostate screening, gynecological examination, routine physical examination, x-rays and laboratory blood tests.**

Frequency limits for mammogram

Ages 35 through 39 .....	one baseline mammogram
Ages 40 and over.....	one every 12 months

**NOTE: Diagnostic mammograms received at a facility are covered under your Outpatient Hospital Services. Routine Screening mammograms received at a facility are covered at 100%**

Frequency limits for Screening Colonoscopies

Ages 50 and over.....	one every 5 to 10 years
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Reimbursement rate:

In Plan Services.....	100%
Out of Plan Services .....	60% after deductible

**Preventive Care - Routine Well Child Care Limits**

Reimbursement rate

In Plan Services.....	100%
Out of Plan Services .....	60% after deductible

**Prosthetics/Orthotics**

Reimbursement rate

In Plan Services.....	80% after deductible
Out of Plan Services .....	60% after deductible

**Skilled Nursing Facility**

Daily limit .....	the facility's semi-private room rate
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Reimbursement rate

In Plan Services.....	80% after deductible
Out of Plan Services .....	60% after deductible

**Speech Therapy**

Reimbursement rate

In Plan Services.....	100% after \$45 co-pay
Out of Plan Services .....	60% after deductible

**Spinal Manipulation/Chiropractic Services**

Reimbursement rate

In Plan Services.....100% after \$45 co-pay  
Out of Plan Services .....60% after deductible

**Substance Abuse Treatment Limits**

Inpatient reimbursement rate

In Plan Services.....80% after deductible  
Out of Plan Services .....60% after deductible

Outpatient reimbursement rate

In Plan Services (office visit) .....100% after \$25 co-pay  
In Plan Services (Outpatient Hospital/Facility) .....80% after deductible  
Out of Plan Services .....60% after deductible

**PIEDMONT COMMUNITY HEALTH PLAN  
PREVENTIVE HEALTH CARE SCHEDULE**

<b>Age of Covered Person</b>	<b>In Plan Covered Services</b>
0 to 12 months	6 checkups, including routine immunizations
13 to 24 months	3 checkups, including routine immunizations and tuberculin test
2 to 19 years	1 checkup/physical exam, including routine immunizations every year up to age 6; every 24 months ages 7 to 19. Annual pap smear for females beginning at age 13.*
20 to 39 years	1 physical exam every 36 months, including pap and physician breast exam for women (gyn care may be done annually if needed). Tetanus-diphtheria booster every 10 years; hepatitis B vaccine, pneumovax vaccine, chicken pox vaccine, influenza vaccine if needed. Fasting serum glucose and cholesterol checked every two to five years. Hematocrit and urinalysis to be checked with gyn exam. 1 baseline mammography screening between ages 35 to 39.
40 to 49 years	1 physical exam every 24 months, including pap and physician breast exam for women (gyn care may be done annually if needed). Digital prostate exam to be done with male exam. Tetanus-diphtheria booster every ten years, hepatitis B vaccine, pneumovax vaccine, chicken pox vaccine, influenza vaccine if needed. Fasting serum glucose and cholesterol checked every two to five years. Hematocrit and urinalysis to be checked with gyn exam. Screening mammography every two years.
50 years and older	1 physical exam every 12 months, including pap and physician breast exam for women, digital prostate exam for men. Tetanus-diphtheria booster every 10 years, hepatitis B vaccine, pneumovax vaccine, chicken pox vaccine, influenza vaccine if needed. Hematocrit and urinalysis to be checked with gyn exam. Fasting serum glucose and cholesterol every two to five years. Annual screening mammography for women. Annual occult blood test. Flexible sigmoidoscopy every three to five years. One baseline EKG. Annual PSA.

**\*Pap smears and mammograms may be covered at an earlier age or more frequently if recommended by a physician.**

**WOMEN'S PREVENTIVE CARE SERVICES  
REQUIRED HEALTH PLAN COVERAGE GUIDELINES**

<b>TYPE OF PREVENTIVE SERVICE</b>	<b>REQUIRED COVERAGE GUIDELINE</b>	<b>FREQUENCY</b>
<b>Well-Woman Visits</b>	Well-woman preventive care visit annually for adult women to obtain the recommended preventive services that are age and developmentally appropriate, including routine preconception and prenatal care covered at 100% as a preventive care service.	Annual, although HHS recognizes that several visits may be needed to obtain all necessary recommended preventive services, depending on a woman's health status, health needs, and other risk factors.
<b>Screening for Gestational Diabetes</b>	Screening for gestational diabetes covered at 100% as a preventive care service.	In pregnant women between 24 and 28 weeks of gestation and at the first prenatal visit for pregnant women identified to be at high risk for diabetes.
<b>Human Papillomavirus (HPV) Testing</b>	High-risk human papillomavirus DNA testing in women with normal cytology results covered at 100% as a preventive care service.	Screening should begin at 30 years of age and should occur no more frequently than every 3 years.
<b>Counseling for Sexually Transmitted Infections (STI)</b>	Counseling on sexually transmitted infections for all sexually active women covered at 100% as a preventive care service.	Annual.
<b>Counseling and Screening for Human Immune-Deficiency Virus (HIV)</b>	Counseling and screening for human immune-deficiency virus infection for all sexually active women covered at 100% as a preventive care service.	Annual.
<b>Contraceptive Methods and Counseling* (Females only)</b>	All Food and Drug Administration approved contraceptive methods, sterilization procedures, and patient education and counseling for all women with reproductive capacity covered at 100% as a preventive care service.**	As prescribed, guidelines subject to Piedmont's standard medical management, network, and formulary restrictions.
<b>Breastfeeding Support, Supplies, and Counseling</b>	Comprehensive lactation support and counseling, by a trained provider during pregnancy and/or in the postpartum period, and costs for renting breastfeeding equipment covered at 100% as a preventive care service.	In conjunction with each birth, subject to Piedmont's standard medical management and network restrictions.***
<b>Screening and Counseling for Interpersonal and Domestic Violence</b>	Screening and counseling for interpersonal and domestic violence covered at 100% as a preventive care service.	Annual.

## PRESCRIPTION DRUG BENEFIT

Script Care, Ltd. Script Care is a Pharmacy Benefit Manager and will begin administering the pharmacy benefits for your employer's health plan effective January 1, 2014. Your mail order pharmacy is Drug Source, Inc. Over 64,000 retail pharmacies nationwide participate in the Script Care network. To locate a participating pharmacy in your area, visit [www.scriptcare.com](http://www.scriptcare.com). Our Customer Service Department is available 24 hours a day, 7 days a week. Please call 1-888-810-9010 or e-mail questions to [customerservice@scriptcare.com](mailto:customerservice@scriptcare.com).

### COVERED MEDICATIONS

See below for some of the general categories that are covered under your prescription plan with Script Care:

Legend Drugs (Drugs That Require a Prescription To Obtain).

Anti-Diabetic Injectables.

Compound Prescriptions

Contraceptives – Injectable, Oral, Transdermal, Vaginal.

Diabetic Supplies.

Epipen.

Insulin and Insulin Syringes.

Prenatal Vitamins.

#### Items Covered With Prior Authorization

ADHD

Fentanyl Lozenge

Injectables, other than those listed.

Oxycodone

#### Items Covered with Quantity Limitations:

Amerge – 9 tablets per 30 day supply.

Axert – 12 tablets per 30 day supply.

Copegus – 168 tablets per 28 day supply.

Frova – 9 tablets per 30 day supply.

Imitrex Injectable – 4 Stat Doses/Systems or 4 vials per 30 day supply.

Imitrex Nasal Spray – 1 box per 30 day supply.

Imitrex Tablets – 18 tablets per 30 day supply.

Maxalt/MLT – 18 tablets per 30 day supply.

Migranal Nasal Spray – 1 box per 30 day supply.

Oral Erectile Dysfunction – 8 tablets per 30 day supply.

Relpax – 6 tablets per 30 day supply.

Stadol Nasal Spray – 2 bottles per 30 day supply.

Zomig Nasal Spray – 1 box per 30 day supply.

Zomig/ZMT – 6 tablets per 30 day supply.

### EXCLUDED MEDICATIONS

Not all prescription medications are covered under your pharmacy benefits. Listed below are some of the general categories of medications that are not covered under your prescription plan with Script Care:

All Other Erectile Dysfunction Drugs.

Biological Serums (Immunological Vaccines).

Contraceptives – Devices, Implants.

Cosmetic Agents.

Diagnostic Agents (Test Kits).

Diet Control Drugs (Anorexics).

Dietary Products.

Fertility Drugs.

Growth Hormones.

Hair Growth Stimulants.

Medical Devices/Supplies.

Non-Insulin Syringes.

Over-The-Counter (OTC) Drugs.

RU486 (Mifepristone).

Smoking Cessation Drugs.

Vitamins other than those listed.

Non-drug items, such as stockings or devices, even if a prescription is required.

Experimental drugs or drugs required to be labeled: "Caution -- Limited by federal law to investigation use."

Refills obtained more than one year after the original prescription date or prior to 75% of the completion of the projected usage.

### RX COPAYS

When your physician issues an Rx, simply present the Rx along with your Script Care identification card to a participating pharmacy, or you may use the mail order pharmacy to fill a 90 day supply of maintenance medications. Refer to the SCL Specialty Pharmacy and SCL Diabetic Program for special instructions. You will pay a copayment based on the following classifications of medications:

	<b>Retail</b>	<b>Mail Order</b>	<b>SCL Specialty</b>	<b>SCL Diabetic (Medications/Supplies)</b>
Brand:	40%, between \$20 & \$100	40%, between \$60 & \$300	40%, between \$20 & \$100	40%, between \$60 & \$300
Generic:	40%, between \$20 & \$50	40%, between \$60 & \$125	40%, between \$20 & \$50	40%, between \$60 & \$125

**PRIOR AUTHORIZATION REQUIRED FOR PRESCRIPTIONS EXCEEDING \$2,000**

**MANDATORY PROGRAMS**

**Mandatory Generic:** If members fill a brand name drug when a generic is available, member will pay the brand copay plus the difference between the cost of the brand and generic.

**Mandatory Mail Order:** Maintenance medications MUST be filled through mail order after four (4) retail fills.

**Specialty Program:** Specialty Drugs MUST be filled through the SCL Specialty Pharmacy after one (1) retail fill.

**Diabetic Program:** Diabetic Medications/Supplies (excluding insulin), MUST be filled through the SCL Diabetic Program after one (1) retail fill.

**DISPENSING LIMITS**

Your physician's orders may limit the amount of medication that can be dispensed at one time. See below for the maximum day supply that your prescription benefit plan allows:

Retail & SCL Specialty Pharmacies: 30 day supply

Mail Order Pharmacy & SCL Diabetic Program: 90 day supply

## MEDICAL MANAGEMENT SERVICES

### Medical Management Services Phone Number

Piedmont Community Health Plan  
1-800-400-7247

The patient or family member must call this number to receive certification of certain Services. This call must be made at least 72 hours in advance of services being rendered.

### UTILIZATION REVIEW

Utilization review is a program designed to help ensure that all Covered Persons receive necessary and appropriate health care while avoiding unnecessary expenses.

The program consists of:

(a) Precertification of the Medical Necessity for the following non-emergency services before Medical and/or Surgical services are provided:

- **Hospitalizations**
- **MRI/PET Scan**
- **Substance Abuse/Mental Disorder treatments**
- **Skilled Nursing Facility stays**
- **Home Health Care**
- **Hospice Care**
- **Durable Medical Equipment**
- **Physical, speech and occupational therapy**
- **Cardiac rehabilitation therapy**
- **Outpatient surgical procedures**
- **Selected out of network services**

The attending Physician does not have to obtain pre-certification from the Plan for prescribing a Hospital length of stay in connection with childbirth for the mother or her newborn child that is 48 hours or less following a vaginal delivery or 96 hours or less following a cesarean delivery.

Obstetric hospitalizations that exceed the 48 or 96 hour time periods and any services that are not associated with the delivery must be pre-certified as set forth in this document.

**NOTE: When the delivery occurs outside a Hospital, the Hospital length of stay begins at the time the mother or newborn is admitted as a Hospital inpatient in connection with childbirth. The attending Physician will determine whether the admission is in connection with childbirth.**

(b) Retrospective review of the Medical Necessity of the listed services provided on an emergency basis;

(c) Concurrent review, based on the admitting diagnosis, of the listed services requested by the attending Physician; and

(d) Certification of services and planning for discharge from a Medical Care Facility or cessation of medical treatment.

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.

If a particular course of treatment or medical service is not certified, it means that the Plan will not consider that course of treatment as appropriate for the maximum reimbursement under the Plan.

In order to maximize Plan reimbursements, please read the following provisions carefully.

### **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 utilization review 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 utilization review program is set in motion by a telephone call from the Covered Person. Contact the utilization review administrator at Piedmont Community Health Plan 888-674-3368 at least 72 hours before services are scheduled to be rendered with the following information:

- **The name of the patient and relationship to the covered Employee**
- **The name, Social Security 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**
- **The proposed rendering of listed medical services**

If there is an **emergency** admission to the Medical Care Facility, the patient, patient's family member, Medical Care Facility or attending Physician must contact Piedmont Community Health Plan **within 48 hours** of the first business day after the admission.

The utilization review 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, the benefit payment will be reduced.

**Concurrent review, discharge planning.** Concurrent review of a course of treatment and discharge planning from a Medical Care Facility are parts of the utilization review program. The utilization review 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.

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

#### **PREADMISSION TESTING SERVICE**

The Medical Benefits will be covered for diagnostic lab tests and x-ray exams when:

- (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.

## PRECERTIFICATION FOR HOSPITAL ADMISSIONS

### PURPOSE

Precertification reviews the necessity and length of your recommended medical hospital stay and identifies and informs you of alternatives to inpatient hospitalization when appropriate.

- In an emergency, you, a family member or your doctor must call your primary physician or PCHP (1-800-400-7247) within 48 hours.
- To precertify a non-emergency admission, call your primary care physician before admission.
- Failure to precertify will reduce covered hospital charges.

### 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 alternate benefit 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.**

## **WELLNESS PROGRAM – ALL EMPLOYEES**

The Wellness Program is structured exclusively for the employees and their eligible dependents.

The program consists of an on-site health risk assessment that includes a questionnaire that is completed by each individual participant and the following tests:

- Complete Blood Count
- Full chemistry screening (includes kidney and liver screening, electrolytes, and blood sugar levels)
- Blood Pressure check
- Biometrics (body mass index, height, weight, circumference)

Physical examinations or other routine/diagnostic testing may be performed as recommended by your physician.

For all other covered preventive care services, such as mammography and colonoscopy, please refer to the Schedule of Benefits section.

The Wellness Program is voluntary and strictly confidential between you and the vendor conducting the health risk assessment.

## 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

**Deductible Amount.** This is an amount of covered charges for which no benefits will be paid. Before benefits can be paid in a Plan Year a Covered Person must meet the deductible shown in the Schedule of Benefits. Services which are subject to a copayment rather than a coinsurance will not be subject to the deductible.

**Family Unit Limit.** When the maximum amount shown in the Schedule of Benefits has been incurred by members of a Family Unit toward their Plan Year deductibles, the deductibles of all members of that Family Unit will be considered satisfied for that year.

**Deductible For a Common Accident.** This provision applies when two or more Covered Persons in a family Unit are injured in the same accident.

These persons need not meet separate deductibles for treatment of injuries incurred in this accident; instead, only one deductible for the Plan Year in which the accident occurred will be required for them as a unit.

### BENEFIT PAYMENT

Each Plan Year, benefits will be paid for the covered charges of a Covered Person that are in excess of the deductible. Payment will be made at the rate shown under Percentage Payable in the Schedule of Benefits. No benefits will be paid in excess of any listed limit of the Plan.

### OUT OF POCKET LIMIT

Covered Charges are payable at the percentages shown each Plan 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 Plan 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 rest of the Plan Year.

### COVERED CHARGES

Covered charges are the Usual and Reasonable Charges that are incurred for the following items of service and supply. These charges are subject to the benefit limits, exclusions and other provisions of this Plan. A charge is incurred on the date that the service or supply is performed or furnished.

- (1) **Hospital Care.** The medical services and supplies furnished by a Hospital or Ambulatory Surgical Center or a Birthing 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.

Room charges made by a Hospital having only private rooms will be paid at 80% of the average private room rate.

- (2) **Skilled Nursing Facility Care.** The room and board and nursing care furnished by a Skilled Nursing Facility will be payable if and when:
  - (a) the patient is confined as a bed patient in the facility;
  - (b) the confinement starts immediately following a Hospital confinement or a period of Home Health Care Utilization;

- (c) the attending Physician certifies that the confinement is needed for further care of the condition that caused the Hospital confinement; and
- (d) 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;
- (e) the Claims Administrator authorizes the services provided.

**(3) Physician Care.** The professional services of a Physician for surgical or medical services.

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 Usual and Reasonable Charge that is allowed for the primary procedures; 50% of the Usual and Reasonable Charge will be allowed for each additional procedure performed during the same operative session; and 50% of the Usual and reasonable Charge will be allowed for each additional procedure performed during the same operative session. 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 Usual and Reasonable 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 Usual and Reasonable percentage allowed for that procedure; and
- (c) If an assistant surgeon is required, the assistant surgeon's covered charge will not exceed 20% of the surgeon's Usual and Reasonable allowance

**(4) Private Duty Nursing Care.** The private duty nursing care by a licensed nurse (R.N., L.P.N. or L.V.N.). Covered charges for this service will be included to this extent:

- (a) **Inpatient Nursing Care.** Charges are covered only when care is Medically Necessary or not Custodial in nature and the Hospital's Intensive Care Unit is filled or the Hospital has no Intensive Care Unit.
- (b) **Outpatient Nursing Care.** Charges are covered only when care is Medically Necessary and not Custodial in nature. The only charges covered for Outpatient nursing care are those shown below, under Home Health Care Services and Supplies. Outpatient private duty nursing care on a shift basis is not covered.

**(5) 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, be contained in a Home Health Care Plan, and be authorized by the Claims Administrator.

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.

**(6) 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 as approved by the Claims Administrator.

- (7) **Other Medical Services and Supplies.** These services and supplies not otherwise included in the items above are covered as follows:
- (a) 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 unless the Plan Administrator finds a longer trip was Medically Necessary.
  - (b) **Anesthetic**; oxygen; blood and blood derivatives that are not donated or replaced; intravenous injections and solutions. Administration of these items is included.
  - (c) **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.
  - (d) Radiation or **chemotherapy** and treatment with radioactive substances. The materials and services of technicians are included.
  - (e) Initial **contact lenses** or glasses required following cataract surgery.
  - (f) Medically Necessary services for care and treatment of **jaw joint conditions, including Temporomandibular Joint syndrome.**
  - (g) **Laboratory studies.**
  - (h) **Early Intervention Services** – benefits for Medically Necessary speech and language therapy, occupational therapy, physical therapy and assistive technology services and devices for dependents from birth to age three who are certified by the Department of Mental health, Mental retardation and Substance Abuse Services as eligible for services under Part H of the Individuals with Disabilities Education Act.
  - (i) **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.
  - (j) The initial purchase, fitting, repair and replacement 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 that occurred while covered under the Plan.
  - (k) **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.
  - (l) **Prescription Drugs** (as defined).
  - (m) The initial purchase, fitting, repair and replacement of fitted **prosthetic devices** which replace body parts provided that the loss occurred while covered under the Plan.
  - (n) **Speech therapy** by a licensed speech therapist.  
Therapy must be ordered by a Physician and follow either: (i) surgery for correction of congenital condition of the oral cavity, throat or nasal complex (other than a frenectomy) of a person; (ii) an injury; or (iii) a sickness that is other than a learning disorder.
  - (o) **Spinal Manipulation/Chiropractic services** by a licensed M.D., D.O. or D.C.
  - (p) **Sterilization** procedures.

- (q) **Surgical dressings**, splints, casts and other devices used in the reduction of fractures and dislocations.
- (r) **Diagnostic x-rays.**
- (s) **Cochlear Implant**, Coverage for cochlear implant will include the following services: Surgery, the implant device/system, medical and surgical follow up visits, and rehabilitative/programming services. Charged amounts greater than the lifetime maximum are not covered services and are the responsibility of the member.

All cochlear implant evaluation requests will be reviewed for medical necessity in accordance with established cochlear implantation guidelines as established by the claims administrator.

- (t) **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, in a manner determined in consultation with the attending Physician and the patient.

## **INJURY TO OR CARE OF 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:

- (1) Excision of tumors and cysts of the jaws, cheeks, lips, tongue, roof and floor of the mouth.
- (2) Emergency repair due to Injury to sound natural teeth. This repair must be made within 12 months from the date of an accident and the accident must have occurred while the person was covered under the Plan.
- (3) Surgery needed to correct accidental injuries to the jaws, cheeks, lips, tongue, floor and roof of the mouth when the Injuries occurred while covered under the Plan.
- (4) Excision of benign bony growths of the jaw and hard palate.
- (5) External incision and drainage of cellulites.
- (6) Incision of sensory sinuses, salivary glands or ducts.
- (7) Reduction of dislocations and excision of temporomandibular joints (TMJs)

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

\* Impacted wisdom teeth are not covered under your medical plan, please refer to your Dental plan.

## **TREATMENT OF MENTAL DISORDERS AND SUBSTANCE ABUSE**

Covered charges for care, supplies and treatment of Mental Disorders and Substance Abuse.

## ORGAN TRANSPLANT COVERAGE 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:

- (1) The transplant must be performed to replace an organ or tissue of the Covered Person.
- (2) Charges for obtaining donor organs are covered charges under the Plan when the recipient is a Covered Person. When the donor has medical coverage, his or her plan will pay first. The benefits under this Plan will be reduced by those payable under the donor's plan. Donor charges include those for:
  - (a) evaluating the organ;
  - (b) removing the organ from the donor; and
  - (c) transportation of the organ from within the United States and Canada to the place where the transplant is to take place.

Benefit payments for donor charges are included under the Organ Transplant maximum benefit limit shown in the Schedule of Benefits.

Benefit payments for donor charges are subject to the separate donor maximum benefit limit as shown in the Schedule of Benefits.

## ROUTINE PREVENTIVE CARE

Covered charges under Medical Benefits are payable for routine Preventive Care as described in the Schedule of Benefits.

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

**Charges for Routine Well Child Care.** Routine well child care includes routine pediatric care and immunizations by a Physician that is not for an Injury or Sickness.

In addition to appropriate immunization, these services of the Physician are included for each visit: (1) physical exam; (2) lab tests; (3) patient history; (4) development assessment; (5) anticipatory guidance.

## COVERAGE OF 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.

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

Coverage for a Hospital stay following a normal vaginal delivery may not be limited to less than 48 hours for both the mother (if a Covered Person) and the newborn child. Coverage for a Hospital stay in connection with childbirth following a Cesarean section may not be limited to less than 72 hours for both the mother (if a Covered Person) and the newborn child.

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

**Charges for Routine Physician Care.** The benefit is limited to the Usual and Reasonable Charges made by a Physician for the first pediatric visit to the newborn child after birth while hospital confined.

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

**COVERAGE OF PREGNANCY**

The Usual and Reasonable Charges for the care and treatment of Pregnancy are covered the same as any other Sickness for a covered Employee or covered Spouse.

There is no coverage of Pregnancy for a Dependent child.

## DEFINED TERMS

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

**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.

**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 1st through December 31st of the same year.

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

**Cochlear Implants** means an artificial hearing device designed to produce useful hearing sensations by electronically stimulating nerves inside the inner ear.

**Cosmetic Surgery** means medically unnecessary surgical procedures, usually, but not limited to, plastic surgery directed toward preserving beauty or correcting scars, burns or disfigurements.

**Covered Person** is an Employee, Retiree or Dependent who is covered under this Plan.

**Creditable Coverage** includes most health coverage, such as coverage under a group health plan (including COBRA continuation coverage), HMO membership, an individual health insurance policy, Medicaid, Medicare, a State health benefits risk pool, a public health plan (including plans established or maintained by a foreign country), or the State Children's Health Insurance Program.

Creditable Coverage does not include coverage consisting solely of dental or vision benefits. Creditable Coverage does not include coverage that was in place before a significant break of coverage of more than 63 days.

**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.

**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.

**Early Intervention Services** – means services for Medically Necessary speech and language therapy, occupational therapy, physical therapy and assistive technology services and devices for dependents from birth to age three who are certified by the Department of Mental health, Mental retardation and Substance Abuse Services as eligible for services under Part H of the Individuals with Disabilities Education Act.

**Employee** means a person who is an Employee of the Employer, regularly scheduled to work for the Employer in an Employee/Employer relationship. The following persons are not eligible for coverage under this Plan: (i) leased employees as defined in Internal Revenue Code section 414(n); (ii) individuals classified by the Employer as

temporary employees or seasonal employees; (iii) individuals classified by the Employer as independent contractors or leased employees (including those who are at any time reclassified as employees by the Internal Revenue Service or a court of competent jurisdiction).

**Employer** is Lynchburg City Schools.

**Enrollment Date** is the first day of coverage or, if there is a Waiting Period, the first day of the Waiting Period.

**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 Claims Administrator must make an independent evaluation of the experimental/non-experimental standings of specific technologies. The Claims 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 Claims 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 ongoing phase I or phase II clinical trials, is the research, experimental, study or Investigational arm of ongoing 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.

Reliable Evidence shall mean only published reports and articles in the authoritative medical and scientific literature; the written protocol or protocols used by the treating facility or the protocol(s) of another facility studying substantially the same drug, device, medical treatment or procedure; or the written informed consent used by the treating facility or by another facility studying substantially the same drug, device, medical treatment or procedure.

**Family Unit** is the covered Employee or Retiree and the family members who are covered as Dependents under the Plan.

**Foster Child** means an unmarried child under the limiting age shown in the Dependent Eligibility Section of this Plan for whom a covered Employee has assumed a legal obligation. All of the following conditions must be met: the child is being raised as the covered Employee's; the child depends on the covered Employee for primary support; the child lives in the home of the covered Employee; and the covered Employee may legally claim the child as a federal income tax deduction.

A covered Foster Child is not a child temporarily living in the covered Employee's home; one placed in the covered Employee's home by a social service agency which retains control of the child; or whose natural parent(s) may exercise or share parental responsibility and control.

**Genetic Information** means information about genes, gene products and inherited characteristics that may derive from an individual or a family member. This includes information regarding carrier status and information derived from laboratory tests that identify mutations in specific genes or chromosomes, physical medical examinations, family histories and direct analysis of genes or chromosomes.

**Health Factor** means, in relation to an individual, any of the following health status-related factors: (i) health status; (ii) Medical Condition; (iii) claims experience; (iv) receipt of health care; (v) medical history; (vi) Genetic Information; (vii) evidence of insurability (including conditions arising out of domestic violence); or (viii) disability.

**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 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 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; 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.
- A facility operating primarily for the treatment of Substance Abuse 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 Abuse.

**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 a Plan Participant 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 Condition** means any condition, whether physical or mental, including, but not limited to, any condition resulting from Illness, Injury (whether or not the Injury is accidental), Pregnancy, or congenital malformation. However, Genetic Information is not a Medical Condition.

**Medical Emergency** means a medical condition manifesting itself by acute symptoms of sufficient severity that a prudent layperson possessing an average knowledge of health and medicine could reasonably expect the absence of immediate medical attention to result in (1) placing the health of the individual (or unborn child) in serious jeopardy; (2) serious impairment to bodily functions; (3) serious dysfunction of any bodily organ or part. It also means a situation in which a Covered Person appears to have a mental or emotional disorder for which immediate observation, care, and treatment is necessary to avoid serious harm to the Covered Person or others.

**Medically Necessary** care and treatment is 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 Plan Administrator has the discretionary authority to decide whether care or treatment is Medically Necessary.

**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.

**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.

**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 Lynchburg City Schools Employee Health Care Benefit Plan, which is a benefits plan for certain employees of Lynchburg City Schools and is described in this document.

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

**Plan Year** is the 12 month period beginning on either the effective date of the Plan or on the day following the end of the first Plan Year which is a short Plan Year.

**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.

**Primary Care Physician** is a Network Provider with a specialty of internal medicine, pediatrics, or family medicine/general practice who provides initial and primary care services to Covered Persons, maintains the continuity of Covered Person's medical care, and helps direct Covered Persons to Specialists and other health care providers.

**Retired Employee** is a former Employee of the Employer who was retired while employed by the Employer under the formal written plan of the Employer and elects to contribute to the Plan the contribution required from the Retired Employee.

**Qualifying Event** is an occurrence that changes your health insurance needs. The purpose of a qualifying event clause is to allow you to adjust your health coverage. Qualifying Change in Status events include, but are not limited to:

- Events that change an Employee's legal marital status, including marriage, death of spouse, divorce, legal separation or annulment.
- Events that change an Employee's number of Dependents, including birth, death, adoption or placement for adoption.
- Events that change the employment status of the Employee, the Employee's Spouse, or the Employee's Dependent. Events include termination or commencement of employment, strike or lockout, commencement of or return from an unpaid leave of absence, change in worksite or change in the individual's employment when they cease to be eligible for the Program.
- Events that cause an Employee's Dependent to satisfy or cease to satisfy eligibility requirements for coverage based on age, student status, marital status or any similar circumstance.
- A change of residence for the Employee, Spouse or Dependent.

**Sickness** is:

For all persons but a covered Dependent daughter: Illness, disease or Pregnancy.

For a covered Dependent daughter: Illness or disease, not including Pregnancy or its 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 utilization review plan.
- (6) It is not, other than incidentally, a place for rest, the aged, drug addicts, alcoholics, mental retardation, Custodial or educational care or care of Mental Disorders.
- (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.

**Specialist** is a health care practitioner who has received training in a specific medical field other than the specialties listed as primary care.

**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 Abuse** is the condition caused by regular excessive compulsive drinking of alcohol and/or physical habitual dependence on drugs that results in a chronic disorder affecting physical health and /or personal or social functioning. This does not include dependence on tobacco and ordinary caffeine containing drinks.

**Temporomandibular Joint (TMJ) syndrome** is the treatment of jaw joint disorders including conditions of structures linking the jaw bone and skull and the complex of muscles, nerves and other tissues related to the temporomandibular joint. Care and treatment shall include, but are not limited to orthodontics, crowns, inlays, physical therapy and any appliance that is attached to or rests on the teeth.

**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.

The Plan will reimburse the actual charge billed if it is lesser than the Usual and Reasonable Charge.

The Claims Administrator has the discretionary authority to decide whether a charge is Usual and Reasonable.

## PLAN EXCLUSIONS

**NOTE: All exclusions related to Prescription Drugs are shown in the Prescription Drug Plan.**

**For all Medical Benefits shown in the Schedule of Benefits, a charge for the following is not covered:**

- (1) **Abortion.** Services, supplies, care or treatment in connection with an abortion unless the life of the mother is endangered.
- (2) **Acupuncture.** Services for acupuncture.
- (3) **Alcohol.** Services, supplies, care or treatment to a Covered Person for an Injury or Sickness which occurred as a result of that Covered Person's illegal use of alcohol. Expenses will be covered for Injured Covered Persons other than the person illegally using alcohol. This exclusion does not apply if the Injury resulted from an act of domestic violence or a Medical Condition.
- (4) **Complications of non-covered treatments.** Care, services or treatment required as a result of complications from a treatment not covered under the Plan. Complications from a non-covered abortion are covered.
- (5) **Cosmetic services.** Care and treatment provided for cosmetic reasons.  
  
Abdominoplasty, penniculectomy, abdominal sculpture, tummy tucks, abdominodermatolipectomy, and liposuction are not cover. Breast reductions unless related to surgical interventions following a mastectomy are not covered.  
  
Reconstructive mammoplasty will be covered after Medically Necessary surgery, providing the reconstruction is performed within five years of the mastectomy.
- (6) **Custodial care.** Services or supplies provided mainly as a rest cure, maintenance or Custodial Care.
- (7) **Educational or vocational testing.** Services for educational or vocational testing or training.
- (8) **Excess charges.** The part of an expense for care and treatment of an Injury or Sickness that is in excess of the Usual and Reasonable Charge.
- (9) **Exercise programs.** Exercise programs for treatment of any condition, except for Physician supervised cardiac rehabilitation, occupational or physical therapy covered by this Plan.
- (10) **Experimental or not Medically Necessary.** Care and treatment that is either Experimental/Investigational or not Medically Necessary.
- (11) **Eye care.** Radial keratotomy or other eye surgery to correct near sightedness. Also, lenses for the eyes and exams for their fitting. This exclusion does not apply to aphakic patients and soft lenses or sclera shells intended for use as corneal bandages.
- (12) **Foot care.** Treatment of weak, strained, flat, unstable or unbalanced feet, metatarsalgia or bunions (except open cutting operations), and treatment of corns, calluses or toenails (unless needed in treatment of a metabolic or peripheral vascular disease).
- (13) **Hair loss.** Care and treatment for hair loss including wigs, hair transplants or any drug that promises hair growth, whether or not prescribed by a Physician
- (14) **Hazardous Hobby.** Care and treatment of an Injury or Sickness that results from engaging in a Hazardous Hobby. A hobby is hazardous if it is an unusual activity which is characterized by a constant threat of danger or risk of bodily harm. Examples of hazardous hobbies are skydiving, auto racing, hang

gliding, or bungee jumping. This exclusion does not apply if the Injury resulted from an act of domestic violence or a Medical Condition.

- (15) **Hearing aids and exams.** Charges for services or supplies in connection with hearing aids or exams for their fitting.
- (16) **Hospital employees.** Professional services billed by a Physician or nurse who is an employee of a Hospital or Skilled Nursing Facility and paid by the Hospital or facility for the service.
- (17) **Illegal acts.** Charges for services received as a result of Injury or Sickness caused by or contributed to by engaging in an illegal act or occupation; by committing or attempting to commit any crime, criminal act, assault or other felonious behavior; or by participating in a riot or public disturbance. This exclusion does not apply if the Injury resulted from an act of domestic violence or a Medical Condition.
- (18) **Illegal drugs or medications.** Services, supplies, care or treatment to a Covered Person for Injury or Sickness resulting from that Covered Person's voluntary taking of or being under the influence of any controlled substance, drug, hallucinogen or narcotic not administered on the advice of a Physician. Expenses will be covered for Injured Covered Persons other than the person using controlled substances. This exclusion does not apply if the Injury resulted from an act of domestic violence or a Medical Condition.
- (19) **Infertility.** Care and treatment for infertility, artificial insemination or in vitro fertilization.
- (20) **No charge.** Care and treatment for which there would not have been a charge if no coverage had been in force.
- (21) **Non-emergency Hospital admissions.** Care and treatment billed by a Hospital for non-Medical Emergency admissions on a Friday or a Saturday, unless approved by the Claims Administrator as Medically Necessary. This does not apply if surgery is performed within 24 hours of admission.
- (22) **No obligation to pay.** Charges incurred for which the Plan has no legal obligation to pay.
- (23) **No Physician recommendation.** Care, treatment, services or supplies not recommended and approved by a Physician; or treatment, services or supplies when the Covered Person is not under the regular care of a Physician. Regular care means ongoing medical supervision or treatment which is appropriate care for the Injury or Sickness.
- (24) **Not specified as covered.** Services, treatments and supplies which are not specified as covered under this Plan.
- (25) **Obesity.** Care and treatment of obesity, weight loss or dietary control whether or not it is, in any case, a part of the treatment plan for another Sickness. Services for weight loss or weight control and related services, including but not limited to gastric bypass surgery or services for complications resulting from gastric bypass surgery.
- (26) **Occupational.** Care and treatment of an Injury or Sickness that is occupational that is, arises from work for wage or profit including self-employment.
- (27) **Personal comfort items.** Personal comfort items or other equipment, such as, but not limited to, air conditioners, air purification units, humidifiers, electric heating units, orthopedic mattresses, blood pressure instruments, scales, elastic bandages or stockings, nonprescription drugs and medicines, and first aid supplies and non-hospital adjustable beds.
- (28) **Plan design excludes.** Charges excluded by the Plan design as mentioned in this document.
- (29) **Pregnancy of daughter.** Care and treatment of Pregnancy and Complications of Pregnancy for a dependent daughter only.

- (30) **Relative giving services.** Professional services performed by a person who ordinarily resides in the Covered Person's home or is related to the Covered Person as a Spouse, parent, child, brother or sister, whether the relationship is by blood or exists in law.
- (31) **Replacement braces.** Replacement of braces of the leg, arm, back, neck, or artificial arms or legs, unless there is sufficient change in the Covered Person's physical condition to make the original device no longer functional.
- (32) **Routine care.** Charges for routine or periodic examinations, screening examinations, evaluation procedures, preventive medical care, or treatment or services not directly related to the diagnosis or treatment of a specific Injury, Sickness or pregnancy related condition which is known or reasonably suspected, unless such care is specifically covered in the Schedule of Benefits.
- (33) **Self Inflicted.** Any loss due to an intentionally self-inflicted Injury, while sane or insane. This exclusion does not apply if the Injury resulted from an act of domestic violence or a Medical Condition.
- (34) **Services before or after coverage.** Care, treatment or supplies for which a charge was incurred before a person was covered under this Plan or after coverage ceased under this Plan.
- (35) **Sex changes.** Care, services or treatment for non-congenital transsexualism, gender dysphoria or sexual reassignment or change. This exclusion includes medications, implants, hormone therapy, surgery, medical or psychiatric treatment.
- (36) **Sleep disorders.** Care and treatment for sleep disorders unless deemed Medically Necessary.
- (37) **Smoking cessation.** Care and treatment for smoking cessation programs, including smoking deterrent patches, unless Medically Necessary due to a severe active lung Illness such as emphysema or asthma.
- (38) **Surgical sterilization reversal.** Care and treatment for reversal of surgical sterilization.
- (39) **Travel or accommodations.** Charges for travel or accommodations, whether or not recommended by a Physician, except for ambulance charges as defined as a covered expense.
- (40) **War.** Any loss that is due to a declared or undeclared act of war.
- (41) Services, treatment, or training related to learning disabilities or developmental delays.
- (42) Primal therapy, psychodrama, megavitamin therapy, bioenergetics therapy.
- (43) Counseling for sexual dysfunction and sexual deviation.
- (44) Services in connection with career, social adjustment, pastoral or financial counseling.
- (45) Charges for custodial care.
- (46) Charges incurred at a residential care facility or halfway house.
- (47) Charges for telephone consultations, missed appointments, or completion of claim forms.
- (48) Family/marital counseling or for hospitalization for environmental change.
- (49) Charges for inpatient treatment of eating disorders unless documented to be Medically Necessary.
- (50) Charges for outpatient treatment of eating disorders, unless a treatment plan has been submitted to and approved by the Claims Administrator prior to initiation of treatment.
- (51) Charges for court-ordered services unless approved as Medically Necessary by the Claims Administrator.

- (52) Charges that exceed benefit maximums.
- (53) Treatment for mental disorders, including mental retardation, conduct disorders, and learning disabilities, unless determined to be Medically Necessary by the Claims Administrator.
- (54) Activities therapy.
- (55) Recreational therapy, i.e. play, sleep, dance, art, crafts.
- (56) Behavioral problems (except for hyperkinetic syndrome of childhood or adulthood ADD).
- (57) Treatment for certain personality disorders, including anti-social personality and inadequate personality.
- (58) More than 1 and ½ hours psychotherapy in a 24 hour time period.
- (59) Group therapy with one therapist with greater than 8 patients.
- (60) Group delinquent reaction of childhood.
- (61) Hypnotherapy, biofeedback.
- (62) Physical Therapy/Chiropractic services. Any physical therapy or chiropractic services that are not considered treatment following an acute condition, which do not restore bodily function or prevent disability following Injury or Sickness, or which are provided as maintenance services for a chronic condition.

## HOW TO SUBMIT A CLAIM

Piedmont Providers will usually submit claims for a Covered Person. When a Covered Person has a claim to submit for payment that person must:

(1) For Plan reimbursements, attach bills for services rendered. ALL BILLS MUST SHOW:

- **Name of Plan**
- **Employee's name**
- **Name of patient**
- **Name, address, telephone number of the provider of care**
- **Diagnosis**
- **Type of services rendered, with diagnosis and/or procedure codes**
- **Date of services**
- **Charges**

(2) Send the above to the Claims Administrator at this address:

**Piedmont Community Health Plan**  
**P.O. Box 14408**  
**Cincinnati, Ohio 45250**  
**(800) 400-7247**

## WHEN CLAIMS SHOULD BE FILED

Claims should be filed with the Claims Administrator within 365 days of the date charges for the service were incurred. Benefits are based on the Plan's provisions at the time the charges were incurred. Claims filed later than that date may be declined or reduced.

The Claims Administrator will determine if enough information has been submitted to enable proper consideration of the claim. If not, more information may be requested from the claimant. The Plan reserves the right to have a Plan Participant seek a second medical opinion.

## CLAIMS PROCEDURE

Following is a description of how the Plan processes Claims for benefits. A Claim is defined as any request for a Plan benefit, made by a claimant or by a representative of a claimant that complies with the Plan's reasonable procedure for making benefit Claims. The times listed are maximum times only. A period of time begins at the time the Claim is filed. Decisions will be made within a reasonable period of time appropriate to the circumstances. "Days" means calendar days.

There are different kinds of Claims and each one has a specific timetable for either approval, payment, request for further information, or denial of the Claim. If you have any questions regarding this procedure, please contact the Plan Administrator.

The definitions of the types of Claims are:

### **Urgent Care Claim**

A Claim involving Urgent Care is any Claim for medical care or treatment where using the timetable for a non-urgent care determination could seriously jeopardize the life or health of the claimant; or the ability of the claimant to regain maximum function; or in the opinion of the attending or consulting Physician, would subject the claimant to severe pain that could not be adequately managed without the care or treatment that is the subject of the Claim.

A Physician with knowledge of the claimant's medical condition may determine if a Claim is one involving Urgent Care. If there is no such Physician, an individual acting on behalf of the Plan applying the judgment of a prudent layperson who possesses an average knowledge of health and medicine may make the determination.

In the case of a Claim involving Urgent Care, the following timetable applies:

Notification to claimant of benefit determination	<b>72 hours</b>
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Insufficient information on the Claim, or failure to follow the Plan's procedure for filing a Claim:

Notification to claimant, orally or in writing	<b>24 hours</b>
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Response by claimant, orally or in writing	<b>48 hours</b>
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Benefit determination, orally or in writing	48 hours after the earlier of the receipt of information or the end of the claimant's response period.
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Ongoing courses of treatment, notification of:

Reduction or termination before the end of treatment	<b>72 hours</b>
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Determination as to extending course of treatment	<b>24 hours</b>
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Review of adverse benefit determination	<b>72 hours</b>
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If there is an adverse benefit determination on a Claim involving Urgent Care, a request for an expedited appeal may be submitted orally or in writing by the claimant. All necessary information, including the Plan's benefit determination on review, may be transmitted between the Plan and the claimant by telephone, facsimile, or other similarly expeditious method.

### **Pre-Service Claim**

A Pre-Service Claim means any Claim for a benefit under this Plan where the Plan conditions receipt of the benefit, in whole or in part, on approval in advance of obtaining medical care. These are, for example, Claims subject to pre-certification. Please see the Medical Management section of this booklet for further information about Pre-Service Claims.

In the case of a Pre-Service Claim, the following timetable applies:

Notification to claimant of benefit determination	<b>15 days</b>
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Extension due to matters beyond the control of the Plan	<b>15 days</b>
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Insufficient information on the Claim:

Notification of	<b>15 days</b>
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Response by claimant	<b>45 days</b>
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Notification, orally or in writing, of failure to follow the Plan's procedures for filing a Claim	<b>5 days</b>
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Ongoing courses of treatment:

Reduction or termination before the end of the treatment	<b>15 days</b>
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Request to extend course of treatment	<b>15 days</b>
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Review of adverse benefit determination **30 days**

### **Post-Service Claim**

A Post-Service Claim means any Claim for a Plan benefit that is not a Claim involving Urgent Care or a Pre-Service Claim; in other words, a Claim that is a request for payment under the Plan for covered medical services already received by the claimant.

In the case of a Post-Service Claim, the following timetable applies:

Notification to claimant of benefit determination **30 days**

Extension due to matters beyond the control of the Plan **15 days**

Insufficient information on the Claim:

Notification of **15 days**

Response by claimant **45 days**

Review of adverse benefit determination **60 days**

### **Notice to claimant of adverse benefit determinations**

Except with Urgent Care Claims, when the notification may be orally followed by written or electronic notification within three days of the oral notification, the Plan Administrator shall provide written or electronic notification of any adverse benefit determination. The notice will state, in a manner calculated to be understood by the claimant:

- (1) The specific reason or reasons for the adverse determination.
- (2) Reference to the specific Plan provisions on which the determination was based.
- (3) A description of any additional material or information necessary for the claimant to perfect the Claim and an explanation of why such material or information is necessary.
- (4) A description of the Plan's review procedures and the time limits applicable to such procedures.
- (5) 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 information relevant to the Claim.
- (6) If the adverse benefit determination was based on an internal rule, guideline, protocol, or other similar criterion, the specific rule, guideline, protocol, or criterion will be provided free of charge. If this is not practical, a statement will be included that such a rule, guideline, protocol, or criterion was relied upon in making the adverse benefit determination and a copy will be provided free of charge to the claimant upon request.
- (7) If the adverse benefit determination is based on the Medical Necessity or Experimental or Investigational treatment or similar exclusion or limit, an explanation of the scientific or clinical judgment for the determination, applying the terms of the Plan to the claimant's medical circumstances, will be provided. If this is not practical, a statement will be included that such explanation will be provided free of charge, upon request.

### **CLAIMS REVIEW/APPEALS PROCESS**

In order to be responsive to the needs of Covered Persons, a claims review process has been developed and is known as the Appeals Process. The first level of appeal is to contact the Claims Administrator's customer service

unit by phone or by letter. Covered Persons who remain dissatisfied with the results may file a written complaint with the Claims Administrator's Appeal Coordinator within 180 days after the event that lead to the complaint. This written complaint should include the Covered Person's name, ID number, the reason for the complaint, the resolution that the Covered Person desires, and supporting information regarding the medical providers involved and services received or requested. The Claims Administrator will provide a written response to this written complaint within 30 days after receiving all pertinent information, including any requested medical or claims records. If the Covered Person continues to be dissatisfied with the resolution of the complaint, he/she may submit a written request within 180 days of the date the response was sent by the Claims Administrator and ask that his/her complaint be heard by the Claims Administrator's Utilization Review Committee (or Mental Health Services Utilization Review Committee if, in the discretion of the Claims Administrator, the complaint is relative to benefits for mental health or substance abuse services). The Claims Administrator's Utilization Review Committee (or Mental Health Services Utilization Review Committee as applicable) will review the appeal within 30 days. The results of this review will be sent to the Covered Person within 15 days of the meeting of the Claims Administrator's Utilization Review Committee (or Mental Health Services Utilization Review Committee as applicable).

## **Appeals**

When a claimant receives an adverse benefit determination, the claimant has 180 days following receipt of the notification in which to appeal the decision. A claimant may submit written comments, documents, records, and other information relating to the Claim. If the claimant so requests, he or she will be provided, free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to the Claim.

The period of time within which a benefit determination on review is required to be made shall begin at the time an appeal is filed in accordance with the procedures of the Plan. This timing is without regard to whether all the necessary information accompanies the filing.

A document, record, or other information shall be considered relevant to a Claim if it:

- (1) was relied upon in making the benefit determination;
- (2) was submitted, considered, or generated in the course of making the benefit determination, without regard to whether it was relied upon in making the benefit determination;
- (3) demonstrated compliance with the administrative processes and safeguards designed to ensure and to verify that benefit determinations are made in accordance with Plan documents and Plan provisions have been applied consistently with respect to all claimants; or
- (4) constituted a statement of policy or guidance with respect to the Plan concerning the denied treatment option or benefit.

The review shall take into account all comments, documents, records, and other information submitted by the claimant relating to the Claim, without regard to whether such information was submitted or considered in the initial benefit determination. The review will not afford deference to the initial adverse benefit determination and will be conducted by a fiduciary of the Plan who is neither the individual who made the adverse determination nor a subordinate of that individual.

If the determination was based on a medical judgment, including determinations with regard to whether a particular treatment, drug, or other item is Experimental, Investigational, or not Medically Necessary or appropriate, the fiduciary shall consult with a health care professional who was not involved in the original benefit determination. This health care professional will have appropriate training and experience in the field of medicine involved in the medical judgment. Additionally, medical or vocational experts whose advice was obtained on behalf of the Plan in connection with the initial determination will be identified.

If the decision on review affirms the initial denial of the claim, the claimant will be furnished with a notice of adverse benefit determination on review setting forth:

- the specific reason(s) for the decision on review,
- the specific Plan provision(s) on which the decision is based,

- a statement of the claimant's right to review (on request and at no charge) relevant documents and other information,
- if an internal rule, guideline, protocol, or other similar criterion is relied on in making the decision on review, a description of the specific rule, guideline, protocol, or other similar criterion or a statement that such a rule, guideline, protocol, or other similar criterion was relied on and that a copy of such rule, guideline, protocol, or other criterion will be provided free of charge to the claimant upon request,
- an explanation of the scientific or clinical judgment for the determination if the adverse benefit determination is based on the Medical Necessity or Experimental or Investigational treatment or similar exclusion or limit, or a statement that such explanation will be provided free of charge, upon request, and

Any suit for benefits must be brought within one year after the date the Plan Administrator (or his or her designee) has made a final denial (or deemed denial) of the claim. Notwithstanding any other provision herein, any suit for benefits must be brought within two years after the date the service or treatment was rendered.

The Claims Administrator may be reached at the following address and telephone number:

**Piedmont Community Health Plan, Inc.  
2316 Atherholt Road  
Lynchburg, VA 24501**

**Telephone Numbers: 434-947-4463  
800-400-7247**

## COORDINATION OF BENEFITS

**Coordination of the benefit plans.** Coordination of benefits sets out rules for the order of payment of Covered Charges when two or more plans including Medicare are paying. When a Covered Person is covered by this Plan and another plan, or the Covered Person's Spouse is covered by this Plan and by another plan or the couple's Covered children are covered under two or more plans, the plans will coordinate benefits when a claim is received.

The plan that pays first according to the rules will pay as if there were no other plan involved. The secondary and subsequent plans will pay the balance up to each one's plan formula. The total reimbursement will never be more than the secondary (or subsequent) plan's formula 50% or 80% or 100% whatever it may be. The balance due, if any, is the responsibility of the Covered Person.

**Benefit plan.** This provision will coordinate the medical and dental 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.
- (6) No Fault Auto Insurance, by whatever name it is called, when not prohibited by law.
- (7) HMO (Health Maintenance Organization) plans.

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

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.

**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 by the following rules, up to the Allowable Charge:
  - (a) The benefits of the plan which covers the person directly (that is, as an employee, member, retiree, or subscriber) ("Plan A") are determined before those of the plan which covers the person as a dependent ("Plan B").

Special Rule. If: (i) the person covered directly is a Medicare beneficiary, and (ii) Medicare is secondary to Plan B, and (iii) Medicare is primary to Plan A (for example, if the person is retired), THEN Plan B will pay before Plan A.

- (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 Retiree 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 are determined before those benefits of a benefit plan which covers that person as 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.
  - (d) 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.
  - (e) 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;
    - (ii) If both parents have the same birthday, the benefits of the benefit plan which has covered the patient for the longer time are determined before those of the benefit plan which covers the other parent.
  - (f) 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.
    - (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.
  - (g) 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.
- (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.
- (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 Plan 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 Plan Administrator or 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.

## COBRA CONTINUATION OPTIONS

Under federal law, the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA), certain Employees and their families covered under the Lynchburg City Schools Employee Health Care Benefit Plan (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.

The Plan Administrator is Lynchburg City Schools, P.O. Box 2497, Lynchburg, Virginia 24505, telephone (434) 515-5000. COBRA continuation coverage for the Plan is administered by Lynchburg City Schools, P.O. Box 2497, Lynchburg, VA 24505, (434) 515-5000. Complete instructions on COBRA, as well as election forms and other information, will be provided by the Plan Administrator 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 family members (called "Qualified Beneficiaries") at group rates for up to a statutory-mandated maximum period of time or until they become ineligible for COBRA continuation coverage, whichever occurs first. The right to COBRA continuation coverage is triggered by the occurrence of one of certain events that result 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 active 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:

- (1) 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 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.
- (2) 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. ***The Employee must enroll the child in the Plan by submitting an Enrollment Form (available from the COBRA or Plan Administrator) to the COBRA Administrator within thirty days after the birth or adoption.*** 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.
- (3) A covered Employee who retired on or before the date of substantial elimination of Plan coverage which is the result of a bankruptcy proceeding under Title 11 of the U.S. Code with respect to the Employer, as is the Spouse, surviving Spouse or Dependent child of such a covered Employee if, on the day before the bankruptcy Qualifying Event, the Spouse, surviving Spouse or Dependent child was a beneficiary under the Plan.

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. A domestic partner is not a Qualified Beneficiary.

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:

- (1) The death of a covered Employee.
- (2) The termination (other than by reason of the Employee's gross misconduct), or reduction of hours, of a covered Employee's employment.
- (3) The divorce or legal separation of a covered Employee from the Employee's Spouse.
- (4) A covered Employee's enrollment in any part of the Medicare program.
- (5) 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).
- (6) A proceeding in bankruptcy under Title 11 of the U.S. Code with respect to an Employer from whose employment a covered Employee retired at any time.

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 entitled to 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 procedure 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 no 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 Plan 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 (if the employer is not the Plan Administrator) will notify the Plan Administrator of the Qualifying Event within 30 days following the date coverage ends when the Qualifying Event is:

- (1) the end of employment or reduction of hours of employment,
- (2) death of the employee,
- (3) commencement of a proceeding in bankruptcy with respect to the employer, or
- (4) enrollment of the employee in any part of Medicare.

**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), the Qualified Beneficiary must notify the Plan Administrator or its designee in writing within 60 days after the later of the date the Qualifying Event occurs or the date the Qualified Beneficiary would lose coverage on account of the Qualifying Event, using the procedures specified below. If these procedures are not followed or if the notice is not provided in writing to the Plan Administrator 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.**

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 the qualified beneficiaries 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 day after the date coverage is lost due to a Qualifying Event and ending not before the earliest of the following dates:

- (1) The last day of the applicable maximum coverage period.
- (2) The first day for which Timely Payment is not made to the Plan with respect to the Qualified Beneficiary.
- (3) The date upon which the Employer ceases to provide any group health plan (including a successor plan) to any employee.

- (4) 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 preexisting condition, other than such an exclusion or limitation that does not apply to, or is satisfied by, the Qualified Beneficiary.
- (5) 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).
- (6) In the case of a Qualified Beneficiary entitled to 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 Qualified Beneficiary must notify the COBRA Administrator in writing within 30 days after the Qualified Beneficiary becomes covered by another group health plan or entitled to Medicare. The Qualified Beneficiary must also notify the COBRA Administrator in writing within 30 days after the date of the final determination by the Social Security Administration that the Qualified Beneficiary is no longer disabled. This written notice must include the names and Plan identification numbers of the Qualified Beneficiaries and the date on which the other coverage (or Medicare) became effective, or the date of the non-disability determination (as applicable).

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.

- (1) 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 date coverage is lost due to a Qualifying Event if there is not a disability extension and 29 months after the date coverage is lost due to a Qualifying Event if there is a disability extension.
- (2) 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 loss of coverage due to termination of employment or reduction of hours of employment.
- (3) In the case of a bankruptcy Qualifying Event, the maximum coverage period for a Qualified Beneficiary who is the covered retiree ends on the date of the retiree's death. The maximum coverage period for a Qualified Beneficiary who is the covered Spouse, surviving Spouse or Dependent child of the retiree ends on the earlier of the Qualified Beneficiary's death or 36 months after the death of the retiree.
- (4) 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.

- (5) In the case of any other Qualifying Event than that described above, the maximum coverage period ends 36 months after the date coverage is lost due to 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. Also, these events can be a second Qualifying Event only if they would have caused the Qualified Beneficiary to lose coverage under the Plan if the first Qualifying Event had not occurred. For example, in most cases a former employee's entitlement to Medicare will not extend the 18-month COBRA continuation coverage period for the employee's spouse and dependents. This is because if the employee had not terminated employment or reduced working hours (i.e., if the first qualifying event had not occurred), entitlement to Medicare would not result in a loss of family coverage under the Plan. By contrast, the divorce of the employee and spouse after the first qualifying event generally will extend the COBRA continuation coverage period for the spouse. If the employee had not terminated employment or reduced working hours (i.e., if the first qualifying event had not occurred), the divorce would result in a loss of coverage for the spouse.

In no circumstance can the COBRA maximum coverage period be expanded to more than 36 months after the date coverage is lost due to the first Qualifying Event. **The Qualified Beneficiary must send written notice of the second Qualifying Event to the COBRA Administrator within 60 days after the later of the date of the Qualifying Event or the date coverage would be lost due to the Qualifying Event. This written notice must include the names and Plan identification numbers of the Qualified Beneficiaries, the type of Qualifying Event, and the date on which the Qualifying Event occurred.**

**How does a Qualified Beneficiary become entitled to 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 before the 60th day of COBRA continuation coverage. ***To qualify for the disability extension, the Qualified Beneficiary must also provide the COBRA Administrator with written notice of the disability determination (including a copy of the determination) on a date that is both within 60 days after the later of the date of the determination or the date coverage is lost due to the Qualifying Event, and before the end of the original 18-month maximum coverage.***

**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 the 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 website at [www.dol.gov/ebsa](http://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 or COBRA Administrator.

## PRIVACY OF MEDICAL INFORMATION

### I. Plan's Designation of Person/Entity to Act on its Behalf

The Plan has determined that it is a group health plan within the meaning of the HIPAA Privacy Rule, and the Plan designates Superintendent to take all actions required to be taken by the Plan in connection with the HIPAA Privacy Rule (e.g., entering into business associate contracts; accepting certification from the Plan Sponsor).

### II. Definitions

All terms defined in the HIPAA Privacy Rule, shall have the meaning set forth therein. The following additional definitions apply to the provisions set forth in this Amendment.

A. Plan means Lynchburg City Schools Employee Health Care Benefit Plan.

B. Plan Documents mean the Plan's governing documents and instruments (i.e., the documents under which the Plan was established and is maintained), including but not limited to the Lynchburg City Schools Employee Benefit Plan's Group Health Plan Document.

C. Plan Sponsor means "plan sponsor" as defined. The Plan Sponsor is the Lynchburg City Schools.

### III. The Plan's Disclosure of Protected Health Information to the Plan Sponsor – Required Certification of Compliance by the Plan Sponsor.

A. Except as provided below with respect to the Plan's disclosure of summary health information, the Plan will (a) disclose Protected Health Information to the Plan Sponsor or (b) provide for or permit the disclosure of Protected Health Information to the Plan Sponsor by a health insurance issuer or HMO with respect to the Plan, only if the Plan has received a certification (signed on behalf of the Plan Sponsor) that:

1. The Plan Documents have been amended to establish the permitted and required uses and disclosures of such information by the Plan Sponsor, consistent with the 504 provisions;
2. The Plan Documents have been amended to incorporate the Plan provisions set forth in this Amendment; and
3. The Plan Sponsor agrees to comply with the Plan provisions as modified by this Amendment.

### IV. Permitted disclosure of individuals' Protected Health Information to the Plan Sponsor

A. The Plan (and any business associate acting on behalf of the Plan), or any health insurance issuer or HMO servicing the Plan will disclose individuals' Protected Health Information to the Plan Sponsor only to permit the Plan Sponsor to carry out plan administration functions. Such disclosure will be consistent with the provisions of this Amendment.

B. All disclosures of the Protected Health Information of the Plan's individuals by the Plan's business associate, health insurance issuer, or HMO to the Plan Sponsor will comply with the restrictions and requirements set forth in this Amendment and in the 504 provisions.

C. The Plan (and any business associate acting on behalf of the Plan), may not, and may not permit a health insurance issuer or HMO, to disclose individuals' Protected Health Information to the Plan Sponsor for employment-related actions and decisions or in connection with any other benefit or employee benefit plan of the Plan Sponsor.

D. The Plan Sponsor will not use or further disclose individuals' Protected Health Information other than as described in the Plan Documents and permitted by the 504 provisions.

E. The Plan Sponsor will ensure that any agent(s), including a subcontractor, to whom it provides individuals' Protected Health Information received from the Plan (or from the Plan's health insurance issuer or HMO),

agrees to the same restrictions and conditions that apply to the Plan Sponsor with respect to such Protected Health Information.

- F. The Plan Sponsor will not use or disclose individuals' Protected Health Information for employment-related actions and decisions or in connection with any other benefit or employee benefit plan of the Plan Sponsor.
- G. The Plan Sponsor will report to the Plan any use or disclosure of Protected Health Information that is inconsistent with the uses or disclosures provided for in the Plan Documents (as amended) and in the 504 provisions, of which the Plan Sponsor becomes aware.

#### **V. Disclosure of individuals' protected health Information – Disclosure by the Plan Sponsor**

- A. The Plan Sponsor will make the Protected health Information of the individual who is the subject of the Protected Health Information available to such individual in accordance with 45 C.F.R. § 164.524.
- B. The Plan Sponsor will make the individuals' Protected Health Information available for amendment and incorporate any amendments to individuals' Protected Health Information in accordance with 45 C.F.R. § 164.526.
- C. The Plan Sponsor will make and maintain an accounting so that it can make available those disclosures of individuals' Protected Health Information that it must account for in accordance with 45 C.F.R. § 164.528.
- D. The Plan Sponsor will make its internal practices, books, and records relating to the use and disclosure of individuals' Protected Health Information received from the Plan available to the U.S. Department of Health and Human Services for purposes of determining compliance by the Plan with the HIPAA Privacy Rule.
- E. The Plan Sponsor will, if feasible, return or destroy all individuals' Protected Health Information received from the Plan (or a health insurance issuer or HMO with respect to the Plan) that the Plan Sponsor still maintains in any form after such information is no longer needed for the purpose for which the use or disclosure was made. Additionally, the Plan Sponsor will not retain copies of such Protected Health Information after such information is no longer needed for the purpose for which the use or disclosure was made. If, however, such return or destruction is not feasible, the Plan Sponsor will limit further uses and disclosures to those purposes that make the return or destruction of the information infeasible.
- F. The Plan Sponsor will ensure that the required adequate separation, described in paragraph VII below, is established and maintained.

#### **VI. Disclosures of Summary Health Information and Enrollment and Disenrollment Information to the Plan Sponsor**

- A. The Plan, or a health insurance issuer or HMO with respect to the Plan, may disclose summary health information for the Plan Sponsor without the need to amend the Plan Documents as provided for in the 504 provisions, if the Plan Sponsor requests the summary health information for the purpose of:
  - 1. Obtaining premium bids from health plans for providing health insurance coverage under the Plan; or
  - 2. Modifying, amending, or terminating the Plan.
- B. The Plan, or a health insurance issuer or HMO with respect to the Plan, may disclose enrollment and disenrollment information to the Plan Sponsor without the need to amend the Plan Documents as provided for in the 504 provisions.

#### **VII. Required Separation between the Plan and the Plan Sponsor**

- A. In accordance with the 504 provisions, this section describes the employees or classes of employees or workforce members under the control of the Plan Sponsor who may be given access to individuals'

Protected Health Information received from the Plan or from a health insurance issuer or HMO servicing the Plan.

1. Chief Financial Officer
2. Benefits Specialist
3. Director of Personnel

- B.** This list reflects the employees, classes of employees, or other workforce members of the Plan Sponsor who receive individuals' Protected Health Information relating to payment under, health care operations of, or other matters pertaining to plan administration functions that the Plan Sponsor provides for the Plan. These individuals will have access to individuals' Protected Health Information solely to perform these identified functions, and they will be subject to disciplinary action and/or sanctions (including termination of employment or affiliation with the Plan Sponsor) for any use or disclosure of individuals' Protected Health Information in violation of, or noncompliance with, the provisions of this Amendment.
- C.** The Plan Sponsor will promptly report any such breach, violation, or noncompliance to the Plan and will cooperate with the Plan to correct the violation or noncompliance, to impose appropriate disciplinary action and/or sanctions, and to mitigate any deleterious effect of the violation or noncompliance.

## RESPONSIBILITIES FOR PLAN ADMINISTRATION

**PLAN ADMINISTRATOR.** An individual may be appointed by Lynchburg City Schools 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, Lynchburg City Schools shall appoint a new Plan Administrator as soon as reasonably possible.

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 delegate to the Claims Administrator, who shall have maximum legal discretionary authority to construe and interpret the terms and provisions of the Plan, to make determinations regarding issues which relate to eligibility for benefits, to decide disputes which may arise relative to a Plan Participant's rights, and to decide questions of Plan interpretation and those of fact relating to the Plan. The decisions of the Plan Administrator will be final and binding on all interested parties.

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

### DUTIES OF THE PLAN ADMINISTRATOR.

- (1) To administer the Plan in accordance with its terms.
- (2) To interpret the Plan, including the right to remedy possible ambiguities, inconsistencies or omissions.
- (3) To decide disputes which may arise relative to a Plan Participant's rights.
- (4) To prescribe procedures for filing a claim for benefits and to review claim denials.
- (5) To keep and maintain the Plan documents and all other records pertaining to the Plan.
- (6) To appoint a Claims Administrator to pay claims.
- (7) To delegate to any person or entity such powers, duties and responsibilities as it deems appropriate.

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

**FIDUCIARY.** A fiduciary exercises discretionary authority or control over management of the Plan or the disposition of its assets, renders investment advice to the Plan or has discretionary authority or responsibility in the administration of the Plan.

**FIDUCIARY DUTIES.** A fiduciary must carry out his or her duties and responsibilities for the purpose of providing benefits to the Employees and their Dependent(s), and defraying reasonable expenses of administering the Plan. These are duties which must be carried out:

- (1) with care, skill, prudence and diligence under the given circumstances that a prudent person, acting in a like capacity and familiar with such matters, would use in a similar situation;
- (2) by diversifying the investments of the Plan so as to minimize the risk of large losses, unless under the circumstances it is clearly prudent not to do so; and

**THE NAMED FIDUCIARY.** A "named fiduciary" is the one named in the Plan. A named fiduciary can appoint others to carry out fiduciary responsibilities (other than as a trustee) under the Plan. These other persons become fiduciaries themselves and are responsible for their acts under the Plan. To the extent that the named fiduciary allocates its responsibility to other persons, the named fiduciary shall not be liable for any act or omission of such person unless either:

**CLAIMS ADMINISTRATOR IS NOT A FIDUCIARY.** A Claims Administrator is not a fiduciary under the Plan by virtue of paying claims in accordance with the Plan's rules as established by the Plan Administrator.

### **FUNDING THE PLAN AND PAYMENT OF BENEFITS**

The cost of the Plan is funded as follows:

**For Employee and Dependent Coverage:** Funding is derived from the funds of the Employer and contributions made by the covered Employees.

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. However, the Plan will not retroactively terminate coverage due to a clerical error. 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 the overpayment. The person or institution receiving the overpayment will be required to return the incorrect amount of money. In the case of a Plan Participant, 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 Plan Participants are limited to expenses incurred before termination.

The Employer intends to maintain this Plan indefinitely; however, it reserves the right, at any time, to amend, suspend or terminate the Plan in whole or in part. This includes amending the benefits under the Plan or the Trust agreement (if any).

#### **Right to make changes:**

From time to time, conditions or circumstances may require that the Lynchburg City Schools make changes, additions, or deletions in its health care coverage for both actives employees and retirees as the Lynchburg City Schools determines are appropriate. This policy does not grant employees or retirees vested health coverage benefits, in other words, employees and retirees are not guaranteed current or future health coverage benefits.

## GENERAL PLAN INFORMATION

### **TYPE OF ADMINISTRATION**

The Plan is a self-funded health plan and the administration is provided through a third party Claims Administrator. The funding for the benefits is derived from the funds of the Employer and contributions made by covered Employees. The Plan is not insured.

**PLAN NAME** Lynchburg City Schools Employee Health Care Benefit Plan

**PLAN NUMBER:** 501

**TAX ID NUMBER:** 54-6001406

**PLAN EFFECTIVE DATE:** October 1, 1997; amended and restated effected January 1, 2014

**PLAN YEAR ENDS:** December 31st

### **EMPLOYER INFORMATION**

Lynchburg City Schools  
P.O. Box 2497  
Lynchburg, Virginia 24505  
(434)515-5000

### **PLAN ADMINISTRATOR**

Lynchburg City School Board

Chief Financial Officer  
P.O. Box 2497  
Lynchburg, Virginia 24505  
(434)515-5000

### **NAMED FIDUCIARY**

Lynchburg City School Board  
Chief Financial Officer  
P.O. Box 2497  
Lynchburg, Virginia 24505

### **AGENT FOR SERVICE OF LEGAL PROCESS**

Lynchburg City School Board  
Chief Financial Officer  
P.O. Box 2497  
Lynchburg, Virginia 24505

### **CLAIMS ADMINISTRATOR**

Piedmont Community Health Plan  
2316 Atherholt Road  
Lynchburg, Virginia 24501  
(434) 947-4463



**This is only a summary.** If you want more detail about your coverage and costs, you can get the complete terms in the policy or plan document at [www.pchp.net](http://www.pchp.net) or by calling 1-800-400-7247. Note: The Uniform Glossary can be accessed at [www.cciio.cms.gov](http://www.cciio.cms.gov)

Important Questions	Answers	Why this Matters:
What is the overall <u>deductible</u> ?	<b>\$750</b> individual / <b>\$1,500</b> family in-network <b>\$1,500</b> individual / <b>\$3,000</b> family out-of-network Does not apply to preventive care or to covered services subject to a copayment rather than coinsurance. Copayments do not count toward the <u>deductible</u> .	You must pay all the costs up to the <u>deductible</u> amount before this plan begins to pay for covered services you use. Check your policy or plan document to see when the <u>deductible</u> starts over (usually, but not always, January 1st). See the chart starting on page 2 for how much you pay for covered services after you meet the <u>deductible</u> .
Are there other <u>deductibles</u> for specific services?	No.	You don't have to meet <u>deductibles</u> for specific services, but see the chart starting on page 2 for other costs for services this plan covers.
Is there an <u>out-of-pocket limit</u> on my expenses?	Yes. <b>\$2,500</b> individual / <b>\$5,000</b> family in-network <b>\$5,000</b> individual / <b>\$10,000</b> family out-of-network	The medical <u>out-of-pocket limit</u> is the most you could pay during a coverage period (usually one year) for your share of the cost of covered services. This limit helps you plan for health care expenses.
What is not included in the <u>out-of-pocket limit</u> ?	Premiums, balance-billed charges, charges in excess of any benefit limitations, and health care this plan doesn't cover.	Even though you pay these expenses, they don't count toward the medical <u>out-of-pocket limit</u> .
Is there an overall annual limit on what the plan pays?	No.	The chart starting on page 2 describes any limits on what the plan will pay for <i>specific</i> covered services, such as office visits.
Does this plan use a <u>network of providers</u> ?	Yes. See <a href="http://www.pchp.net">www.pchp.net</a> or call 1-800-400-7247 for a list of in-network providers.	If you use an in-network doctor or other health care <u>provider</u> , this plan will pay some or all of the costs of covered services. Be aware, your in-network doctor or hospital may use an out-of-network <u>provider</u> for some services. Plans use the term in-network, <u>preferred</u> , or participating for <u>providers</u> in their <u>network</u> . See the chart starting on page 2 for how this plan pays different kinds of <u>providers</u> .

**Questions:** Call 1-800-400-7247 or visit us at [www.pchp.net](http://www.pchp.net).

If you aren't clear about any of the underlined terms used in this form, see the Glossary. You can view the Glossary at [www.cciio.cms.gov](http://www.cciio.cms.gov) or call 1-800-400-7247 to request a copy.

OMB Control Numbers 1545-2229, 1210-0147, and 0938-1146

Released on April 23, 2013 (corrected)

Do I need a referral to see a <u>specialist</u> ?	No. You don't need a referral to see a <u>specialist</u> .	You can see the <u>specialist</u> you choose without permission from this plan.
Are there services this plan doesn't cover?	Yes.	Some of the services this plan doesn't cover are listed on page 5. See your policy or plan document for additional information about <u>excluded services</u> .



- **Copayments** are fixed dollar amounts (for example, \$15) you pay for covered health care, usually when you receive the service.
- **Coinsurance** is *your* share of the costs of a covered service, calculated as a percent of the **allowed amount** for the service. For example, if the plan's **allowed amount** for an overnight hospital stay is \$1,000, your **coinsurance** payment of 20% would be \$200. This may change if you haven't met your **deductible**.
- The amount the plan pays for covered services is based on the **allowed amount**. If an out-of-network **provider** charges more than the **allowed amount**, you may have to pay the difference. For example, if an out-of-network hospital charges \$1,500 for an overnight stay and the **allowed amount** is \$1,000, you may have to pay the \$500 difference. (This is called **balance billing**.)
- This plan may encourage you to use in-network **providers** by charging you lower **deductibles**, **copayments** and **coinsurance** amounts.

Common Medical Event	Services You May Need	Your Cost If You Use an In-Network Provider	Your Cost If You Use an Out-of-Network Provider	Limitations & Exceptions
If you visit a health care <u>provider's</u> office or clinic	Primary care visit to treat an injury or illness	\$25 copay/visit	40% coinsurance	Doctor office labs covered at No Charge after office visit copay.
	Specialist visit	\$45 copay/visit	40% coinsurance	Doctor office labs covered at No Charge after office visit copay.
	Other practitioner office visit	\$45 copay/visit	40% coinsurance	Chiropractic maintenance therapy is Not Covered. Acupuncture is Not Covered.
	Preventive care/screening/immunization	No charge	40% coinsurance	_____none_____
If you have a test	Diagnostic test (x-ray, blood work)	20% coinsurance	40% coinsurance	Doctor office labs covered at No Charge after office visit copay.
	Imaging (CT/PET scans, MRIs)	20% coinsurance	40% coinsurance	Pre-authorization required.

**Questions:** Call 1-800-400-7247 or visit us at [www.pchp.net](http://www.pchp.net).

If you aren't clear about any of the underlined terms used in this form, see the Glossary. You can view the Glossary at [www.cciio.cms.gov](http://www.cciio.cms.gov) or call 1-800-400-7247 to request a copy.

Common Medical Event	Services You May Need	Your Cost If You Use an In-Network Provider	Your Cost If You Use an Out-of-Network Provider	Limitations & Exceptions
<p><b>If you need drugs to treat your illness or condition</b></p> <p>More information about <u>prescription drug coverage</u> is available from Script Care at 1-888-810-9010 or visit <a href="http://www.scriptcare.com">www.scriptcare.com</a>.</p>	Generic drugs	40%, between \$20 & \$50 (retail) 40%, between \$60 & \$125 (mail order)	40%, between \$20 & \$50 (retail) 40%, between \$60 & \$125 (mail order)	<p>Copays are per prescription; any one prescription is limited to a 30 day or 90 day supply depending on type.</p> <p>Separate prescription drug <b>out-of-pocket limit</b> of \$4,100 individual / \$8,200 family per year applies.</p> <p>Mandatory mail-order for maintenance Rx after 4 retail fills.</p> <p>Prior Authorization required for prescriptions exceeding \$2,000.</p> <p>Mandatory Generic: If members fill a brand name drug when a generic is available, member will pay the brand copay plus the difference between the cost of the brand and generic.</p> <p>If a drug is purchased from an Out-of-Network Provider, the amount payable in excess of the copayment will be the ingredient cost and dispensing fee.</p>
	Preferred brand drugs	40%, between \$20 & \$100 (retail) 40%, between \$60 & \$300 (mail order)	40%, between \$20 & \$100 (retail) 40%, between \$60 & \$300 (mail order)	
	Non-preferred brand drugs	40%, between \$20 & \$100 (retail) 40%, between \$60 & \$300 (mail order)	40%, between \$20 & \$100 (retail) 40%, between \$60 & \$300 (mail order)	
	<p>Specialty drugs - Must be filled through the SCL Specialty Pharmacy after one retail fill.</p> <p>[Diabetic meds/supplies (excluding insulin) - Must be filled through the SCL Diabetic Program after one retail fill (40%, between \$60 &amp; \$300 brand; 40% between \$60 &amp; \$125 generic)]</p>	40%, between \$20 & \$100 (SCL Specialty Brand) 40% between \$20 & \$50 (SCL Specialty Generic)	40%, between \$20 & \$100 (SCL Specialty Brand) 40% between \$20 & \$50 (SCL Specialty Generic)	
<p><b>If you have outpatient surgery</b></p>	Facility fee (e.g., ambulatory surgery center)	20% coinsurance	40% coinsurance	<p>Pre-authorization required. Covered as Out-of-Network without pre-auth.</p>
	Physician/surgeon fees	20% coinsurance	40% coinsurance	
<p><b>If you need immediate medical attention</b></p>	Emergency room services	\$200 copay/visit	\$200 copay/visit	<p>If not an actual emergency, covered at 40% coinsurance after deductible.</p> <p>ER copay waived if admitted; then subject to inpatient ded/coinsurance.</p>
	Emergency medical transportation	20% coinsurance	20% coinsurance	
	Urgent care	\$45 copay/visit	\$45 copay/visit	

**Questions:** Call 1-800-400-7247 or visit us at [www.pchp.net](http://www.pchp.net).

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Common Medical Event	Services You May Need	Your Cost If You Use an In-Network Provider	Your Cost If You Use an Out-of-Network Provider	Limitations & Exceptions
<b>If you have a hospital stay</b>	Facility fee (e.g., hospital room)	20% coinsurance	40% coinsurance	Pre-authorization required. Covered as Out-of-Network without pre-auth.
	Physician/surgeon fee	20% coinsurance	40% coinsurance	
<b>If you have mental health, behavioral health, or substance abuse needs</b>	Mental/Behavioral health outpatient services	\$25 copay/office visit and 20% coinsurance other outpatient services	40% coinsurance	Doctor office labs covered at No Charge after office visit copay. Pre-authorization required for any inpatient or outpatient facility services. Pre-authorization required for any services and office visits from Out-of-Network providers. Covered as Out-of-Network without pre-authorization.
	Mental/Behavioral health inpatient services	20% coinsurance	40% coinsurance	
	Substance use disorder outpatient services	\$25 copay/office visit and 20% coinsurance other outpatient services	40% coinsurance	
	Substance use disorder inpatient services	20% coinsurance	40% coinsurance	
<b>If you are pregnant</b>	Prenatal and postnatal care	\$45 copay	40% coinsurance	Prenatal care is covered at \$0 copay. Routine labs covered at No Charge.
	Delivery and all inpatient services	20% coinsurance	40% coinsurance	Pregnancy for a dependent child is Not Covered.
<b>If you need help recovering or have other special health needs</b>	Home health care	20% coinsurance	40% coinsurance	Limited to 100 visits per year. Pre-authorization required.
	Rehabilitation services	20% coinsurance	40% coinsurance	Pre-authorization required.
	Habilitation services	Not Covered	Not Covered	Habilitation services are Not Covered.
	Skilled nursing care	20% coinsurance	40% coinsurance	Pre-authorization required.
	Durable medical equipment	20% coinsurance	40% coinsurance	Pre-authorization required.
	Hospice service	20% coinsurance	40% coinsurance	Pre-authorization required.
<b>If your child needs dental or eye care</b>	Eye exam	Not Covered	Not Covered	Routine eye exam is Not Covered for children.
	Glasses	Not Covered	Not Covered	Glasses and routine dental check-ups Not Covered for children.
	Dental check-up	Not Covered	Not Covered	

**Questions:** Call 1-800-400-7247 or visit us at [www.pchp.net](http://www.pchp.net).

If you aren't clear about any of the underlined terms used in this form, see the Glossary. You can view the Glossary at [www.cciio.cms.gov](http://www.cciio.cms.gov) or call 1-800-400-7247 to request a copy.

**Excluded Services & Other Covered Services:**

**Services Your Plan Does NOT Cover** (This isn't a complete list. Check your policy or plan document for other excluded services.)

- Acupuncture
- Bariatric surgery
- Cosmetic surgery
- Dental care (Adult) (except for accidental injury)
- Glasses
- Habilitation services
- Hearing aids
- Infertility treatment
- Long-term care
- Routine eye care (Adult)
- Routine foot care (unless you are under active treatment for a metabolic or peripheral vascular disease, such as diabetes)
- Weight loss programs

**Other Covered Services** (This isn't a complete list. Check your policy or plan document for other covered services and your costs for these services.)

- Chiropractic care (maintenance therapy services are Not Covered)
- Non-emergency care when traveling outside the U.S. (covered as Out-of-Network and subject to balance billing)
- Private-duty nursing

**Questions:** Call 1-800-400-7247 or visit us at [www.pchp.net](http://www.pchp.net).

If you aren't clear about any of the underlined terms used in this form, see the Glossary. You can view the Glossary at [www.cciio.cms.gov](http://www.cciio.cms.gov) or call 1-800-400-7247 to request a copy.

## Your Rights to Continue Coverage:

If you lose coverage under the plan, then, depending upon the circumstances, Federal and State laws may provide protections that allow you to keep health coverage. Any such rights may be limited in duration and will require you to pay a **premium**, which may be significantly higher than the premium you pay while covered under the plan. Other limitations on your rights to continue coverage may also apply.

For more information on your rights to continue coverage, contact the plan at 1-800-400-7247. You may also contact your state insurance department, the U.S. Department of Labor, Employee Benefits Security Administration at 1-866-444-3272 or [www.dol.gov/ebsa](http://www.dol.gov/ebsa), or the U.S. Department of Health and Human Services at 1-877-267-2323 x61565 or [www.cciio.cms.gov](http://www.cciio.cms.gov).

## Your Grievance and Appeals Rights:

If you have a complaint or are dissatisfied with a denial of coverage for claims under your plan, you may be able to **appeal** or file a **grievance**. For questions about your rights, this notice, or assistance, you can contact Piedmont Community Health Plan at 1-800-400-7247 (434-947-4463 if local) or visit [www.pchp.net](http://www.pchp.net). You may also contact the U.S. Department of Labor, Employee Benefits Security Administration at 1-866-444-3272 or visit [www.dol.gov/ebsa/healthreform](http://www.dol.gov/ebsa/healthreform). For prescription drug information, contact Script Care at 1-888-810-9010 or visit [www.scriptcare.com](http://www.scriptcare.com).

## Does this Coverage Provide Minimum Essential Coverage?

The Affordable Care Act requires most people to have health care coverage that qualifies as “minimum essential coverage”. **This plan or policy does provide minimum essential coverage.**

## Does this Coverage Meet the Minimum Value Standard?

The Affordable Care Act establishes a minimum value standard of benefits of a health plan. The minimum value standard is 60% (actuarial value). **This health coverage does meet the minimum value standard for the benefits it provides.**

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*To see examples of how this plan might cover costs for a sample medical situation, see the next page.*

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**Questions:** Call 1-800-400-7247 or visit us at [www.pchp.net](http://www.pchp.net).

If you aren't clear about any of the underlined terms used in this form, see the Glossary. You can view the Glossary at [www.cciio.cms.gov](http://www.cciio.cms.gov) or call 1-800-400-7247 to request a copy.

## About these Coverage Examples:

These examples show how this plan might cover medical care in given situations. Use these examples to see, in general, how much financial protection a sample patient might get if they are covered under different plans. These examples were completed using the cost sharing for the Employee Only (Individual) coverage tier.



**This is not a cost estimator.**

Don't use these examples to estimate your actual costs under this plan. The actual care you receive will be different from these examples, and the cost of that care will also be different.

See the next page for important information about these examples.

### Having a baby (normal delivery)

- Amount owed to providers: \$7,540
- Plan pays \$5,720
- Patient pays \$1,820

#### Sample care costs:

Hospital charges (mother)	\$2,700
Routine obstetric care	\$2,100
Hospital charges (baby)	\$900
Anesthesia	\$900
Laboratory tests	\$500
Prescriptions	\$200
Radiology	\$200
Vaccines, other preventive	\$40
<b>Total</b>	<b>\$7,540</b>

#### Patient pays:

Deductibles	\$750
Copays	\$70
Coinsurance	\$800
Limits or exclusions	\$200
<b>Total</b>	<b>\$1,820</b>

### Managing type 2 diabetes (routine maintenance of a well-controlled condition)

- Amount owed to providers: \$5,400
- Plan pays \$2,620
- Patient pays \$ 2,780

#### Sample care costs:

Prescriptions	\$2,900
Medical Equipment and Supplies	\$1,300
Office Visits and Procedures	\$700
Education	\$300
Laboratory tests	\$100
Vaccines, other preventive	\$100
<b>Total</b>	<b>\$5,400</b>

#### Patient pays:

Deductibles	\$0
Copays	\$1,500
Coinsurance	\$1,200
Limits or exclusions	\$80
<b>Total</b>	<b>\$2,780</b>

**Questions:** Call 1-800-400-7247 or visit us at [www.pchp.net](http://www.pchp.net).

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## Questions and answers about the Coverage Examples:

### What are some of the assumptions behind the Coverage Examples?

- Costs don't include premiums.
- Sample care costs are based on national averages supplied by the U.S. Department of Health and Human Services, and aren't specific to a particular geographic area or health plan.
- The patient's condition was not an excluded or preexisting condition.
- All services and treatments started and ended in the same coverage period.
- There are no other medical expenses for any member covered under this plan.
- Out-of-pocket expenses are based only on treating the condition in the example.
- The patient received all care from in-network providers. If the patient had received care from out-of-network providers, costs would have been higher.

### What does a Coverage Example show?

For each treatment situation, the Coverage Example helps you see how deductibles, copayments, and coinsurance can add up. It also helps you see what expenses might be left up to you to pay because the service or treatment isn't covered or payment is limited.

### Does the Coverage Example predict my own care needs?

- ✗ **No.** Treatments shown are just examples. The care you would receive for this condition could be different based on your doctor's advice, your age, how serious your condition is, and many other factors.

### Does the Coverage Example predict my future expenses?

- ✗ **No.** Coverage Examples are not cost estimators. You can't use the examples to estimate costs for an actual condition. They are for comparative purposes only. Your own costs will be different depending on the care you receive, the prices your providers charge, and the reimbursement your health plan allows.

### Can I use Coverage Examples to compare plans?

- ✓ **Yes.** When you look at the Summary of Benefits and Coverage for other plans, you'll find the same Coverage Examples. When you compare plans, check the "Patient Pays" box in each example. The smaller that number, the more coverage the plan provides.

### Are there other costs I should consider when comparing plans?

- ✓ **Yes.** An important cost is the premium you pay. Generally, the lower your premium, the more you'll pay in out-of-pocket costs, such as copayments, deductibles, and coinsurance. You should also consider contributions to accounts such as health savings accounts (HSAs), flexible spending arrangements (FSAs) or health reimbursement accounts (HRAs) that help you pay out-of-pocket expenses.

**Questions:** Call 1-800-400-7247 or visit us at [www.pchp.net](http://www.pchp.net).

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## PCHP PARTICIPANTS 3-13

### **2021-City of Lynchburg**

Loc 01-Active

Loc 02-Circuit Court

Loc 03-HRA

Loc 04-Retirees > 65

Loc 05-Retirees < 65

Loc 07- Retirees > 65 - EE Only - No Dependents

LOC 08 - Line of Duty Members

Loc 06-Active other

Loc 98-Cobra

Quick list pulled

Laurel Both Spouse Work 750                    52030-31

Laurel Both Spouse Work 1500                52030-32

Client Code ->. PIEDS . 52030 . 30 .

Client Name . LYNCHBURG CITY SCHOOLS

Report/ID Name. 20/20 \$750

Client Code ->. PIEDS . 52030 . 13

Client Name . LYNCHBURG CITY SCHOOLS

Report/ID Name. Laurel \$750 RETIREE

Client Code ->. PIEDS . 52030 . 11

Client Name . LYNCHBURG CITY SCHOOLS

Report/ID Name. Laurel \$750

Client Code ->. PIEDS . 52030 . 23

Client Name . LYNCHBURG CITY SCHOOLS

Report/ID Name. Food Service \$750

Client Code ->. PIEDS . 52030 . 03

Client Name . LYNCHBURG CITY SCHOOLS

Report/ID Name. Food Service \$1500

Client Code ->. PIEDS . 52030 . 29 .

Client Name . LYNCHBURG CITY SCHOOLS

Report/ID Name. Both Work \$750

Client Code ->. PIEDS . 52030 . 25 .

Client Name . LYNCHBURG CITY SCHOOLS

Report/ID Name. Retiree \$750

Client Code ->. PIEDS . 52030 . 21 .  
Client Name . LYNCHBURG CITY SCHOOLS  
Report/ID Name. MONTHLY \$750

Client Code ->. PIEDS . 52030 . 14 .  
Client Name . LYNCHBURG CITY SCHOOLS  
Report/ID Name. Laurel \$1500 Retiree

Client Code ->. PIEDS . 52030 . 12 .  
Client Name . LYNCHBURG CITY SCHOOLS  
Report/ID Name. Laurel \$1500

Client Code ->. PIEDS . 52030 . 05 .  
Client Name . LYNCHBURG CITY SCHOOLS  
Report/ID Name. RETIREE \$1500

Client Code ->. PIEDS . 52030 . 09 .  
Client Name . LYNCHBURG CITY SCHOOLS  
Report/ID Name. BOTH WORK \$1500

Client Code ->. PIEDS . 52030 . 01 .  
Client Name . LYNCHBURG CITY SCHOOLS  
Report/ID Name. MONTHLY \$1500

Client Code ->. PIEDS . 52030 . 07 .  
Client Name . LYNCHBURG CITY SCHOOLS  
Report/ID Name. 20/20 \$1500

Client Code ->. PIEDS . 52030 . 16 .  
Client Name . LYNCHBURG CITY SCHOOLS  
Report/ID Name. GOVENORS \$1500

Client Code ->. PIEDS . 52030 . 18  
Client Name . LYNCHBURG CITY SCHOOLS

Report/ID Name. STEP WITH LINKS \$1500

Client Code ->. PIEDS . 52030 . 28 .

Client Name . LYNCHBURG CITY SCHOOLS

Report/ID Name. STEM ACADEMY \$1500

Client Code ->. PIEDS . 52030 . 92 .

Client Name . LYNCHBURG CITY SCHOOLS

Report/ID Name. COBRA \$750

Address 1 . PO BOX 1599

Client Code ->. PIEDS . 52030 . 17

Client Name . LYNCHBURG CITY SCHOOLS

Report/ID Name. STEP WITH LINKS \$750

Address 1 . PO BOX 1599

Client Code ->. PIEDS . 52030 . 20 .

Client Name . LYNCHBURG CITY SCHOOLS

Report/ID Name. STEM ACADEMY \$750

Client Code ->. PIEDS . 52030 . 98 .

Client Name . LYNCHBURG CITY SCHOOLS

Report/ID Name. COBRA \$1500

Client Code ->. PIEDS . 52030 . 15 .

Client Name . LYNCHBURG CITY SCHOOLS

Report/ID Name. GOVERNORS \$750

## Role of the On-Site Healthcare Provider

Often times one does not address symptoms of emerging health issues because they are not considered severe enough to warrant taking hours from a day to visit with a physician. If left unattended, these warning signs of developing health problems can evolve into serious conditions requiring specialty medical services at great cost to you and your company's health plan. A benefit is being sponsored by your Employer that will provide convenient and personal access to a healthcare provider on-site where you work to assist you with the management of your health. This professional is licensed and trained to provide the following health services:

- ✓ Diagnosis and treatment of minor medical conditions
- ✓ Physician referrals
- ✓ Order diagnostic testing services
- ✓ Blood draw and specimen analysis
- ✓ Prescribe medications and write prescriptions
- ✓ Manage emerging chronic disease symptoms
- ✓ Health education and advisory services
- ✓ Interpretation of test results and outcomes of treatment received

It is important to understand that the purpose of this program is not to interrupt your relationship with a physician. Instead, it should complement the care you may receive from your doctor, and for those who do not have a doctor or do not visit as frequently as you should, it will be a convenient health resource to help you stay on track with disease symptom management activities.



HUMAN RESOURCES DEPARTMENT

# Employee Health Management Clinic

Monument Terrace Building – 901 Church St

Hours: Monday, Wednesday & Friday 8-5 (Tuesday and Thursday by appointment only)

455-4078 or nurse@lynchburgva.gov

The Health Management Clinic is a City benefit for active employees who are covered by the City's health plan. Centra Medical Group (CMG) provides staff and services through the clinic. Brenda Harlow, Licensed Practical Nurse, and Regina Scott, Certified Nurse Practitioner, staff the clinic daily and provide managed health care and education to the City's full time workforce. Check out the following FAQ's for more information.

➤ **What is the Health Management Program (HMP)?**

The HMP is a medical approach designed to proactively address the health needs of our employees, effectively change unhealthy behaviors, prevent diseases, help high risk employees control and improve their health, and promote wellness. The clinic provides non-work related medical services for employee members.

➤ **How do I enroll in the HMP?**

To participate in the program you first complete an on-line questionnaire and then have an initial Risk Assessment completed by the clinic staff. Go to this web-site to complete the questionnaire <https://ha.healthawareservices.com/ra/701> and the staff will call you for a follow up appointment.

➤ **What do services at the Clinic cost?**

There is **no cost** to employees for services and no co-pay at the Clinic; however you will have to pay for any prescriptions prescribed.

➤ **Where is the clinic located?**

The Clinic is located in the Monument Terrace Building at 901 Church Street (across from City Hall). There are two clinic designated parking spaces in Lot B (adjacent to the Monument Terrace Building)

➤ **How do you make an appointment?**

Appointments can be made by calling (434) 455-4078. Please leave a message if the nurse is unable to answer the phone (she may be with a patient). Tuesdays and Thursdays are usually dedicated to employee education and you can leave a message so that appointments can be made as soon as possible.

➤ **What services are provided at the clinic?**

The clinic does not provide the full range of services provided by your primary care provider, however; some examples of the services the clinic does provide are listed below:

Services	Examples
Diagnose & treat and/or refer for acute illnesses	<ul style="list-style-type: none"> <li>• Gastrointestinal problems (upset stomach, nausea, vomiting)</li> <li>• Respiratory problems (cough/cold/flu, sinus problems, sore throat/strep)</li> <li>• Psychiatric problems (depression, anxiety, sleep disturbances)</li> <li>• Musculoskeletal issues (gout, joint pain, sprains/strains, arthritis pain)</li> <li>• Genitourinary problems (uti, pelvic pain)</li> </ul>
Wellness Services	<ul style="list-style-type: none"> <li>• Health Risk Assessments</li> <li>• Vision checks</li> <li>• Healthy Edge progress reports (Weight Watchers, Y Change, Centra Learn)</li> </ul>
Nursing Services	<ul style="list-style-type: none"> <li>• Blood pressure checks</li> <li>• Blood sugar checks</li> <li>• Weight management checks</li> </ul>
Follow up care	<ul style="list-style-type: none"> <li>• Diabetes</li> <li>• Repeat labs</li> <li>• High cholesterol</li> </ul>
Lab draws	<ul style="list-style-type: none"> <li>• Routine blood draws</li> <li>• Flu/ strep /mono testing</li> <li>• Urinalysis</li> </ul>
Referrals	<ul style="list-style-type: none"> <li>• Primary care provider</li> <li>• Cardiology</li> <li>• Orthopedic</li> <li>• Radiology services</li> </ul>
Patient education classes	<ul style="list-style-type: none"> <li>• Hypertension</li> <li>• Diet and exercise</li> <li>• High cholesterol</li> <li>• Metabolic syndrome</li> <li>• Diabetes</li> </ul>

City of Lynchburg HMP Clinic

Lab Tests	CPT Code
Basic Metabolic Panel	
CBC	
CBC w/ diff	
Comprehensive Metabolic Panel	
Coronary Risk Profile (lipid panel)	
Free T4	
Glycohemoglobin (Hgb A1c)	
hCG, Quant	
HCT	
Hep C screening	
HGB	
Iron	
Liver Function Tests	
Misc culture	
PSA	
Throat culture	
TSH	
TSH w/ Reflex	
Urinalysis	
Urine Culture	
Urine w/ micro	
Urine w/ reflex	
Vit D	

ANY LAB COULD BE ORDERED IN SPECIAL SITUATIONS

2016 COL Medical Rates

	EE Monthly Cost	ER Monthly Cost	Total Monthly Cost
EE Only	\$19	\$367	\$386
EE + Child	\$198	\$420	\$618
EE + Children	\$284	\$605	\$889
EE + Spouse	\$247	\$526	\$773
Family	\$408	\$867	\$1,275
Family (Both City EE's)*	\$115	\$1,160	\$1,275

\*Rate not available  
to new enrollees  
after 1/1/16.

+\$37 if  
not in  
HMP

## Lynchburg City Schools 2015-2016 Benefits Codes & Rates

Description	Deductible Amount	Pre-Tax Code	Taxable Code	Semi - Monthly Cost -EE	Monthly Cost -EE	Semi - Monthly Cost -ER	Monthly Cost - ER
<b>24 Pays (12 Month)</b>							
Hospital Single	<b>1500</b>	HOSP00	THOS00	\$14.00	\$28.00	\$202.11	\$404.22
Hospital Single	750	HOSP01	THOS01	\$38.50	\$77.00	\$190.64	\$381.28
Hospital Employee + Spouse	<b>1500</b>	HOSP02	THOS02	\$146.36	\$292.72	\$227.64	\$455.28
Hospital Employee + Spouse	750	HOSP03	THOS03	\$191.39	\$382.78	\$205.11	\$410.22
Hospital Employee + Children	<b>1500</b>	HOSP04	THOS04	\$144.50	\$289.00	\$214.23	\$428.46
Hospital Employee + Children	750	HOSP05	THOS05	\$182.50	\$365.00	\$195.58	\$391.16
Hospital Family	<b>1500</b>	HOSP06	THOS06	\$229.50	\$459.00	\$222.16	\$444.32
Hospital Family	750	HOSP07	THOS07	\$277.00	\$554.00	\$197.32	\$394.64
Hospital Family/Both Employed	<b>1500</b>	HOSP08	THOS08	\$44.50	\$89.00	\$203.58	\$407.16
Hospital Family/Both Employed	750	HOSP09	THOS09	\$92.00	\$184.00	\$191.16	\$382.32
<b>Hospital Family/Both - Spouse</b>	<b>1500</b>	<b>HOSBSL</b>	<b>THOBSL</b>	<b>\$0.00</b>	<b>\$0.00</b>	<b>\$201.50</b>	<b>\$403.00</b>
<b>Hospital Family/Both - Spouse</b>	<b>750</b>	<b>HOSBSH</b>	<b>THOBSH</b>	<b>\$0.00</b>	<b>\$0.00</b>	<b>\$190.00</b>	<b>\$380.00</b>
Hospital Employee + Child	<b>1500</b>	HOSP12	THOS12	\$117.01	\$234.02	\$181.99	\$363.98
Hospital Employee + Child	750	HOSP13	THOS13	\$149.51	\$299.02	\$167.49	\$334.98
<b>22 Pays (11 Month)</b>							
Hospital Single	<b>1500</b>	HOSP40	THOS40	\$15.27	\$30.55	\$220.48	\$440.96
Hospital Single	750	HOSP41	THOS41	\$42.00	\$84.00	\$207.97	\$415.95
Hospital Employee + Spouse	<b>1500</b>	HOSP42	THOS42	\$159.66	\$319.33	\$248.34	\$496.67
Hospital Employee + Spouse	750	HOSP43	THOS43	\$208.79	\$417.58	\$223.75	\$447.51
Hospital Employee + Children	<b>1500</b>	HOSP44	THOS44	\$157.64	\$315.27	\$233.71	\$467.42
Hospital Employee + Children	750	HOSP45	THOS45	\$199.09	\$398.18	\$213.36	\$426.73
Hospital Family	<b>1500</b>	HOSP46	THOS46	\$250.36	\$500.73	\$242.35	\$484.71
Hospital Family	750	HOSP47	THOS47	\$302.18	\$604.36	\$215.25	\$430.51
Hospital Employee + Child	<b>1500</b>	HOSP48	THOS48	\$127.65	\$255.29	\$198.54	\$397.07
Hospital Employee + Child	750	HOSP49	THOS49	\$163.10	\$326.20	\$182.72	\$365.44