Plan Document
&
Summary Plan Description
The City of Lynchburg

Health Care Plan

Effective January 1, 2014

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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. 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

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

Benefits	In-Plan	Out-of-Plan
Chiropractic Services (20 visits per Calendar Year)	100% after $30 copayment	60% after deductible
Physical/Occupational Therapy (30 visits combined per Calendar Year) In office Outpatient	 100% after $30 copayment 80% after deductible	 60% after deductible 60% after deductible
Speech Therapy (30 visits per Calendar Year) In office Outpatient	 100% after $30 copayment 80% after deductible	 60% after deductible 60% after deductible
Wig after Chemotherapy	80% after deductible	60% after deductible
Ambulance	80% after deductible	60% after deductible
Skilled Nursing Facility Care 30 day limit	80% after deductible	60% after deductible
Home Health Care (100 visits Calendar Year maximum combined)	80% after deductible	60% after deductible
Hospice	80% after deductible	60% after deductible
Organ Transplants	80% after deductible	60% after deductible
Pregnancy Inpatient (includes delivery) In doctor's office	 80% after deductible First visit $100 copayment then 100% thereafter	 60% after deductible 60% after deductible
* **Prescription Drugs** Retail 30 day supply Mail Order 90 day supply	 Coinsurance: Generic 40% Brand 40% Coinsurance: Generic 40% Brand 40% • Mandatory Generic • Mandatory Mail Order for Maintenance Prescriptions	 Coinsurance: Generic 40% Brand 40% Coinsurance: Generic 40% Brand 40% • Mandatory Generic • Mandatory Mail Order for Maintenance Prescriptions

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 1st, 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

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

<u>NOTE</u>: 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

<u>NOTE:</u> 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

Age of Covered Person	In-Plan Covered Services
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 12 months ages 7 to 19. Annual pap smear for females beginning at age 13.*
20 to 39 years	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.
40 to 49 years	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.
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. 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.
55 year and older	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.

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

PREADMISSION 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:

Notification to claimant of benefit determination	**72 hours**

Insufficient information on the Claim, or failure to follow the Plan's procedure for filing a Claim:

Notification to claimant, orally or in writing	**24 hours**
Response by claimant, orally or in writing	**48 hours**
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.**

Ongoing courses of treatment, notification of:

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

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:

Notification to claimant of benefit determination	**15 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**
Notification, orally or in writing, of failure to follow the Plan's procedures for filing a Claim	**5 days**
Ongoing courses of treatment:	
Reduction or termination before the end of the treatment	**15 days**

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.
-

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.

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