

# Piedmont Community HealthCare

<http://www.pchp.net>

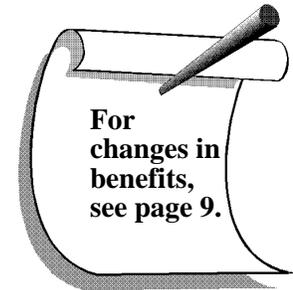
## 2007

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### A Health Maintenance Organization with a point of service product and a high deductible health plan

**Serving:** The Virginia cities of Bedford and Lynchburg; the Virginia counties of Albemarle, Amherst, Appomattox, Bedford, Buckingham, Campbell, Charlotte, Cumberland, Halifax, Lunenburg, Nelson, Nottoway, Pittsylvania, and Prince Edward.

**Enrollment in this Plan is limited. You must live or work in our Geographic service area to enroll. See page 7 for requirements.**



**Enrollment code for this Plan:**

**2C1 High Option - Self Only**

**2C2 High Option - Self and Family**

**2C4 High Deductible Health Plan (HDHP) - Self Only**

**2C5 High Deductible Health Plan (HDHP) - Self and Family**

**Special notice:** This Plan is offering a High Deductible Health Plan for the first time under the FEHB Program during the 2006 open season.



Authorized for distribution by the:



**United States  
Office of Personnel Management**

Center for  
Retirement and Insurance Services  
<http://www.opm.gov/insure>

**Important Notice from Piedmont Community HealthCare About  
Our Prescription Drug Coverage and Medicare**

OPM has determined that Piedmont Community HealthCare prescription drug coverage is, on average, expected to pay out as much as the standard Medicare prescription drug coverage will pay for all plan participants and is considered Creditable Coverage. Thus you do not need to enroll in Medicare Part D and pay extra for prescription drug benefit coverage. If you decide to enroll in Medicare Part D later, you will not have to pay a penalty for late enrollment as long as you keep your FEHB coverage.

However, if you choose to enroll in Medicare Part D, you can keep your FEHB coverage and your FEHB plan will coordinate benefits with Medicare.

Remember: If you are an annuitant and you terminate your FEHB coverage, you may not re-enroll in the FEHB Program.

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**Please be advised**

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If you lose or drop your FEHB coverage and go 63 days or longer without prescription drug coverage that's at least as good as Medicare's prescription drug coverage, your monthly premium will go up at least 1% per month for every month that you did not have that coverage. For example, if you go 19 months without Medicare Part D prescription drug coverage, your premium will always be at least 19 percent higher than what most other people pay. You'll have to pay this higher premium as long as you have Medicare prescription drug coverage. In addition, you may have to wait until the next Annual Coordinated Election Period (November 15th through December 31st) to enroll in Medicare Part D.

**Medicare's Low Income Benefits**

*For people with limited income and resources, extra help paying for a Medicare prescription drug plan is available. Information regarding this program is available through the Social Security Administration (SSA) online at [www.socialsecurity.gov](http://www.socialsecurity.gov), or call the SSA at 1-800-772-1213 (TTY 1-800-325-0778).*

You can get more information about Medicare prescription drug plans and the coverage offered in your area from these places:

- Visit [www.medicare.gov](http://www.medicare.gov) for personalized help,
- Call 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048.

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## Introduction

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This brochure describes the benefits of *Piedmont Community HealthCare* under our contract (CS 2858) with the United States Office of Personnel Management, as authorized by the Federal Employees Health Benefits law. The address for *Piedmont Community HealthCare* administrative offices is:

Piedmont Community HealthCare Benefit Plan  
2512 Langhorne Road  
Lynchburg, VA 24501

This brochure is the official statement of benefits. No oral statement can modify or otherwise affect the benefits, limitations, and exclusions of this brochure. It is your responsibility to be informed about your health benefits.

If you are enrolled in this Plan, you are entitled to the benefits described in this brochure. If you are enrolled in Self and Family coverage, each eligible family member is also entitled to these benefits. You do not have a right to benefits that were available before January 1, 2007, unless those benefits are shown in this brochure.

OPM negotiates benefits and rates with each plan annually. Benefit changes are effective January 1, 2007, and changes are summarized on page 8. Rates are shown at the end of this brochure.

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## Plain Language

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All FEHB brochures are written in plain language to make them responsive, accessible, and understandable to the public. For instance,

- Except for necessary technical terms, we use common words. For instance, “you” means the enrollee or family member, “we” means *Piedmont Community HealthCare*.
- We limit acronyms to ones you know. FEHB is the Federal Employees Health Benefits Program. OPM is the United States Office of Personnel Management. If we use others, we tell you what they mean first.
- Our brochure and other FEHB plans’ brochures have the same format and similar descriptions to help you compare plans.

If you have comments or suggestions about how to improve the structure of this brochure, let OPM know. Visit OPM’s “Rate Us” feedback area at [www.opm.gov/insure](http://www.opm.gov/insure) or e-mail OPM at [fehwebcomments@opm.gov](mailto:fehwebcomments@opm.gov). You may also write to OPM at the U.S. Office of Personnel Management, Insurance Services Programs, Program Planning & Evaluation Group, 1900 E Street, NW, Washington, DC 20415-3650.

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## Stop Health Care Fraud!

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Fraud increases the cost of health care for everyone and increases your Federal Employees Health Benefits Program premium.

OPM’s Office of the Inspector General investigates all allegations of fraud, waste, and abuse in the FEHB Program regardless of the agency that employs you or from which you retired.

**Protect Yourself From Fraud** – Here are some things that you can do to prevent fraud:

- Do not give your plan identification (ID) number over the telephone or to people you do not know, except for your health care providers, authorized health benefits plan, or OPM representative.
- Let only the appropriate medical professionals review your medical record or recommend services.
- Avoid using health care providers who say that an item or service is not usually covered, but they know how to bill us to get it paid.
- Carefully review explanations of benefits (EOBs) statements that you receive from us.
- Do not ask your doctor to make false entries on certificates, bills or records in order to get us to pay for an item or service.

- If you suspect that a provider has charged you for services you did not receive, billed you twice for the same service, or misrepresented any information, do the following:

Call the provider and ask for an explanation. There may be an error.

If the provider does not resolve the matter, call us at (434) 947-4463 and explain the situation.

If we do not resolve the issue:

**CALL - THE HEALTH CARE FRAUD HOTLINE**

**202-418-3300**

**OR WRITE TO:**

**United States Office of Personnel Management**

**Office of the Inspector General Fraud Hotline**

**1900 E Street NW Room 6400**

**Washington, DC20415-1100**

- Do not maintain as a family member on your policy:
  - Your former spouse after a divorce decree or annulment is final (even if a court order stipulates otherwise); or
  - Your child over age 22 (unless he/she is disabled and incapable of self support).
- If you have any questions about the eligibility of a dependent, check with your personnel office if you are employed, with your retirement office (such as OPM) if you are retired, or with the National Finance Center if you are enrolled under Temporary Continuation of Coverage.
- You can be prosecuted for fraud and your agency may take action against you if you falsify a claim to obtain FEHB benefits or try to obtain services for someone who is not an eligible family member or who is no longer enrolled in the Plan.

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## **Preventing medical mistakes**

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An influential report from the Institute of Medicine estimates that up to 98,000 Americans die every year from medical mistakes in hospitals alone. That's about 3,230 preventable deaths in the FEHB Program a year. While death is the most tragic outcome, medical mistakes cause other problems such as permanent disabilities, extended hospital stays, longer recoveries, and even additional treatments. By asking questions, learning more and understanding your risks, you can improve the safety of your own health care, and that of your family members. Take these simple steps:

### **1. Ask questions if you have doubts or concerns.**

- Ask questions and make sure you understand the answers.
- Choose a doctor with whom you feel comfortable talking.
- Take a relative or friend with you to help you ask questions and understand answers.

### **2. Keep and bring a list of all the medicines you take.**

- Give your doctor and pharmacist a list of all the medicines that you take, including non-prescription medicines.
- Tell them about any drug allergies you have.
- Ask about any risks or side effects of the medication and what to avoid while taking it. Be sure to write down what your doctor or pharmacist says.
- Make sure your medicine is what the doctor ordered. Ask the pharmacist about the medication if it looks different than you expected.

- Read the label and patient package insert when you get your medicine, including all warnings.
- Know how to use your medicine. Especially note the times and conditions when your medicine should and should not be taken.
- Contact your doctor or pharmacist if you have any questions.

### **3. Get the results of any test or procedure.**

- Ask when and how you will get the results of tests or procedures.
- Don't assume the results are fine if you do not get them when expected, be it in person, by phone, or by mail.
- Call your doctor and ask for your results.
- Ask what the results mean for your care.

### **4. Talk to your doctor about which hospital is best for your health needs.**

- Ask your doctor about which hospital has the best care and results for your condition if you have more than one hospital to choose from to get the health care you need.
- Be sure you understand the instructions you get about follow-up care when you leave the hospital.

### **5. Make sure you understand what will happen if you need surgery.**

- Make sure you, your doctor, and your surgeon all agree on exactly what will be done during the operation.
- Ask your doctor, "Who will manage my care when I am in the hospital?"
- Ask your surgeon:
  - Exactly what will you be doing?
  - About how long will it take?
  - What will happen after surgery
  - How can I expect to feel during recovery?
- Tell the surgeon, anesthesiologist, and nurses about any allergies, bad reaction to anesthesia, and any medications you are taking.

Visit these Web sites for more information about patient safety.

Ø [www.ahrq.gov/path/beactive.htm](http://www.ahrq.gov/path/beactive.htm). The Agency for Healthcare Research and Quality makes available a wide-ranging list of topics not only to inform consumers about patient safety but to help choose quality health care providers and improve the quality of care you receive.

Ø [www.npsf.org](http://www.npsf.org). The National Patient Safety Foundation has information on how to ensure safer health care for you and your family.

Ø [www.talkaboutrx.org](http://www.talkaboutrx.org). The National Council on Patient Information and Education is dedicated to improving communication about the safe, appropriate use of medicines.

Ø [www.leapfroggroup.org](http://www.leapfroggroup.org). The Leapfrog Group is active in promoting safe practices in hospital care.

Ø [www.ahqa.org](http://www.ahqa.org). The American Health Quality Association represents organizations and health care professionals working to improve patient safety.

Ø [www.quic.gov/report](http://www.quic.gov/report). Find out what federal agencies are doing to identify threats to patient safety and help prevent mistakes in the nation's health care delivery system.

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## Section 1 Facts about this HMO plan

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This Plan is a health maintenance organization (HMO). We require you to see specific physicians, hospitals, and other providers that contract with us. These Plan providers coordinate your health care services. The Plan is solely responsible for the selection of these providers in your area. Contact the Plan for a copy of their most recent provider directory.

HMOs emphasize preventive care such as routine office visits, physical exams, well-baby care, and immunizations, in addition to treatment for illness and injury. Our providers follow generally accepted medical practice when prescribing any course of treatment.

When you receive services from Plan providers, you will not have to submit claim forms or pay bills. You only pay the copayments, coinsurance, and deductibles described in this brochure. When you receive emergency services from non-Plan providers, you may have to submit claim forms.

**You should join an HMO because you prefer the plan's benefits, not because a particular provider is available. You cannot change plans because a provider leaves our Plan. We cannot guarantee that any one physician, hospital, or other provider will be available and/or remain under contract with us.**

### **General features of our High Option:**

The in-plan annual deductible does not apply to services that have a copayment. You do not have to meet the in-plan deductible before receiving the copayment benefit. The copayments do not count towards the deductible. The deductible and copayments, except for outpatient mental health and prescription drug count towards the out-of-pocket maximum.

The office visit copayment covers all services that are performed in that office visit.

### **We have Point-of-Service (POS) benefits:**

Our HMO offers Point-of-Service (POS) benefits. This means you can receive covered services from a participating provider without a required referral, or from a non-participating provider. These out-of-network benefits have higher out-of-pocket costs than our in-network benefits.

### **How we pay providers**

We contract with individual physicians, medical groups, and hospitals to provide the benefits in this brochure. These Plan providers accept a negotiated payment from us, and you will only be responsible for your copayments or coinsurance.

Your Piedmont Community HealthCare physician provides your health care. Your primary care physician will coordinate all of your health care needs. Please note that a referral from your primary care physician is not necessary for emergency services or for up to two office visits each year for female members to a Plan OB/GYN physician.

### **General features of our High Deductible Health Plan (HDHP)**

HDHPs have higher annual deductibles and annual out-of-pocket maximum limits than other types of FEHB plans.

### **Preventive care services**

Preventive care services are generally paid as first dollar coverage or after a small deductible or copayment.

### **Annual deductible**

The annual deductible must be met before Plan benefits are paid for care other than preventive care services.

### **Health Savings Account (HSA)**

You are eligible for an HSA if you are enrolled in an HDHP, not covered by any other health plan that is not an HDHP (including a spouse's health plan, but does not include specific injury insurance and accident, disability, dental care, vision care, or long-term coverage), not enrolled in Medicare, and are not claimed as a dependent on someone else's tax return.

Piedmont Community HealthCare works with Bank of the James to offer an HSA. You should contact Bank of the James directly to establish a HSA account. They can be reached at (434) 455-7544.

- You may use the money in your HSA to pay all or a portion of the annual deductible, copayments, coinsurance, or other out-of-pocket costs that meet the IRS definition of a qualified medical expense.
- Distributions from your HSA are tax-free for qualified medical expenses for you, your spouse, and your dependents, even if they are not covered by a HDHP.
- You may withdraw money from your HSA for items other than qualified medical expenses, but it will be subject to income tax and, if you are under 65 years old, an additional 10% penalty tax on the amount withdrawn.
- For each month that you are enrolled in an HDHP and eligible for an HSA, the HDHP will pass through (contribute) a portion of the health plan premium to your HSA. In addition, you (the account holder) may contribute your own money to your HSA up to an allowable amount determined by IRS rules. In addition, your HSA dollars earn tax-free interest.
- You may allow the contributions in your HSA to grow over time, like a savings account. The HSA is portable – you may take the HSA with you if you leave the Federal government or switch to another plan.

### **Health Reimbursement Arrangement (HRA)**

If you are not eligible for an HSA, or become ineligible to continue an HSA, you are eligible for a Health Reimbursement Arrangement (HRA). Although an HRA is similar to an HSA, there are major differences.

- An HRA does not earn interest.
- An HRA is not portable if you leave the Federal government or switch to another plan.
- To establish an HRA, please contact Piedmont Community HealthCare at (434) 947-4463.

### **Catastrophic protection**

We protect you against catastrophic out-of-pocket expenses for covered services. Your annual in-plan out-of-pocket expenses for covered services, including deductibles and copayments, cannot exceed \$4,000 for Self Only enrollment, or \$8,000 family coverage.

### **Your rights**

OPM requires that all FEHB Plans provide certain information to their FEHB members. You may get information about us, our networks, and our providers. OPM's FEHB website ( [www.opm.gov/insure](http://www.opm.gov/insure) ) lists the specific types of information that we must make available to you. Some of the required information is listed below.

- Piedmont Community HealthCare, Inc. has been in existence eight years,
- Piedmont Community HealthCare, Inc. is a for profit company,
- Customer satisfaction surveys are conducted each year for Piedmont Community HealthCare in conjunction with the parent company, Piedmont Community Health Plan,
- The network providers include approximately 170 primary care physicians and over 400 specialists, and
- Providers are compensated based on our fee schedule and have agreed to a 20 percent withhold from their payments.

If you want more information about us, call 434/947-4463, or write to Piedmont Community HealthCare, 2512 Langhorne Road, Lynchburg, VA24501. You may also contact us by fax at 434/947-4465 or visit our website at [www.pchp.net](http://www.pchp.net) .

### **Service Area**

To enroll in this Plan, you must live in or work in our Service Area. This is where our providers practice. Our service area is: the cities of Bedford and Lynchburg; the counties of Albemarle, Amherst, Appomattox, Bedford, Buckingham, Campbell, Charlotte, Cumberland, Halifax, Lunenburg, Nelson, Nottoway, Pittsylvania, and Prince Edward.

Ordinarily, you should get your care from providers who contract with us. If you receive care outside our service area, we will pay only for emergency care or point-of-service benefits.

If you or a covered family member move outside of our service area, you can enroll in another plan. If your dependents live out of the area (for example, if your child goes to college in another state), you should consider enrolling in a fee-for-service plan or an HMO that has agreements with affiliates in other areas. Children in college are covered for emergency and urgent care, however, routine care is not covered at the higher point-of-service level while outside of our service area. If you or a family member move, you do not have to wait until Open Season to change plans. Contact your employing or retirement office.

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## Section 2 How we change for 2007

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Do not rely on these change descriptions; this Section is not an official statement of benefits. For that, go to Section 5 Benefits. Also, we edited and clarified language throughout the brochure; any language change not shown here is a clarification that does not change benefits.

### **Changes to this Plan**

- Your share of the non-postal premium will increase by 22.8% for self only; and increase by 25.8% for Self and Family.

### **Changes to High Option only**

Prescription drug copayments have changed to the following:

- \$15 for generic drugs for a 30 day supply or 100 units
- \$40 for brand name drugs for a 30 day supply or 100 units
- \$55 for non-formulary drugs for a 30 day supply or 100 units
  
- \$30 for generic mail order drugs for a 90 day supply or 300 units
- \$80 for brand name mail order drugs for a 90 day supply or 300 units
- \$110 for non-formulary mail order drugs for a 90 day supply or 300 units

### **We are offering a High Deductible Health Plan for 2007**

- This is a new offering for 2007.

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## Section 3. How you get care

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### Identification cards

We will send you an identification (ID) card. You should carry your ID card with you at all times. You must show it whenever you receive services from a Plan provider, or fill a prescription at a Plan pharmacy. Until you receive your ID card, use your copy of the Health Benefits Election Form, SF-2809, your health benefits enrollment confirmation (for annuitants), or your electronic enrollment system (such as Employee Express) confirmation letter.

If you do not receive your ID card within 30 days after the effective date of your enrollment, or if you need replacement cards, call us at 1-800-400-7247.

### Where you get covered care

You get care from “Plan providers” and “Plan facilities.” You will only pay copayments, or coinsurance, and you will not have to file claims. If you use our point-of-service program, you can also get care from non-Plan providers, or from participating providers without a required referral, but it will cost you more. In those instances, you will have a deductible and higher coinsurance with no copayments.

- **Plan providers**

Plan providers are physicians, specialists and other health care professionals in our service area that we contract with to provide covered services to our members. We credential Plan providers according to national standards.

We list Plan providers in the provider directory, which we update periodically. The list is also on our Web site.

- **Plan facilities**

Plan facilities are hospitals and other facilities in our service area that we contract with to provide covered services to our members. We list these in the provider directory, which we update periodically. The list is also on our Web site.

### What you must do to get covered care

It depends on the type of care you need. First, you and each family member must choose a primary care physician. This decision is important since your primary care physician provides or arranges for most of your health care. Simply complete the primary care physician selection form and return it to us.

- **Primary care**

Your primary care physician can be a family practitioner, general practitioner, internist or pediatrician. Your primary care physician will provide most of your health care, or give you a referral to see a specialist.

If you want to change primary care physicians or if your primary care physician leaves the Plan, call us. We will help you select a new one

- **Specialty care**

Your primary care physician will refer you to a specialist for needed care. When you receive a referral from your primary care physician, you must return to the primary care physician after the consultation, unless your primary care physician authorized a certain number of visits without additional referrals. The primary care physician must provide or authorize all follow-up care. Do not go to the specialist for return visits unless your primary care physician gives you a referral. However, you may see participating OB/GYN physicians twice a year without a referral.

Here are some other things you should know about specialty care:

- If you need to see a specialist frequently because of a chronic, complex, or serious medical condition, your primary care physician will work with your specialist and us to develop a treatment plan that allows you to see your specialist for a certain number of visits without additional referrals. Your primary care physician will use our criteria when creating your treatment plan (the physician may have to get an authorization or approval beforehand).

- If you are seeing a specialist when you enroll in our Plan, talk to your primary care physician. Your primary care physician will decide what treatment you need. If he or she decides to refer you to a specialist, ask if you can see your current specialist. If your current specialist does not participate with us, you must receive treatment from a specialist who does. Generally, you will receive point-of-service benefits when you see a specialist who does not participate with our Plan.
- If you are seeing a specialist and your specialist leaves the Plan, call your primary care physician, who will arrange for you to see another specialist. You may receive services from your current specialist until we can make arrangements for you to see someone else.
- If you have a chronic or disabling condition and lose access to your specialist because we:
  - Terminate our contract with your specialist for other than cause; or
  - Drop out of the Federal Employees Health Benefits (FEHB) Program and you enroll in another FEHB program Plan; or
  - Reduce our service area and you enroll in another FEHB Plan,

you may be able to continue seeing your specialist for up to 90 days after you receive notice of the change. Contact us, or if we drop out of the Program, contact your new plan.

If you are in the second or third trimester of pregnancy and you lose access to your specialist based on the above circumstances, you can continue to see your specialist until the end of your postpartum care, even if it is beyond the 90 days.

**• If you are hospitalized when your enrollment begins**

Your Plan primary care physician or specialist will make necessary hospital arrangements and supervise your care. This includes admission to a skilled nursing or other type of facility.

If you are in the hospital when your enrollment in our Plan begins, call our customer service department immediately at 1-800-400-7247. If you are new to the FEHB Program, we will arrange for you to receive care and reimburse you for your covered expenses while you are in the hospital beginning on the effective date of your coverage.

If you changed from another FEHB plan to us, your former plan will pay for the hospital stay until:

- You are discharged, not merely moved to an alternative care center; or
- The day your benefits from your former plan run out; or
- The 92nd day after you become a member of this Plan, whichever happens first.

These provisions apply only to the hospital benefits of the hospitalized person.

**Circumstances beyond our control**

Under certain extraordinary circumstances, such as natural disasters, we may have to delay your services or we may be unable to provide them. In that case, we will make all reasonable efforts to provide you with the necessary care.

**Services requiring our prior approval**

Your primary care physician has authority to refer you for most services. For certain services, however, your physician must obtain approval from us. Before giving approval, we consider if the service is covered, medically necessary, and follows generally accepted medical practice.

We call this review and approval process *precertification*. Except for services rendered under our Point of Service benefits, your physician must obtain precertification for the following services such as:

- referrals for covered services to non-participating providers
- transplants

non-emergency ambulance or air ambulance transportation

physical therapy, occupational therapy, and speech therapy

drugs to treat sexual dysfunction

Your primary care physician will submit a referral to us for these services. We will establish that the appropriate criteria have been met and provide an authorization to your primary care physician and to the provider to whom you have been referred. Without the proper authorization, services may be paid at the out-of-network benefit level or not covered at all.

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## Section 4 Your costs for covered services

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You must share the costs of some services. You are responsible for:

### **Copayments**

A copayment is a fixed amount of money you pay to the provider, facility, pharmacy, etc., when you receive certain services.

Example: When you see your primary care physician you pay a copayment of \$25 per office visit.

### **Deductible**

A deductible is a fixed expense you must incur for certain covered services and supplies before we start paying benefits for them. Copayments do not count toward any deductible. The calendar year deductible is \$500 per individual and \$1,000 per family for in-plan benefits. A \$1,500 individual and \$3,000 family deductible applies to out-of-plan benefits.

Note: If you change plans during open season, you do not have to start a new deductible under your old plan between January 1 and the effective date of your new plan. If you change plans at another time during the year, you must begin a new deductible under your new plan.

### **Coinsurance**

Coinsurance is the percentage of our allowance that you must pay for your care. Coinsurance doesn't begin until you meet your deductible. Coinsurance applies to all services except for office visits and emergency/urgent care services.

Example: In our Plan, you pay 20% of our allowance for all hospital related services including inpatient, outpatient and diagnostic testing, infertility services and durable medical equipment .

### **Waivers**

In some instances, a Piedmont provider may ask you to sign a "waiver" prior to receiving care. This waiver may state that you accept responsibility for the total charge for any care that is not covered by your health plan. If you sign such a waiver, whether you are responsible for the total charge depends on the content of the contracts that the Plan has with its providers. If you are asked to sign this type of waiver, please be aware that, if benefits are denied for the services, you could be legally liable for the related expenses. If you would like more information about waivers, please contact us at 1-800-400-7247.

### **Your catastrophic protection out-of-pocket maximum**

After your copayments and coinsurance total \$3,000 per person or \$6,000 per family enrollment in any calendar year, you do not have to pay any more for covered services received in-plan. However, copayments or coinsurance for the following services do not count toward your out-of-pocket maximum, and you must continue to pay copayments or coinsurance for these services:

- Prescription drug copayments
- Vision exam copayments

Be sure to keep accurate records of your copayments and coinsurance since you are responsible for informing us when you reach the maximum. Please note that your out-of-pocket maximum for Point of Service benefits total to \$6,000 per person and \$12,000 per family. (See page 40)

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## Section 5 High Option Benefits

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See page 9 for how our benefits changed this year. Page 93 is a benefits summary. Make sure that you review the benefits that are available to you under this plan.

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**Section 5(a) Medical services and supplies  
provided by physicians and other health care professionals**

**Important things you should keep in mind about these benefits:**

- Please remember that all benefits are subject to the definitions, limitations, and exclusions in this brochure and are payable only when we determine they are medically necessary.
- Plan physicians must provide or arrange your care.
- The calendar year deductible is \$500 per individual and \$1000 per family for in-plan benefits.
- Be sure to read Section 4, *Your costs for covered services*, for valuable information about how cost sharing works. Also read Section 9 about coordinating benefits with other coverage, including with Medicare.

Benefit Description	You pay After the calendar year deductible...
<p><b>Note: The calendar year deductible applies to almost all benefits in this Section. We say “(No deductible)” when it does not apply.</b></p>	
<b>Diagnostic and treatment services</b>	<b>High Option</b>
Professional services of physicians <ul style="list-style-type: none"> <li>• In physician’s office</li> </ul>	\$25 per office visit
Professional services of physicians <ul style="list-style-type: none"> <li>• In an urgent care center</li> <li>• Office medical consultations</li> </ul>	\$25 per office visit
<ul style="list-style-type: none"> <li>• Second surgical opinion</li> <li>• During a hospital stay</li> <li>• In a skilled nursing facility</li> </ul>	20% of allowable charge after deductible
At home	\$25 per physician visit  20% of allowable charge after deductible for home health services
<b>Lab, X-ray and other diagnostic tests</b>	<b>High Option</b>
Tests, such as: <ul style="list-style-type: none"> <li>• Blood tests</li> <li>• Urinalysis</li> <li>• Non-routine Pap tests</li> <li>• Pathology</li> <li>• X-rays</li> <li>• Non-routine Mammograms</li> <li>• CAT Scans/MRI</li> <li>• Ultrasound</li> <li>• Electrocardiogram and EEG</li> </ul>	Nothing if you receive these services during your office visit; otherwise, \$25 per visit  20% of allowable charge after deductible for services performed at a hospital

Benefit Description	You pay After the calendar year deductible...
<b>Preventive care, adult</b>	<b>High Option</b>
Routine screenings, such as: <ul style="list-style-type: none"> <li>• Total Blood Cholesterol - once every three years</li> <li>• Colorectal Cancer Screening, including               <ul style="list-style-type: none"> <li>- Fecal occult blood test</li> <li>- Sigmoidoscopy, screening – every five years starting at age 50</li> <li>- Double contrast barium enema – every five years starting at age 50</li> <li>- Colonoscopy screening – every ten years starting at age 50</li> </ul> </li> </ul>	\$25 per office visit
Routine Prostate Specific Antigen (PSA) test – one annually for men age 40 and older	\$25 per office visit
Routine Pap test  Note: The office visit is covered if pap test is received on the same day; see <i>Diagnostic and treatment services</i> , above.	\$25 per office visit
Routine mammogram screening – covered for women age 35 and older, as follows: <ul style="list-style-type: none"> <li>• From age 35 through 39, one during this five year period</li> <li>• From age 40 and older, one every calendar year</li> </ul>	\$25 per office visit
<i>Not covered: Physical exams required for obtaining or continuing employment or insurance, attending schools or camp, or travel.</i>	<i>All charges.</i>
Routine immunizations endorsed by the Centers for Disease Control and Prevention (CDC): <ul style="list-style-type: none"> <li>• Tetanus-diphtheria (Td) booster – once every 10 years, ages 20 and over (except as provided for under Childhood immunizations)</li> <li>• Influenza vaccine, annually</li> <li>• Pneumococcal vaccine, age 65 and older</li> </ul>	\$25 per office visit
<b>Preventive care, children</b>	<b>High Option</b>
<ul style="list-style-type: none"> <li>• Childhood immunizations recommended by the American Academy of Pediatrics</li> </ul>	\$25 per office visit
<ul style="list-style-type: none"> <li>• Well-child care charges for routine examinations, immunizations and care (up to age 22)</li> <li>• Examinations, such as:               <ul style="list-style-type: none"> <li>- Eye exams through age 17 to determine the need for vision correction</li> <li>- Ear exams through age 17 to determine the need for hearing correction</li> <li>- Examinations done on the day of immunizations (up to age 22)</li> </ul> </li> </ul>	\$25 per office visit

Benefit Description	You pay After the calendar year deductible...
<b>Maternity care</b>	
<p>Complete maternity (obstetrical) care, such as:</p> <ul style="list-style-type: none"> <li>• Prenatal care</li> <li>• Delivery</li> <li>• Postnatal care</li> </ul> <p>Note: Here are some things to keep in mind:</p> <ul style="list-style-type: none"> <li>• You will need one referral from your primary care physician to your OB/GYN for pregnancy, prenatal care, delivery and postnatal care. Precertification for your normal delivery is included with your referral; see page 25 and 28 for other circumstances, such as extended stays for you or your baby.</li> <li>• You may remain in the hospital up to 48 hours after a regular delivery and 96 hours after a cesarean delivery. We will extend your inpatient stay if medically necessary.</li> <li>• We cover routine nursery care of the newborn child during the covered portion of the mother’s maternity stay. We will cover other care of an infant who requires non-routine treatment only if we cover the infant under a Self and Family enrollment. Surgical benefits, not maternity benefits apply to circumcision.</li> <li>• We pay hospitalization and surgeon services (delivery) the same as for illness and injury. See Hospital benefits (Section 5c) and Surgery benefits (Section 5b).</li> </ul>	<p style="text-align: center;"><b>High Option</b></p> <p>\$25 per visit (initial visit only, all other routine visits, routine testing and delivery require no additional copayments)</p>
<p><i>Not covered: Non-diagnostic routine sonograms to determine fetal age, size or sex</i></p>	<p><i>All charges.</i></p>
<b>Family planning</b>	
<p>A range of voluntary family planning services, limited to:</p> <ul style="list-style-type: none"> <li>• Voluntary sterilization (See Surgical procedures Section 5 (b))</li> <li>• Surgically implanted contraceptives (such as Norplant)</li> <li>• Injectable contraceptive drugs (such as Depo provera)</li> <li>• Intrauterine devices (IUDs)</li> <li>• Diaphragms</li> </ul> <p>Note: We cover oral contraceptives under the prescription drug benefit.</p>	<p style="text-align: center;"><b>High Option</b></p> <p>\$25 per office visit</p> <p>20% of allowable charge after deductible (procedures performed at a hospital-inpatient or outpatient)</p>
<p><i>Not covered: reversal of voluntary surgical sterilization, genetic counseling</i></p>	<p><i>All charges.</i></p>
<b>Infertility services</b>	
<p>Diagnosis and treatment of infertility such as:</p> <ul style="list-style-type: none"> <li>• Artificial insemination: <ul style="list-style-type: none"> <li>- intravaginal insemination (IVI)</li> <li>- intracervical insemination (ICI)</li> <li>- intrauterine insemination (IUI)</li> </ul> </li> <li>• Fertility drugs</li> </ul>	<p style="text-align: center;"><b>High Option</b></p> <p>\$25 per visit (office visit)</p> <p>20% of allowable charge after deductible (outpatient facility)</p>

*Infertility services - continued on next page*

Benefit Description	You pay After the calendar year deductible...
<b>Infertility services (cont.)</b>	<b>High Option</b>
<p>Note: We cover injectible fertility drugs under medical benefits and oral fertility drugs under the prescription drug benefit.</p>	<p>\$25 per visit (office visit)</p> <p>20% of allowable charge after deductible (outpatient facility)</p>
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> <li>• <i>Assisted reproductive technology (ART) procedures, such as:</i> <ul style="list-style-type: none"> <li>- <i>in vitro fertilization</i></li> <li>- <i>embryo transfer, gamete intra-fallopian transfer (GIFT) and zygote intra-fallopian transfer (ZIFT)</i></li> </ul> </li> <li>• <i>Services and supplies related to ART procedures</i></li> <li>• <i>Cost of donor sperm</i></li> <li>• <i>Cost of donor egg.</i></li> </ul>	<p><i>All charges.</i></p>
<b>Allergy care</b>	<b>High Option</b>
<p>Testing and treatment</p>	<p>\$25 per office visit</p>
<p>Allergy injection</p>	<p>\$5 per office visit</p>
<p>Allergy serum</p>	<p>Nothing</p>
<p><i>Not covered: Provocative food testing and sublingual allergy desensitization</i></p>	<p><i>All charges.</i></p>
<b>Treatment therapies</b>	<b>High Option</b>
<ul style="list-style-type: none"> <li>• Chemotherapy and radiation therapy</li> </ul> <p>Note: High dose chemotherapy in association with autologous bone marrow transplants is limited to those transplants listed under Organ/Tissue Transplants on page 26.</p> <ul style="list-style-type: none"> <li>• Respiratory and inhalation therapy</li> <li>• Dialysis – hemodialysis and peritoneal dialysis</li> <li>• Intravenous (IV)/Infusion Therapy – Home IV and antibiotic therapy</li> <li>• Growth hormone therapy (GHT)</li> </ul> <p>Note: Growth hormone is covered under the prescription drug benefit.</p> <p>Note: – We will only cover GHT when we preauthorize the treatment. Call 434-947-3590 for preauthorization. We will ask you to submit information that establishes that the GHT is medically necessary. Ask us to authorize GHT before you begin treatment; otherwise, we will only cover GHT services from the date you submit the information. If you do not ask or if we determine GHT is not medically necessary, we will not cover the GHT or related services and supplies.</p>	<p>\$25 per visit (office visit)</p> <p>20% of allowable charge after deductible (outpatient facility)</p>

Benefit Description	You pay After the calendar year deductible...
<b>Early Intervention Services</b>	<b>High Option</b>
Benefits for speech and language therapy, occupational therapy, physical therapy and assistive technology services and devices for dependents from birth to age three who are certified by the Department of Mental Health, Mental Retardation and Substance Abuse Services as eligible for services under Part H of the Individuals with Disabilities Education Act are limited to \$5,000 per member per calendar year.	\$25 per office visit
<b>Physical and occupational therapies</b>	<b>High Option</b>
90 visits per condition for the services of each of the following: <ul style="list-style-type: none"> <li>• qualified physical therapists and</li> <li>• occupational therapists</li> </ul> <p>Note: We only cover therapy to restore bodily function when there has been a total or partial loss of bodily function due to illness or injury. Services are limited to those which can be expected to result in significant improvement within a period of 90 days.</p> <p>Cardiac rehabilitation following a heart transplant, bypass surgery or a myocardial infarction is provided for up to 90 sessions.</p>	\$25 per visit (office visit)  20% of allowable charge after deductible (inpatient or outpatient facility)
<i>Not covered:</i> <ul style="list-style-type: none"> <li>• Long-term rehabilitative therapy</li> <li>• Exercise programs</li> </ul>	<i>All charges.</i>
<b>Speech therapy</b>	<b>High Option</b>
<ul style="list-style-type: none"> <li>• 90 visits per condition</li> </ul> <p>Note: Speech therapy services are limited to a \$1000 per member per calendar year.</p>	\$25 per visit (office visit)  20% of allowable charge after deductible (inpatient or outpatient facility)
<b>Hearing services (testing, treatment, and supplies)</b>	<b>High Option</b>
<ul style="list-style-type: none"> <li>• First hearing aid and testing only when necessitated by accidental injury</li> <li>• Hearing testing for children through age 17 (see <i>Preventive care, children</i>)</li> </ul>	\$25 per office visit
<i>Not covered:</i> <ul style="list-style-type: none"> <li>• All other hearing testing</li> <li>• Hearing aids, testing and examinations for them</li> </ul>	<i>All charges.</i>
<b>Vision services (testing, treatment, and supplies)</b>	<b>High Option</b>
<ul style="list-style-type: none"> <li>• One pair of eyeglasses or contact lenses to correct an impairment directly caused by accidental ocular injury or intraocular surgery (such as for cataracts)</li> <li>• Eye exam to determine the need for vision correction for children through age 17 (see <i>Preventive care, children</i>)</li> <li>• Annual eye refractions</li> </ul> <p>Note: See <i>Preventive Care, children</i> for eye exams for children.</p>	\$25 per office visit  \$25 per office visit
<i>Not covered:</i>	

*Vision services (testing, treatment, and supplies) - continued on next page*

Benefit Description	You pay After the calendar year deductible...
<b>High Option</b>	
<p><b>Vision services (testing, treatment, and supplies) (cont.)</b></p> <ul style="list-style-type: none"> <li>• Eyeglasses or contact lenses and, after age 17, examinations for them</li> <li>• Eye exercises and orthoptics</li> <li>• Radial keratotomy and other refractive surgery</li> </ul>	<p><i>All charges.</i></p>
<b>High Option</b>	
<p><b>Foot care</b></p> <p>Routine foot care when you are under active treatment for a metabolic or peripheral vascular disease, such as diabetes.</p> <p>See Orthopedic and prosthetic devices for information on podiatric shoe inserts.</p>	<p>\$25 per office visit</p>
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> <li>• Cutting, trimming or removal of corns, calluses, or the free edge of toenails, and similar routine treatment of conditions of the foot, except as stated above</li> <li>• Treatment of weak, strained or flat feet or bunions or spurs; and of any instability, imbalance or subluxation of the foot (unless the treatment is by open cutting surgery)</li> </ul>	<p><i>All charges.</i></p>
<b>High Option</b>	
<p><b>Orthopedic and prosthetic devices</b></p> <ul style="list-style-type: none"> <li>• Artificial limbs and eyes; stump hose</li> <li>• Externally worn breast prostheses and surgical bras, including necessary replacements following a mastectomy</li> <li>• Internal prosthetic devices, such as artificial joints, pacemakers, cochlear implants, and surgically implanted breast implant following mastectomy. Note: We pay internal prosthetic devices as hospital benefits; see Section 5 (c) for payment information. See 5 (b) for coverage of the surgery to insert the device.</li> <li>• Corrective orthopedic appliances for non-dental treatment of temporomandibular joint (TMJ) pain dysfunction syndrome.</li> </ul>	<p>20% of allowable charge after deductible</p>
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> <li>• Orthopedic and corrective shoes</li> <li>• Arch supports</li> <li>• Foot orthotics</li> <li>• Heel pads and heel cups</li> <li>• Lumbosacral supports</li> <li>• Corsets, trusses, elastic stockings, support hose, and other supportive devices</li> <li>• Prosthetic replacements provided less than 3 years after the last one we covered</li> </ul>	<p><i>All charges</i></p>

Benefit Description	You pay After the calendar year deductible...
<b>Durable medical equipment (DME)</b>	<b>High Option</b>
<p>We cover rental or purchase of durable medical equipment at our option, including repair and adjustment. Limited to \$2,000 per member per calendar year for any combination of items. Covered items include:</p> <ul style="list-style-type: none"> <li>• Oxygen;</li> <li>• Dialysis equipment;</li> <li>• hospital beds;</li> <li>• wheelchairs;</li> <li>• canes, crutches, walkers, slings, splints, cervical collars, and traction apparatus;</li> <li>• bedside commode, shower chair, and tub rails;</li> <li>• oxygen and oxygen equipment;</li> <li>• ostomy supplies, including bags, flanges, and belts;*</li> <li>• catheters and catheter bags;*</li> <li>• respirators;</li> <li>• jobst stockings or equivalent when prescribed by a vascular surgeon following vascular surgery;</li> <li>• the first pair of contact lenses or eyeglasses following approved cataract surgery without implant; and</li> <li>• prosthetic devices</li> </ul> <p><i>* Supplies to be purchased in quantities or units equivalent to a 30-day supply.</i></p> <p>Note: Call us at 434-947-3590 as soon as your Plan physician prescribes this equipment. We will arrange with a health care provider to rent or sell you durable medical equipment at discounted rates and will tell you more about this service when you call.</p>	20% of allowable charge after deductible
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> <li>• <i>Motorized wheel chairs</i></li> <li>• <i>Any durable medical equipment not listed above is not covered.</i></li> </ul>	<i>All charges.</i>
<b>Home health services</b>	<b>High Option</b>
<ul style="list-style-type: none"> <li>• Home health care ordered by a Plan physician and provided by a registered nurse (R.N.), licensed practical nurse (L.P.N.), licensed vocational nurse (L.V.N.), or home health aide.</li> <li>• Services include oxygen therapy, intravenous therapy and medications.</li> </ul>	20% of allowable charge after deductible
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> <li>• <i>Nursing care requested by, or for the convenience of, the patient or the patient's family;</i></li> <li>• <i>Services primarily for hygiene, feeding, exercising, moving the patient, homemaking, companionship or giving oral medication.</i></li> </ul>	<i>All charges.</i>

Benefit Description	You pay After the calendar year deductible...
<b>Chiropractic</b>	<b>High Option</b>
Limited to \$500 per calendar year <ul style="list-style-type: none"> <li>• Manipulation of the spine and extremities</li> <li>• Adjunctive procedures such as ultrasound, electrical muscle stimulation, vibratory therapy, and cold pack application</li> </ul>	\$25 per visit
<i>Not covered:</i> <ul style="list-style-type: none"> <li>• <i>maintenance services</i></li> </ul>	<i>All Charges:</i>
<b>Alternative treatments</b>	<b>High Option</b>
<i>Not covered:</i> <ul style="list-style-type: none"> <li>• <i>Acupuncture services</i></li> <li>• <i>Naturopathic services</i></li> <li>• <i>Hypnotherapy</i></li> <li>• <i>Biofeedback</i></li> </ul>	<i>All charges.</i>
<b>Educational classes and programs</b>	<b>High Option</b>
Coverage is limited to: <ul style="list-style-type: none"> <li>• Diabetes self management</li> <li>• Diabetes nutritional counseling for newly diagnosed patients</li> </ul>	\$25 per office visit

**Section 5(b) Surgical and anesthesia services provided by physicians and other health care professionals**

**Important things you should keep in mind about these benefits:**

- Please remember that all benefits are subject to the definitions, limitations, and exclusions in this brochure and are payable only when we determine they are medically necessary.
- Plan physicians must provide or arrange your care.
- The calendar year deductible is \$500 per individual and \$1000 per family for in-plan benefits.
- Be sure to read Section 4, *Your costs for covered services*, for valuable information about how cost sharing works. Also read Section 9 about coordinating benefits with other coverage, including with Medicare.
- The amounts listed below are for the charges billed by a physician or other health care professional for your surgical care. Look in Section 5(c) for charges associated with the facility.

**YOU OR YOUR PRIMARY CARE PHYSICIAN MUST GET PRECERTIFICATION OF SOME SURGICAL PROCEDURES.** Please refer to the precertification information shown in Section 3 to be sure which services require precertification and identify which surgeries require precertification.

Benefit Description	You pay After the calendar year deductible...
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**Note: The calendar year deductible applies to almost all benefits in this Section.  
We say “(No deductible)” when it does not apply.**

Surgical procedures	High Option
<p>A comprehensive range of services, such as:</p> <ul style="list-style-type: none"> <li>• Operative procedures</li> <li>• Treatment of fractures, including casting</li> <li>• Normal pre- and post-operative care by the surgeon</li> <li>• Correction of amblyopia and strabismus</li> <li>• Endoscopy procedures</li> <li>• Biopsy procedures</li> <li>• Removal of tumors and cysts</li> <li>• Correction of congenital anomalies (see <i>Reconstructive surgery</i>)</li> <li>• Surgical treatment of morbid obesity -- a condition in which an individual weighs 100 pounds or 100% over his or her normal weight according to current underwriting standards; eligible members must be age 18 or over, have a BMI of 40 or greater, or a BMI of 35 with co-morbid conditions; have actively participated in non-surgical methods of weight reduction for at least a year under the supervision of a physician ; the physician requesting surgery must confirm that the patient has had an evaluation by a psychiatrist or psychologist documenting that he/she is able to understand, tolerate, and comply with all phases of care; the patients post-operative expectations have been addressed; the patient has received a thorough explanation of the risks and benefits; and the patients treatment plan includes pre and postoperative dietary evaluations conducted by a dietician/nutritionist.</li> <li>• Insertion of internal prosthetic devices . See 5(a) – <i>Orthopedic and prosthetic devices</i> for device coverage information</li> <li>• Voluntary sterilization (e.g., tubal ligation, vasectomy)</li> </ul>	<p>20% of allowable charge after deductible</p>

*Surgical procedures - continued on next page*  
High Option Section 5(b)

Benefit Description	You pay After the calendar year deductible...
<b>Surgical procedures (cont.)</b>	
<ul style="list-style-type: none"> <li>• Treatment of burns</li> </ul> <p>Note: Generally, we pay for internal prostheses (devices) according to where the procedure is done. For example, we pay Hospital benefits for a pacemaker and Surgery benefits for insertion of the pacemaker.</p>	<b>High Option</b>  20% of allowable charge after deductible
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> <li>• <i>Reversal of voluntary sterilization</i></li> <li>• <i>Routine treatment of conditions of the foot; see Foot care</i></li> <li>• <i>Dorsal rhizotomy to treat spasticity</i></li> </ul>	<i>All Charges.</i>
<b>Reconstructive surgery</b>	
<ul style="list-style-type: none"> <li>• Surgery to correct a functional defect</li> <li>• Surgery to correct a condition caused by injury or illness if:               <ul style="list-style-type: none"> <li>- the condition produced a major effect on the member's appearance and</li> <li>- the condition can reasonably be expected to be corrected by such surgery</li> </ul> </li> <li>• Surgery to correct a condition that existed at or from birth and is a significant deviation from the common form or norm. Examples of congenital anomalies are: protruding ear deformities; cleft lip; cleft palate; birth marks; webbed fingers; and webbed toes.</li> <li>• All stages of breast reconstruction surgery following a mastectomy, such as:               <ul style="list-style-type: none"> <li>- surgery to produce a symmetrical appearance on the other breast;</li> <li>- treatment of any physical complications, such as lymphedemas;</li> <li>- breast prostheses and surgical bras and replacements (see <i>Prosthetic devices</i>)</li> </ul> </li> </ul> <p>Note: If you need a mastectomy, you may choose to have the procedure performed on an inpatient basis and remain in the hospital up to 48 hours after the procedure.</p>	<b>High Option</b>  20% of allowable charge after deductible
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> <li>• <i>Cosmetic surgery – any surgical procedure (or any portion of a procedure) performed primarily to improve physical appearance through change in bodily form, except repair of accidental injury</i></li> <li>• <i>Surgeries related to sex transformation</i></li> </ul>	<i>All Charges.</i>
<b>Oral and maxillofacial surgery</b>	
<p>Oral surgical procedures, limited to:</p> <ul style="list-style-type: none"> <li>• Reduction of fractures of the jaws or facial bones;</li> <li>• Surgical correction of cleft lip, cleft palate or severe functional malocclusion;</li> <li>• Removal of stones from salivary ducts;</li> <li>• Excision of leukoplakia or malignancies;</li> </ul>	<b>High Option</b>  20% of allowable charge after deductible

*Oral and maxillofacial surgery - continued on next page*

Benefit Description	You pay After the calendar year deductible...
<b>Oral and maxillofacial surgery (cont.)</b>	
<ul style="list-style-type: none"> <li>• Excision of cysts and incision of abscesses when done as independent procedures; and</li> <li>• Other surgical procedures that do not involve the teeth or their supporting structures.</li> </ul>	20% of allowable charge after deductible
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> <li>• <i>Oral implants and transplants</i></li> <li>• <i>Procedures that involve the teeth or their supporting structures (such as the periodontal membrane, gingiva, and alveolar bone)</i></li> </ul>	<i>All charges.</i>
<b>Organ/tissue transplants</b>	
<p>Solid organ transplants are limited to:</p> <ul style="list-style-type: none"> <li>• Cornea</li> <li>• Heart</li> <li>• Heart/lung</li> <li>• Single, double lung</li> <li>• Kidney</li> <li>• Liver</li> <li>• Pancreas</li> <li>• Intestinal transplants                             <ul style="list-style-type: none"> <li>- Small intestine</li> <li>- Small intestine with the liver</li> <li>- Small intestine with multiple organs, such as the liver, stomach, and pancreas</li> </ul> </li> </ul>	20% of allowable charge after deductible
<p>Blood or marrow stem cell transplants limited to the stages of the following diagnoses. The medical necessity limitation is considered satisfied if the patient meets the staging description.</p> <ul style="list-style-type: none"> <li>• Allogeneic transplants for                             <ul style="list-style-type: none"> <li>- Acute lymphocytic or non-lymphocytic (i.e., myelogenous) leukemia</li> <li>- Advanced Hodgkin’s lymphoma</li> <li>- Advanced non-Hodgkin’s lymphoma</li> <li>- Chronic myelogenous leukemia</li> <li>- Severe combined immunodeficiency</li> <li>- Severe or very severe aplastic anemia</li> </ul> </li> <li>• Autologous transplants for                             <ul style="list-style-type: none"> <li>- Acute lymphocytic or nonlymphocytic (i.e., myelogenous) leukemia</li> <li>- Advanced Hodgkin’s lymphoma</li> <li>- Advanced non-Hodgkin’s lymphoma</li> <li>- Advanced neuroblastoma</li> </ul> </li> </ul>	20% of allowable charge after deductible

*Organ/tissue transplants - continued on next page*

Benefit Description	You pay After the calendar year deductible...
<b>Organ/tissue transplants (cont.)</b>	<b>High Option</b>
<ul style="list-style-type: none"> <li>• Autologous tandem transplants for recurrent germ cell tumors (including testicular cancer)</li>   <li>Blood or marrow stem cell transplants for</li> <li>• Allogeneic transplants for               <ul style="list-style-type: none"> <li>- Phagocytic deficiency diseases (e.g., Wiskott-Aldrich syndrome)</li> </ul> </li> <li>• Autologous transplants for               <ul style="list-style-type: none"> <li>- Multiple myeloma</li> <li>- Testicular, mediastinal, retroperitoneal, and ovarian germ cell tumors</li> </ul> </li> </ul>	20% of allowable charge after deductible
<p>Limited Benefits – Treatment for breast cancer, multiple myeloma, and epithelial ovarian cancer may be provided in a National Cancer Institute – or National Institutes of Health-approved clinical trial at a Plan-designated center of excellence and if approved by the Plan’s medical director in accordance with the Plan’s protocols.</p> <p>Note: We cover related medical and hospital expenses of the donor when we cover the recipient.</p>	
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> <li>• Donor screening tests and donor search expenses, except those performed for the actual donor</li> <li>• Implants of artificial organs</li> <li>• Transplants not listed as covered</li> </ul>	<i>All Charges</i>
<b>Anesthesia</b>	<b>High Option</b>
<p>Professional services provided in –</p> <ul style="list-style-type: none"> <li>• Hospital (inpatient)</li> </ul>	20% of allowable charge after deductible
<p>Professional services provided in –</p> <ul style="list-style-type: none"> <li>• Hospital outpatient department</li> <li>• Skilled nursing facility</li> <li>• Ambulatory surgical center</li> </ul>	20% of allowable charge after deductible

**Section 5(c) Services provided by a hospital or other facility, and ambulance services**

**Important things you should keep in mind about these benefits:**

- Please remember that all benefits are subject to the definitions, limitations, and exclusions in this brochure and are payable only when we determine they are medically necessary.
- Plan physicians must provide or arrange your care and you must be hospitalized in a Plan facility.
- The calendar year deductible is \$500 per individual and \$1,000 per family for in-plan benefits.
- Be sure to read Section 4, *Your costs for covered services* for valuable information about how cost sharing works. Also read Section 9 about coordinating benefits with other coverage, including with Medicare.
- The amounts listed below are for the charges billed by the facility (i.e., hospital or surgical center) or ambulance service for your surgery or care. Any costs associated with the professional charge (i.e., physicians, etc.) are in Sections 5(a) or (b).

**YOU or YOUR PRIMARY CARE PHYSICIAN MUST GET PRECERTIFICATION OF HOSPITAL STAYS.** Please refer to Section 3 to be sure which services require precertification.

Benefit Description	You pay
<b>Note: The calendar year deductible applies only when we say below: “(calendar year deductible applies)”.</b>	
<b>Inpatient hospital</b>	<b>High Option</b>
Room and board, such as <ul style="list-style-type: none"> <li>• Ward, semiprivate, or intensive care accommodations;</li> <li>• General nursing care; and</li> <li>• Meals and special diets.</li> </ul> Note: If you want a private room when it is not medically necessary, you pay the additional charge above the semiprivate room rate.	20% of allowable charge after deductible
Other hospital services and supplies, such as: <ul style="list-style-type: none"> <li>• Operating, recovery, maternity, and other treatment rooms</li> <li>• Prescribed drugs and medicines</li> <li>• Diagnostic laboratory tests and X-rays</li> <li>• Administration of blood and blood products</li> <li>• Blood or blood plasma, if not donated or replaced</li> <li>• Dressings, splints, casts, and sterile tray services</li> <li>• Medical supplies and equipment, including oxygen</li> <li>• Anesthetics, including nurse anesthetist services</li> <li>• Take-home items</li> </ul> Medical supplies, appliances, medical equipment, and any covered items billed by a hospital for use at home	20% of allowable charge after deductible
Not covered: <ul style="list-style-type: none"> <li>• Custodial care</li> <li>• Non-covered facilities, such as nursing homes, extended care facilities, schools</li> <li>• Personal comfort items, such as telephone, television, barber services, guest meals and beds</li> </ul>	<i>All Charges</i>

*Inpatient hospital - continued on next page*

<b>Benefit Description</b>	<b>You pay</b>
<b>Inpatient hospital (cont.)</b>	<b>High Option</b>
<ul style="list-style-type: none"> <li>• <i>Private nursing care</i></li> </ul>	<i>All Charges</i>
<b>Outpatient hospital or ambulatory surgical center</b>	<b>High Option</b>
<ul style="list-style-type: none"> <li>• Operating, recovery, and other treatment rooms</li> <li>• Prescribed drugs and medicines</li> <li>• Diagnostic laboratory tests, X-rays , and pathology services</li> <li>• Administration of blood, blood plasma, and other biologicals</li> <li>• Blood and blood plasma , if not donated or replaced</li> <li>• Pre-surgical testing</li> <li>• Dressings, casts , and sterile tray services</li> <li>• Medical supplies, including oxygen</li> <li>• Anesthetics and anesthesia service</li> </ul> <p>Note: We cover hospital services and supplies related to dental procedures when necessitated by a non-dental physical impairment. We do not cover the dental procedures.</p>	20% of allowable charge after deductible
<i>Not covered: Blood and blood derivatives not replaced by the member</i>	<i>All charges.</i>
<b>Extended care benefits/Skilled nursing care facility benefits</b>	<b>High Option</b>
Skilled nursing facility (SNF): limited to 100 days per member per calendar year	20% of allowable charge after deductible
<i>Not covered: Custodial care</i>	<i>All Charges.</i>
<b>Hospice care</b>	<b>High Option</b>
Hospice services include supportive or palliative care for a terminally ill member in the home or a hospice facility. Services include inpatient and outpatient care, and family counseling; these services are provided under the direction of a Plan doctor who certifies that the patient is in the terminal stages of illness, with a life expectancy of approximately six months or less.	20% of allowable charge after deductible
<i>Not covered: Independent nursing, homemaker services</i>	<i>All Charges</i>
<b>Ambulance</b>	<b>High Option</b>
Local professional ambulance service when medically appropriate	20% of allowable charge after deductible

## Section 5(d) Emergency services/accidents

### Important things you should keep in mind about these benefits:

- Please remember that all benefits are subject to the definitions, limitations, and exclusions in this brochure.
- The calendar year deductible is \$500 per individual and \$1,000 per family for in-plan benefits.
- Be sure to read Section 4, *Your costs for covered services*, for valuable information about how cost sharing works. Also read Section 9 about coordinating benefits with other coverage, including with Medicare.

### What is a medical emergency?

A medical emergency is the sudden and unexpected onset of a condition or an injury that you believe endangers your life or could result in serious injury or disability, and requires immediate medical or surgical care. Some problems are emergencies because, if not treated promptly, they might become more serious; examples include deep cuts and broken bones. Others are emergencies because they are potentially life-threatening, such as heart attacks, strokes, poisonings, gunshot wounds, or sudden inability to breathe. There are many other acute conditions that we may determine are medical emergencies – what they all have in common is the need for quick action.

### What to do in case of emergency:

#### Emergencies within our service area:

- Medical care is available through your primary care physician 7 days a week, 24 hours a day. If you need medical care, you should call your primary care physician immediately for instructions on how to receive care.
- If the emergency is such that immediate medical attention is needed, you should be taken to the nearest appropriate medical facility.
- The Plan covers services rendered by providers other than participating Piedmont providers when the condition treated is an emergency as defined above.
- A telephone call from you to your primary care physician while at an urgent care center or emergency room will not be treated as a proper referral for urgent care or other non-emergency services.
- Emergency services provided within our service area shall include covered services from non-participating Piedmont providers only when a delay in receiving care from a participating Piedmont Provider could reasonably be expected to cause your condition to worsen if left unattended.

#### Emergencies outside our service area:

- Urgent care and emergency services outside the service area are covered services if you sustain an injury or become ill while temporarily away from the service area. Accordingly, benefits for these services are limited to care which is required immediately and unexpectedly. Neither elective care nor care required as a result of circumstances which could reasonably have been foreseen prior to departure from the service area is a covered service. Benefits for maternity care do not cover normal term delivery outside the service area, but do include earlier complications of pregnancy or unexpected delivery occurring outside the service area.
- If an emergency or urgent situation occurs when you are temporarily outside the service area, you should obtain care at the nearest medical facility. You or your representative are responsible for notifying your primary care physician on the next working day or within 48 hours. Failure to do so may result in reduced benefits or no benefits.
- Benefits for continuing or follow-up treatment must be pre-arranged by your primary care physician and provided in the service area.

Benefit Description	You pay After the calendar year deductible...
<b>Emergency within our service area</b>	
Emergency care at a doctor's office	\$25 per visit
Emergency care at an urgent care center	\$25 per visit
Emergency care as an outpatient or inpatient at a hospital , including doctors' services	\$100 per visit (waived if admitted) subject to inpatient coinsurance
<i>Not covered: Elective care or non-emergency care</i>	<i>All Charges.</i>
<b>Emergency outside our service area</b>	
Emergency care at a doctor's office	\$25 per visit
Emergency care at an urgent care center	\$25 per visit
Emergency care as an outpatient or inpatient at a hospital, including doctors' services	\$100 per visit, (waived if admitted) subject to inpatient coinsurance
<i>Not covered:</i> <ul style="list-style-type: none"> <li>• <i>Elective care or non-emergency care</i></li> <li>• <i>Emergency care provided outside the service area if the need for care could have been foreseen before leaving the service area</i></li> <li>• <i>Medical and hospital costs resulting from a normal full-term delivery of a baby outside the service area</i></li> </ul>	<i>All Charges.</i>
<b>Ambulance</b>	
Professional ambulance service when medically appropriate. Air ambulance when medically necessary. See 5(c) for non-emergency service.	20% of allowable charge after deductible

**Section 5(e) Mental health and substance abuse benefits**

When you get our approval for services and follow a treatment plan we approve, cost-sharing and limitations for Plan mental health and substance abuse benefits will be no greater than for similar benefits for other illnesses and conditions.

**Important things you should keep in mind about these benefits:**

- All benefits are subject to the definitions, limitations, and exclusions in this brochure.
- The calendar year deductible is \$500 per individual and \$1,000 per family for in-plan benefits.
- Be sure to read Section 4, *Your costs for covered services*, for valuable information about how cost sharing works. Also read Section 9 about coordinating benefits with other coverage, including with Medicare.
- **YOU MUST GET PREAUTHORIZATION OF THESE SERVICES.** See the instructions after the benefits description below.

Benefit Description	You pay After the calendar year deductible...
<p><b>Note: The calendar year deductible applies to almost all benefits in this Section. We say “(No deductible)” when it does not apply.</b></p>	
Mental health and substance abuse benefits	High Option
<p>All diagnostic and treatment services recommended by a Plan provider and contained in a treatment plan that we approve. The treatment plan may include services, drugs, and supplies described elsewhere in this brochure.</p> <p>Note: Plan benefits are payable only when we determine the care is clinically appropriate to treat your condition and only when you receive the care as part of a treatment plan that we approve.</p>	<p>Your cost sharing responsibilities are no greater than for other illnesses or conditions.</p>
<ul style="list-style-type: none"> <li>• Professional services, including individual or group therapy by providers such as psychiatrists, psychologists, or clinical social workers</li> <li>• Medication management</li> </ul>	<p>\$25 per office visit</p>
<ul style="list-style-type: none"> <li>• Diagnostic tests</li> <li>• Services provided by a hospital or other facility</li> <li>• Services in approved alternative care settings such as partial hospitalization, half-way house, residential treatment, full-day hospitalization, facility based intensive outpatient treatment</li> </ul>	<p>\$25 per office visit</p> <p>20% of allowable charge after deductible for services performed at a hospital or facility 20% of allowable charge after deductible</p>
<p><i>Not covered: Services we have not approved.</i></p> <p><i>Note: OPM will base its review of disputes about treatment plans on the treatment plan's clinical appropriateness. OPM will generally not order us to pay or provide one clinically appropriate treatment plan in favor of another.</i></p>	<p><i>All Charges.</i></p>

<p>Preauthorization</p>	<p>To be eligible to receive these benefits you must obtain a treatment plan and follow all of the following network authorization processes:</p> <p>Contact Piedmont Community HealthCare for authorization. Piedmont Community HealthCare can be reached locally at (434) 947-4463 or toll free at 1-800-400-7247</p>
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## Section 5(f) Prescription drug benefits

**Important things you should keep in mind about these benefits:**

- We cover prescribed drugs and medications, as described in the chart beginning on the next page.
- Please remember that all benefits are subject to the definitions, limitations and exclusions in this brochure and are payable only when we determine they are medically necessary.
- Be sure to read Section 4, *Your costs for covered services*, for valuable information about how cost sharing works. Also read Section 9 about coordinating benefits with other coverage, including with Medicare.

**There are important features you should be aware of.** These include:

- **Who can write your prescription.** A plan physician or licensed dentist must write the prescription.
- **Where you can obtain them.** You must fill the prescription at a plan pharmacy, or by mail for a maintenance medication.
- **These are the dispensing limitations.** Medically necessary prescribed legend drugs (drugs not available over the counter) incidental to outpatient care are covered services, including compound medications of which at least one ingredient is a legend drug, injectable insulin and syringes and needles for the administration thereof. For each prescription filled at the pharmacy, we will cover up to a 30-day or 100 unit supply, whichever is less. For maintenance medications received through the mail order benefit, we will cover up to a 90-day or 300 unit supply, whichever is less. Generic drugs will be dispensed except when a participating physician requires brand name drugs. If the physician does not require a brand name drug, you may request a brand name drug and pay the difference between the brand name drug and the generic drug, in addition to your appropriate copayment. Only maintenance medications may be ordered through the mail order benefit. You should allow two weeks for delivery. At least 60% of the maintenance medication must be used before a refill can be issued. If you are in the military and called to active duty due to an emergency, please contact us if you need assistance in filling a prescription before your departure.
- **Why use generic drugs?** Generic drugs are lower-priced drugs that are the therapeutic equivalent to more expensive brand-name drugs. They must contain the same active ingredients and must be equivalent in strength and dosage to the original brand-name product. Generics cost less than the equivalent brand-name product. The U.S. Food and Drug Administration sets quality standards for generic drugs to ensure that these drugs meet the same standards of quality and strength as brand-name drugs.
- **You can save money by using generic drugs.** However, you and your physician have the option to request a name-brand if a generic option is available. Using the most cost-effective medication saves money.
- **When you have to file a claim.** Our participating providers will file claims for you. If you need to file a claim, contact customer service at 1-800-400-7247 and request a medical claim form. Complete the form, attach any receipts and mail it in to the address on the form.

Benefit Description	You pay After the calendar year deductible...
<p><b>Note: The calendar year deductible applies to almost all benefits in this Section.</b> We say "(No deductible)" when it does not apply.</p>	
Covered medications and supplies	High Option
<p>We cover the following medications and supplies prescribed by a Plan physician and obtained from a Plan pharmacy or through our mail order program:</p> <ul style="list-style-type: none"> <li>• Drugs and medicines that by Federal law of the United States require a physician's prescription for their purchase, except as excluded below.</li> <li>• Insulin</li> <li>• Disposable needles and syringes for the administration of covered medications</li> </ul>	<p>\$15 per generic (30-day supply)</p> <p>\$40 per brand name (30-day supply)</p> <p>\$55 for non-formulary drugs (30-day supply)</p> <p>\$30 per generic (90-day supply through mail service)</p> <p>\$80 per brand name (90-day supply through mail service)</p>

*Covered medications and supplies - continued on next page*

Benefit Description	You pay After the calendar year deductible...
<b>Covered medications and supplies (cont.)</b>	<b>High Option</b>
<ul style="list-style-type: none"> <li>• Drugs for sexual dysfunction (see Prior authorization on page 11)</li> <li>• Contraceptive drugs and devices</li> <li>• Fertility drugs</li> <li>• Growth Hormone drugs</li> </ul>	<p>\$15 per generic (30-day supply)</p> <p>\$40 per brand name (30-day supply)</p> <p>\$55 for non-formulary drugs (30-day supply)</p> <p>\$30 per generic (90-day supply through mail service)</p> <p>\$80 per brand name (90-day supply through mail service)</p> <p>\$110 for non-formulary drugs (90-day supply through mail service)</p> <p>Note: If there is no generic equivalent available, you will still have to pay the brand name copay.</p>
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> <li>• <i>Drugs and supplies for cosmetic purposes</i></li> <li>• <i>Drugs to enhance athletic performance</i></li> <li>• <i>Vitamins, nutrients and food supplements even if a physician prescribes or administers them</i></li> <li>• <i>Nonprescription medicines</i></li> <li>• <i>Drugs obtained from a non-Plan pharmacy, unless emergency</i></li> <li>• <i>Tobacco cessation products</i></li> <li>• <i>Anorexiant</i></li> <li>• <i>Drugs and medications not approved by the FDA</i></li> <li>• <i>DESI drugs (i.e. drugs which are of questionable therapeutic value as designated by the FDA's Federal Drug Efficacy Study)</i></li> <li>• <i>Any other drug deemed not medically necessary by the Plan.</i></li> </ul>	<p><i>All Charges.</i></p>

## Section 5(g) Special features

Feature	Description
Feature	High Option
<b>Local Service and Assistance</b>	As a company located in the heart of its service area, which spans across the Central Virginia area only, we can offer our members local service and assistance. We are in the same community with you and work with your medical providers on a daily basis. Customer service representatives and medical management staff are in the office and available to assist you.
<b>Eyewear Discounts</b>	By presenting your Piedmont Community HealthCare identification card at these Lynchburg locations: AG Jefferson, Inc.; Cooper & Elder Optical; Key Healthcare Optical Center; Virginia Eye Clinic-Dr. Timothy J. Wilson and Associates, Optometrists; Dr. David a. West, OD; Dr. Victor Weatherholt; McBride & Blackburn Opticians, Inc.; Visionary Opticians; Drs. Newman, Blackstock & Associates; Dr. Elizabeth Darby; Lynchburg Sears Optical and Pearle Vision, you will receive discounts on eyewear.
<b>Lasik Procedure Discounts</b>	By presenting your Piedmont Community HealthCare identification card at these Lynchburg locations: Harman Eye Center and Piedmont Eye Center, you will receive discounts on Lasik procedures.
<b>Fitness Club Discounts</b>	By presenting your Piedmont Community HealthCare identification card at these locations: Bedford YMCA and Gold's Gym (Lynchburg location), you will receive discounts on club fees and/or monthly dues.
<b>Mail Order Benefit at Select Local Pharmacies</b>	Piedmont Community HealthCare has a list of local pharmacies that may be used to fill mail order prescriptions instead of mailing the prescription in. These are listed in the back of the network directory and on the web site at <a href="http://www.pchp.net">www.pchp.net</a> , or you can contact customer service at 1-800-400-7247. Please contact these local pharmacies to verify the benefit offering and find out the details on filling prescriptions.

**Section 5(h) Dental benefits**

**Important things you should keep in mind about these benefits:**

- We do not provide dental benefits except for accidental injury.

<b>Benefit Description</b>	<b>You Pay</b>
<b>Accidental injury benefit</b>	<b>High Option</b>
We cover restorative services and supplies necessary to promptly repair (but not replace) sound natural teeth. The need for these services must result from an accidental injury if the jaw is broken, the accident occurred while you were enrolled with the Plan and you submit a plan of treatment within 60 days of the date of your injury.	You pay 20% of the allowable charge after deductible.

**Dental benefits**

We have no other dental benefits.

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## Section 5(i) Point of Service benefits

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### Important things you should keep in mind about these benefits:

- Please remember that all benefits are subject to the definitions, limitations, and exclusions in this brochure and are payable only when we determine they are medically necessary.
- Point of service benefits or out-of-network benefits will be provided when you receive services from providers other than your primary care physician without a referral from your primary care physician. Exceptions are emergency care and two visits per year to participating Plan OB/GYN physicians.
- The calendar year deductible is \$1,500 per individual and \$3,000 per family for out-of-network benefits.
- Be sure to read Section 4, *Your costs for covered services*, for valuable information about how cost sharing works. Also read Section 9 about coordinating benefits with other coverage, including with Medicare.
- The amounts listed below are for the charges billed by the facility (i.e., hospital or surgical center) or ambulance service for your surgery or care. Any costs associated with the professional charge (i.e., physicians, etc.) are covered in Section 5 (a) or (b).

### Point of Service (POS) Benefits

#### Facts about this Plan's POS option

At your option, you may choose to obtain benefits covered by this Plan from non-Plan doctors and hospitals whenever you need care, except for the benefits listed below under "What is not covered." Benefits not covered under Point of Service must either be received from or arranged by Plan doctors to be covered. When you obtain covered non-emergency medical treatment from a non-Plan doctor or a Plan doctor without a referral from your primary care physician, you are subject to the deductibles, coinsurance and maximum benefit stated below.

#### What is covered

All medical services listed as covered in the previous sections are covered services under the point of service or out-of-plan benefit.

Once you receive services from a non-Plan provider or without a referral from your primary care physician, then all charges related to those services are paid at the point of service or out-of-plan level. For example, if you see a specialist, Plan specialist or non-Plan specialist, without a referral from your primary care physician and then that specialist send you to a facility, Plan facility or non-Plan facility, then all of those charges will be paid at the point of service or out-of-plan level. Therefore, point of service coverage may be obtained in the service area or out of the service area.

#### Precertification

Precertification is not required for point of service or out-of-plan benefits.

#### Deductible

\$1,500 per individual per calendar year, \$3,000 per family per calendar year.

#### Coinsurance

You pay 30% of the allowable charge after the deductible for all covered services.

#### Maximum benefit

There is no maximum benefit under the point of service benefits; however, you do have an out-of-pocket maximum of \$6,000 per individual per calendar year, and \$12,000 per family per calendar year. Amounts over the allowable charge amounts, outpatient mental health services, prescription drug copayments and the vision exam copayment do not count towards the out-of-pocket maximum.

#### Hospital/extended care

The same covered services listed in the previous sections are covered under the point of service benefits. The same limitations apply. The allowable charge for facilities is the same as the actual charge so you will be responsible for 30% of those facility charges. The facility charge does not cover any charges for doctors' services.

Emergency benefits

Non-emergent conditions treated at an emergency room are always payable as out-of-plan benefits.

What is not covered

The same services listed as not covered in the previous sections, are not covered under the point of service or out-of-plan benefits either. In addition, all charges over the allowable charge amount are not covered.

How to obtain benefits

You may be required to file claim forms for services received from non-Plan providers. Contact customer service at 1-800-400-7247 to request claim forms. Complete the form, attach your receipt and mail in to the address on the form.

## High Deductible Health Plan Benefits

See page 9 for how our benefits changed this year and page 95 for a benefits summary.

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## Section 5 High Deductible Health Plan Benefits Overview

**This Plan offers a High Deductible Health Plan (HDHP). The HDHP benefit package is described in this section. Make sure that you review the benefits that are available under the benefit product in which you are enrolled.**

HDHP Section 5, which describes the HDHP benefits, is divided into subsections. Please read the important things you should keep in mind at the beginning of each subsection. Also read the General Exclusions in Section 6; they apply to benefits in the following subsections. To obtain claim forms, claims filing advice, or more information about HDHP benefits, contact us at 1-800-400-7247 or at our Web site at [www.pchp.net](http://www.pchp.net).

Our HDHP option provides comprehensive coverage for high-cost medical events and a tax-advantaged way to help you build savings for future medical expenses. The Plan gives you greater control over how you use your health care benefits. When you enroll in this HDHP, we establish either a Health Savings Account (HSA) or a Health Reimbursement Arrangement (HRA) for you. We automatically pass through a portion of the total health Plan premium to your HSA or HRA based upon your eligibility.

With this Plan, preventive care is covered with an office visit copayment. As you receive other non-preventive medical care, you must meet the Plan's deductible before we pay benefits according to the benefits described on page 54. You can choose to use funds available in your HSA to make payments toward the deductible or you can pay toward your deductible entirely out-of-pocket, allowing your savings to continue to grow.

This HDHP includes five key components: preventive care; traditional medical coverage health care that is subject to the deductible; savings; catastrophic protection for out-of-pocket expenses; and health education resources and account management tools.

- **Preventive care**

The Plan covers preventive care services, such as periodic health evaluations (e.g., annual physicals), screening services (e.g., screening mammograms), routine prenatal and well-child care, child and adult immunizations, disease management and wellness programs. These services are covered at 100% after the office visit copayment per visit if you use your primary care physician and are fully described in Section 5 *Preventive care*. *You do not have to meet the deductible before using these services.*
- **Traditional medical coverage**

After you have paid the Plan's deductible, we pay benefits under traditional medical coverage described in Section 5. The Plan typically pays 80% for in-network and 70% for out-of-network care.

Covered services include:

  - Medical services and supplies provided by physicians and other health care professionals
  - Surgical and anesthesia services provided by physicians and other health care professionals
  - Hospital services; other facility or ambulance services
  - Emergency services/accidents
  - Mental health and substance abuse benefits
  - Prescription drug benefits
  - Dental benefits.
- **Savings**

Health Savings Accounts or Health Reimbursement Arrangements provide a means to help you pay out-of-pocket expenses (see page 47 for more details).

• **Health Savings Accounts (HSA)**

By law, HSAs are available to members who are not enrolled in Medicare, cannot be claimed as a dependent on someone else’s tax return, have not received VA benefits within the last three months or do not have other health insurance coverage other than another high deductible health plan. In 2007, for each month you are eligible for an HSA premium pass through, we will contribute to your HSA \$83.34 per month for a Self Only enrollment or \$166.67 per month for a Self and Family enrollment. In addition to our monthly contribution, you have the option to make additional tax-free contributions to your HSA, so long as total contributions do not exceed the limit established by law, which is \$2000 for Self Only enrollment and \$4,000 for Self and Family enrollment. See maximum contribution information on page 48. You can use funds in your HSA to help pay your health plan deductible. You own your HSA, so the funds can go with you if you change plans or employment.

**Federal tax tip:** There are tax advantages to fully funding your HSA as quickly as possible. Your HSA contribution payments are fully deductible on your Federal tax return. By fully funding your HSA early in the year, you have the flexibility of paying medical expenses from tax-free HSA dollars or after tax out-of-pocket dollars. If you don’t deplete your HSA and you allow the contributions and the tax-free interest to accumulate, your HSA grows more quickly for future expenses.

**HSA features include:**

Your HSA is administered by Bank of the James

Your contributions to the HSA are tax deductible

Your HSA earns tax-free interest

You can make tax-free withdrawals for qualified medical expenses for you, your spouse and dependents (see IRS publication 502 for a complete list of eligible expenses)

Your unused HSA funds and interest accumulate from year to year

It’s portable - the HSA is owned by you and is yours to keep, even when you leave Federal employment or retire

When you need it, funds up to the actual HSA balance are available.

**Important consideration if you want to participate in a Health Care Flexible Spending Account:** If you are enrolled in this HDHP with a Health Savings Account (HSA), and start or become covered by a health care flexible spending account (such as FSAFEDS offers – see Section 12), this HDHP cannot continue to contribute to your HSA. Instead, when you inform us of your coverage in an FSA, we will establish an HRA for you.

• **Health Reimbursement Arrangements (HRA)**

If you aren’t eligible for an HSA, for example you are enrolled in Medicare or have another health plan, we will administer and provide an HRA instead. You must notify us that you are ineligible for an HSA.

In 2007, we will give you an HRA credit of \$1000 per year for a Self Only enrollment and \$2000 per year for a Self and Family enrollment. You can use funds in your HRA to help pay your health plan deductible and/or for certain expenses that don’t count toward the deductible.

**HRA features include:**

- For our HDHP option, the HRA is administered by Piedmont Community HealthCare
- Entire HRA credit (prorated from your effective date to the end of the plan year) is available from your effective date of enrollment
- Tax-free credit can be used to pay for qualified medical expenses for you and any individuals covered by this HDHP

- Unused credits carryover from year to year
- HRA credit does not earn interest
- HRA credit is forfeited if you leave Federal employment or switch health insurance plans.
- An HRA does not affect your ability to participate in an FSAFEDS Health Care Flexible Spending Account (HCFSA). However, you must meet FSAFEDS eligibility requirements. See *Who is eligible to enroll?* in Section 12 under The Federal Flexible Spending Account Program – *FSAFEDS*.

• **Catastrophic protection for out-of-pocket expenses**

When you use network providers, your annual maximum for out-of-pocket expenses (deductibles, coinsurance and copayments) for covered services is limited to \$ 4,000 per person or \$ 8,000 per family enrollment. However, certain expenses do not count toward your out-of-pocket maximum and you must continue to pay these expenses once you reach your out-of-pocket maximum (such as expenses in excess of the Plan’s allowable amount or benefit maximum). Refer to Section 4 Your catastrophic protection out-of-pocket maximum and HDHP Section 5 *Traditional medical coverage subject to the deductible* for more details.

• **Health education resources and account management tools**

HDHP Section 5(i) describes the health education resources and account management tools available to you to help you manage your health care and your health care dollars.

**Section 5 Savings – HSAs and HRAs**

Feature Comparison	Health Savings Account (HSA)	Health Reimbursement Arrangement (HRA)  Provided when you are ineligible for an HSA
<b>Administrator</b>	The Plan will establish an HSA for you with Bank of the James, this HDHP's fiduciary (an administrator, trustee or custodian as defined by Federal tax code and approved by IRS.)	Piedmont Community HealthCare is the HRA fiduciary for this Plan.
<b>Fees</b>	Set-up fee is paid by the HDHP.  \$3.50 per month administrative fee charged by the fiduciary and taken out of the account balance.	None.
<b>Eligibility</b>	<p>You must:</p> <ul style="list-style-type: none"> <li>• Enroll in this HDHP</li> <li>• Have no other health insurance coverage (does not apply to specific injury, accident, disability, dental, vision or long-term care coverage)</li> <li>• Not be enrolled in Medicare Part A or Part B</li> <li>• Not be claimed as a dependent on someone else's tax return</li> <li>• Must not have received VA benefits in the last three months</li> <li>• Complete and return all banking paperwork.</li> </ul> <p>Eligibility for contributions is determined on the first day of the month following your effective date of enrollment and will be prorated for length of enrollment.</p>	<p>You must enroll in this HDHP.</p> <p>Eligibility is determined on the first day of the month following your effective day of enrollment and will be prorated for length of enrollment.</p>
<b>Funding</b>	If you are eligible for HSA contributions, a portion of your monthly health plan premium is deposited to your HSA each month. Premium pass through contributions are based on the effective date of your enrollment in the HDHP.	Eligibility for the annual credit will be determined on the first day of the month and will be prorated for length of enrollment. The entire amount of your HRA will be available to you upon your enrollment.
• <b>Self Only enrollment</b>	For 2007, a monthly premium pass through of \$83.34 will be made by the HDHP directly into your HSA.	For 2007, your HRA annual credit is \$1000 (prorated for length of enrollment).
• <b>Self and Family enrollment</b>	For 2007, a monthly premium pass through of \$166.67 will be made by the HDHP directly into your HSA.	For 2007, your HRA annual credit is \$2000 (prorated for length of enrollment).
<b>Contributions/credits</b>	The maximum that can be contributed to your HRA is an annual combination of HDHP premium pass through and enrollee contribution funds, which when combined, do not exceed the amount of the deductible, which is \$2,000. This amount is reduced by 1/12 for any month you were ineligible to contribute to an HSA.	The full HRA credit will be available, subject to proration, on the effective date of enrollment. The HRA does not earn interest.

	<p>For each month you are eligible for HSA contributions, if you choose to contribute to your HSA,</p> <ul style="list-style-type: none"> <li>• The maximum allowable contribution is a combination of employee and employer funds up to the amount of the deductible of \$2,000 for Self Only or \$4,000 for Self and Family. To determine the maximum allowable contribution, take the amount of your deductible divided by 12, times the number of full months enrolled in the HDHP. Subtract the amount the Plan will contribute to your account for the year from the maximum allowable contribution to determine the amount you may contribute.</li> <li>• You may rollover funds you have in other HSAs to this HDHP HSA (rollover funds do not affect your annual maximum contribution under this HDHP).</li> <li>• HSAs earn tax-free interest (does not affect your annual maximum contribution).</li> <li>• Catch-up contribution discussed on page 50.</li> </ul>	
<ul style="list-style-type: none"> <li>• <b>Self Only enrollment</b></li> </ul>	You may make an annual maximum contribution of \$1,000.	You cannot contribute to the HRA.
<ul style="list-style-type: none"> <li>• <b>Self and Family enrollment</b></li> </ul>	You may make an annual maximum contribution of \$2000.	You cannot contribute to the HRA.
<b>Access funds</b>	<p>You can access your HSA by the following methods:</p> <ul style="list-style-type: none"> <li>• Debit card</li> <li>• Checks</li> </ul>	For qualified medical expenses under your HDHP, you will be automatically reimbursed when claims are submitted through the HDHP. For expenses not covered by the HDHP, such as orthodontia, a reimbursement form will be sent to you upon your request.
<p><b>Distributions/withdrawals</b></p> <ul style="list-style-type: none"> <li>• <b>Medical</b></li> </ul>	<p>You can pay the out-of-pocket expenses for yourself, your spouse or your dependents (even if they are not covered by the HDHP) from the funds available in your HSA.</p> <p>See IRS Publication 502 for a list of eligible medical expenses, including over-the-counter drugs.</p>	<p>You can pay the out-of-pocket expenses for qualified medical expenses for individuals covered under the HDHP. Non-reimbursed qualified medical expenses are allowable if they occur after the effective date of your enrollment in this Plan.</p> <p>See <i>Availability of funds</i> below for information on when funds are available in the HRA.</p> <p>See IRS Publication 502 for a list of eligible medical expenses. Over-the-counter drugs and Medicare premiums are also reimbursable. Most other types of medical insurance premiums are not reimbursable.</p>
<ul style="list-style-type: none"> <li>• <b>Non-medical</b></li> </ul>	If you are under age 65, withdrawal of funds for non-medical expenses will create a 10% income tax penalty in addition to any other income taxes you may owe on the withdrawn funds.	Not applicable – distributions will not be made for anything other than non-reimbursed qualified medical expenses.

	When you turn age 65, distributions can be used for any reason without being subject to the 10% penalty, however they will be subject to ordinary income tax.	
<b>Availability of funds</b>	<p>Funds are not available for withdrawal until all the following steps are completed:</p> <ul style="list-style-type: none"> <li>• Your enrollment in this HDHP is effective (effective date is determined by your agency in accord with the event permitting the enrollment change).</li> <li>• The HDHP receives record of your enrollment and initially establishes your HSA account with the fiduciary by providing information it must furnish and by contributing the minimum amount required to establish an HSA.</li> <li>• The fiduciary sends you HSA paperwork for you to complete and the fiduciary receives the completed paperwork back from you.</li> </ul>	The entire amount of your HRA will be available to you upon your enrollment in the HDHP.
<b>Account owner</b>	FEHB enrollee	HDHP
<b>Portable</b>	You can take this account with you when you change plans, separate or retire. If you do not enroll in another HDHP, you can no longer contribute to your HSA.	<p>If you retire and remain in this HDHP, you may continue to use and accumulate credits in your HRA.</p> <p>If you terminate employment or change health plans, only eligible expenses incurred while covered under the HDHP will be eligible for reimbursement subject to timely filing requirements. Unused funds are forfeited.</p>
<b>Annual rollover</b>	Yes, accumulates without a maximum cap.	Yes, accumulates without a maximum cap.

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## If You Have an HSA

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### If you have an HSA

- **Contributions**

All contributions are aggregated and cannot exceed the annual maximum contribution. You may contribute your own money to your account through payroll deductions (if available), or you may make lump sum contributions at any time, in any amount not to exceed an annual maximum limit. If you contribute, you can claim the total amount you contributed for the year as a tax deduction when you file your income taxes. You receive tax advantages in any case. You have until April 15 of the following year to make HSA contributions for the current year.

IRS contribution rules reduce the total annual maximum contribution if you are not eligible for the HDHP during the whole month. For instance, if your enrollment in this Plan was effective after January 1, 2007, you would need to deduct 1/12 of the annual maximum contribution. Contact Bank of the James for more details.
- **Catch-up contributions**

If you are age 55 or older, the IRS permits you to make additional “catch-up” contributions to your HSA. In 2007, you may contribute up to \$800 in catch-up contributions. Catch-up contributions in later years increase up to a maximum of \$1,000 in 2009 and beyond. Contributions must stop once an individual is enrolled in Medicare. Additional details are available on the U.S. Department of Treasury Web site at [www.ustreas.gov/offices/public-affairs/hsa/](http://www.ustreas.gov/offices/public-affairs/hsa/).
- **If you die**

If you do not have a named beneficiary, if you are married, it becomes your spouse’s HSA; otherwise, it becomes part of your taxable estate.
- **Qualified expenses**

You can pay for “qualified medical expenses,” as defined by IRS Code 213(d). These expenses include, but are not limited to, medical plan deductibles, diagnostic services covered by your plan, long-term care premiums, health insurance premiums if you are receiving Federal unemployment compensation, over-the-counter drugs, LASIK surgery, and some nursing services.

When you enroll in Medicare, you can use the account to pay Medicare premiums or to purchase any health insurance other than a Medigap policy. You may not, however, continue to make contributions to your HSA once you are enrolled in Medicare.

For a detailed list of IRS-allowable expenses, request a copy of IRS Publication 502 by calling 1-800-829-3676, or visit the IRS Web site at [www.irs.gov](http://www.irs.gov) and click on “Forms and Publications.” Note: Although over-the-counter drugs are not listed in the publication, they are reimbursable from your HSA. Also, insurance premiums are reimbursable under limited circumstances.
- **Non-qualified expenses**

You may withdraw money from your HSA for items other than qualified health expenses, but it will be subject to income tax and if you are under 65 years old, an additional 10% penalty tax on the amount withdrawn.
- **Tracking your HSA balance**

You will receive a periodic statement that shows the “premium pass through”, withdrawals, and interest earned on your account.
- **Minimum reimbursements from your HSA**

You can request reimbursement in any amount. Generally, there will not be reimbursements since the HSA uses checks and/or debit card to withdraw from the account.

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## If You Have an HRA

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### If you have an HRA

- **Why an HRA is established**

If you don't qualify for an HSA when you enroll in this HDHP, or later become ineligible for an HSA, we will establish an HRA for you. If you are enrolled in Medicare, you are ineligible for an HSA and we will establish an HRA for you. You must tell us if you become ineligible to contribute to an HSA.

- **How an HRA differs**

Please review the chart on page 47 which details the differences between an HRA and an HSA. The major differences are:

- You cannot make contributions to an HRA
- Funds are forfeited if you leave the HDHP
- An HRA does not earn interest, and
- HRAs can only pay for qualified medical expenses, such as deductibles, copayments, and coinsurance expenses, for individuals covered by the HDHP.

**Section 5 Preventive care**

**Important things you should keep in mind about these benefits:**

- Preventive care services listed in this Section are not subject to the deductible. You only owe your copay for covered preventive care services.
- You must use providers that are part of our network.
- For all other covered expenses, please see Section 5 – *Traditional medical coverage subject to the deductible.*

Benefit Description	You pay
<b>Preventive care, adult</b>	<b>High Option</b>
Routine screenings, such as: <ul style="list-style-type: none"> <li>• Blood tests</li> <li>• Urinalysis</li> <li>• Total Blood Cholesterol - once every three years</li> <li>• Routine Prostate Specific Antigen (PSA) test — one annually for men age 40 and older</li> <li>• Colorectal Cancer Screening, including                             <ul style="list-style-type: none"> <li>- Fecal occult blood test yearly starting at age 50,</li> <li>- Sigmoidoscopy screening — every five years starting at age 50,</li> <li>- Double contrast barium enema — every five years starting at age 50;</li> <li>- Colonoscopy screening — every 10 years starting at age 50</li> </ul> </li> <li>• Routine well-woman exam including Pap test, one visit every 12 months from last date of service</li> <li>• Routine mammogram — covered for women age 35 and older, as follows:                             <ul style="list-style-type: none"> <li>- From age 35 through 39, one during this five year period</li> <li>- From age 40 and older, one every calendar year</li> </ul> </li> </ul>	\$25 per office visit
Routine immunizations endorsed by the Centers for Disease Control and Prevention (CDC): <ul style="list-style-type: none"> <li>• Tetanus-diphtheria (Td) booster – once every 10 years, ages 19 and over (except as provided for under Childhood immunizations)</li> <li>• Influenza vaccine, annually</li> <li>• Pneumococcal vaccine, age 65 and older</li> </ul> Routine physicals which include: <ul style="list-style-type: none"> <li>• One exam every 24 months up to age 65</li> <li>• One exam every 12 months age 65 and older</li> </ul> Routine exams limited to: <ul style="list-style-type: none"> <li>• 1 routine OB/GYN exam every 12 months including 1 Pap smear and related services</li> </ul>	\$25 per office visit
<i>Not covered:</i> <ul style="list-style-type: none"> <li>• <i>Physical exams required for obtaining or continuing employment or insurance, attending schools or camp, athletic exams or travel.</i></li> </ul>	<i>All Charges.</i>

Benefit Description	You pay
<b>Preventive care, adult (cont.)</b>	<b>High Option</b>
<ul style="list-style-type: none"> <li>• <i>Immunizations, boosters, and medications for travel or work-related exposure.</i></li> </ul>	<i>All Charges.</i>
<b>Preventive care, children</b>	<b>High Option</b>
Professional services, such as: <ul style="list-style-type: none"> <li>• Well-child visits for routine examinations, immunizations and care (up to age 22)</li> <li>• Childhood immunizations recommended by the American Academy of Pediatrics</li> <li>• Examinations, such as:               <ul style="list-style-type: none"> <li>- Eye exam through age 17 to determine the need for vision correction</li> <li>- Hearing exams through age 17 to determine the need for hearing correction</li> </ul> </li> </ul>	\$25 per office visit
<i>Not covered:</i> <ul style="list-style-type: none"> <li>• <i>Physical exams required for obtaining or continuing employment or insurance, attending schools or camp, or travel.</i></li> <li>• <i>Immunizations, boosters, and medications for travel.</i></li> </ul>	<i>All Charges.</i>

## Section 5 Traditional medical coverage subject to the deductible

**Important things you should keep in mind about these benefits:**

- Please remember that all benefits are subject to the definitions, limitations, and exclusions in this brochure and are payable only when we determine they are medically necessary.
- In-network preventive care is covered with office visits copayments (see page 52) and is not subject to the calendar year deductible.
- The deductible is \$2,000 per person or \$4,000 per family enrollment. The family deductible can be satisfied by one or more family members. The deductible applies to almost all benefits under Traditional medical coverage. You must pay your deductible before your Traditional medical coverage may begin.
- Under Traditional medical coverage, you are responsible for your coinsurance and copayments for covered expenses.
- When you use network providers, you are protected by an annual catastrophic maximum on out-of-pocket expenses for covered services. After your coinsurance, copayments and deductibles total \$4,000 per person or \$8,000 per family enrollment in any calendar year, you do not have to pay any more for covered services from network providers. However, certain expenses do not count toward your out-of-pocket maximum and you must continue to pay these expenses once you reach your out-of-pocket maximum (such as expenses in excess of the Plan’s benefit maximum, or if you use out-of-network providers, amounts in excess of the Plan allowance).
- In-network benefits apply only when you use a network provider. When a network provider is not available, out-of-network benefits apply.
- Be sure to read Section 4, Your costs for covered services, for valuable information about how cost sharing works. Also read Section 9 about coordinating benefits with other coverage, including with Medicare.

Benefit Description	You pay After the calendar year deductible...
<b>Deductible before Traditional medical coverage begins</b>	<b>High Option</b>
The deductible applies to almost all benefits in this Section. In the You pay column, we say “No deductible” when it does not apply. When you receive covered services from network providers, you are responsible for paying the allowable charges until you meet the deductible.	100% of allowable charges until you meet the deductible of \$2000 per person or \$4000 per family enrollment
After you meet the deductible, we pay the allowable charge (less your coinsurance or copayment) until you meet the annual catastrophic out-of-pocket maximum.	<p>In-network: After you meet the deductible, you pay the indicated coinsurance or copayments for covered services. You may choose to pay the coinsurance and copayments from your HSA or HRA, or you can pay for them out-of-pocket.</p> <p>Out-of-network: After you meet the deductible, you pay the indicated coinsurance based on our Plan allowance and any difference between our allowance and the billed amount.</p>

**Section 5(a) Medical services and supplies  
provided by physicians and other health care professionals**

**Important things you should keep in mind about these benefits:**

- Please remember that all benefits are subject to the definitions, limitations, and exclusions in this brochure and are payable only when we determine they are medically necessary.
- Plan physicians must provide or arrange your care.
- The deductible is \$2,000 for Self Only enrollment and \$4,000 for Self and Family enrollment each calendar year. The Self and Family deductible can be satisfied by one or more family members. The deductible applies to all benefits in this Section unless we indicate differently.
- After you have satisfied your deductible, coverage begins for traditional medical services.
- Under your Traditional medical coverage, you will be responsible for your coinsurance amounts or copayments for eligible medical expenses and prescriptions.
- Be sure to read Section 4, *Your costs for covered services*, for valuable information about how cost sharing works. Also read Section 9 about coordinating benefits with other coverage, including with Medicare.

Benefit Description	You pay After the calendar year deductible...
<b>Diagnostic and treatment services</b>	<b>High Option</b>
Professional services of physicians <ul style="list-style-type: none"> <li>• In physician’s office</li> <li>• In an urgent care center</li> <li>• During a hospital stay</li> <li>• In a skilled nursing facility</li> <li>• Office medical consultations</li> <li>• Second surgical opinion</li> </ul>	20% of allowable charge after deductible
<b>Lab, X-ray and other diagnostic tests</b>	<b>High Option</b>
Tests, such as: <ul style="list-style-type: none"> <li>• Blood tests</li> <li>• Urinalysis</li> <li>• Non-routine Pap tests</li> <li>• Pathology</li> <li>• X-rays</li> <li>• Non-routine mammograms</li> <li>• CAT Scans/MRI</li> <li>• Ultrasound</li> <li>• Electrocardiogram and EEG</li> </ul>	20% of allowable charge after deductible

Benefit Description	You pay After the calendar year deductible...
<b>Maternity care</b>	
<p>Complete maternity (obstetrical) care, such as:</p> <ul style="list-style-type: none"> <li>• Prenatal care</li> <li>• Delivery</li> <li>• Postnatal care</li> </ul> <p>Note: Here are some things to keep in mind:</p> <ul style="list-style-type: none"> <li>• You do not need to precertify your normal delivery; see page xx for other circumstances, such as extended stays for you or your baby.</li> <li>• You may remain in the hospital up to 48 hours after a regular delivery and 96 hours after a cesarean delivery. We will extend your inpatient stay if medically necessary.</li> <li>• We cover routine nursery care of the newborn child during the covered portion of the mother’s maternity stay. We will cover other care of an infant who requires non-routine treatment only if we cover the infant under a Self and Family enrollment. Surgical benefits, not maternity benefits, apply to circumcision.</li> <li>• We pay hospitalization and surgeon services (delivery) the same as for illness and injury. See <i>Hospital benefits</i> (Section 5c) and <i>Surgery benefits</i> (Section 5b).</li> </ul>	<p><b>High Option</b></p> <p>20% of allowable charge after deductible</p>
<p><i>Not covered: Non-diagnostic routine sonograms to determine fetal age, size or sex</i></p>	<p><i>All charges.</i></p>
<b>Family planning</b>	
<p>A range of voluntary family planning services, limited to:</p> <ul style="list-style-type: none"> <li>• Voluntary sterilization (See Surgical procedures Section 5 (b))</li> <li>• Surgically implanted contraceptives (such as Norplant)</li> <li>• Injectable contraceptive drugs (such as Depo provera)</li> <li>• Intrauterine devices (IUDs)</li> <li>• Diaphragms</li> </ul> <p>Note: We cover oral contraceptives under the prescription drug benefit.</p>	<p><b>High Option</b></p> <p>20% of allowable charge after deductible</p>
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> <li>• <i>Reversal of voluntary surgical sterilization</i></li> <li>• <i>Genetic counseling.</i></li> </ul>	<p><i>All Charges.</i></p>
<b>Infertility services</b>	
<p>Diagnosis and treatment of infertility such as:</p> <ul style="list-style-type: none"> <li>• Artificial insemination: <ul style="list-style-type: none"> <li>- intravaginal insemination (IVI)</li> <li>- intracervical insemination (ICI)</li> <li>- intrauterine insemination (IUI)</li> </ul> </li> <li>• Fertility drugs</li> </ul>	<p><b>High Option</b></p> <p>20% of allowable charge after deductible</p>

*Infertility services - continued on next page*

Benefit Description	You pay After the calendar year deductible...
<b>Infertility services (cont.)</b>	<b>High Option</b>
<p>Note: We cover injectible fertility drugs under medical benefits and oral fertility drugs under the prescription drug benefit.</p>	20% of allowable charge after deductible
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> <li>• <i>Assisted reproductive technology (ART) procedures, such as:</i> <ul style="list-style-type: none"> <li>- <i>in vitro fertilization</i></li> <li>- <i>embryo transfer, gamete intra-fallopian transfer (GIFT) and zygote intra-fallopian transfer (ZIFT)</i></li> </ul> </li> <li>• <i>Services and supplies related to ART procedures</i></li> <li>• <i>Cost of donor sperm</i></li> <li>• <i>Cost of donor egg</i></li> </ul>	<i>All Charges.</i>
<b>Allergy care</b>	<b>High Option</b>
<ul style="list-style-type: none"> <li>• Testing and treatment</li> <li>• Allergy injections</li> </ul>	20% of allowable charge after deductible
Allergy serum	Nothing
<i>Not covered: Provocative food testing and sublingual allergy desensitization</i>	<i>All Charges.</i>
<b>Treatment therapies</b>	<b>High Option</b>
<ul style="list-style-type: none"> <li>• Chemotherapy and radiation therapy</li> </ul> <p>Note: High dose chemotherapy in association with autologous bone marrow transplants is limited to those transplants listed under Organ/Tissue Transplants on page 66.</p> <ul style="list-style-type: none"> <li>• Respiratory and inhalation therapy</li> <li>• Dialysis – hemodialysis and peritoneal dialysis</li> <li>• Intravenous (IV)/Infusion Therapy – Home IV and antibiotic therapy</li> <li>• Growth hormone therapy (GHT)</li> </ul> <p>Note: Growth hormone is covered under the prescription drug benefit.</p> <p>Note: – We only cover GHT when we preauthorize the treatment. Call 434-947-3590 for preauthorization. We will ask you to submit information that establishes that the GHT is medically necessary. Ask us to authorize GHT before you begin treatment; otherwise, we will only cover GHT services from the date you submit the information. If you do not ask or if we determine GHT is not medically necessary, we will not cover the GHT or related services and supplies. See <i>Services requiring our prior approval</i> in Section 3.</p>	20% of allowable charge after deductible

Benefit Description	You pay After the calendar year deductible...
<b>Physical and occupational therapies</b>	
<p>90 visits for the services of each of the following:</p> <ul style="list-style-type: none"> <li>• qualified physical therapists and</li> <li>• occupational therapists</li> </ul> <p>Note: We only cover therapy to restore bodily function when there has been a total or partial loss of bodily function due to illness or injury. Services are limited to those which can be expected to result in significant improvement within a period of 90 days.</p> <ul style="list-style-type: none"> <li>• Cardiac rehabilitation following a heart transplant, bypass surgery or a myocardial infarction is provided for up to 90 sessions.</li> </ul>	<p><b>High Option</b></p> <p>20% of allowable charge after deductible</p>
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> <li>• Long-term rehabilitative therapy</li> <li>• Exercise programs</li> </ul>	<p><i>All Charges.</i></p>
<b>Speech therapy</b>	
<p>90 visits per condition</p>	<p><b>High Option</b></p> <p>20% of allowable charge after deductible</p>
<b>Hearing services (testing, treatment, and supplies)</b>	
<p>First hearing aid and testing only when necessitated by accidental injury</p> <p>Hearing exams for children through age 17, which include: (see <i>Preventive care, children</i>)</p>	<p><b>High Option</b></p> <p>20% of allowable charge after deductible</p> <p>\$25 per office visit</p>
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> <li>• All other hearing testing</li> <li>• Hearing aids, testing and examinations for them</li> </ul>	<p><i>All Charges.</i></p>
<b>Vision services (testing, treatment, and supplies)</b>	
<p>One pair of eyeglasses or contact lenses to correct an impairment directly caused by accidental ocular injury or intraocular surgery (such as for cataracts)</p> <p>Annual eye refractions</p>	<p><b>High Option</b></p> <p>20% of allowable charge after deductible</p> <p>\$25 per office visit</p>
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> <li>• Eyeglasses or contact lenses, except as shown above</li> <li>• Eye exercises and orthoptics</li> <li>• Radial keratotomy and other refractive surgery</li> </ul>	<p><i>All Charges.</i></p>
<b>Foot care</b>	
<p>Routine foot care when you are under active treatment for a metabolic or peripheral vascular disease, such as diabetes.</p>	<p><b>High Option</b></p> <p>20% of allowable charge after deductible</p>
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> <li>• Cutting, trimming or removal of corns, calluses, or the free edge of toenails, and similar routine treatment of conditions of the foot, except as stated above</li> </ul>	<p><i>All Charges.</i></p>

*Foot care - continued on next page*

Benefit Description	You pay After the calendar year deductible...
<b>Foot care (cont.)</b>	<b>High Option</b>
<ul style="list-style-type: none"> <li>• <i>Treatment of weak, strained or flat feet or bunions or spurs; and of any instability, imbalance or subluxation of the foot (unless the treatment is by open cutting surgery)</i></li> </ul>	<i>All Charges.</i>
<b>Orthopedic and prosthetic devices</b>	<b>High Option</b>
<ul style="list-style-type: none"> <li>• Artificial limbs and eyes; stump hose</li> <li>• Externally worn breast prostheses and surgical bras, including necessary replacements following a mastectomy</li> <li>• Internal prosthetic devices, such as artificial joints, pacemakers, cochlear implants, and surgically implanted breast implant following mastectomy. Note: See 5(b) for coverage of the surgery to insert the device.</li> </ul>	20% of allowable charge after deductible
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> <li>• <i>Orthopedic and corrective shoes</i></li> <li>• <i>Arch supports</i></li> <li>• <i>Foot orthotics</i></li> <li>• <i>Heel pads and heel cups</i></li> <li>• <i>Lumbosacral supports</i></li> <li>• <i>Corsets, trusses, elastic stockings, support hose, and other supportive devices</i></li> <li>• <i>Prosthetic replacements provided less than 3 years after the last one we covered</i></li> </ul>	<i>All Charges.</i>
<b>Durable medical equipment (DME)</b>	<b>High Option</b>
<p>We cover rental or purchase of durable medical equipment, at our option, including repair and adjustment. Limited to \$2,000 per member per calendar year for any combination of items. Covered items include:</p> <ul style="list-style-type: none"> <li>• Oxygen;</li> <li>• Dialysis equipment;</li> <li>• Hospital beds;</li> <li>• Wheelchairs;</li> <li>• Canes, crutches, walkers slings, cervical collars, and traction apparatus;</li> <li>• Bedside commode, shower chair, and tub rails;</li> <li>• Ostomy supplies, including bags, flanges, and belts;*</li> <li>• Catheters and catheter bags;*</li> <li>• Jobst stockings or equivalent when prescribed by a vascular surgeon following vascular surgery;</li> <li>• The first pair of contact lenses or eyeglasses following approved cataract surgery without implant;</li> <li>• Prosthetic devices;</li> <li>• Blood glucose monitors; and</li> <li>• Insulin pumps.</li> </ul>	20% of allowable charge after deductible

*Durable medical equipment (DME) - continued on next page*

Benefit Description	You pay After the calendar year deductible...
<b>Durable medical equipment (DME) (cont.)</b>	
<p>*Supplies to be purchased in quantities or units equivalent to a 30-day supply.</p> <p>Note: Call us at 434-947-3590 as soon as your Plan physician prescribes this equipment. We will arrange with a health care provider to rent or sell you durable medical equipment at discounted rates and will tell you more about this service when you call.</p>	<p><b>High Option</b></p> <p>20% of allowable charge after deductible</p>
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> <li>• <i>Motorized wheelchairs</i></li> <li>• <i>Any durable medical equipment not listed above is not covered.</i></li> </ul>	<p><i>All Charges.</i></p>
<b>Home health services</b>	
<ul style="list-style-type: none"> <li>• Home health care ordered by a Plan physician and provided by a registered nurse (R.N.), licensed practical nurse (L.P.N.), licensed vocational nurse (L.V.N.), or home health aide.</li> <li>• Services include oxygen therapy, intravenous therapy and medications.</li> </ul>	<p><b>High Option</b></p> <p>20% of allowable charge after deductible</p>
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> <li>• <i>Nursing care requested by, or for the convenience of, the patient or the patient's family;</i></li> <li>• <i>Home care primarily for personal assistance that does not include a medical component and is not diagnostic, therapeutic, or rehabilitative.</i></li> </ul>	<p><i>All Charges.</i></p>
<b>Chiropractic</b>	
<p>Limited to \$500 per calendar year</p> <ul style="list-style-type: none"> <li>• Manipulation of the spine and extremities</li> <li>• Adjunctive procedures such as ultrasound, electrical muscle stimulation, vibratory therapy, and cold pack application</li> </ul>	<p><b>High Option</b></p> <p>20% of allowable charge after deductible</p>
<p><i>Not covered: Maintenance services.</i></p>	<p><i>All Charges.</i></p>
<b>Alternative treatments</b>	
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> <li>• <i>Acupuncture services</i></li> <li>• <i>Naturopathic services</i></li> <li>• <i>Hypnotherapy</i></li> <li>• <i>Biofeedback</i></li> </ul>	<p><b>High Option</b></p> <p><i>All Charges.</i></p>

Benefit Description	You pay After the calendar year deductible...
<b>Educational classes and programs</b>	<b>High Option</b>
Coverage is limited to: <ul style="list-style-type: none"> <li>• Diabetes self management</li> <li>• Diabetes nutritional counseling for newly diagnosed patients</li> </ul>	20% of allowable charge after deductible

**Section 5(b) Surgical and anesthesia services  
provided by physicians and other health care professionals**

**Important things you should keep in mind about these benefits:**

- Please remember that all benefits are subject to the definitions, limitations, and exclusions in this brochure and are payable only when we determine they are medically necessary.
- Plan physicians must provide or arrange your care.
- The deductible is \$2,000 for Self Only enrollment and \$4,000 for Self and Family enrollment each calendar year. The Self and Family deductible can be satisfied by one or more family members. The deductible applies to almost all benefits in this Section.
- After you have satisfied your deductible, your Traditional medical coverage begins.
- Under your Traditional medical coverage, you will be responsible for your coinsurance amounts or copayments for eligible medical expenses and prescriptions.
- The amounts listed below are for the charges billed by a physician or other health care professional for your surgical care. Look in Section 5(c) for charges associated with the facility (i.e. hospital, surgical center, etc.).
- **YOUR PHYSICIAN MUST GET PRECERTIFICATION OF SOME SURGICAL PROCEDURES.** Please refer to the precertification information shown in Section 3 to be sure which services require precertification and identify which surgeries require precertification.

Benefit Description	You pay After the calendar year deductible...
<p><b>Surgical procedures</b></p> <p>A comprehensive range of services, such as:</p> <ul style="list-style-type: none"> <li>• Operative procedures</li> <li>• Treatment of fractures, including casting</li> <li>• Normal pre- and post-operative care by the surgeon</li> <li>• Correction of amblyopia and strabismus</li> <li>• Endoscopy procedures</li> <li>• Biopsy procedures</li> <li>• Removal of tumors and cysts</li> <li>• Correction of congenital anomalies (see <i>Reconstructive surgery</i>)</li> <li>• Surgical treatment of morbid obesity (bariatric surgery) – a condition in which an individual weighs 100 pounds or 100% over his or her normal weight according to current underwriting standards; eligible members must be age 18 or over, have a BMI of 40 or greater, or a BMI of 35 with co-morbid conditions; have actively participated in non-surgical methods of weight reduction for at least a year under the supervision of a physician; the physician requesting surgery must confirm that the patient has had an evaluation by a psychiatrist or psychologist documenting that he/she is able to understand, tolerate, and comply with all phases of care; the patient’s postoperative expectations have been addressed; the patient has received a thorough explanation of the risks and benefits; and the patient’s treatment plan includes pre and postoperative dietary evaluations conducted by a dietician/nutritionist.</li> </ul>	<p align="center"><b>High Option</b></p> <p>20% of allowable charge after deductible</p>

*Surgical procedures - continued on next page*

Benefit Description	You pay After the calendar year deductible...
<b>Surgical procedures (cont.)</b>	
<ul style="list-style-type: none"> <li>• Insertion of internal prosthetic devices . See 5(a) <i>Orthopedic and prosthetic devices</i> for device coverage information</li> <li>• Voluntary sterilization (e.g., tubal ligation, vasectomy)</li> <li>• Treatment of burns</li> </ul> <p>Note: Generally, we pay for internal prostheses (devices) according to where the procedure is done. For example, we pay Hospital benefits for a pacemaker and Surgery benefits for insertion of the pacemaker.</p>	<b>High Option</b>
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> <li>• <i>Reversal of voluntary sterilization</i></li> <li>• <i>Routine treatment of conditions of the foot; see Foot care</i></li> <li>• <i>Dorsal rhizotomy to treat spasticity</i></li> </ul>	<i>All Charges.</i>
<b>Reconstructive surgery</b>	
<ul style="list-style-type: none"> <li>• Surgery to correct a functional defect</li> <li>• Surgery to correct a condition caused by injury or illness if:               <ul style="list-style-type: none"> <li>- the condition produced a major effect on the member’s appearance and</li> <li>- the condition can reasonably be expected to be corrected by such surgery</li> </ul> </li> <li>• Surgery to correct a condition that existed at or from birth and is a significant deviation from the common form or norm. Examples of congenital anomalies are: protruding ear deformities; cleft lip; cleft palate; birth marks; and webbed fingers and toes.</li> <li>• All stages of breast reconstruction surgery following a mastectomy, such as:               <ul style="list-style-type: none"> <li>- surgery to produce a symmetrical appearance of breasts;</li> <li>- treatment of any physical complications, such as lymphedemas;</li> <li>- breast prostheses and surgical bras and replacements (see Prosthetic devices)</li> </ul> </li> </ul> <p>Note: If you need a mastectomy, you may choose to have the procedure performed on an inpatient basis and remain in the hospital up to 48 hours after the procedure.</p>	<b>High Option</b>
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> <li>• <i>Cosmetic surgery – any surgical procedure (or any portion of a procedure) performed primarily to improve physical appearance through change in bodily form, except repair of accidental injury</i></li> <li>• <i>Surgeries related to sex transformation</i></li> </ul>	<i>All Charges.</i>

Benefit Description	You pay After the calendar year deductible...
<b>Oral and maxillofacial surgery</b>	
<p>Oral surgical procedures, limited to:</p> <ul style="list-style-type: none"> <li>• Reduction of fractures of the jaws or facial bones;</li> <li>• Surgical correction of cleft lip, cleft palate or severe functional malocclusion;</li> <li>• Removal of stones from salivary ducts;</li> <li>• Excision of leukoplakia or malignancies;</li> <li>• Excision of cysts and incision of abscesses when done as independent procedures; and</li> <li>• Other surgical procedures that do not involve the teeth or their supporting structures.</li> </ul>	<b>High Option</b>  20% of allowable charge after deductible
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> <li>• <i>Oral implants and transplants</i></li> <li>• <i>Procedures that involve the teeth or their supporting structures (such as the periodontal membrane, gingiva, and alveolar bone)</i></li> </ul>	<i>All Charges.</i>
<b>Organ/tissue transplants</b>	
<p>Solid organ transplants are subject to medical necessity and experimental/investigational review. Refer to <i>Other services</i> in Section 3 for prior authorization procedures. The medical necessity limitation is considered satisfied for other tissue transplants if the patient meets the staging description and can safely tolerate the procedure.</p> <ul style="list-style-type: none"> <li>• Cornea</li> <li>• Heart</li> <li>• Heart/lung</li> <li>• Single, double lung</li> <li>• Kidney</li> <li>• Liver</li> <li>• Pancreas</li> <li>• Intestinal transplants               <ul style="list-style-type: none"> <li>- Small intestine</li> <li>- Small intestine with the liver</li> <li>- Small intestine with multiple organs, such as the liver, stomach, and pancreas</li> </ul> </li> </ul>	<b>High Option</b>  20% of allowable charge after deductible
<p>Blood or marrow stem cell transplants limited to the stages of the following diagnoses:</p> <ul style="list-style-type: none"> <li>• Allogeneic transplants for               <ul style="list-style-type: none"> <li>- Acute lymphocytic or non-lymphocytic (i.e., myelogenous) leukemia</li> <li>- Advanced Hodgkin’s lymphoma</li> <li>- Advanced non-Hodgkin’s lymphoma</li> <li>- Chronic myleognous leukemia</li> <li>- Severe combined immunodeficiency</li> </ul> </li> </ul>	20% of allowable charge after deductible

*Organ/tissue transplants - continued on next page*  
HDHP Section 5(b)

Benefit Description	You pay After the calendar year deductible...
<b>Organ/tissue transplants (cont.)</b>	<b>High Option</b>
<ul style="list-style-type: none"> <li>- Severe or very severe aplastic anemia</li> <li>• Autologous transplants for               <ul style="list-style-type: none"> <li>- Acute lymphocytic or nonlymphocytic (i.e., myelogenous) leukemia</li> <li>- Advanced Hodgkin’s lymphoma</li> <li>- Advanced non-Hodgkin’s lymphoma</li> <li>- Advanced neuroblastoma</li> </ul> </li> <li>• Autologous tandem transplants for recurrent germ cell tumors (including testicular cancer)</li> </ul>	20% of allowable charge after deductible
<p>Blood or marrow stem cell transplants for</p> <ul style="list-style-type: none"> <li>• Allogeneic transplants for               <ul style="list-style-type: none"> <li>- Phagocytic deficiency diseases (e.g., Wiskott-Aldrich syndrome)</li> </ul> </li> <li>• Autologous transplants for               <ul style="list-style-type: none"> <li>- Multiple myeloma</li> <li>- Testicular, mediastinal, retroperitoneal, and ovarian germ cell tumors</li> </ul> </li> </ul>	20% of allowable charge after deductible
<p>Limited Benefits – Treatment for breast cancer, multiple myeloma, and epithelial ovarian cancer may be provided in a National Cancer Institute – or National Institutes of Health-approved clinical trial at a Plan-designated center of excellence and if approved by the Plan’s medical director in accordance with the Plan’s protocols.</p> <p>Note: We cover related medical and hospital expenses of the donor when we cover the recipient.</p>	
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> <li>• <i>Donor screening tests and donor search expenses, except those performed for the actual donor</i></li> <li>• <i>Implants of artificial organs</i></li> <li>• <i>Transplants not listed as covered</i></li> </ul>	<i>All Charges.</i>
<b>Anesthesia</b>	<b>High Option</b>
<p>Professional services provided in –</p> <ul style="list-style-type: none"> <li>• Hospital (inpatient)</li> </ul>	20% of allowable charge after deductible
<p>Professional services provided in –</p> <ul style="list-style-type: none"> <li>• Hospital outpatient department</li> <li>• Skilled nursing facility</li> <li>• Ambulatory surgical center</li> <li>• Office</li> </ul>	20% of allowable charge after deductible

**Section 5(c) Services provided by a hospital or other facility,  
and ambulance services**

**Important things you should keep in mind about these benefits:**

- Please remember that all benefits are subject to the definitions , limitations, and exclusions in this brochure and are payable only when we determine they are medically necessary .
- Plan physicians must provide or arrange your care and you must be hospitalized in a Plan facility.
- The deductible is \$2,000 for Self Only enrollment and \$4,000 for Self and Family enrollment each calendar year. The Self and Family deductible can be satisfied by one or more family members. The deductible applies to all benefits in this Section.
- After you have satisfied your deductible, your Traditional medical coverage begins.
- Under your Traditional medical coverage, you will be responsible for your coinsurance amounts or copayments for eligible medical expenses and prescriptions.
- Be sure to read Section 4, *Your costs for covered services* for valuable information about how cost sharing works. Also read Section 9 about coordinating benefits with other coverage, including with Medicare.
- The amounts listed below are for the charges billed by the facility (i.e., hospital or surgical center) or ambulance service for your surgery or care. Any costs associated with the professional charge (i. e., physicians, etc.) are in Sections 5(a) or (b).

**YOUR PHYSICIAN MUST GET PRECERTIFICATION OF HOSPITAL STAYS.** Please refer to Section 3 to be sure which services require precertification.

Benefit Description	You Pay High Option
<b>Inpatient hospital</b>	
Room and board, such as <ul style="list-style-type: none"> <li>• Ward, semiprivate, or intensive care accommodations;</li> <li>• General nursing care; and</li> <li>• Meals and special diets.</li> </ul> Note: If you want a private room when it is not medically necessary, you pay the additional charge above the semiprivate room rate.	20% of allowable charge after deductible
Other hospital services and supplies, such as: <ul style="list-style-type: none"> <li>• Operating, recovery, maternity, and other treatment rooms</li> <li>• Prescribed drugs and medicines</li> <li>• Diagnostic laboratory tests and X-rays</li> <li>• Administration of blood and blood products</li> <li>• Blood or blood plasma, if not donated or replaced</li> <li>• Dressings , splints , casts , and sterile tray services</li> <li>• Medical supplies and equipment, including oxygen</li> <li>• Anesthetics, including nurse anesthetist services</li> <li>• Take-home items</li> <li>• Medical supplies, appliances, medical equipment, and any covered items billed by a hospital for use at home (Note: calendar year deductible applies.)</li> </ul>	20% of allowable charge after deductible
<i>Not covered:</i>	

*Inpatient hospital - continued on next page*

Benefit Description	You Pay
<b>Inpatient hospital (cont.)</b>	<b>High Option</b>
<ul style="list-style-type: none"> <li>• Custodial care</li> <li>• Non-covered facilities, such as nursing homes, extended care facilities, schools</li> <li>• Personal comfort items, such as telephone, television, barber services, guest meals and beds</li> <li>• Private nursing care</li> </ul>	All Charges.
<b>Outpatient hospital or ambulatory surgical center</b>	<b>High Option</b>
<ul style="list-style-type: none"> <li>• Operating, recovery, and other treatment rooms</li> <li>• Prescribed drugs and medicines</li> <li>• Diagnostic laboratory tests, X-rays , and pathology services</li> <li>• Administration of blood, blood plasma, and other biologicals</li> <li>• Blood and blood plasma, if not donated or replaced</li> <li>• Pre-surgical testing</li> <li>• Dressings, casts , and sterile tray services</li> <li>• Medical supplies, including oxygen</li> <li>• Anesthetics and anesthesia service</li> </ul> <p>Note: We cover hospital services and supplies related to dental procedures when necessitated by a non-dental physical impairment. We do not cover the dental procedures.</p>	20% of allowable charge after deductible
<i>Not covered: Blood and blood derivatives not replaced by the member</i>	All Charges.
<b>Extended care benefits/Skilled nursing care facility benefits</b>	<b>High Option</b>
Skilled nursing facility (SNF): limited to 100 days per member per calendar year	20% of allowable charge after deductible
<i>Not covered: Custodial care</i>	All charges.
<b>Hospice care</b>	<b>High Option</b>
Hospice services include supportive or palliative care for a terminally ill member in the home or a hospice facility. Services include inpatient and outpatient care, and family counseling; these services are provided under the direction of a Plan doctor who certifies that the patient is in the terminal stages of illness, with a life expectancy of approximately six months or less.	20% of allowable charge after deductible
<i>Not covered: Independent nursing, homemaker services</i>	All charges.
<b>Ambulance</b>	<b>High Option</b>
Local professional ambulance service when medically appropriate	20% of allowable charge after deductible

**Section 5(d) Emergency services/accidents**

**Important things you should keep in mind about these benefits:**

- Please remember that all benefits are subject to the definitions, limitations, and exclusions in this brochure and are payable only when we determine they are medically necessary.
- The deductible is \$2,000 for Self Only enrollment and \$4,000 for Self and Family enrollment each calendar year. The Self and Family deductible can be satisfied by one or more family members. The deductible applies to all benefits in this Section.
- After you have satisfied your deductible, your Traditional medical coverage begins.
- Under your Traditional medical coverage, you will be responsible for your coinsurance amounts and copayments for eligible medical expenses and prescriptions.
- Be sure to read Section 4, *Your costs for covered services*, for valuable information about how cost sharing works. Also read Section 9 about coordinating benefits with other coverage, including with Medicare.

**What is a medical emergency?**

A medical emergency is the sudden and unexpected onset of a condition or an injury that you believe endangers your life or could result in serious injury or disability, and requires immediate medical or surgical care. Some problems are emergencies because, if not treated promptly, they might become more serious; examples include deep cuts and broken bones. Others are emergencies because they are potentially life-threatening, such as heart attacks, strokes, poisonings, gunshot wounds, or sudden inability to breathe. There are many other acute conditions that we may determine are medical emergencies – what they all have in common is the need for quick action.

**What to do in case of emergency:**

**Emergencies within our service area:**

- Medical care is available through your primary care physician 7 days a week, 24 hours a day. If you need medical care, you should call your primary care physician immediately for instructions on how to receive care.
- If the emergency is such that immediate medical attention is needed, you should be taken to the nearest appropriate medical facility.
- The Plan covers services rendered by providers other than participating Piedmont providers when the condition treated is an emergency as defined above.
- A telephone call from you to your primary care physician while at an urgent care center or emergency room will not be treated as a proper referral for urgent care or other non-emergency services.
- Emergency services provided within our service area shall include covered services from non-participating Piedmont providers only when a delay in receiving care from a participating Piedmont Provider could reasonably be expected to cause your condition to worsen if left unattended.

**Emergencies outside our service area:**

- Urgent care and emergency services outside the service area are covered services if you sustain an injury or become ill while temporarily away from the service area. Accordingly, benefits for these services are limited to care which is required immediately and unexpectedly. Neither elective care nor care required as a result of circumstances which could reasonably have been foreseen prior to departure from the service area is a covered service. Benefits for maternity care do not cover normal term delivery outside the service area, but do include earlier complications of pregnancy or unexpected delivery occurring outside the service area.
- If an emergency or urgent situation occurs when you are temporarily outside the service area, you should obtain care at the nearest medical facility. You or your representative are responsible for notifying your primary care physician on the next working day or within 48 hours. Failure to do so may result in reduced benefits or no benefits.
- Benefits for continuing or follow-up treatment must be pre-arranged by your primary care physician and provided in the service area.

Benefit Description	You pay After the calendar year deductible...
<b>Emergency within our service area</b>	
<ul style="list-style-type: none"> <li>Emergency care at a doctor’s office</li> <li>Emergency care at an urgent care center</li> <li>Emergency care as an outpatient in a hospital, including doctors’ services</li> </ul>	<p><b>High Option</b></p> <p>20% of allowable charge after deductible</p>
<i>Not covered: Elective care or non-emergency care</i>	<i>All Charges.</i>
<b>Emergency outside our service area</b>	
<ul style="list-style-type: none"> <li>Emergency care at a doctor’s office</li> <li>Emergency care at an urgent care center</li> <li>Emergency care as an outpatient in a hospital, including doctors’ services</li> </ul>	<p><b>High Option</b></p> <p>20% of allowable charge after deductible</p>
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> <li><i>Elective care or non-emergency care and follow-up care recommended by non-Plan providers that has not been approved by the Plan or provided by Plan providers</i></li> <li><i>Emergency care provided outside the service area if the need for care could have been foreseen before leaving the service area</i></li> <li><i>Medical and hospital costs resulting from a normal full-term delivery of a baby outside the service area</i></li> </ul>	<i>All Charges.</i>
<b>Ambulance</b>	
<p>Professional ambulance service when medically appropriate.</p> <p>Air ambulance when medically necessary.</p> <p>Note: See 5(c) for non-emergency service.</p>	<p><b>High Option</b></p> <p>20% of allowable charge after deductible</p>

**Section 5(e) Mental health and substance abuse benefits**

When you get our approval for services and follow a treatment plan we approve, cost-sharing and limitations for Plan mental health and substance abuse benefits will be no greater than for similar benefits for other illnesses and conditions.

**Here are some important things to keep in mind about these benefits:**

- Please remember that all benefits are subject to the definitions, limitations, and exclusions in this brochure and are payable only when we determine they are medically necessary.
- The deductible is \$2,000 for Self Only enrollment and \$4,000 for Self and Family enrollment each calendar year. The Self and Family deductible can be satisfied by one or more family members. The deductible applies to all benefits in this Section.
- After you have satisfied your deductible, your Traditional medical coverage begins.
- Under your Traditional medical coverage, you will be responsible for your coinsurance amounts and copayments for eligible medical expenses and prescriptions.
- Be sure to read Section 4, *Your costs for covered services*, for valuable information about how cost sharing works. Also read Section 9 about coordinating benefits with other coverage, including with Medicare.
- **YOU MUST GET PREAUTHORIZATION OF THESE SERVICES.** See the instructions after the benefits description below.

Benefit Description	You pay After the calendar year deductible...
<b>Mental health and substance abuse benefits</b>	<b>High Option</b>
<p>All diagnostic and treatment services recommended by a Plan provider and contained in a treatment plan that we approve. The treatment plan may include services, drugs, and supplies described elsewhere in this brochure.</p> <p>Note: Plan benefits are payable only when we determine the care is clinically appropriate to treat your condition and only when you receive the care as part of a treatment plan that we approve.</p>	<p>Your cost sharing responsibilities are no greater than for other illnesses or conditions.</p>
<ul style="list-style-type: none"> <li>• Professional services, including individual or group therapy by providers such as psychiatrists, psychologists, or clinical social workers</li> <li>• Medication management</li> </ul>	<p>20% of allowable charge after deductible</p>
<ul style="list-style-type: none"> <li>• Diagnostic tests</li> </ul>	<p>20% of allowable charge after deductible</p>
<ul style="list-style-type: none"> <li>• Services provided by a hospital or other facility</li> <li>• Services in approved alternative care settings such as partial hospitalization, half-way house, residential treatment, full-day hospitalization, facility based intensive outpatient treatment</li> </ul>	<p>20% of allowable charge after deductible</p>
<p><i>Not covered: Services we have not approved.</i></p> <p><i>Note: OPM will base its review of disputes about treatment plans on the treatment plan's clinical appropriateness. OPM will generally not order us to pay or provide one clinically appropriate treatment plan in favor of another.</i></p>	<p><i>All Charges.</i></p>

**Preauthorization**

To be eligible to receive these benefits you must obtain a treatment plan and follow all of the following network authorization processes:

Contact Piedmont Community HealthCare for authorization. Piedmont Community HealthCare can be reached locally at (434) 947-4463 or toll free at 1-800-400-7247.

## Section 5(f) Prescription drug benefits

**Here are some important things to keep in mind about these benefits:**

- We cover prescribed drugs and medications, as described in the chart beginning on the next page.
- Please remember that all benefits are subject to the definitions, limitations and exclusions in this brochure and are payable only when we determine they are medically necessary.
- The deductible is \$2,000 for Self Only enrollment and \$4,000 for Self and Family enrollment each calendar year. The Self and Family deductible can be satisfied by one or more family members. The deductible applies to all benefits in this Section.
- After you have satisfied your deductible, your Traditional medical coverage begins.
- Under your Traditional medical coverage, you will be responsible for your coinsurance amounts for eligible medical expenses or copayments for eligible prescriptions.
- Be sure to read Section 4, *Your costs for covered services*, for valuable information about how cost sharing works. Also read Section 9 about coordinating benefits with other coverage, including with Medicare.

**There are important features you should be aware of.** These include:

- **Who can write your prescription.** A plan physician or licensed dentist must write the prescription.
- **Where you can obtain them.** You must fill the prescription at a plan pharmacy, or by mail for a maintenance medication
- **We use a formulary.** We cover non-formulary drugs prescribed by a Plan doctor. We have an open formulary. If your physician believes a name brand product is necessary or there is no generic available, your physician may prescribe a name brand drug from a formulary list. This list of name brand drugs is a preferred list of drugs that we selected to meet patient needs at a lower cost. To order a prescription drug brochure, call 1-800-400-7247.
- **These are the dispensing limitations.** Medically necessary prescribed legend drugs (drugs not available over the counter) incidental to outpatient care are covered services, including compound medications of which at least one ingredient is a legend drug, injectable insulin and syringes and needles for the administration thereof. For each prescription filled at the pharmacy, we will cover up to a 30-day or 100 unit supply, whichever is less. For maintenance medications received through the mail order benefit, we will cover up to a 90-day or 300 unit supply, whichever is less. Generic drugs will be dispensed except when a participating physician requires brand name drugs. If the physician does not require a brand name drug, you may request a brand name drug and pay the difference between the brand name drug and the generic drug, in addition to your appropriate copayment. Only maintenance medications may be ordered through the mail order benefit. You should allow two weeks for delivery. At least 60% of the maintenance medication must be used before a refill can be issued. If you are in the military and called to active duty due to an emergency, please contact us if you need assistance in filling a prescription before your departure.
- **A generic equivalent will be dispensed if it is available,** unless your physician specifically requires a name brand. If you receive a name brand drug when a Federally-approved generic drug is available, and your physician has not specified Dispense as Written for the name brand drug, you have to pay the difference in cost between the name brand drug and the generic.
- **Why use generic drugs?** Generic drugs are lower-priced drugs that are the therapeutic equivalent to more expensive brand-name drugs. They must contain the same active ingredients and must be equivalent in strength and dosage to the original brand-name product. Generics cost less than the equivalent brand-name product. The U.S. Food and Drug Administration sets quality standards for generic drugs to ensure that these drugs meet the same standards of quality and strength as brand-name drugs.
- **When you do have to file a claim.** Our participating providers will file claims for you. If you need to file a claim, contact customer service at 1-800-400-7247 and request a medical claim form. Complete the form, attach any receipts and mail it in to the address on the form.

Benefit Description	You pay After the calendar year deductible...
<b>Covered medications and supplies</b>	<b>High Option</b>
<p>We cover the following medications and supplies prescribed by a Plan physician and obtained from a Plan pharmacy or through our mail order program:</p> <ul style="list-style-type: none"> <li>• Drugs and medicines that by Federal law of the United States require a physician’s prescription for their purchase, except those listed as <i>Not covered</i>.</li> <li>• Insulin</li> <li>• Disposable needles and syringes for the administration of covered medications</li> <li>• Drugs for sexual dysfunction</li> <li>• Contraceptive drugs and devices</li> <li>• Fertility drugs</li> <li>• Growth Hormone drugs</li> </ul>	<p>\$15 per generic (30-day supply)</p> <p>\$40 per brand name (30-day supply)</p> <p>\$55 for non-formulary drugs (30-day supply)</p> <p>\$30 per generic (90-day supply through mail service)</p> <p>\$80 per brand name (90-day supply through mail service)</p> <p>\$110 for non-formulary drugs (90-day supply through mail service)</p> <p>Note: If there is no generic equivalent available, you will still have to pay the name brand copay.</p>
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> <li>• <i>Drugs and supplies for cosmetic purposes</i></li> <li>• <i>Drugs to enhance athletic performance</i></li> <li>• <i>Drugs obtained at a non-Plan pharmacy; except for out-of-area emergencies</i></li> <li>• <i>Vitamins, nutrients and food supplements even if a physician prescribes or administers them</i></li> <li>• <i>Nonprescription medicines</i></li> <li>• <i>Smoking cessation drugs</i></li> <li>• <i>Anorexiant</i></li> <li>• <i>Drugs and medications not approved by the FDA</i></li> <li>• <i>DESI drugs (i.e. drugs which are of questionable therapeutic value as designated by the FDA’s Federal Drug Efficacy Study)</i></li> <li>• <i>Any other drug deemed not medically necessary by the Plan.</i></li> </ul>	<p><i>All charges.</i></p>

**Section 5(g) Special features**

Feature	Description
Feature	High Option
<p><b>Local Service and Assistance</b></p>	<p>As a company located in the heart of its service area, which spans across the Central Virginia area only, we can offer our members local service and assistance. We are in the same community with you and work with your medical providers on a daily basis. Customer service representatives and medical management staff are in the office and available to assist you.</p>
<p><b>Eyewear Discounts</b></p>	<p>By presenting your Piedmont Community HealthCare identification card at these Lynchburg locations: AG Jefferson, Inc.; Cooper &amp; Elder Optical; Key Healthcare Optical Center; Virginia Eye Clinic-Dr. Timothy J. Wilson and Associates, Optometrists; Dr. David a. West, OD; Dr. Victor Weatherholt; McBride &amp; Blackburn Opticians, Inc.; Visionary Opticians; Drs. Newman, Blackstock &amp; Associates; Dr. Elizabeth Darby; Lynchburg Sears Optical and Pearle Vision, you will receive discounts on eyewear.</p>
<p><b>Lasik Procedure Discounts</b></p>	<p>By presenting your Piedmont Community HealthCare identification card at these Lynchburg locations: Harman Eye Center and Piedmont Eye Center, you will receive discounts on Lasik procedures.</p>
<p><b>Fitness Club Discounts</b></p>	<p>By presenting your Piedmont Community HealthCare identification card at these locations: Bedford YMCA and Gold's Gym (Lynchburg location), you will receive discounts on club fees and/or monthly dues.</p>
<p><b>Mail Order Benefit at Select Local Pharmacies</b></p>	<p>Piedmont Community HealthCare has a list of local pharmacies that may be used to fill mail order prescriptions instead of mailing the prescription in. These are listed in the back of the network directory and on the web site at <a href="http://www.pchp.net">www.pchp.net</a>, or you can contact customer service at 1-800-400-7247. Please contact these local pharmacies to verify the benefit offering and find out the details on filling prescriptions.</p>

**Section 5(h) Dental benefits**

**Important things you should keep in mind about these benefits:**

- We do not provide dental benefits except for accidental injury.

Accidental injury benefit	You Pay	
We cover restorative services and supplies necessary to promptly repair (but not replace) sound natural teeth. The need for these services must result from an accidental injury if the jaw is broken, the accident occurred while you were enrolled with the Plan and you submit a plan of treatment within 60 days of the date of your injury.	20% of allowable charge after deductible	
Dental benefits	You Pay	
We have no other dental benefits		

**Section 5(i) Health education resources and account management tools**

Special features	Description
<b>Health education resources</b>	Visit our Web site at <a href="http://www.pchp.net">www.pchp.net</a> for useful health and wellness information.
<b>Account management tools</b>	<p>For each HSA and HRA account holder, we maintain a complete claims payment history. In addition, you will receive an EOB after every claim.</p> <p>If you have an <b>HSA</b>,</p> <ul style="list-style-type: none"> <li>• You will receive a statement outlining your account balance and activity for the month.</li> <li>• You may also access your account on-line at <a href="http://www.BankofTheJames.com">www.BankofTheJames.com</a>.</li> </ul> <p>If you have an <b>HRA</b>,</p> <ul style="list-style-type: none"> <li>• Your HRA balance will be available online through <a href="http://www.pchp.net">www.pchp.net</a>.</li> <li>• Your balance will also be shown on your EOB form.</li> </ul>
<b>Consumer choice information</b>	As a member of this HDHP, you may choose any provider. However, you will receive discounts when you see a network provider. Directories are available online at <a href="http://www.pchp.net">www.pchp.net</a> . Link to online pharmacy through <a href="http://www.pchp.net">www.pchp.net</a> .

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## Section 6 General exclusions – things we don't cover

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The exclusions in this section apply to all benefits. **Although we may list a specific service as a benefit, we will not cover it unless your Plan doctor determines it is medically necessary to prevent, diagnose, or treat your illness, disease, injury, or condition (see specifics regarding transplants).**

We do not cover the following:

- Care by non-plan providers except for authorized referrals or emergencies (see *Emergency services/accidents*);
- Services, drugs, or supplies you receive while you are not enrolled in this Plan;
- Services, drugs, or supplies not medically necessary;
- Services, drugs, or supplies not required according to accepted standards of medical, dental, or psychiatric practice;
- Experimental or investigational procedures, treatments, drugs or devices (see specifics regarding transplants);
- Services, drugs, or supplies related to abortions, except when the life of the mother would be endangered if the fetus were carried to term, or when the pregnancy is the result of an act of rape or incest
- Services, drugs, or supplies related to sex transformations;
- Services, drugs, or supplies you receive from a provider or facility barred from the FEHB Program; or
- Services, drugs, or supplies you receive without charge while in active military service.

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## Section 7 Filing a claim for covered services

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When you see Plan physicians, receive services at Plan hospitals and facilities, or obtain your prescription drugs at Plan pharmacies, you will not have to file claims. Just present your identification card and pay your copayment, coinsurance, or deductible.

You will only need to file a claim when you receive emergency services from non-plan providers. Sometimes these providers bill us directly. Check with the provider. If you need to file the claim, here is the process:

### **Medical and hospital benefits**

In most cases, providers and facilities file claims for you. Physicians must file on the form HCFA-1500, Health Insurance Claim Form. Your facility will file on the UB-92 form. For claims questions and assistance, call us at 1-800-400-7247.

When you must file a claim – such as for services you received outside the Plan’s service area – submit it on the HCFA-1500 or a claim form that includes the information shown below. Bills and receipts should be itemized and show:

- Covered member’s name and ID number;
- Name and address of the physician or facility that provided the service or supply;
- Dates you received the services or supplies;
- Diagnosis;
- Type of each service or supply;
- The charge for each service or supply;
- A copy of the explanation of benefits, payments, or denial from any primary payer – such as the Medicare Summary Notice (MSN); and
- Receipts, if you paid for your services.

**Submit your claims to: Piedmont Community HealthCare, P.O. Box 14408, Cincinnati, Ohio 45250-0408**

### **Prescription drugs**

Prescriptions must be received from Plan pharmacies in order to be covered. Plan pharmacies file the claims for you. If for some reason you need to file a claim, contact customer service at 800-966-5772 to request a claim form, complete the form and mail it to the address below.

**Submit your claims to: Caremark, PO Box 52116, Phoenix, Arizona 85072-2116**

### **Deadline for filing your claim**

Send us all of the documents for your claim as soon as possible. You must submit the claim by December 31 of the year after the year you received the service, unless timely filing was prevented by administrative operations of Government or legal incapacity, provided the claim was submitted as soon as reasonably possible.

### **When we need more information**

Please reply promptly when we ask for additional information. We may delay processing or deny benefits for your claim if you do not respond.

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## Section 8 The disputed claims process

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Follow this Federal Employees Health Benefits Program disputed claims process if you disagree with our decision on your claim or request for services, drugs, or supplies – including a request for preauthorization/prior approval required by Section 3. Disagreements between you and the HDHP fiduciary regarding the administration of an HSA or HRA are not subject to the disputed claims process.:

- 1** Ask us in writing to reconsider our initial decision. You must:
  - a) Write to us within 6 months from the date of our decision; and
  - b) Send your request to us at: Piedmont Community HealthCare, 2512 Langhorne Road, Lynchburg, VA 24501, ATTN: Operations Manager; and
  - c) Include a statement about why you believe our initial decision was wrong, based on specific benefit provisions in this brochure; and
  - d) Include copies of documents that support your claim, such as physicians' letters, operative reports, bills, medical records, and explanation of benefits (EOB) forms.
  
- 2** We have 30 days from the date we receive your request to:
  - a) Pay the claim (or, if applicable, arrange for the health care provider to give you the care); or
  - b) Write to you and maintain our denial - go to step 4; or
  - c) Ask you or your provider for more information. If we ask your provider, we will send you a copy of our request—go to step 3.
  
- 3** You or your provider must send the information so that we receive it within 60 days of our request. We will then decide within 30 more days.

If we do not receive the information within 60 days, we will decide within 30 days of the date the information was due. We will base our decision on the information we already have.

We will write to you with our decision.
  
- 4** If you do not agree with our decision, you may ask OPM to review it.

You must write to OPM within

  - 90 days after the date of our letter upholding our initial decision; or
  - 120 days after you first wrote to us - if we did not answer that request in some way within 30 days; or
  - 120 days after we asked for additional information.

Write to OPM at: United States Office of Personnel Management, Insurance Services Programs, Health Insurance Group 3, 1900 E Street, NW, Washington, DC 20415-3630.

Send OPM the following information:

  - A statement about why you believe our decision was wrong, based on specific benefit provisions in this brochure;
  - Copies of documents that support your claim, such as physicians' letters, operative reports, bills, medical records, and explanation of benefits (EOB) forms;
  - Copies of all letters you sent to us about the claim;
  - Copies of all letters we sent to you about the claim; and
  - Your daytime phone number and the best time to call.

Note: If you want OPM to review more than one claim, you must clearly identify which documents apply to which claim.

Note: You are the only person who has a right to file a disputed claim with OPM. Parties acting as your representative, such as medical providers, must include a copy of your specific written consent with the review request.

Note: The above deadlines may be extended if you show that you were unable to meet the deadline because of reasons beyond your control.

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OPM will review your disputed claim request and will use the information it collects from you and us to decide whether our decision is correct. OPM will send you a final decision within 60 days. There are no other administrative appeals.

If you do not agree with OPM's decision, your only recourse is to sue. If you decide to sue, you must file the suit against OPM in Federal court by December 31 of the third year after the year in which you received the disputed services, drugs, or supplies or from the year in which you were denied precertification or prior approval. This is the only deadline that may not be extended.

OPM may disclose the information it collects during the review process to support their disputed claim decision. This information will become part of the court record.

You may not sue until you have completed the disputed claims process. Further, Federal law governs your lawsuit, benefits, and payment of benefits. The Federal court will base its review on the record that was before OPM when OPM decided to uphold or overturn our decision. You may recover only the amount of benefits in dispute.

Note: **If you have a serious or life threatening condition** (one that may cause permanent loss of bodily functions or death if not treated as soon as possible), and

a) We haven't responded yet to your initial request for care or preauthorization/prior approval, then call us at 434-947-4463 or 1-800-400-7247 and we will expedite our review; or

b) We denied your initial request for care or preauthorization/prior approval, then:

If we expedite our review and maintain our denial, we will inform OPM so that they can give your claim expedited treatment too, or

You may call OPM's Health Insurance Group III at 202/606-0755 between 8 a.m. and 5 p.m. eastern time..

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## Section 9 Coordinating benefits with other coverage

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### When you have other health coverage

You must tell us if you or a covered family member have coverage under any other health plan or have automobile insurance that pays health care expenses without regard to fault. This is called “double coverage”.

When you have double coverage, one plan normally pays its benefits in full as the primary payer and the other plan pays a reduced benefit as the secondary payer. We, like other insurers, determine which coverage is primary according to the National Association of Insurance Commissioners’ guidelines.

When we are the primary payer, we will pay the benefits described in this brochure.

When we are the secondary payer, we will determine our allowance. After the primary plan pays, we will pay what is left of our allowance, up to our regular benefit. We will not pay more than our allowance. Limitations work the same way. We will not exceed our number of visits where applicable.

### What is Medicare?

Medicare is a Health Insurance Program for:

- People 65 years of age or older;
- Some people with disabilities under 65 years of age; and
- People with End-Stage Renal Disease (permanent kidney failure requiring dialysis or a transplant).

Medicare has four parts:

- Part A (Hospital Insurance). Most people do not have to pay for Part A. If you or your spouse worked for at least 10 years in Medicare-covered employment, you should be able to qualify for premium-free Part A insurance. (If you were a Federal employee at any time both before and during January 1983, you will receive credit for your Federal employment before January 1983.) Otherwise, if you are age 65 or older, you may be able to buy it. Contact 1-800-MEDICARE for more information.
- Part B (Medical Insurance). Most people pay monthly for Part B. Generally, Part B premiums are withheld from your monthly Social Security check or your retirement check.
- Part C (Medicare Advantage). You can enroll in a Medicare Advantage Plan to get your Medicare benefits. We offer a Medicare Advantage plan. Please review the information on coordinating benefits with Medicare Advantage plans on the next page.
- Part D (Medicare prescription drug coverage). There is a monthly premium for Part D. If you have limited savings and a low income, you may be eligible for Medicare’s Low-Income Benefits. For people with limited income and resources, extra help in paying for a Medicare prescription drug plan is available. Information regarding this program is available through the Social Security Administration (SSA). For more information about this extra help, visit SSA online at [www.socialsecurity.gov](http://www.socialsecurity.gov), or call them at 1-800-772-1213 (TTY 1-800-325-0778). Before enrolling in a new Medicare Part D, please review the important disclosure notice from us about the FEHB prescription drug coverage and Medicare. This notice is on the first inside page of this brochure. This notice will give you guidance on enrolling in Medicare Part D.

### • Should I enroll in Medicare?

The decision to enroll in Medicare is yours. We encourage you to apply for Medicare benefits 3 months before you turn age 65. It’s easy. Just call the Social Security Administration toll-free number 1-800-772-1213 to set up an appointment to apply. If you do not apply for one or more Parts of Medicare, you can still be covered under the FEHB Program.

If you can get premium-free Part A coverage, we advise you to enroll in it. Most Federal employees and annuitants are entitled to Medicare Part A at age 65 **without cost**. When you don't have to pay premiums for Medicare Part A, it makes good sense to obtain the coverage. It can reduce your out-of-pocket expenses as well as costs to the FEHB, which can help keep FEHB premiums down.

Everyone is charged a premium for Medicare Part B coverage. The Social Security Administration can provide you with premium and benefit information. Review the information and decide if it makes sense for you to buy the Medicare Part B coverage.

If you are eligible for Medicare, you may have choices in how you get your health care. Medicare Advantage is the term used to describe the various private health plan choices available to Medicare beneficiaries. The information in the next few pages shows how we coordinate benefits with Medicare, depending on whether you are in the Original Medicare Plan or a private Medicare Advantage plan.

- **The Original Medicare Plan (Part A or Part B)**

The Original Medicare Plan (Original Medicare) is available everywhere in the United States. It is the way everyone used to get Medicare benefits and is the way most people get their Medicare Part A and Part B benefits now. You may go to any doctor, specialist, or hospital that accepts Medicare. The Original Medicare Plan pays its share and you pay your share.

When you are enrolled in Original Medicare along with this plan, you still need to follow the rules in this brochure for us to cover your care. Your care must continue to be authorized by your Plan PCP, or precertified as required. We will waive some copayments, coinsurance, and deductibles, as follows:

If Medicare pays more on the claim than the Plan, then you will not be required to pay your copayments, coinsurance, and deductibles under the Plan benefits.

**Claims process when you have the Original Medicare Plan** – You will probably not need to file a claim form when you have both our Plan and the Original Medicare Plan.

- When we are the primary payer, we process the claim first.
- When Original Medicare is the primary payer, Medicare processes your claim first. In most cases, your claim will be coordinated automatically and we will then provide secondary benefits for covered charges. You will not need to do anything. To find out if you need to do something to file your claim, call us at 1-800-400-7247 or contact us at [www.pchp.net](http://www.pchp.net)

**We do not waive any costs if the Original Medicare Plan is your primary payer.**

- **Medicare Advantage (Part C)**

If you are eligible for Medicare, you may choose to enroll in and get your Medicare benefits from a Medicare Advantage plan. These are private health care choices (like HMOs and regional PPOs) in some areas of the country. To learn more about enrolling in a Medicare Advantage plans, contact Medicare at 1-800-MEDICARE (1-800-633-4227) or at [www.medicare.gov](http://www.medicare.gov).

If you enroll in a Medicare Advantage plan, the following options are available to you:

This Plan and another plan's Medicare Advantage plan: You may enroll in another plan's Medicare Advantage plan and also remain enrolled in our FEHB plan. We will still provide benefits when your Medicare Advantage plan is primary, even out of the Medicare Advantage plan's network and/or service area (if you use our Plan providers), but we will not waive any of our copayments, coinsurance, or deductibles. If you enroll in a Medicare Advantage plan, tell us. We will need to know whether you are in the Original Medicare Plan or in a Medicare Advantage plan so we can correctly coordinate benefits with Medicare.

Suspended FEHB coverage to enroll in a Medicare Advantage plan: If you are an annuitant or former spouse, you can suspend your FEHB coverage to enroll in a Medicare Advantage plan, eliminating your FEHB premium. (OPM does not contribute to your Medicare Advantage plan premium.) For information on suspending your FEHB enrollment, contact your retirement office. If you later want to re-enroll in the FEHB Program, generally you may do so only at the next Open Season unless you involuntarily lose coverage or move out of the Medicare Advantage plan's service area.

- **Medicare prescription drug coverage (Part D)**

When we are the primary payer, we process the claim first. If you enroll in Medicare Part D and we are the secondary payer, we will review claims for your prescription drug costs that are not covered by Medicare Part D and consider them for payment under the FEHB plan.

Medicare always makes the final determination as to whether they are the primary payer. The following chart illustrates whether Medicare or this Plan should be the primary payer for you according to your employment status and other factors determined by Medicare. It is critical that you tell us if you or a covered family member has Medicare coverage so we can administer these requirements correctly.

Primary Payer Chart		
A. When you - or your covered spouse - are age 65 or over and have Medicare and you?	The primary payer for the individual with Medicare is?	
	Medicare	This Plan
1) Have FEHB coverage on your own as an active employee or through your spouse who is an active employee		✓
2) Have FEHB coverage on your own as an annuitant or through your spouse who is an annuitant	✓	
3) Are a reemployed annuitant with the Federal government and your position is excluded from the FEHB (your employing office will know if this is the case) and you are not covered under FEHB through your spouse under #1 above	✓	
4) Are a reemployed annuitant with the Federal government and your position is not excluded from the FEHB (your employing office will know if this is the case) and • You have FEHB coverage on your own or through your spouse who is also an active employee		✓
• You have FEHB coverage through your spouse who is an annuitant	✓	
5) Are a Federal judge who retired under title 28, U.S.C., or a Tax Court judge who retired under Section 7447 of title 26, U.S.C. (or if your covered spouse is this type of judge) and you are not covered under FEHB through your spouse under #1 above	✓	
6) Are enrolled in Part B only, regardless of your employment status	✓ for Part B services	✓ for other services
7) Are a former Federal employee receiving Workers' Compensation and the Office of Workers' Compensation Programs has determined that you are unable to return to duty	✓ *	
B. When you or a covered family member?		
1) Have Medicare solely based on end stage renal disease (ESRD) and • It is within the first 30 months of eligibility for or entitlement to Medicare due to ESRD (30-month coordination period)		✓
• It is beyond the 30-month coordination period and you or a family member are still entitled to Medicare due to ESRD	✓	
2) Become eligible for Medicare due to ESRD while already a Medicare beneficiary and • This Plan was the primary payer before eligibility due to ESRD		✓ for 30-month coordination period
• Medicare was the primary payer before eligibility due to ESRD	✓	
C. When either you or a covered family member are eligible for Medicare solely due to disability and you?		
1) Have FEHB coverage on your own as an active employee or through a family member who is an active employee		✓
2) Have FEHB coverage on your own as an annuitant or through a family member who is an annuitant	✓	
D. When you are covered under the FEHB Spouse Equity provision as a former spouse		
	✓	

\*Workers' Compensation is primary for claims related to your condition under Workers' Compensation.

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## Primary Payer Chart

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### **TRICARE and CHAMPVA**

TRICARE is the health care program for eligible dependents of military persons, and retirees of the military. TRICARE includes the CHAMPUS program. CHAMPVA provides health coverage to disabled Veterans and their eligible dependents. IF TRICARE or CHAMPVA and this Plan cover you, we pay first. See your TRICARE or CHAMPVA Health Benefits Advisor if you have questions about these programs.

**Suspended FEHB coverage to enroll in TRICARE or CHAMPVA:** If you are an annuitant or former spouse, you can suspend your FEHB coverage to enroll in one of these programs, eliminating your FEHB premium. (OPM does not contribute to any applicable plan premiums.) For information on suspending your FEHB enrollment, contact your retirement office. If you later want to re-enroll in the FEHB Program, generally you may do so only at the next Open Season unless you involuntarily lose coverage under TRICARE or CHAMPVA.

### **Workers' Compensation**

We do not cover services that:

- You need because of a workplace-related illness or injury that the Office of Workers' Compensation Programs (OWCP) or a similar Federal or State agency determines they must provide; or
- OWCP or a similar agency pays for through a third-party injury settlement or other similar proceeding that is based on a claim you filed under OWCP or similar laws.

Once OWCP or similar agency pays its maximum benefits for your treatment, we will cover your care.

### **Medicaid**

When you have this Plan and Medicaid, we pay first.

**Suspended FEHB coverage to enroll in Medicaid or a similar State-sponsored program of medical assistance:** If you are an annuitant or former spouse, you can suspend your FEHB coverage to enroll in one of these State programs, eliminating your FEHB premium. For information on suspending your FEHB enrollment, contact your retirement office. If you later want to re-enroll in the FEHB Program, generally you may do so only at the next Open Season unless you involuntarily lose coverage under the State program.

### **When other Government agencies are responsible for your care**

We do not cover services and supplies when a local, State, or Federal government agency directly or indirectly pays for them.

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## Section 10 Definitions of terms we use in this brochure

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<b>Calendar year</b>	January 1 through December 31 of the same year. For new enrollees, the calendar year begins on the effective date of their enrollment and ends on December 31 of the same year.
<b>Coinsurance</b>	Coinsurance is the percentage of our allowance that you must pay for your care. See page 12.
<b>Copayment</b>	A copayment is a fixed amount of money you pay when you receive covered services. See page 12.
<b>Covered services</b>	Care we provide benefits for, as described in this brochure.
<b>Custodial care</b>	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. Custodial care that lasts 90 days or more is sometimes known as Long term care. Please see page 56 for your specific benefit.
<b>Deductible</b>	A deductible is a fixed amount of covered expenses you must incur for certain covered services and supplies before we start paying benefits for those services. See page 12.
<b>Experimental or investigational services</b>	<p>Experimental or investigative means any service or supply which is determined to be experimental or investigative in the Plan's sole discretion. The Plan will apply the following criteria in exercising its discretion:</p> <p>Any supply or drug used must have received final approval to market by the United States Food and Drug Administration;</p> <p>There must be sufficient information in the peer reviewed medical and scientific literature to enable the Plan to make conclusions about safety and efficacy;</p> <p>The available scientific evidence must demonstrate a beneficial effect on health outcomes outside a research setting; and</p> <p>The service or supply must be a safe and effective outside a research setting as existing diagnostic or therapeutic alternatives.</p> <p>A service or supply will be experimental or investigative if the Plan determines that any one of the four criteria is not satisfied.</p>
<b>Medical necessity</b>	Medically necessary services mean those covered services received are consistent with the diagnosis and treatment of the member's condition, are efficacious, are in accordance with standards of good medical practice, are not simply for the convenience of the member of provider and are performed in the most cost-effective setting available to the member. We will determine the medical necessity of a given service or procedure.
<b>Plan allowance</b>	Plan allowance is the amount we use to determine our payment and your coinsurance for covered services. Plans determine their allowances in different ways. We determine our allowance by a set fee schedule for covered services. Our allowable charge means the amount determined by the Plan for a specified covered service or the provider's actual charge for that service, whichever is less. We will never pay more than our allowable charge for any covered service.
<b>Us/We</b>	Us and We refer to Piedmont Community HealthCare.
<b>You</b>	You refers to the enrollee and each covered family member.

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## Section 11 FEHB Facts

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### Coverage information

#### No pre-existing condition limitation

We will not refuse to cover the treatment of a condition you had before you enrolled in this Plan solely because you had the condition before you enrolled.

#### Where you can get information about enrolling in the FEHB Program

See [www.opm.gov/insure](http://www.opm.gov/insure) for enrollment information as well as:

- Information on the FEHB Program and plans available to you
- A health plan comparison tool
- A list of agencies who participate in Employee Express
- A link to Employee Express
- Information on and links to other electronic systems

Also, your employing or retirement office can answer your questions, and give you a *Guide to Federal Employees Health Benefits Plans*, brochures for other plans, and other materials you need to make an informed decision about your FEHB coverage. These materials tell you:

- When you may change your enrollment;
- How you can cover your family members;
- What happens when you transfer to another Federal agency, go on leave without pay, enter military service, or retire;
- When your enrollment ends; and
- When the next open season for enrollment begins.

We don't determine who is eligible for coverage and, in most cases, cannot change your enrollment status without information from your employing or retirement office.

#### Types of coverage available for you and your family

Self Only coverage is for you alone. Self and Family coverage is for you, your spouse, and your unmarried dependent children under age 22, including any foster children or stepchildren your employing or retirement office authorizes coverage for. Under certain circumstances, you may also continue coverage for a disabled child 22 years of age or older who is incapable of self-support.

If you have a Self Only enrollment, you may change to a Self and Family enrollment if you marry, give birth, or add a child to your family. You may change your enrollment 31 days before to 60 days after that event. The Self and Family enrollment begins on the first day of the pay period in which the child is born or becomes an eligible family member. When you change to Self and Family because you marry, the change is effective on the first day of the pay period that begins after your employing office receives your enrollment form; benefits will not be available to your spouse until you marry.

Your employing or retirement office will **not** notify you when a family member is no longer eligible to receive benefits, nor will we. Please tell us immediately when family members are added or lose coverage for any reason, including your marriage, divorce, annulment, or when your child under age 22 turns 22 or has a change in marital status, divorce, or when your child under age 22 marries.

If you or one of your family members is enrolled in one FEHB plan, that person may not be enrolled in or covered as a family member by another FEHB plan.

#### Children's Equity Act

OPM has implemented the Federal Employees Health Benefits Children's Equity Act of 2000. This law mandates that you be enrolled for Self and Family coverage in the FEHB Program, if you are an employee subject to a court or administrative order requiring you to provide health benefits for your child(ren).

If this law applies to you, you must enroll for Self and Family coverage in a health plan that provides full benefits in the area where your children live or provide documentation to your employing office that you have obtained other health benefits coverage for your children. If you do not do so, your employing office will enroll you involuntarily as follows:

- If you have no FEHB coverage, your employing office will enroll you for Self and Family coverage in the Blue Cross and Blue Shield Service Benefit Plan's Basic Option;
- If you have a Self Only enrollment in a fee-for-service plan or in an HMO that serves the area where your children live, your employing office will change your enrollment to Self and Family in the same option of the same plan; or
- If you are enrolled in an HMO that does not serve the area where the children live, your employing office will change your enrollment to Self and Family in the Blue Cross and Blue Shield Service Benefit Plan's Basic Option.

As long as the court/administrative order is in effect, and you have at least one child identified in the order who is still eligible under the FEHB Program, you cannot cancel your enrollment, change to Self Only, or change to a plan that doesn't serve the area in which your children live, unless you provide documentation that you have other coverage for the children. If the court/administrative order is still in effect when you retire, and you have at least one child still eligible for FEHB coverage, you must continue your FEHB coverage into retirement (if eligible) and cannot cancel your coverage, change to Self Only, or change to a plan that doesn't serve the area in which your children live as long as the court/administrative order is in effect. Contact your employing office for further information.

**When benefits and premiums start**

The benefits in this brochure are effective January 1. If you joined this Plan during Open Season, your coverage begins on the first day of your first pay period that starts on or after January 1. If you changed plans or plan options during Open Season and you receive care between January 1 and the effective date of coverage under your new plan or option, your claims will be paid according to the 2007 benefits of your old plan or option. However, if your old plan left the FEHB Program at the end of the year, you are covered under that plan's 2006 benefits until the effective date of your coverage with your new plan. Annuitants' coverage and premiums begin on January 1. If you joined at any other time during the year, your employing office will tell you the effective date of coverage.

**When you retire**

When you retire, you can usually stay in the FEHB Program. Generally, you must have been enrolled in the FEHB Program for the last five years of your Federal service. If you do not meet this requirement, you may be eligible for other forms of coverage, such as Temporary Continuation of Coverage (TCC).

**When you lose benefits**

**When FEHB coverage ends**

You will receive an additional 31 days of coverage, for no additional premium, when:

- Your enrollment ends, unless you cancel your enrollment, or
- You are a family member no longer eligible for coverage.

Any person covered under the 31 day extension of coverage who is confined in a hospital or other institution for care or treatment on the 31st day of the temporary extension is entitled to continuation of the benefits of the Plan during the continuance of the confinement but not beyond the 60th day after the end of the 31 day temporary extension.

You may be eligible for spouse equity coverage or Temporary Continuation of Coverage (TCC), or a conversion policy (a non-FEHB individual policy.)

## Upon divorce

If you are divorced from a Federal employee or annuitant, you may not continue to get benefits under your former spouse's enrollment. This is the case even when the court has ordered your former spouse to provide health coverage to you. However, you may be eligible for your own FEHB coverage under either the spouse equity law or Temporary Continuation of Coverage (TCC). If you are recently divorced or are anticipating a divorce, contact your ex-spouse's employing or retirement office to get RI 70-5, the *Guide To Federal Employees Health Benefits Plans for Temporary Continuation of Coverage and Former Spouse Enrollees*, or other information about your coverage choices. You can also download the guide from OPM's Web site, [www.opm.gov/insure](http://www.opm.gov/insure).

## Temporary Continuation of Coverage (TCC)

If you leave Federal service, or if you lose coverage because you no longer qualify as a family member, you may be eligible for Temporary Continuation of Coverage (TCC). For example, you can receive TCC if you are not able to continue your FEHB enrollment after you retire, if you lose your Federal job, if you are a covered dependent child and you turn 22 or marry, etc.

You may not elect TCC if you are fired from your Federal job due to gross misconduct.

**Enrolling in TCC.** Get the RI 79-27, which describes TCC, and the RI 70-5, the *Guide to Federal Employees Health Benefits Plans for Temporary Continuation of Coverage and Former Spouse Enrollees*, from your employing or retirement office or from [www.opm.gov/insure](http://www.opm.gov/insure). It explains what you have to do to enroll.

## Converting to individual coverage

You may convert to a non-FEHB individual policy if:

- Your coverage under TCC or the spouse equity law ends (If you canceled your coverage or did not pay your premium, you cannot convert);
- You decided not to receive coverage under TCC or the spouse equity law; or
- You are not eligible for coverage under TCC or the spouse equity law.

If you leave Federal service, your employing office will notify you of your right to convert. You must apply in writing to us within 31 days after you receive this notice. However, if you are a family member who is losing coverage, the employing or retirement office will **not** notify you. You must apply in writing to us within 31 days after you are no longer eligible for coverage.

Your benefits and rates will differ from those under the FEHB Program; however, you will not have to answer questions about your health, and we will not impose a waiting period or limit your coverage due to pre-existing conditions.

## Getting a Certificate of Group Health Plan Coverage

The Health Insurance Portability and Accountability Act of 1996 (HIPAA) is a Federal law that offers limited Federal protections for health coverage availability and continuity to people who lose employer group coverage. If you leave the FEHB Program, we will give you a Certificate of Group Health Plan Coverage that indicates how long you have been enrolled with us. You can use this certificate when getting health insurance or other health care coverage. Your new plan must reduce or eliminate waiting periods, limitations, or exclusions for health related conditions based on the information in the certificate, as long as you enroll within 63 days of losing coverage under this Plan. If you have been enrolled with us for less than 12 months, but were previously enrolled in other FEHB plans, you may also request a certificate from those plans.

For more information, get OPM pamphlet RI 79-27, *Temporary Continuation of Coverage (TCC) under the FEHB Program*. See also the FEHB Web site at [www.opm.gov/insure/health](http://www.opm.gov/insure/health); refer to the "TCC and HIPAA" frequently asked questions. These highlight HIPAA rules, such as the requirement that Federal employees must exhaust any TCC eligibility as one condition for guaranteed access to individual health coverage under HIPAA, and information about Federal and State agencies you can contact for more information.

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## Section 12 Three Federal Programs complement FEHB benefits

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### Important information

OPM wants to be sure you are aware of three Federal programs that complement the FEHB Program.

First, the **Federal Long Term Care Insurance Program (FLTCIP)** helps cover long term care costs, which are not covered under the FEHB Program.

Second, the **Federal Flexible Spending Account Program**, also known as **FSAFEDS**, lets you set aside pre-tax money to pay for health and dependent care expenses. The result can be a discount of 20% to more than 40% on services you routinely pay for out-of-pocket.

Third, the new **Federal Employees Dental and Vision Insurance Program (FEDVIP)**, offers a variety of dental plans and vision plans to anyone who is eligible to enroll in the Federal Employees Health Benefits Program. Under **FEDVIP** you may choose self only, self plus one, or self and family coverage for yourself and any qualified dependents. Premiums are on an enrollee-pays-all basis

### The Federal Long Term Care Insurance Program – *FLTCIP*

#### It's important protection

Why should you consider applying for coverage under the **Federal Long Term Care Insurance Program(FLTCIP)**?

**FEHB plans do not cover the cost of long term care.** Also called “custodial care,” long term care is help you receive to perform activities of daily living – such as bathing or dressing yourself - or supervision you receive because of a severe cognitive impairment. The need for long term care can strike anyone at any age and the cost of care can be substantial.

**The Federal Long Term Care Insurance Program can help protect you from the potentially high cost of long term care.** This coverage gives you options regarding the type of care you receive and where you receive it. With FLTCIP coverage, you won't have to worry about relying on your loved ones to provide or pay for your care.

**It's to your advantage to apply sooner rather than later.** To qualify for coverage under the FLTCIP, you must apply and pass a medical screening (called underwriting). Certain medical conditions, or combinations of conditions, will prevent some people from being approved for coverage. By applying while you're in good health, you could avoid the risk of having a future change in your health disqualify you from obtaining coverage. Also, the younger you are when you apply, the lower your premiums. If you are a new or newly eligible employee, you (and your spouse, if applicable) have a limited opportunity to apply using the abbreviated underwriting application, which asks fewer questions about your health. Newly married spouses of employees also have a limited opportunity to apply using abbreviated underwriting.

**Qualified relatives are also eligible to apply.** Qualified relatives include spouses and adult children of employees and annuitants, and parents, parents-in-law, and stepparents of employees.

**To request an Information Kit and application.** Call 1-800-LTC-FEDS (1-800-582-3337) (TTY 1-800-843-3557) or visit [www.ltcfeds.com](http://www.ltcfeds.com).

### The Federal Flexible Spending Account Program – *FSAFEDS*

#### What is an FSA?

It is a tax-favored benefit that allows you to set aside pre-tax money from your paychecks to pay for a variety of eligible expenses.

There are three types of FSAs offered by FSAFEDS. Each type has a minimum annual election of \$250 and a maximum annual election of \$5,000.

**Health Care FSA (HCFSA)** –Pays for eligible health care expenses for you and your dependents which are not covered or reimbursed by FEHBP coverage or other insurance.

**Limited Expense Health Care FSA (LEX HCFSA)** – Designed for employees enrolled in or covered by a High Deductible Health Plan with a Health Savings Account. Eligible expenses are limited to dental and vision care expenses for you and your dependents, which are not covered or reimbursed, by FEHBP or FEDVIP coverage or other insurance.

**Dependent Care FSA (DCFSA)** – Pays for eligible dependent care expenses that allow you (and your spouse if married) to work, look for work (as long as you have earned income for the year), or attend school full-time.

**What expenses can I pay with an FSAFEDS account?**

For the HCFSA– Health plan copayments, deductibles, over-the-counter medications and products, sunscreen, eyeglasses, contacts, other vision and dental expenses (but not insurance premiums).

For the LEX HCFSA– Dental and vision care expenses including eligible over-the-counter medicines and products related to dental and vision care (but not insurance premiums).

For the DCFSA – Daycare expenses (including summer camp) for your child(ren) under age 13, dependent care expenses for dependents unable to care for themselves.

AND MUCH MORE! Visit [www.FSAFEDS.com](http://www.FSAFEDS.com)

**Who is eligible to enroll?**

Most Federal employees in the Executive branch and many in non-Executive branch agencies are eligible. For specifics on eligibility, visit [www.FSAFEDS.com](http://www.FSAFEDS.com) or call an FSAFEDS Benefits Counselor toll-free at 1-877-FSAFEDS (1-877-372-3337), Monday through Friday, 9 a.m. until 9 p.m., EST. TTY: 1-800-952-0450.

**When can I enroll?**

If you wish to participate, you must make an election to enroll each year by visiting [www.FSAFEDS.com](http://www.FSAFEDS.com) or calling the number above during the FEHB Open Season or within 60 days of employment (for new employees).

**Even if you enrolled for 2006, you must make a new election to continue participating in 2007. Enrollment DOES NOT carry over from year to year.**

**Who is SHPS?**

SHPS is the Third Party Administrator hired by OPM to manage the FSAFEDS Program. SHPS is responsible for enrollment, claims processing, customer service, and day-to-day operations of FSAFEDS.

**Who is BENEFEDS?**

BENEFEDS is the name of the voluntary benefits portal hired by OPM to work with the FSAFEDS Program to set up payroll deductions for FSAFEDS allotments.

**The Federal Employees Dental and Vision Insurance Program – *FEDVIP***

**Important Information**

The Federal Employees Dental and Vision Insurance Program (FEDVIP) is a new program, separate and different from the FEHB Program, established by the Federal Employee Dental and Vision Benefits Enhancement Act of 2004.

OPM has contracted with several insurance carriers to make supplemental dental and vision benefits available to eligible Federal and USPS employees, annuitants, and their eligible family members.

**Dental Insurance**

Dental plans will provide a comprehensive range of services, including the following:

Class A (Basic) services, which include oral examinations, prophylaxis, diagnostic evaluations, sealants and x-rays.

Class B (Intermediate) services, which include restorative procedures such as fillings, prefabricated stainless steel crowns, periodontal scaling, tooth extractions, and denture adjustments.

Class C (Major) services, which include endodontic services such as root canals, periodontal services such as gingivectomy, major restorative services such as crowns, oral surgery, bridges and prosthodontic services such as complete dentures.

Class D (Orthodontic) services with a 24-month waiting period

Please review the dental plans' benefits material for detailed information on the benefits covered, cost-sharing requirements, and preferred provider listings.

**Vision Insurance**

Vision plans will provide comprehensive eye examinations and coverage for lenses, frames and contact lenses. Other benefits such as discounts on LASIK surgery may also be available.

Please review the vision plans' benefits material for detailed information on the benefits covered, cost-sharing requirements, and preferred provider listings.

**What plans are available?**

You can find a comparison of the plans available and their premiums on the OPM website at [www.opm.gov/insure/dentalvision](http://www.opm.gov/insure/dentalvision). This site also provides links to each plan's website, where you can view detailed information about benefits and preferred providers.

**Premiums**

The premiums will vary by plan and by enrollment type (self, self plus one, or self and family). There is no government contribution to the premiums. If you are an active employee, your premiums will be taken from your salary on a pre-tax basis when your salary is sufficient to make the premium withholding. If you are an annuitant, premiums will be withheld from your monthly annuity check when your annuity is sufficient. Pre-tax premiums are not available to annuitants. For information on each plan's specific premiums, visit [www.opm.gov/insure/dentalvision](http://www.opm.gov/insure/dentalvision).

**Who is eligible to enroll?**

Federal and Postal Service employees eligible for FEHB coverage (whether or not enrolled) and annuitants (regardless of FEHB status) are eligible to enroll in a dental plan and/or a vision plan.

**Enrollment types available**

- Self-only, which covers only the enrolled employee or annuitant;
- Self plus one, which covers the enrolled employee or annuitant plus one eligible family member specified by the enrollee; and
- Self and family, which covers the enrolled employee or annuitant and all eligible family members.

**Which family members are eligible to enroll?**

Eligible family members include your spouse, unmarried dependent children under age 22, and unmarried dependent children age 22 or over incapable of self-support because of a mental or physical disability that existed before age 22.

**When can I enroll?**

Eligible employees and annuitants can enroll in a dental and/or vision plan during this open season -- November 13 to December 11, 2006. You can enroll, disenroll, or change your enrollment during subsequent annual open seasons, or because of a qualified life event. New employees will have 60 days from their first eligibility date to enroll.

**How do I enroll?**

You enroll on the Internet at [www.BENEFEDS.com](http://www.BENEFEDS.com). BENEFEDS is a secure enrollment website sponsored by OPM where you enter your name, personal information like address and Social Security Number, the agency you work for (or retirement plan that pays your annuity), and the dental and/or vision plan you select. For those without access to a computer, call 1-877-888- FEDS (TTY number, 1-877-TTY-5680). If you do not have access to a computer or a phone, contact your employing office or retirement system for guidance on how to enroll.

You cannot enroll in a FEDVIP plan using the Health Benefits Election Form (SF 2809) or through an agency self-service system, such as Employee Express, MyPay, or Employee Personal Page. However, those sites may provide a link to BENEFEDS.

**When will coverage be effective?**

The new Program will be effective December 31, 2006. Coverage for those who enroll during this year's open season (November 13 – December 11, 2006) will be effective December 31, 2006. Coverage for any other enrollments will be effective on/or after December 31, 2006.

**How does this coverage work with my FEHB plan's dental or vision coverage?**

Some FEHB plans already cover some dental and vision services. When you are covered by more than one health/dental plan, federal law permits your insurers to follow a procedure called "coordination of benefits" to determine how much each should pay when you have a claim. The goal is to make sure that the combined payments of all plans do not add up to more than your covered expenses.

Coverage provided under your FEHB plan remains as your primary coverage. FEDVIP coverage pays secondary to that coverage. When you enroll in a dental and/or vision plan on BENEFEDS.com, you will be asked to provide information on your FEHB plan so that your plans can coordinate benefits. Providing your FEHB information may reduce your out-of-pocket cost.

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Do not rely on this page; it is for your convenience and may not show all pages where the terms appear.

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## Summary of benefits for the High Option of Piedmont Community HealthCare - 2007

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**Do not rely on this chart alone.** All benefits are provided in full unless indicated and are subject to the definitions, limitations, and exclusions in this brochure. On this page we summarize specific expenses we cover; for more detail, look inside. If you want to enroll or change your enrollment in this Plan, be sure to put the correct enrollment code from the cover on your enrollment form.

We only cover services provided or arranged by Plan physicians, except in emergencies.

Below, an asterisk (\*) means the item is subject to the \$500 per individual and \$1000 per family per calendar year deductible for in-plan benefits.

High Option Benefits	You pay	Page
<b>Medical services provided by physicians:</b>		16
Diagnostic and treatment services provided in the office	Office visit copay: \$25 per office visit	16
<b>Services provided by a hospital:</b>		28
• <b>Inpatient</b>	* 20% of allowable charge	28
• <b>Outpatient</b>	* 20% of allowable charge	29
<b>Emergency benefits:</b>		30
• <b>In-area</b>	\$100 per visit (waived if admitted)	31
• <b>Out-of-area</b>	\$100 per visit (waived if admitted)	31
<b>Mental health and substance abuse treatment:</b>	Regular cost sharing	32
<b>Prescription drugs</b>	<u>30 day supply or 100 units</u>	33
	• \$15.00 per generic	
	• \$40.00 per brand name	
	• \$55.00 per non-preferred brand name	
	<u>90 day supply 300 units (mail service)</u>	
	• \$30.00 per generic	
	• \$80.00 per brand name	
	• \$110.00 per non-preferred brand name	
<b>Dental care:</b>	No benefit.	36
<b>Vision care:</b>	\$25 per office visit	20
<b>Special features:</b>	Local Service and Assistance, Eyewear Discounts, Lasik Procedure Discounts, Fitness Club Discounts, and Mail Order Benefit at Select Local Pharmacies.	35
<b>Protection against catastrophic costs</b> (in-plan out-of-pocket maximum):	Nothing after \$3,000/Self Only or \$6,000/Family enrollment per year. (Some costs do not count toward this protection)	13
<b>Point of Service benefits:</b>		37

**Protection against catastrophic costs** (out-of pocket maximum)

Nothing after \$6,000/Self Only or \$12,000/ Family enrollment per year. (Some costs do not count toward this protection)

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## Summary of benefits for the HDHP of Piedmont Community HealthCare - 2007

**Do not rely on this chart alone.** All benefits are subject to the definitions, limitations, and exclusions in this brochure. On this page we summarize specific expenses we cover; for more detail, look inside. If you want to enroll or change your enrollment in this Plan, be sure to put the correct enrollment code from the cover on your enrollment form.

In 2007 for each month you are eligible for the HSA, will deposit a monthly premium pass through of \$83.34 for Self Only enrollment or \$166.67 for Self and Family enrollment to your HSA. For the Health Savings Account (HSA), you must satisfy your calendar year deductible of \$2,000 for Self Only and \$4,000 for Self and Family before using your HSA. Once you satisfy your calendar year deductible, Traditional medical coverage begins.

For the Health Reimbursement Arrangement (HRA), your health charges are applied to your annual HRA Fund of \$1,000 for Self Only and \$2,000 for Self and Family. Once your HRA is exhausted, you must satisfy your calendar year deductible. Once your calendar year deductible is satisfied, Traditional medical coverage begins.

Below, an asterisk (\*) means the item is subject to the \$2000/\$4000 calendar year deductible. And, after we pay, you generally pay any difference between our allowance and the billed amount if you use a Non-PPO physician or other health care professional.

HDHP Benefits	You Pay	Page
<b>In-network medical and dental preventive care</b>	<ul style="list-style-type: none"> <li>• \$25 per office visit</li> <li>• No dental preventive benefit.</li> </ul>	49
<b>Medical services provided by physicians:</b>		52
Diagnostic and treatment services provided in the office	* 20% of allowable charge	52
<b>Services provided by a hospital:</b>		63
• Inpatient	* 20% of allowable charge	63
• Outpatient	* 20% of allowable charge	64
<b>Emergency benefits:</b>		65
• In-area	* 20% of allowable charge	66
• Out-of-area	* 20% of allowable charge	66
<b>Mental health and substance abuse treatment:</b>	* 20% of allowable charge	67
<b>Prescription drugs:</b>		69
• Retail pharmacy	<u>30 day supply or 100 units</u> * \$15.00 per generic * \$40.00 per brand name * \$55.00 per non-preferred brand name	70
• Mail order	<u>90 day supply 300 units (mail service)</u> * \$30.00 per generic * \$80.00 per brand name * \$110.00 per non-preferred brand name	70
<b>Dental care:</b>	No benefit	72
<b>Vision care:</b>	\$25 per office visit	55
<b>Special features:</b>		

	Local Service and Assistance, Eyewear Discounts, Lasik Procedure Discounts, Fitness Club Discounts, and Mail Order Benefit at Select Local Pharmacies	71
<b>Protection against catastrophic costs</b> (out-of-pocket maximum):	Nothing after \$4,000/Self Only or \$8,000/Family enrollment per year. (Some costs do not count toward this protection)	43

## 2007 Rate Information for Piedmont Community HealthCare

**Non-Postal rates** apply to most non-Postal employees. If you are in a special enrollment category, refer to the FEHB Guide for that category or contact the agency that maintains your health benefits enrollment.

**Postal rates** apply to career Postal Service employees. Most employees should refer to the FEHB Guide for United States Postal Service Employees, RI 70-2. Different postal rates apply and a special FEHB guide is published for Postal Service Inspectors and Office of Inspector General (OIG) employees (see RI 70-2IN).

Postal rates do not apply to non-career postal employees, postal retirees, or associate members of any postal employee organization who are not career postal employees. Refer to the applicable FEHB Guide.

Type of Enrollment	Enrollment Code	Non-Postal Premium				Postal Premium	
		Biweekly		Monthly		Biweekly	
		Gov't Share	Your Share	Gov't Share	Your Share	USPS Share	Your Share
<b>High Option Self Only</b>	2C1	\$141.92	\$55.30	\$307.49	\$119.82	\$167.54	\$29.68
<b>High Option Self and Family</b>	2C2	\$321.89	\$129.72	\$697.43	\$281.06	\$380.01	\$71.60
<b>HDHP Option Self Only</b>	2C4	\$137.81	\$45.93	\$298.58	\$99.52	\$163.07	\$20.67
<b>HDHP Option Self and Family</b>	2C5	\$306.87	\$102.29	\$664.88	\$221.63	\$363.13	\$46.03