



The Summary of Benefits and Coverage (SBC) document will help you choose a health plan. The SBC shows you how you and the plan would share the cost for covered health care services. **NOTE: Information about the cost of this plan (called the premium) will be provided separately. This is only a summary.** For more information about your coverage, or to get a copy of the complete terms of coverage, call 1-800-400-7247 or visit our website at www.pchp.net. For general definitions of common terms, such as allowed amount, balance billing, coinsurance, copayment, deductible, provider, or other underlined terms see the Glossary. You can view the Glossary at www.healthcare.gov/sbc-glossary/ or call 1-800-400-7247 to request a copy.

| Important Questions | Answers | Why This Matters: |
|---|--|--|
| What is the overall <u>deductible</u> ? | \$3,000 Individual / \$6,000 Family Unit In-Network Not Covered Individual / Not Covered Family Unit Out-of-Network | Generally, you must pay all of the costs from <u>providers</u> up to the <u>deductible</u> amount before this <u>plan</u> begins to pay. If you have other family members on the <u>plan</u> , each family member must meet their own individual <u>deductible</u> until the total amount of <u>deductible</u> expenses paid by all family members meets the overall family <u>deductible</u> . |
| Are there services covered before you meet your <u>deductible</u> ? | Yes. <u>Preventive care</u> and some primary care services are covered before you meet your <u>deductible</u> . | This <u>plan</u> covers some items and services even if you haven't yet met the <u>deductible</u> amount. But a <u>copayment</u> or <u>coinsurance</u> may apply. For example, this <u>plan</u> covers certain <u>preventive services</u> without <u>cost-sharing</u> and before you meet your <u>deductible</u> . See a list of covered <u>preventive services</u> at https://www.healthcare.gov/coverage/preventive-care-benefits/ . |
| Are there other <u>deductibles</u> for specific services? | Yes. Prescription drugs – \$150 individual, \$300 family In-Network Not Covered individual, Not Covered family Out-of-Network There are no other specific <u>deductibles</u> . Does not apply to Tier 1 and Tier 2 drugs. | You must pay all of the costs for these services up to the specific <u>deductible</u> amount before this <u>plan</u> begins to pay for these services. |
| What is the <u>out-of-pocket limit</u> for this <u>plan</u> ? | For <u>network providers</u> \$5,500 Individual / \$11,000 Family Unit; for <u>out-of-network providers</u> Not Covered Individual / Not Covered Family Unit | The <u>out-of-pocket limit</u> is the most you could pay in a year for covered services. If you have other family members in this <u>plan</u> , they have to meet their own <u>out-of-pocket limits</u> until the overall family <u>out-of-pocket limit</u> has been met. |
| What is not included in the <u>out-of-pocket limit</u> ? | <u>Premiums</u> , <u>balance-billing</u> charges, and health care this <u>plan</u> doesn't cover. | Even though you pay these expenses, they don't count toward the <u>out-of-pocket limit</u> . |
| Will you pay less if you use a <u>network provider</u> ? | Yes. See www.pchp.net or call 1-800-400-7247 for a list of <u>network providers</u> . | This <u>plan</u> uses a <u>provider network</u> . You will pay less if you use a <u>provider</u> in the <u>plan's network</u> . You will pay the most if you use an <u>out-of-network provider</u> , and you might receive a bill from a <u>provider</u> for the difference between the <u>provider's</u> charge and what your <u>plan</u> pays (<u>balance billing</u>). Be aware your <u>network provider</u> might use an |

| Important Questions | Answers | Why This Matters: |
|--|---|---|
| | | <u>out-of-network provider</u> for some services (such as lab work). Check with your <u>provider</u> before you get services. |
| Do you need a <u>referral</u> to see a <u>specialist</u> ? | No. To see a <u>specialist</u> , you don't need a <u>referral</u> from this plan. | You can see the <u>specialist</u> you choose without a <u>referral</u> . |



All copayment and coinsurance costs shown in this chart are after your deductible has been met, if a deductible applies.

| Common Medical Event | Services You May Need | What You Will Pay | | Limitations, Exceptions, & Other Important Information |
|---|---|--|--|---|
| | | Network Provider (You will pay the least) | Out-of-Network Provider (You will pay the most) | |
| If you visit a health care <u>provider's</u> office or clinic | Primary care visit to treat an injury or illness | \$30 <u>copay</u> /office visit; <u>deductible</u> does not apply | Not Covered | Allergy Injections (excluding serum) are a \$5 <u>copay</u> . Telemedicine is a \$0 <u>copay</u> for Centra 24/7 Telehealth and a \$25 <u>copay</u> for all other Telemedicine. |
| | <u>Specialist</u> visit | \$50 <u>copay</u> /visit; <u>deductible</u> does not apply | Not Covered | ————None———— |
| | <u>Preventive care</u> / <u>screening</u> /immunization | No charge | Not Covered | You may have to pay for services that aren't <u>preventive</u> . Ask your <u>provider</u> if the services you need are preventive. Then check what your <u>plan</u> will pay for. |
| If you have a test | <u>Diagnostic test</u> (x-ray, blood work) | No Charge when performed as part of an office visit | Not Covered | Diagnostic mammogram/\$100 <u>copay</u> . Outpatient Diagnostic Test – 30% <u>coinsurance</u> ; Imaging – 30% Outpatient Facility; 20% Office/Free-Standing |
| | Imaging (CT/PET scans, MRIs) | 30% or 20% <u>coinsurance</u> | Not Covered | |
| If you need drugs to treat your illness or condition More information about <u>prescription drug coverage</u> is available at www.pchp.net . | Generic drugs (Tier 1) (Deductible does not apply) | \$15 <u>copay</u> /retail \$38 <u>copay</u> /mail order | Not Covered | <u>Copays</u> are per prescription. Covers up to a 30-day or 100 unit supply (retail prescription); Covers up to a 90-day or 300 unit supply (mail order prescription). This plan requires “mandatory” generic substitution if the FDA has determined the generic to be equivalent to the brand product, unless an In-Network provider requires brand name drugs. |
| | Preferred brand drugs (Tier 2) (Deductible does not apply) | \$50 <u>copay</u> /retail. \$125 <u>copay</u> /mail order | Not Covered | |
| | Non-preferred brand drugs (Tier 3) (\$350 maximum per script retail, \$875 maximum per script mail order) | 30% <u>coinsurance</u> (retail) 30% <u>coinsurance</u> (mail order) | Not Covered | |

* For more information about limitations and exceptions, see the plan or policy document at www.pchp.net.

| Common Medical Event | Services You May Need | What You Will Pay | | Limitations, Exceptions, & Other Important Information |
|---|--|--|--|---|
| | | Network Provider (You will pay the least) | Out-of-Network Provider (You will pay the most) | |
| | <u>Specialty drugs - Preferred</u> (Tier 4) (\$350 maximum per script retail, <u>Specialty drugs - Non-Preferred</u> (Tier 5) (\$350 maximum per script retail) | 30% <u>coinsurance</u> (retail) | Not Covered | Prescriptions filled at an Out-of-Network pharmacy are Not Covered unless that pharmacy has previously agreed in writing to accept reimbursement at rates for In-Network retail pharmacies. |
| If you have outpatient surgery | Facility fee (e.g., ambulatory surgery center) | 30% <u>coinsurance</u> | Not Covered | <u>Preauthorization</u> is required. If you don't get <u>preauthorization</u> , benefits are Not Covered. |
| | Physician/surgeon fees | 30% <u>coinsurance</u> | Not Covered | —————None————— |
| If you need immediate medical attention | <u>Emergency room care</u> | \$350 <u>copay</u> /visit + 30% <u>coinsurance</u> | \$350 <u>copay</u> /visit + 30% <u>coinsurance</u> | If not an actual emergency, services are Not Covered. Urgent Care – <u>deductible</u> does not apply. |
| | <u>Emergency medical transportation</u> | 30% <u>coinsurance</u> | Not Covered | |
| | <u>Urgent care</u> | \$50 <u>copay</u> /visit | \$50 <u>copay</u> /visit | |
| If you have a hospital stay | Facility fee (e.g., hospital room) | 30% <u>coinsurance</u> | Not Covered | <u>Preauthorization</u> is required. If you don't get <u>preauthorization</u> , benefits are Not Covered. |
| | Physician/surgeon fees | 30% <u>coinsurance</u> | Not Covered | |
| If you need mental health, behavioral health, or substance abuse services | Outpatient services | \$30 <u>copay</u> /office visit | Not Covered | <u>Preauthorization</u> required for any inpatient or outpatient facility services. If you don't get <u>preauthorization</u> , benefits are Not Covered. |
| | Inpatient services | 30% <u>coinsurance</u> | Not Covered | |
| If you are pregnant | Office visits | 30% <u>coinsurance</u> | Not Covered | <u>Cost sharing</u> does not apply to certain <u>preventive services</u> . Depending on the type of services, <u>coinsurance</u> may apply. Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound). |
| | Childbirth/delivery professional services | 30% <u>coinsurance</u> | Not Covered | |
| | Childbirth/delivery facility services | 30% <u>coinsurance</u> | Not Covered | |
| If you need help recovering or have other special health needs | <u>Home health care</u> | 30% <u>coinsurance</u> | Not Covered | Limited to 100 visits/calendar year |
| | <u>Rehabilitation services</u> | \$35 <u>copay</u> /office visit and 30% <u>coinsurance</u> for other outpatient services | Not Covered | Physical/Occupational therapy or Speech therapy limited to 30 visits/year each for rehabilitative or habilitative services. No <u>deductible</u> In-Network. |

* For more information about limitations and exceptions, see the [plan](#) or policy document at www.pchp.net.

| Common Medical Event | Services You May Need | What You Will Pay | | Limitations, Exceptions, & Other Important Information |
|--|----------------------------------|--|--|--|
| | | Network Provider (You will pay the least) | Out-of-Network Provider (You will pay the most) | |
| | <u>Habilitation services</u> | \$35 <u>copay</u> /office visit and 30% <u>coinsurance</u> for other outpatient services | Not Covered | |
| | <u>Skilled nursing care</u> | 30% <u>coinsurance</u> | Not Covered | Limited to 100 visits/calendar year |
| | <u>Durable medical equipment</u> | 30% <u>coinsurance</u> | Not Covered | <u>Preauthorization</u> requirement is based on CPT code. |
| | <u>Hospice services</u> | 30% <u>coinsurance</u> | Not Covered | <u>Preauthorization</u> is required. If you don't get <u>preauthorization</u> , benefits are Not Covered. |
| If your child needs dental or eye care | Children's eye exam | No Charge | Not Covered | Limited to one routine eye exam per year. |
| | Children's glasses | No Charge with limitations | Not Covered | Limited to one pair of standard glasses (lenses and frames), or one pair of contact lenses per year from a limited collection. |
| | Children's dental check-up | Not Covered | Not Covered | Dental check-up is Not Covered. |

Excluded Services & Other Covered Services:

Services Your Plan Generally Does NOT Cover (Check your policy or plan document for more information and a list of any other excluded services.)

- Abortion (except in cases of rape, incest, or when the life of the mother is endangered)
- Acupuncture
- Bariatric Surgery
- Cosmetic Surgery
- Dental Care (Adult) (except for accidental injury)
- Glasses (except for pediatric vision benefits)
- Hearing aids
- Infertility Treatment
- Long Term Care
- Non-emergency care when traveling outside the U.S.
- Routine Foot Care (unless you are under active treatment for a metabolic or peripheral vascular disease, such as diabetes)
- Weight loss programs

Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your plan document.)

- Chiropractic Care (total spinal manipulation / chiropractic services limited to 30 visits each per year for rehabilitative or habilitative services)
- Habilitation services
- Private-duty nursing (limited to 16 hours per year)
- Routine eye care (Adult) (limited to one routine eye exam per year)

Your Rights to Continue Coverage: There are agencies that can help if you want to continue your coverage after it ends. The contact information for those agencies is: Virginia Bureau of Insurance at 1-800-552-7945 or bureauofinsurance@scc.virginia.gov. You may also contact the U.S. Department of Labor, Employee Benefits Security Administration at 1-866-444-3272 or www.dol.gov/ebsa/healthreform, or the U.S. Department of Health and Human Services at 1-877-267-2323 x61565 or www.cciio.cms.gov. Other coverage options may be available to you too, including buying individual insurance coverage through the **Health Insurance Marketplace**. For more information about the **Marketplace**, visit www.HealthCare.gov or call 1-800-318-2596.

Your Grievance and Appeals Rights: There are agencies that can help if you have a complaint against your **plan** for a denial of a **claim**. This complaint is called a **grievance** or **appeal**. For more information about your rights, look at the explanation of benefits you will receive for that medical **claim**. Your **plan** documents also provide complete information on how to submit a **claim**, **appeal**, or a **grievance** for any reason to your **plan**. For more information about your rights, this notice, or assistance, contact: : Piedmont at 1-800-400-7247 (434-947-4463 if local) or visit www.pchp.net. You may also contact the U.S. Department of Labor at 1-866-444-3272 or visit www.dol.gov/ebsa/healthreform; or call the Virginia Bureau of Insurance at 1-877-310-6560 or visit www.scc.virginia.gov/boi/omb. Additionally, a consumer assistance program can help you file your appeal. Contact the Virginia Bureau of Insurance, Office of Managed Care Ombudsman at 1-877-310-6560 or , www.scc.virginia.gov/boi/omb, or for assistance with complaints regarding the quality of health care services received, contact the Virginia Department of Health, Office of Licensure at 1-800-955-1819 or www.vdh.state.va.us/OLC/Complaint.

Does this plan provide Minimum Essential Coverage? Yes. **Minimum Essential Coverage** generally includes **plans**, **health insurance** available through the **Marketplace** or other individual market policies, Medicare, Medicaid, CHIP, TRICARE, and certain other coverage. If you are eligible for certain types of **Minimum Essential Coverage**, you may not be eligible for the **premium tax credit**.

Does this plan meet the Minimum Value Standards? Yes. If your **plan** doesn't meet the **Minimum Value Standards**, you may be eligible for a **premium tax credit** to help you pay for a **plan** through the **Marketplace**.

Language Access Services:

English ATTENTION: If you speak English, language assistance services, free of charge, are available to you. Call 1-800-400-7247 (TTY: 711).

Espanol si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-800-400-7247 (TTY: 1-877-295-1454).

Korean 주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 1-800-400-7247 (TTY: 1-877-295-1454)번으로 전화해 주십시오.

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

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About these Coverage Example:



This is not a cost estimator. Treatments shown are just examples of how this [plan](#) might cover medical care. Your actual costs will be different depending on the actual care you receive, the prices your [providers](#) charge, and many other factors. Focus on the [cost-sharing](#) amounts ([deductibles](#), [copayments](#) and [coinsurance](#)) and [excluded services](#) under the [plan](#). Use this information to compare the portion of costs you might pay under different health [plans](#). Please note these coverage examples are based on self-only coverage.

Peg is Having a Baby

(9 months of in-network pre-natal care and a hospital delivery)

- The [plan's overall deductible](#) \$3,000
- [Specialist copayment](#) \$50
- Hospital (facility) [coinsurance](#) 30%
- Other [coinsurance](#) 30%

This EXAMPLE event includes services like:

- [Specialist](#) office visits (*prenatal care*)
- Childbirth/Delivery Professional Services
- Childbirth/Delivery Facility Services
- [Diagnostic tests](#) (*ultrasounds and blood work*)
- [Specialist](#) visit (*anesthesia*)

Total Example Cost \$12,700

In this example, Peg would pay:

| Cost Sharing | |
|-----------------------------------|----------------|
| Deductibles | \$3,000 |
| Copayments | \$10 |
| Coinsurance | \$2,400 |
| What isn't covered | |
| Limits or exclusions | \$60 |
| The total Peg would pay is | \$5,470 |

Managing Joe's Type 2 Diabetes

(a year of routine in-network care of a well-controlled condition)

- The [plan's overall deductible](#) \$3,000
- [Specialist copayment](#) \$50
- Hospital (facility) [coinsurance](#) 30%
- Other [coinsurance](#) 30%

This EXAMPLE event includes services like:

- [Primary care physician](#) office visits (*including disease education*)
- [Diagnostic tests](#) (*blood work*)
- [Prescription drugs](#)
- [Durable medical equipment](#) (*glucose meter*)

Total Example Cost \$5,600

In this example, Joe would pay:

| Cost Sharing | |
|-----------------------------------|----------------|
| Deductibles | \$0 |
| Copayments | \$1,700 |
| Coinsurance | \$0 |
| What isn't covered | |
| Limits or exclusions | \$20 |
| The total Joe would pay is | \$1,720 |

Mia's Simple Fracture

(in-network emergency room visit and follow up care)

- The [plan's overall deductible](#) \$3,000
- [Specialist copayment](#) \$50
- Hospital (facility) [coinsurance](#) 30%
- Other [coinsurance](#) 30%

This EXAMPLE event includes services like:

- [Emergency room care](#) (*including medical supplies*)
- [Diagnostic test](#) (*x-ray*)
- [Durable medical equipment](#) (*crutches*)
- [Rehabilitation services](#) (*physical therapy*)

Total Example Cost \$2,800

In this example, Mia would pay:

| Cost Sharing | |
|-----------------------------------|----------------|
| Deductibles | \$2,000 |
| Copayments | \$300 |
| Coinsurance | \$0 |
| What isn't covered | |
| Limits or exclusions | \$0 |
| The total Mia would pay is | \$2,300 |

The [plan](#) would be responsible for the other costs of these EXAMPLE covered services.



Nondiscrimination Notice

Piedmont Community Health Plan, on behalf of itself and its affiliates (hereafter “Piedmont”) complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. Piedmont does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex.

Piedmont:

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

If you need these services, contact Customer Service at 1-800-400-7247 (TTY: 711)

If you believe that Piedmont has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance with our Compliance Officer by mail or phone:

Compliance Officer
Piedmont Community Health Plan
2316 Atherholt Road
Lynchburg, VA 24501
434-947-4463 (TTY: 711)

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

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

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

PIEDMONT COMMUNITY HEALTH PLAN

English ATTENTION: If you speak English, language assistance services, free of charge, are available to you. Call 1-800-400-7247 (TTY: 711).

Español (Spanish) ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-800-400-7247 (TTY: 711).

한국어 (Korean) 주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 1-800-400-7247 (TTY: 711) 번으로 전화해 주십시오.

Tiếng Việt (Vietnamese) CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số 1-800-400-7247 (TTY: 711).

繁體中文 (Chinese) 注意: 如果您使用繁體中文, 您可以免費獲得語言援助服務。請致電 1-800-400-7247 (TTY: 711)

العربية (Arabic) ملحوظة: إذا كنت تتحدث اذكر اللغة، فإن خدمات المساعدة اللغوية تتوافر لك بالمجان. اتصل برقم 1-800-400-7247 (رقم هاتف الصم والبكم: 711).

Tagalog (Tagalog – Filipino) PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tumawag sa 1-800-400-7247 (TTY: 711).

فارسی (Farsi) توجه: اگر به زبان فارسی گفتگو می کنید، تسهیلات زبانی بصورت رایگان برای شما فراهم می باشد. با 1-800-400-7247 (TTY: 711) تماس بگیرید.

አማርኛ (Amharic) ማሳሰቢያ: የሚናገሩት ቋንቋ አማርኛ ከሆነ የትርጉም እርዳታ ድርጅቶች፣ በነጻ ሊያገዝዎት ተዘጋጅተዋል። ወደ ሚከተለው ቁጥር ይደውሉ 1-800-400-7247 (መስማት ለተሳናቸው: 711)።

اُردُو (Urdu) خبردار: اگر آپ اردو بولتے ہیں، تو آپ کو زبان کی مدد کی خدمات مفت میں دستیاب ہیں۔ کال کریں 1-800-400-7247 (TTY: 711)۔

Français (French) ATTENTION: Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le 1-800-400-7247 (ATS: 711).

Русский (Russian) ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните 1-800-400-7247 (телетайп: 711).

हिंदी (Hindi) ध्यान दें: यदि आप हिंदी बोलते हैं तो आपके लिए मुफ्त में भाषा सहायता सेवाएं उपलब्ध हैं। 1-800-400-7247 (TTY: 711) पर कॉल करें।

Deutsch (German) ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Rufnummer: 1-800-400-7247 (TTY: 711).

বাংলা (Bengali) লক্ষ্য করুন: যদি আপনি বাংলা, কথা বলতে পারেন, তাহলে নি:খরচায় ভাষা সহায়তা পরিষেবা উপলব্ধ আছে। ফোন করুন ১-৮০০-৪০০-৭২৪৭ (TTY: 711)।

Bàsòò-wùdù-po-nyò (Bassa) Dè dè nià ke dyédé gbo: Ǿ jù ké m̄ [Bàsòò-wùdù-po-nyò] jù ní, níí, à wuḍu kà kò dò po-poò béin m̄ gbo kpáa. Đá 1-800-400-7247 (TTY:711)

Igbo asusu (Ibo) Ige nti: O buru na asu Ibo asusu, enyemaka diri gi site na call 1-800-400-7247 (TTY: 711).

èdè Yorùbá (Yoruba) AKIYESI: Ti o ba nso ede Yoruba ofe ni iranlowo lori ede wa fun yin o. E pe ero ibanisoro yi 1-800-400-7247 (TTY: 711).