Piedmont Community Healthcare HMO, Inc.
Schedule of Benefits - Small Group - Centra Community HMO
Piedmont Gold 3000/30/50/150 HMO

Benefits	In-Network You Pay	Out-of-Network You Pay
Benefit Year Deductible		
Individual Unit - Medical per Participant	$3,000	Not Covered
Family Unit - Medical for all Participants combined, amounts will accumulate for each family member until the "Family Unit" amount is met; however, no individual family member will pay more than the "per person" amount shown.	$3,000/person $6,000/family unit	Not Covered Not Covered
Individual Unit - Prescription Drug (Rx) per Participant	$150	Not Covered
Family Unit - Prescription Drug (Rx) for all Participants combined, amounts will accumulate for each family member until the "Family Unit" amount is met; however, no individual family member will pay more than the "per person" amount shown.	$150/person $300/family unit	Not Covered Not Covered
Benefit Year Out-of-Pocket Maximum		
Individual Unit (includes medical & prescription drug coverage) per Participant.	$5,500	Not Covered
Family Unit (includes medical & prescription drug coverage) for all Participants combined, amounts will accumulate for each family member until the "Family Unit" amount is met; however, no individual family member will pay more than the "per person" amount shown.	$5,500/person $11,000/family unit	Not Covered Not Covered
Office Visits		
PCP (family, general, internal medicine, and pediatric physicians)	$30 Copayment	Not Covered
Telemedicine services - interactive virtual visits		
Centra 24/7 Telehealth - Visit www.Centra247.com	$0 Copayment	Not Covered
All Other Telemedicine Service Providers	$25 Copayment	Not Covered
Retail Health Clinic	$30 Copayment	Not Covered
Mental Health/Substance Use Disorder office visits	$30 Copayment	Not Covered
Specialist (all other physicians and professionals)	$50 Copayment	Not Covered
Other services performed in office (including but not limited to x-rays, diagnostic labs/tests and surgery)	Included with office visit Copayment	Not Covered
Reference Labs	$0 Copayment	Not Covered
Services requiring additional cost-sharing: injectable/infused medications, allergy serum, sleep studies, labs sent from office to outpatient facilities, and off-campus outpatient hospital visits	30% of AC[1] after deductible	Not Covered
Allergy Injections	$5 Copayment	Not Covered
Preventive Care		
Routine physical exams (including testing)	$0 Copayment	Not Covered
Women's preventive care	$0 Copayment	Not Covered
Routine well-child care	$0 Copayment	Not Covered
Child and adult immunizations	$0 Copayment	Not Covered
Screening Mammogram / Screening Colonoscopy	$0 Copayment	Not Covered
Other PPACA[2] covered preventive care services	$0 Copayment	Not Covered
Diagnostic Mammogram (to examine abnormalities)	$100 Copayment	Not Covered
Diagnostic Colonoscopy	30% of AC after deductible	Not Covered
Outpatient Diagnostic Imaging Services & Tests (X-ray, etc.)	30% of AC after deductible	Not Covered
Advanced Imaging Services (MRI, CT Scan, etc.)**Office/Free-Standing**	20% of AC after deductible	Not Covered
Advanced Imaging Services (MRI, CT Scan, etc.) **Outpatient Facility**	30% of AC after deductible	Not Covered
Maternity Care		
Prenatal/Postnatal visits - Routine (including routine labs/tests)	$0 Copayment	Not Covered
Prenatal visits - Non-Routine (services outside of Global charge)	30% of AC after deductible	Not Covered
Global maternity charge from OB/GYN	30% of AC after deductible	Not Covered
Inpatient and facility charges (including professional services)	30% of AC after deductible	Not Covered
Hospital Services		
Inpatient/Facility and Services	30% of AC after deductible	Not Covered
Outpatient and Facility testing, and Observation	30% of AC after deductible	Not Covered
Mental Health/Substance Use Disorder (inpatient/outpatient/partial day)	30% of AC after deductible	Not Covered
Medical/Surgical Services	30% of AC after deductible	Not Covered

Benefits	In-Network You Pay	Out-of-Network You Pay
Emergency Room Services (including professional services) Emergency Room Facility Charge Emergency Room Doctor and other Facility/Imaging Charges	$350 Copayment per visit after deductible 30% of AC after deductible	
Urgent Care	$50 Copayment	
Ambulance	30% of AC after deductible	Not Covered
Rehabilitative/Habilitative Services[3] Inpatient/Outpatient Facility and Services	30% of AC after deductible	Not Covered
Skilled Nursing Facility Care (100 days per admission limit)	30% of AC after deductible	Not Covered
Private Duty Nursing (16 hours per Benefit year limit)	30% of AC after deductible	Not Covered
Chiropractic/Osteopathic/Manipulation Therapy[4]	$35 Copayment	Not Covered
Physical/Occupational Therapy[3] **(**office setting)	$35 Copayment	Not Covered
Speech Therapy[3] (office setting)	$35 Copayment	Not Covered
Home Health Care (100 visits per benefit year limit)	30% of AC after deductible	Not Covered
Durable Medical Equipment	30% of AC after deductible	Not Covered
Prosthetic Device and Components	30% of AC after deductible	Not Covered
Hospice	30% of AC after deductible	Not Covered
Adult Vision (annual routine eye examination)	$20 Copayment	Not Covered
Pediatric Vision (up to the end of the month the participant turns 19) Coverage includes one routine eye exam per Benefit Year; also one pair of standard single vision, bifocal, trifocal or progressive lenses and one standard frame from a limited collection per Benefit Year, or one pair of standard contact lenses from a limited collection per Benefit Year.	No Charge	Not Covered

Prescription Drug (In-Network or Out-of-Network Retail Pharmacy)[5]	**Retail 30-day**	**Retail/Mail Order 90-day**
Tier 0 - Affordable Care Act $0 preventive drugs	$0	$0
Tier 1 - Generic (Rx deductible does not apply)	$15 Copayment	$38 Copayment
Tier 2 - Preferred Brand Name (Rx deductible does not apply)	$50 Copayment	$125 Copayment
Tier 3 - Non-preferred Brand Name (Rx deductible applies)	30% Coinsurance ($350 Maximum per script)	30% Coinsurance ($875 Maximum per script)
Tier 4 - Preferred Specialty (Rx deductible applies)	30% Coinsurance ($350 Maximum per script)	Not Available
Tier 5 - Non-preferred Specialty (Rx deductible applies)	30% Coinsurance ($350 Maximum per script)	Not Available
Generic contraceptive drugs and contraceptive drugs for which there is no generic equivalent are covered at 100% under Preventive Care.		
Prescriptions dispensed by a network pharmacy for a partial supply to synchronize medications are covered at a prorated cost-sharing rate.		
The cost-sharing payment for a covered prescription insulin drug is limited to a $50 maximum per 30-day supply, and any deductible is waived.		
Specialty Drugs must be purchased from the Pharmacy Benefit Manager's Specialty Pharmacy, unless another Pharmacy or its intermediary has sent previous notification to plan or PBM of its agreement to accept reimbursement for its services at rates applicable to the PBM's Specialty Pharmacy.		

Out of-plan ambulance services are those received other than in an actual Emergency (as defined elsewhere in this Evidence of Coverage) and the provider of the service does not participate.

When preauthorization is the responsibility of Piedmont's In-Network Providers, any reduction or denial of benefits for not obtaining a preauthorization should not affect the Participant.

[1]AC is the allowable charge.

[2]PPACA is the Patient Protection and Affordable Care Act.

[3]Rehabilitative/Habilitative Services - physical/occupational therapy limited to 30 visits per benefit year for Rehabilitative and 30 visits per benefit year for Habilitative, speech therapy limited to 30 visits per benefit year for Rehabilitative and 30 visits per benefit year for Habilitative Services.

[4]Chiropractic/Osteopathic/Manipulation Therapy limited to 30 visits per benefit year for Rehabilitative and 30 visits per benefit year for Habilitative Services.

[5]When prescription drugs are purchased from a non-participating Out-of-Network retail pharmacy who has previously agreed in writing on its own behalf or through an intermediary to accept reimbursement for its services at rates applicable to participating In-Network retail pharmacies, you will not be required to make payment for the full cost of the drug at point of service; you will only be required to make any copayment or other applicable charge that is consistently imposed for In-Network retail pharmacies.

NOTE: All benefits described herein are subject to other benefit limits as described elsewhere in this Evidence of Coverage. This Schedule of Benefits is part of and should be read together with your Evidence of Coverage. Pediatric Dental benefits are NOT included in this plan; they are available separately on or off the Exchange.