Piedmont Community Healthcare HMO, Inc.
Schedule of Benefits - Small Group - Virginia Expanded Choice POS
Piedmont Choice POS Silver HSA 2850/20%/5500

Benefits	In-Network You Pay	Out-of-Network You Pay
Benefit Year Deductible		
Individual Unit (includes medical and prescription drug coverage) per Participant.	$2,850	$5,700
Family Unit (includes medical and 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.	$2,850/person $5,700/family unit	$5,700/person $11,400/family unit
Benefit Year Out-of-Pocket Maximum		
Individual Unit (includes medical & prescription drug coverage) per Participant.	$5,500	$11,000
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	$11,000/person $22,000/family unit
Office Visits		
PCP (family, general, internal medicine, and pediatric physicians)	20% of AC[1] after deductible	40% of AC after deductible
Telemedicine services - interactive virtual visits		
Centra 24/7 Telehealth - Visit www.Centra247.com	20% of AC after deductible	40% of AC after deductible
All Other Telemedicine Service Providers	20% of AC after deductible	40% of AC after deductible
Retail Health Clinic	20% of AC after deductible	40% of AC after deductible
Mental Health/Substance Use Disorder office visits	20% of AC after deductible	40% of AC after deductible
Specialist (all other physicians and professionals)	20% of AC after deductible	40% of AC after deductible
Other services performed in office (including but not limited to x-rays, diagnostic labs/tests and surgery)	20% of AC after deductible	40% of AC after deductible
Reference Labs	20% of AC after deductible	40% of AC after deductible
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	20% of AC after deductible	40% of AC after deductible
Allergy Injections	20% of AC after deductible	40% of AC after deductible
Preventive Care		
Routine physical exams (including testing)	$0 Copayment	40% of AC after deductible
Women's preventive care	$0 Copayment	40% of AC after deductible
Routine well-child care	$0 Copayment	40% of AC after deductible
Child and adult immunizations	$0 Copayment	40% of AC after deductible
Screening Mammogram / Screening Colonoscopy	$0 Copayment	40% of AC after deductible
Other PPACA[2] covered preventive care services	$0 Copayment	40% of AC after deductible
Diagnostic Mammogram (to examine abnormalities)	20% of AC after deductible	40% of AC after deductible
Diagnostic Colonoscopy	20% of AC after deductible	40% of AC after deductible
Outpatient Diagnostic Imaging Services & Tests (X-ray, etc.)	20% of AC after deductible	40% of AC after deductible
Advanced Imaging Services (MRI, CT Scan, etc.)**Office/Free-Standing**	10% of AC after deductible	40% of AC after deductible
Advanced Imaging Services (MRI, CT Scan, etc.) **Outpatient Facility**	20% of AC after deductible	40% of AC after deductible
Maternity Care		
Prenatal/Postnatal visits - Routine (including routine labs/tests)	$0 Copayment	40% of AC after deductible
Prenatal visits - Non-Routine (services outside of Global charge)	20% of AC after deductible	40% of AC after deductible
Global maternity charge from OB/GYN	20% of AC after deductible	40% of AC after deductible
Inpatient and facility charges (including professional services)	20% of AC after deductible	40% of AC after deductible
Hospital Services		
Inpatient/Facility and Services	20% of AC after deductible	40% of AC after deductible
Outpatient and Facility testing, and Observation	20% of AC after deductible	40% of AC after deductible
Mental Health/Substance Use Disorder (inpatient/outpatient/partial day)	20% of AC after deductible	40% of AC after deductible
Medical/Surgical Services	20% of AC after deductible	40% of AC after deductible

Benefits	In-Network You Pay	Out-of-Network You Pay
Emergency Room Services (including professional services)		
Emergency Room Facility Charge	20% of AC after deductible	
Emergency Room Doctor and other Facility/Imaging Charges	20% of AC after deductible	
Urgent Care	20% of AC after deductible	
Ambulance	20% of AC after deductible	40% of AC after deductible
Rehabilitative/Habilitative Services[3]		
Inpatient/Outpatient Facility and Services	20% of AC after deductible	40% of AC after deductible
Skilled Nursing Facility Care (100 days per admission limit)	20% of AC after deductible	40% of AC after deductible
Private Duty Nursing (16 hours per Benefit year limit)	20% of AC after deductible	40% of AC after deductible
Chiropractic/Osteopathic/Manipulation Therapy[4]	20% of AC after deductible	40% of AC after deductible
Physical/Occupational Therapy[3] (office setting)	20% of AC after deductible	40% of AC after deductible
Speech Therapy[3] (office setting)	20% of AC after deductible	40% of AC after deductible
Home Health Care (100 visits per benefit year limit)	20% of AC after deductible	40% of AC after deductible
Durable Medical Equipment	20% of AC after deductible	40% of AC after deductible
Prosthetic Device and Components	20% of AC after deductible	40% of AC after deductible
Hospice	20% of AC after deductible	40% of AC after deductible
Adult Vision (annual routine eye examination)	$20 Copayment	40% of AC after deductible
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	40% of AC after deductible

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	$15 Copay after deductible	$38 Copay after deductible
Tier 2 - Preferred Brand Name	$50 Copay after deductible	$125 Copay after deductible
Tier 3 - Non-preferred Brand Name	30% Coinsurance after deductible	30% Coinsurance after deductible
Tier 4 - Preferred Specialty	30% Coinsurance after deductible	Not Available
Tier 5 - Non-preferred Specialty	30% Coinsurance after deductible	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. When prescription drugs are purchased from a non-participating Out-of-Network retail pharmacy who hasn't agreed to accept reimbursement at In-Network rates, you will be reimbursed up to the amount that would have been paid to an In-Network pharmacy (less your applicable Copayment, Coinsurance, and Out-of-Network Deductible).

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.