PIEDMONT
COMMUNITY HEALTH PLAN

Piedmont Community Healthcare HMO, Inc.
Schedule of Benefits - Small Group - Centra Community HMO
Piedmont Platinum 0/10/30 HMO

Benefits	In-Network You Pay	Out-of-Network You Pay
Benefit Year Deductible		
Individual Unit - Medical per Participant	$0	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.	$0/person $0/family unit	Not Covered Not Covered
Benefit Year Out-of-Pocket Maximum		
Individual Unit (includes medical and Rx coverage) per Participant	$3,500	Not Covered
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.	$3,500/person $7,000/family unit	Not Covered Not Covered
Office Visits*		
PCP (family, general, internal medicine, and pediatric physicians)	$10 Copay	Not Covered
Telemedicine services - interactive virtual visits		
Piedmont Preferred Telemedicine Providers	$0 Copay	Not Covered
All Other Telemedicine Service Providers	$5 Copay	Not Covered
Retail Health Clinic	$10 Copay	Not Covered
Mental Health/Substance Use Disorder office visits	$10 Copay	Not Covered
Specialist (all other physicians and professionals)	$30 Copay	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
Services requiring additional cost-sharing: injectable and infused medications allergy serum, sleep studies, labs sent from office to outpatient facilities, and off-campus outpatient hospital visits*	20% of AC[1] after deductible	Not Covered
Allergy Testing	$30 Copay	Not Covered
Allergy Injections	$5 Copay	Not Covered
Preventive Care		
Routine physical exams (including testing), women's preventive care, routine well-child care, child and adult immunizations, screening mammogram/ colonoscopy, other PPACA[2] covered preventive care services	$0 Copay	Not Covered
Diagnostic Mammogram (to examine abnormalities)	$100 Copay	Not Covered
Diagnostic Colonoscopy	20% of AC[1] after deductible	Not Covered
Outpatient Diagnostic Imaging Services & Tests (X-ray, etc.)	20% of AC[1] after deductible	Not Covered
Advanced Imaging Services (MRI, CT Scan, etc.) Office/Free-Standing	10% of AC[1] after deductible	Not Covered
Advanced Imaging Services (MRI, CT Scan, etc.) Outpatient Facility	20% of AC[1] after deductible	Not Covered
Maternity Care		
Prenatal visits - Routine (including routine lab/diagnostic tests)	$0 Copay	Not Covered
Prenatal visits - Non-Routine (services outside of Global charge)	20% of AC[1] after deductible	Not Covered
Postnatal office visit	$0 Copay	Not Covered
ObGyn's Global fee (prenatal, postnatal, and delivery services)	20% of AC[1] after deductible	Not Covered
Inpatient and facility charges (including professional services)	20% of AC[1] after deductible	Not Covered
Hospital Services		
Inpatient/Facility and Services	20% of AC[1] after deductible	Not Covered
Outpatient and Facility testing, and Observation	20% of AC[1] after deductible	Not Covered
Off-Campus Outpatient Hospital Visits	20% of AC[1] after deductible	Not Covered
Mental Health/Substance Use Disorder (inpatient/outpatient/partial day)	20% of AC[1] after deductible	Not Covered
Medical/Surgical Expenses	20% of AC[1] after deductible	Not Covered
Emergency Room Services (including professional services)		
Emergency Room Facility Charge	$400 Copay	$400 Copay
Emergency Room Doctor and other Facility/Imaging Charges	0% of AC[1] after deductible	0% of AC[1] after deductible
Urgent Care	$30 Copay	$30 Copay
Ambulance	20% of AC[1] after deductible	Not Covered

Benefits	In-Network You Pay	Out-of-Network You Pay
Rehabilitative/Habilitative Services[3] Inpatient/Outpatient Facility and Services	20% of AC[1] after deductible	Not Covered
Skilled Nursing Facility Care (100 days per admission limit)	20% of AC[1] after deductible	Not Covered
Private Duty Nursing (16 hours per year)	20% of AC[1] after deductible	Not Covered
Chiropractic/Osteopathic/Manipulation Therapy[4] (office setting)	$15 Copay	Not Covered
Physical/Occupational Therapy[3] (office setting)	$15 Copay	Not Covered
Speech Therapy[3] (office setting)	$15 Copay	Not Covered
Cardiac Rehabilitation (office setting)	20% of AC[1] after deductible	Not Covered
Chemo/Radiation Therapy (office setting)	20% of AC[1] after deductible	Not Covered
Respiratory Therapy (office setting)	20% of AC[1] after deductible	Not Covered
Dialysis/Hemodialysis (office setting)	20% of AC[1] after deductible	Not Covered
Reference Labs	$0 Copay	Not Covered
Home Health Care (100 visits per year)	20% of AC[1] after deductible	Not Covered
Durable Medical Equipment	20% of AC[1] after deductible	Not Covered
Prosthetic Device and Components	20% of AC[1] after deductible	Not Covered
Hospice	20% of AC[1] after deductible	Not Covered
Adult Vision (annual routine eye examination)	$20 Copay	Not Covered
Pediatric Vision Coverage includes (up to the end of the month the participant turns 19) 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 Drugs (In-Network; Out-of-Network Not Covered)[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)	$45 Copayment	$113 Copayment
Insulin (any deductible is waived)	$35 Copayment	$105 Copayment
Tier 3 - Non-preferred Brand Name (Rx deductible applies)	25% (up to $200 max/script)	25% (up to $500 max/script)
Insulin (any deductible is waived)	$50 Copayment	$150 Copayment
Tier 4 - Specialty (Rx deductible applies)	25% (up to $400 max/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. 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/Benefit Year for Rehabilitative and 30 visits/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/Benefit Year for Rehabilitative and 30 visits/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.

* Some free-standing Offices bill as extensions of an Outpatient Hospital/Facility; please check with your provider to determine if a Copay or Deductible/Coinsurance applies to your visit.

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.

The cost-sharing payment for a covered prescription insulin drug is limited to a $50 max per 30-day supply, and any deductible is waived.