



Piedmont Community Healthcare HMO, Inc.
Schedule of Benefits - Small Group - Centra Community HMO
Piedmont HMO Silver 4350 Med Ded/250 Rx Ded

| Benefits | In-Network You Pay | Out-of-Network You Pay |
|---|--|-------------------------------|
| Benefit Year Deductible | | |
| Individual Unit - Medical per Participant | \$4,350 | 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. | \$4,350/person \$8,700/family unit | Not Covered Not Covered |
| Individual Unit - Prescription Drug (Rx) per Participant | \$250 | 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. | \$250/person \$500/family unit | Not Covered Not Covered |
| Benefit Year Out-of-Pocket Maximum | | |
| Individual Unit (includes medical and Rx coverage) per Participant | \$8,700 | 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. | \$8,700/person \$17,400/family unit | Not Covered Not Covered |
| Office Visits* | | |
| PCP (family, general, internal medicine, and pediatric Physicians) | \$50 Copayment | Not Covered |
| Mental Health/Substance Use Disorder (MH/SUD) office visits | \$50 Copayment | Not Covered |
| Telemedicine Services - interactive virtual visits | | |
| MDLIVE Virtual Visits | \$0 Copayment | Not Covered |
| PCP & MH/SUD - Telemedicine Providers | \$45 Copayment | Not Covered |
| Specialist - Telemedicine Providers | \$70 Copayment | Not Covered |
| Retail Health Clinic | \$50 Copayment | Not Covered |
| Specialist (all other Physicians and professionals) | \$75 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 |
| 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* | 50% of AC ¹ after deductible | Not Covered |
| Allergy Testing | \$75 Copayment | Not Covered |
| Allergy Injections | \$5 Copayment | 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 Copayment | Not Covered |
| Diagnostic Mammogram (to examine abnormalities) | \$100 Copayment | Not Covered |
| Diagnostic Colonoscopy (to examine abnormalities) | 50% of AC ¹ after deductible | Not Covered |
| Outpatient Diagnostic Imaging Services & Tests (X-ray, etc.) | 50% of AC ¹ after deductible | Not Covered |
| Advanced Imaging Services (MRI, CT Scan, etc.) Office/Free-Standing | 40% of AC ¹ after deductible | Not Covered |
| Advanced Imaging Services (MRI, CT Scan, etc.) Outpatient Facility | 50% of AC ¹ after deductible | Not Covered |
| Maternity Care | | |
| Prenatal visits - Routine (including routine lab/diagnostic tests) | \$0 Copayment | Not Covered |
| Prenatal visits - Non-Routine (services outside of Global charge) | 50% of AC ¹ after deductible | Not Covered |
| Postnatal office visit | \$0 Copayment | Not Covered |
| ObGyn's Global fee (prenatal, postnatal, and delivery services) | 50% of AC ¹ after deductible | Not Covered |
| Inpatient and Facility charges (including professional services) | 50% of AC ¹ after deductible | Not Covered |
| Hospital Services | | |
| Inpatient/Facility and Services | 50% of AC ¹ after deductible | Not Covered |
| Outpatient and Facility testing, and Observation | 50% of AC ¹ after deductible | Not Covered |
| Off-Campus Outpatient Hospital Visits | 50% of AC ¹ after deductible | Not Covered |
| Mental Health/Substance Use Disorder (Inpatient/Outpatient/partial day) | 50% of AC ¹ after deductible | Not Covered |
| Medical/Surgical Expenses | 50% of AC ¹ after deductible | Not Covered |
| Emergency Room Services (including professional services) | | |
| Emergency Room Facility Charge | \$350 Copayment after deductible ⁷ | |
| Emergency Room Doctor and other Facility/Imaging Charges | 50% of AC ¹ after deductible ⁷ | |
| Urgent Care | \$75 Copayment ⁷ | |
| Ambulance | 50% of AC ¹ after deductible ⁷ | |

| Benefits | In-Network You Pay | Out-of-Network You Pay |
|---|---|---------------------------------|
| Rehabilitative/Habilitative Services³ Inpatient/Outpatient Facility and Services | 50% of AC ¹ after deductible | Not Covered |
| Skilled Nursing Facility Care (100 days per admission limit) | 50% of AC ¹ after deductible | Not Covered |
| Private Duty Nursing (16 hours per Benefit Year limit) | 50% of AC ¹ after deductible | Not Covered |
| Chiropractic/Osteopathic/Manipulation Therapy⁴ (office setting) | \$50 Copayment | Not Covered |
| Physical/Occupational Therapy³ (office setting) | \$50 Copayment | Not Covered |
| Speech Therapy³ (office setting) | \$50 Copayment | Not Covered |
| Cardiac Rehabilitation (office setting) | 50% of AC ¹ after deductible | Not Covered |
| Chemo/Radiation Therapy (office setting) | 50% of AC ¹ after deductible | Not Covered |
| Respiratory Therapy (office setting) | 50% of AC ¹ after deductible | Not Covered |
| Dialysis/Hemodialysis (office setting) | 50% of AC ¹ after deductible | Not Covered |
| Reference Labs | \$0 Copayment | Not Covered |
| Home Health Care (100 visits per Benefit Year limit) | 50% of AC ¹ after deductible | Not Covered |
| Durable Medical Equipment | 50% of AC ¹ after deductible | Not Covered |
| Prosthetic Device and Components | 30% of AC ¹ after deductible | Not Covered |
| Hospice | 50% of AC ¹ after deductible | Not Covered |
| Hearing Aids for Children⁶ | \$0 Copayment | Not Covered |
| Adult Vision (annual routine eye examination) | \$20 Copayment | 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. | | |

When prior authorization is the responsibility of Piedmont's In-Network Providers, any reduction or denial of benefits for not obtaining a prior authorization 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.

⁶ One hearing aid per hearing-impaired ear up to a cost of \$1,500 every 24 months. Coverage is only provided for children 18 years of age or younger.

⁷ Out-of-Network Cost Share for these services is applied to the In-Network Deductible and Out-of-Pocket Maximum, as applicable.

* Note: 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.

Mental Health Parity and Addiction Equity Act - Visit limits will not apply in connection with the treatment of MH/SUD conditions.

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.