



Piedmont Community Healthcare HMO, Inc.
Schedule of Benefits - Small Group - Virginia Expanded Choice POS
Piedmont Choice POS Silver 2650 Med Ded/250 Rx Ded

| Benefits | In-Network You Pay | Out-of-Network You Pay |
|---|--|---|
| Benefit Year Deductible | | |
| Individual Unit - Medical per Participant | \$2,650 | \$5,300 |
| 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. | \$2,650/person \$5,300/family unit | \$5,300/person \$10,600/family unit |
| Individual Unit - Prescription Drug (Rx) per Participant | \$250 | \$500 |
| 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 | \$500/person \$1,000/person |
| Benefit Year Out-of-Pocket Maximum | | |
| Individual Unit (includes medical and Rx coverage) per Participant | \$8,900 | \$17,800 |
| 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. | \$8,900/person \$17,800/family unit | \$17,800/person \$35,600/family unit |
| Office Visits* | | |
| PCP (family, general, internal medicine, and pediatric Physicians) | \$50 Copayment | 50% of AC ¹ after deductible |
| Mental Health/Substance Use Disorder (MH/SUD) office visits | \$50 Copayment | 50% of AC ¹ after deductible |
| Telemedicine Services - interactive virtual visits | | |
| MDLIVE Virtual Visits | \$0 Copayment | 50% of AC ¹ after deductible |
| PCP & MH/SUD - Telemedicine Providers | \$45 Copayment | 50% of AC ¹ after deductible |
| Specialist - Telemedicine Providers | \$70 Copayment | 50% of AC ¹ after deductible |
| Retail Health Clinic | | |
| Specialist (all other Physicians and professionals) | \$50 Copayment | 50% of AC ¹ after deductible |
| Other services performed in office (including but not limited to x-rays, diagnostic labs/tests and surgery) | \$75 Copayment | 50% of AC ¹ after deductible |
| 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* | Included with office visit Copayment | 50% of AC ¹ after deductible |
| Allergy Testing | 50% of AC ¹ after deductible | 50% of AC ¹ after deductible |
| Allergy Injections | \$75 Copayment | 50% of AC ¹ after deductible |
| | \$5 Copayment | 50% of AC ¹ after deductible |
| 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 | 50% of AC ¹ after deductible |
| Diagnostic Mammogram (to examine abnormalities) | \$100 Copayment | 50% of AC ¹ after deductible |
| Diagnostic Colonoscopy (to examine abnormalities) | 50% of AC ¹ after deductible | 50% of AC ¹ after deductible |
| Outpatient Diagnostic Imaging Services & Tests (X-ray, etc.) | 50% of AC ¹ after deductible | 50% of AC ¹ after deductible |
| Advanced Imaging Services (MRI, CT Scan, etc.) Office/Free-Standing | 40% of AC ¹ after deductible | 50% of AC ¹ after deductible |
| Advanced Imaging Services (MRI, CT Scan, etc.) Outpatient Facility | 50% of AC ¹ after deductible | 50% of AC ¹ after deductible |
| Maternity Care | | |
| Prenatal visits - Routine (including routine lab/diagnostic tests) | \$0 Copayment | 50% of AC ¹ after deductible |
| Prenatal visits - Non-Routine (services outside of Global charge) | 50% of AC ¹ after deductible | 50% of AC ¹ after deductible |
| Postnatal office visit | \$0 Copayment | 50% of AC ¹ after deductible |
| ObGyn's Global fee (prenatal, postnatal, and delivery services) | 50% of AC ¹ after deductible | 50% of AC ¹ after deductible |
| Inpatient and Facility charges (including professional services) | 50% of AC ¹ after deductible | 50% of AC ¹ after deductible |
| Hospital Services | | |
| Inpatient/Facility and Services | 50% of AC ¹ after deductible | 50% of AC ¹ after deductible |
| Outpatient and Facility testing, and Observation | 50% of AC ¹ after deductible | 50% of AC ¹ after deductible |
| Off-Campus Outpatient Hospital Visits | 50% of AC ¹ after deductible | 50% of AC ¹ after deductible |
| Mental Health/Substance Use Disorder (Inpatient/Outpatient/partial day) | 50% of AC ¹ after deductible | 50% of AC ¹ after deductible |
| Medical/Surgical Expenses | 50% of AC ¹ after deductible | 50% of AC ¹ after deductible |
| 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 | 50% of AC ¹ after deductible |
| Skilled Nursing Facility Care (100 days per admission limit) | 50% of AC ¹ after deductible | 50% of AC ¹ after deductible |
| Private Duty Nursing (16 hours per Benefit Year limit) | 50% of AC ¹ after deductible | 50% of AC ¹ after deductible |
| Chiropractic/Osteopathic/Manipulation Therapy⁴ (office setting) | \$50 Copayment | 50% of AC ¹ after deductible |
| Physical/Occupational Therapy³ (office setting) | \$50 Copayment | 50% of AC ¹ after deductible |
| Speech Therapy³ (office setting) | \$50 Copayment | 50% of AC ¹ after deductible |
| Cardiac Rehabilitation (office setting) | 50% of AC ¹ after deductible | 50% of AC ¹ after deductible |
| Chemo/Radiation Therapy (office setting) | 50% of AC ¹ after deductible | 50% of AC ¹ after deductible |
| Respiratory Therapy (office setting) | 50% of AC ¹ after deductible | 50% of AC ¹ after deductible |
| Dialysis/Hemodialysis (office setting) | 50% of AC ¹ after deductible | 50% of AC ¹ after deductible |
| Reference Labs | \$0 Copayment | 50% of AC ¹ after deductible |
| Home Health Care (100 visits per Benefit Year limit) | 50% of AC ¹ after deductible | 50% of AC ¹ after deductible |
| Durable Medical Equipment | 50% of AC ¹ after deductible | 50% of AC ¹ after deductible |
| Prosthetic Device and Components | 30% of AC ¹ after deductible | 50% of AC ¹ after deductible |
| Hospice | 50% of AC ¹ after deductible | 50% of AC ¹ after deductible |
| Hearing Aids for Children⁶ | \$0 Copayment | 50% of AC ¹ after deductible |
| Adult Vision (annual routine eye examination) | \$20 Copayment | 50% of AC ¹ after deductible |
| 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 | 50% of AC ¹ after deductible |
| Prescription Drugs (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) | \$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.

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).

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.