PIEDMONT COMMUNITY HEALTH PLAN

Piedmont Community Healthcare HMO, Inc.
Schedule of Benefits - Small Group - Virginia Expanded Choice POS
Piedmont Choice POS 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	$8,700
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	$8,700/person $17,400/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	$8,700	$17,400
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	$17,400/person $34,800/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	$50 Copayment	50% of AC[1] after deductible
Specialist (all other Physicians and professionals)	$75 Copayment	50% of AC[1] after deductible
Other services performed in office (including but not limited to x-rays, diagnostic labs/tests and surgery)	Included with office visit 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*	50% of AC[1] after deductible	50% of AC[1] after deductible
Allergy Testing	$75 Copayment	50% of AC[1] after deductible
Allergy Injections	$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 Services[3] 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 Therapy[4] (office setting)	$50 Copayment	50% of AC[1] after deductible
Physical/Occupational Therapy[3] (office setting)	$50 Copayment	50% of AC[1] after deductible
Speech Therapy[3] (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 Children[6]	$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.