



Piedmont Community Healthcare HMO, Inc.
Schedule of Benefits - Large Group - Centra Community HMO
Piedmont HMO Basic 6000/35/60 Centra Community

| Benefits | In-Plan You Pay | Out-of-Plan You Pay |
|---|---|---|
| Annual Deductible | | |
| Individual Unit - Medical per Participant | \$6,000 | 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. | \$6,000/person \$12,000/family unit | Not Covered Not Covered |
| Annual Out-of-Pocket Maximum | | |
| Individual Unit (includes medical and Rx coverage) per Participant | \$7,500 | 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. | \$7,500/person \$15,000/family unit | Not Covered Not Covered |
| Office Visits* | | |
| PCP (family, general, internal medicine, and pediatric physicians) | \$35 Copayment | Not Covered |
| Telemedicine services - interactive virtual visits | | |
| Piedmont Preferred Telemedicine Providers | \$0 Copayment | Not Covered |
| All Other Telemedicine Service Providers | \$30 Copayment | Not Covered |
| Retail Health Clinic | \$35 Copayment | Not Covered |
| Mental Health/Substance Use Disorder office visits | \$35 Copayment | Not Covered |
| Specialist (all other physicians and professionals) | \$60 Copayment | Not Covered |
| Other services performed in office (including but not limited to x-rays, diagnostic labs/tests, allergy serum and surgery) | Included with office visit Copayment | Not Covered |
| Services requiring additional cost-sharing: injectable and infused medications, labs sent from office to outpatient facilities, sleep studies, and off-campus outpatient hospital/facility visits* | 30% of AC ¹ after deductible | Not Covered |
| Allergy Testing | \$60 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 | 30% of AC ¹ after deductible | Not Covered |
| Outpatient Diagnostic Imaging Services & Tests (X-ray, etc.) | 30% of AC ¹ after deductible | Not Covered |
| Advanced Imaging Services (MRI, CT Scan, etc.) Office/Free-Standing | 20% of AC ¹ after deductible | Not Covered |
| Advanced Imaging Services (MRI, CT Scan, etc.) Outpatient Facility | 30% 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) | 30% of AC ¹ after deductible | Not Covered |
| Postnatal office visit | \$60 Copayment | Not Covered |
| ObGyn's Global fee (prenatal, postnatal, and delivery services) | 30% of AC ¹ after deductible | Not Covered |
| Inpatient and facility charges (including professional services) | 30% of AC ¹ after deductible | Not Covered |
| Hospital Services | | |
| Inpatient/Facility and Services | 30% of AC ¹ after deductible | Not Covered |
| Outpatient and Facility testing, and Observation | 30% of AC ¹ after deductible | Not Covered |
| Off-Campus Outpatient Hospital Visits | 30% of AC ¹ after deductible | Not Covered |
| Mental Health/Substance Use Disorder (inpatient/outpatient/partial day) | 30% of AC ¹ after deductible | Not Covered |
| Medical/Surgical Expenses | 30% of AC ¹ after deductible | Not Covered |
| Emergency Room Services (including professional services) | | |
| Emergency Room Facility Charge | 30% of AC ¹ after deductible | 30% of AC ¹ after deductible |
| Emergency Room Doctor and other Facility/Imaging Charges | 30% of AC ¹ after deductible | 30% of AC ¹ after deductible |
| Urgent Care | \$60 Copayment | \$60 Copayment |
| Ambulance | 30% of AC ¹ after deductible | Not Covered |

| Benefits | In-Plan You Pay | Out-of-Plan You Pay |
|---|---|---------------------|
| Rehabilitative/Habilitative Services³ Inpatient/Outpatient Facility and Services | 30% of AC ¹ after deductible | Not Covered |
| Skilled Nursing Facility Care (100 days per admission limit) | 30% of AC ¹ after deductible | Not Covered |
| Private Duty Nursing (16 hours per year) | 30% of AC ¹ after deductible | Not Covered |
| Chiropractic/Osteopathic/Manipulation Therapy⁴ (office setting) | \$60 Copayment | Not Covered |
| Physical/Occupational Therapy³ (office setting) | \$60 Copayment | Not Covered |
| Speech Therapy³ (office setting) | \$60 Copayment | Not Covered |
| Cardiac Rehabilitation (office setting) | 30% of AC ¹ after deductible | Not Covered |
| Chemo/Radiation Therapy (office setting) | 30% of AC ¹ after deductible | Not Covered |
| Respiratory Therapy (office setting) | 30% of AC ¹ after deductible | Not Covered |
| Dialysis/Hemodialysis (office setting) | 30% of AC ¹ after deductible | Not Covered |
| Reference Labs | \$0 Copayment | Not Covered |
| Home Health Care (100 visits per year) | 30% of AC ¹ after deductible | Not Covered |
| Durable Medical Equipment | 30% of AC ¹ after deductible | Not Covered |
| Prosthetic Device and Components | 30% of AC ¹ after deductible | Not Covered |
| Hospice | \$0 Copayment | Not Covered |

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.

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 per calendar year for Rehabilitative/Habilitative services combined.

* 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.

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.

In all other cases, prescription drugs purchased from a non-participating Out-of-Network retail pharmacy are Not Covered.

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.

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.