PIEDMONT COMMUNITY HEALTH PLAN

Piedmont Community HealthCare, Inc.
Schedule of Benefits - Large Group - Virginia Expanded PPO
Piedmont PPO Preferred 2000/25/50

Benefits	In-Plan You Pay	Out-of-Plan You Pay
Annual Deductible		
Individual Unit - Medical per Participant	$2,000	$4,000
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.	$2,000/person $4,000/family unit	$4,000/person $8,000/family unit
Annual Out-of-Pocket Maximum		
Individual Unit (includes medical and Rx coverage) per Participant	$4,500	$9,000
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.	$4,500/person $9,000/family unit	$9,000/person $18,000/family unit
Office Visits*		
PCP (family, general, internal medicine, and pediatric physicians)	$25 Copayment	40% of AC[1] after deductible
Telemedicine services - interactive virtual visits		
Piedmont Preferred Telemedicine Providers	$0 Copayment	40% of AC[1] after deductible
All Other Telemedicine Service Providers	$20 Copayment	40% of AC[1] after deductible
Retail Health Clinic	$25 Copayment	40% of AC[1] after deductible
Mental Health/Substance Use Disorder office visits	$25 Copayment	40% of AC[1] after deductible
Specialist (all other physicians and professionals)	$50 Copayment	40% of AC[1] after deductible
Other services performed in office (including but not limited to x-rays, diagnostic labs/tests, allergy serum and surgery)	Included with office visit Copayment	40% of AC[1] after deductible
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*	20% of AC[1] after deductible	40% of AC[1] after deductible
Allergy Testing	$50 Copayment	40% of AC[1] after deductible
Allergy Injections	$5 Copayment	40% 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	40% of AC[1] after deductible
Diagnostic Mammogram (to examine abnormalities)	$100 Copayment	40% of AC[1] after deductible
Diagnostic Colonoscopy	20% of AC[1] after deductible	40% of AC[1] after deductible
Outpatient Diagnostic Imaging Services & Tests (X-ray, etc.)	20% of AC[1] after deductible	40% of AC[1] after deductible
Advanced Imaging Services (MRI, CT Scan, etc.) Office/Free-Standing	20% of AC[1] after deductible	40% of AC[1] after deductible
Advanced Imaging Services (MRI, CT Scan, etc.) Outpatient Facility	20% of AC[1] after deductible	40% of AC[1] after deductible
Maternity Care		
Prenatal visits - Routine (including routine lab/diagnostic tests)	$0 Copayment	40% of AC[1] after deductible
Prenatal visits - Non-Routine (services outside of Global charge)	20% of AC[1] after deductible	40% of AC[1] after deductible
Postnatal office visit	$0 Copayment	40% of AC[1] after deductible
ObGyn's Global fee (prenatal, postnatal, and delivery services)	$450 Copayment	40% of AC[1] after deductible
Inpatient and facility charges (including professional services)	20% of AC[1] after deductible	40% of AC[1] after deductible
Hospital Services		
Inpatient/Facility and Services	20% of AC[1] after deductible	40% of AC[1] after deductible
Outpatient and Facility testing, and Observation	20% of AC[1] after deductible	40% of AC[1] after deductible
Off-Campus Outpatient Hospital Visits	20% of AC[1] after deductible	40% of AC[1] after deductible
Mental Health/Substance Use Disorder (inpatient/outpatient/partial day)	20% of AC[1] after deductible	40% of AC[1] after deductible
Medical/Surgical Expenses	20% of AC[1] after deductible	40% of AC[1] after deductible
Emergency Room Services (including professional services)		
Emergency Room Facility Charge	20% of AC[1] after deductible	20% of AC[1] after deductible
Emergency Room Doctor and other Facility/Imaging Charges	20% of AC[1] after deductible	20% of AC[1] after deductible
Urgent Care	$50 Copayment	$50 Copayment
Ambulance	$100 Copayment	40% of AC[1] after deductible

Benefits	In-Plan You Pay	Out-of-Plan You Pay
Rehabilitative/Habilitative Services[3] Inpatient/Outpatient Facility and Services	20% of AC[1] after deductible	40% of AC[1] after deductible
Skilled Nursing Facility Care (100 days per admission limit)	20% of AC[1] after deductible	40% of AC[1] after deductible
Private Duty Nursing (16 hours per year)	20% of AC[1] after deductible	40% of AC[1] after deductible
Chiropractic/Osteopathic/Manipulation Therapy[4] (office setting)	$25 Copayment after deductible	40% of AC[1] after deductible
Physical/Occupational Therapy[3] (office setting)	20% of AC[1] after deductible	40% of AC[1] after deductible
Speech Therapy[3] **(**office setting)	20% of AC[1] after deductible	40% of AC[1] after deductible
Cardiac Rehabilitation (office setting)	20% of AC[1] after deductible	40% of AC[1] after deductible
Chemo/Radiation Therapy (office setting)	20% of AC[1] after deductible	40% of AC[1] after deductible
Respiratory Therapy (office setting)	20% of AC[1] after deductible	40% of AC[1] after deductible
Dialysis/Hemodialysis (office setting)	20% of AC[1] after deductible	40% of AC[1] after deductible
Reference Labs	$0 Copayment	40% of AC[1] after deductible
Home Health Care (100 visits per year)	$25 Copayment	40% of AC[1] after deductible
Durable Medical Equipment	30% of AC[1] after deductible	40% of AC[1] after deductible
Prosthetic Device and Components	20% of AC[1] after deductible	40% of AC[1] after deductible
Hospice	$0 Copayment	40% of AC[1] after deductible

Out-of-plan ambulance services are those received other than in an actual Emergency (as defined elsewhere in this Certificate 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.

If you use an Out-of-Network retail pharmacy, you may have to pay the full cost of the drug up-front and your reimbursement from Piedmont depends on the following circumstances; In-Network benefits are provided at point of sale for prescriptions filled at a pharmacy that is not an In-Network Provider if that pharmacy or its intermediary agrees in writing to accept the same reimbursement terms as a pharmacy that is an In-Network Provider. Otherwise, prescriptions filled at a pharmacy that is an Out-of-Network Provider will be reimbursed to you up to the amount that would have been paid to an In-Network Provider pharmacy (less your applicable Copayment, Coinsurance, and Out-of-Network Deductible)

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 Certificate of Coverage. This Schedule of Benefits is part of and should be read together with your Certificate of Coverage.