The Summary of Benefits and Coverage (SBC) document will help you choose a health plan. The SBC shows you how you and the plan would share the cost for covered health care services. NOTE: Information about the cost of this plan (called the premium) will be provided separately.
This is only a summary. For more information about your coverage, or to get a copy of the complete terms of coverage, please call 1-800-400-7247 or visit our website at www.pchp.net. For general definitions of common terms, such as allowed amount, balance billing, coinsurance, copayment, deductible, provider, or other underlined terms, see the Glossary. You can view the Glossary at www.healthcare.gov/sbc-glossary/ or call 1-800-400-7247 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	For network providers: $25/Individual or $50/Family; For out-of-network providers: Not Covered/Individual or Not Covered/Family	Generally, you must pay all of the costs from providers up to the deductible amount before this plan begins to pay. If you have other family members on the plan, each family member must meet their own individual deductible until the total amount of deductible expenses paid by all family members meets the overall family deductible.
Are there services covered before you meet your deductible?	Yes. Preventive care and some primary care services are covered before you meet your deductible.	This plan covers some items and services even if you haven't yet met the deductible amount. But a copayment or coinsurance may apply. For example, this plan covers certain preventive services without cost-sharing and before you meet your deductible. See a list of covered preventive services at https://www.healthcare.gov/coverage/preventive-care-benefits/.
Are there other deductibles for specific services?	No.	You don't have to meet deductibles for specific services.
What is the out-of-pocket limit for this plan?	For network providers: $1,500/Individual or $3,000/Family; For out-of-network providers: Not Covered/Individual or Not Covered/Family	The out-of-pocket limit is the most you could pay in a year for covered services. If you have other family members in this plan, they have to meet their own out-of-pocket limits until the overall family out-of-pocket limit has been met.
What is not included in the out-of-pocket limit?	Premiums, balance-billing charges, and health care this plan doesn't cover.	Even though you pay these expenses, they don't count toward the out–of–pocket limit.
Will you pay less if you use a network provider?	Yes. See www.pchp.net or call 1-800-400-7247 for a list of network providers.	This plan uses a provider network. You will pay less if you use a provider in the plan's network. You will pay the most if you use an out-of-network provider, and you might receive a bill from a provider for the difference between the provider's charge and what your plan pays (balance billing). Be aware, your network provider might use an out-of-network provider for some services (such as lab work). Check with your provider before you get services.
Do you need a referral to see a specialist?	No.	You can see the specialist you choose without a referral.

All **copayment** and **coinsurance** costs shown in this chart are after your **deductible** has been met, if a **deductible** applies.

Common Medical Event	Services You May Need	What You Will Pay: Network Provider (You will pay the least)	What You Will Pay: Out-of-Network Provider (You will pay the most)	Limitations, Exceptions, & Other Important Information
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	$5 Copayment/visit and 10% Coinsurance for other office services; deductible only applies to coinsurance.	Not Covered	None
	Specialist visit	10% Coinsurance/visit and 10% Coinsurance for other office services; deductible only applies to coinsurance.	Not Covered	None
	Preventive care/screening/ immunization	No Charge	Not Covered	You may have to pay for services that aren't preventive. Ask your provider if the services you need are preventive. Then check what your plan will pay for.
If you have a test	Diagnostic test (x-ray, blood work)	10% Coinsurance	Not Covered	Network Diagnostic Mammogram: $100 Copayment; Preauthorization may be required for imaging.
	Imaging (CT/PET scans, MRIs)	50% Coinsurance	Not Covered	
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at www.pchp.net	Generic drugs (Tier 1)	30-Day: $5 Copayment 90-Day: $13 Copayment	Not Covered	Covers up to a 30-day supply (retail) or 31 to 90-day supply (mail order). Tier 2 insulin drug copayment will not exceed $35 for a 30-day supply. Tier 3 insulin drug copayment will not exceed $50 for a 30-day supply.
	Preferred brand drugs (Tier 2)	30-Day: $25 Copayment 90-Day: $63 Copayment	Not Covered	
	Non-preferred brand drugs (Tier 3)	30-Day: 50% Coinsurance 90-Day: 50% Coinsurance	Not Covered	
	Specialty drugs (Tier 4)	30-Day: 50% Coinsurance 90-Day: 50% Coinsurance	Not Covered	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	10% Coinsurance	Not Covered	Preauthorization may be required.
	Physician/surgeon fees	10% Coinsurance	Not Covered	None
If you need immediate medical attention	Emergency room care	50% Coinsurance		None
	Emergency medical transportation	10% Coinsurance		
	Urgent care	$10 Copayment		
If you have a hospital stay	Facility fee (e.g., hospital room)	10% Coinsurance	Not Covered	Preauthorization is required.

Common Medical Event	Services You May Need	What You Will Pay: Network Provider (You will pay the least)	What You Will Pay: Out-of-Network Provider (You will pay the most)	Limitations, Exceptions, & Other Important Information
	Physician/surgeon fees	10% Coinsurance	Not Covered	None
If you need mental health, behavioral health, or substance abuse services	Outpatient services	10% Coinsurance/office visit and 10% Coinsurance for other outpatient services	Not Covered	Preauthorization is required for inpatient facility services.
	Inpatient services	10% Coinsurance	Not Covered	
If you are pregnant	Office visits	10% Coinsurance	Not Covered	Cost sharing does not apply to certain preventive services. Depending on the type of services, coinsurance may apply. Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound).
	Childbirth/delivery professional services	10% Coinsurance	Not Covered	
	Childbirth/delivery facility services	10% Coinsurance	Not Covered	
If you need help recovering or have other special health needs	Home health care	10% Coinsurance	Not Covered	100 visits/year
	Rehabilitation services	10% Coinsurance	Not Covered	30 visits/year for rehabilitative and 30 visits/year for habilitative services. Includes Occupational/Physical/Speech Therapy.
	Habilitation services	10% Coinsurance	Not Covered	
	Skilled nursing care	10% Coinsurance	Not Covered	100 visits/year
	Durable medical equipment	10% Coinsurance	Not Covered	Preauthorization may be required.
	Hospice services	10% Coinsurance	Not Covered	Preauthorization may be required.
If your child needs dental or eye care	Children's eye exam	$0 Copayment/visit	Not Covered	Coverage limited to one exam/year for each covered child (up to age 19).
	Children's glasses	No Charge	Not Covered	Coverage limited to one pair of standard glasses or contacts from a limited collection per year.
	Children's dental check-up	Not Covered	Not Covered	Dental check-up is not covered.

Excluded Services & Other Covered Services:

Services Your Plan Generally Does NOT Cover (Check your policy or plan document for more information and a list of any other excluded services.)

- Abortion (Except in cases of rape, incest, or when the life of the mother is endangered)
- Acupuncture
- Bariatric Surgery
- Cosmetic Surgery
- Dental Care (Adult) (except for accidental injury)
- Glasses (Adult)
- Hearing Aids
- Infertility Treatment
- Long-Term Care
- Non-emergency care when traveling outside the U.S.
- Routine Eye Care (Adult)
- Routine Foot Care (Except for diabetes, etc.)
- Weight Loss Programs

Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your plan document.)	
• Chiropractic Care (Limited to 30 visits/year for rehabilitative services and 30 visits/year for habilitative services)	• Private-Duty Nursing (Limit of 16 hours/year)

Your Rights to Continue Coverage: There are agencies that can help if you want to continue your coverage after it ends. The contact information for those agencies are: VA Bureau of Insurance (BOI) at 1-800-552-7945 or www.scc.virginia.gov/boi/index.aspx, and CCIIO Virginia Consumer Assistance at www.cms.gov/CCIIO/Resources/Consumer-Assistance-Grants/va.html. Other coverage options may be available to you too, including buying individual insurance coverage through the Health Insurance Marketplace. For more information about the Marketplace, visit www.HealthCare.gov or call 1-800-318-2596.

Your Grievance and Appeals Rights: There are agencies that can help if you have a complaint against your plan for a denial of a claim. This complaint is called a grievance or appeal. For more information about your rights, look at the explanation of benefits you will receive for that medical claim. Your plan documents also provide complete information to submit a claim, appeal, or a grievance for any reason to your plan. For more information about your rights, this notice, or assistance, contact: Piedmont Community Healthcare HMO at 1-800-400-7247 or www.pchp.net, VA Bureau of Insurance (BOI) at 1-800-552-7945 or www.scc.virginia.gov/boi/index.aspx, or the VA Department of Health (VDH) Complaint Unit at 1-800-955-1819 or www.vdh.virginia.gov/licensure-and-certification/complaint-unit/.

Does this plan provide Minimum Essential Coverage? Yes

Minimum Essential Coverage generally includes plans, health insurance available through the Marketplace or other individual market policies, Medicare, Medicaid, CHIP, TRICARE, and certain other coverage. If you are eligible for certain types of Minimum Essential Coverage, you may not be eligible for the premium tax credit.

Does this plan meet Minimum Value Standards? Not Applicable

If your plan doesn't meet the Minimum Value Standards, you may be eligible for a premium tax credit to help you pay for a plan through the Marketplace.

Language Access Services:

ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-800-400-7247 (TTY:711).

주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 1-800-400-7247 (TTY: 711) 번으로 전화해 주십시오.

CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số 1-800-400-7247 (TTY: 711).

注意：如果您使用繁體中文，您可以免費獲得語言援助服務。請致電 1-800-400-7247（TTY：711）。

To see examples of how this plan might cover costs for a sample medical situation, see the next section.

PRA Disclosure Statement

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-1146. The time required to complete this information collection is estimated to average 0.08 hours per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.

About these Coverage Examples

This is not a cost estimator. Treatments shown are just examples of how this plan might cover medical care. Your actual costs will be different depending on the actual care you receive, the prices your providers charge, and many other factors. Focus on the cost sharing amounts (deductibles, copayments and coinsurance) and excluded services under the plan. Use this information to compare the portion of costs you might pay under different health plans. Please note these coverage examples are based on self-only coverage.

Peg is Having a Baby
(9 months of in-network pre-natal care and a hospital delivery)

- **The plan's overall deductible** **$25**
- **Specialist Coinsurance** **10%**
- **Hospital (Facility) Coinsurance** **10%**
- **Other Coinsurance** **10%**

This EXAMPLE event includes services like:
Specialist office visits (*prenatal care)*
Childbirth/Delivery Professional Services
Childbirth/Delivery Facility Services
Diagnostic tests (*ultrasounds and blood work)*
Specialist visit *(anesthesia)*

Total Example Cost	**$12,700**

In this example, Peg would pay:

Cost Sharing	
Deductibles	$25.00
Copayments	$10.00
Coinsurance	$1,300.00
What isn't covered	
Limits or exclusions	$60.00
The total Peg would pay is	**$1,395.00**

Managing Joe's Type 2 Diabetes
(a year of routine in-network care of a well-controlled condition)

- **The plan's overall deductible** **$25**
- **Specialist Coinsurance** **10%**
- **Hospital (Facility) Coinsurance** **10%**
- **Other Coinsurance** **10%**

This EXAMPLE event includes services like:
Primary care physician office visits (*including disease education)*
Diagnostic tests *(blood work)*
Prescription drugs
Durable medical equipment *(glucose meter)*

Total Example Cost	**$5,600**

In this example, Joe would pay:

Cost Sharing	
Deductibles	$25.00
Copayments	$900.00
Coinsurance	$40.00
What isn't covered	
Limits or exclusions	$20.00
The total Joe would pay is	**$985.00**

Mia's Simple Fracture
(in-network emergency room visit and follow up care)

- **The plan's overall deductible** **$25**
- **Specialist Coinsurance** **10%**
- **Hospital (Facility) Coinsurance** **10%**
- **Other Coinsurance** **10%**

This EXAMPLE event includes services like:
Emergency room care *(including medical supplies)*
Diagnostic test *(x-ray)*
Durable medical equipment *(crutches)*
Rehabilitation services *(physical therapy)*

Total Example Cost	**$2,800**

In this example, Mia would pay:

Cost Sharing	
Deductibles	$25.00
Copayments	$10.00
Coinsurance	$600.00
What isn't covered	
Limits or exclusions	$0.00
The total Mia would pay is	**$635.00**

The **plan** would be responsible for the other costs of these EXAMPLE covered services.

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Nondiscrimination Notice

Piedmont Community Healthcare HMO, Inc. (hereafter "Piedmont") complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. Piedmont does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex.

Piedmont:

- Provides free aids and services to people with disabilities to communicate effectively with us, such as:
  - Qualified sign language interpreters
  - Written information in other formats (large print, audio, accessible electronic formats, other formats)
- Provides free language services to people whose primary language is not English, such as:
  - Qualified interpreters
  - Information written in other languages

If you need these services, contact Customer Service at 1-800-400-7247 (TTY: 711)

If you believe that Piedmont has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance with our Compliance Officer by mail or phone:

Compliance Officer
Piedmont Community Healthcare HMO
2316 Atherholt Road
Lynchburg, VA 24501
434-947-4463 (TTY: 711)

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights electronically through the Office for Civil Rights Complaint Portal, available at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf, or by mail or phone at:

U.S. Department of Health and Human Services
200 Independence Avenue SW
Room 509F, HHH Building
Washington, DC 20201
1-800-368-1019, 800-537-7697 (TDD).

Complaint forms are available at http://www.hhs.gov/ocr/office/file/index.html.

Language Assistance Services

English ATTENTION: If you speak English, language assistance services, free of charge, are available to you. Call 1-800-400-7247 (TTY: 711).

Español (Spanish) ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-800-400-7247 (TTY: 711).

한국어 (Korean) 주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 1-800-400-7247 (TTY: 711) 번으로 전화해 주십시오.

Tiếng Việt (Vietnamese) CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số 1-800-400-7247 (TTY: 711).

繁體中文 (Chinese) 注意：如果您使用繁體中文，您可以免費獲得語言援助服務。請致電 1-800-400-7247 (TTY：711)

العربية(Arabic) ملحوظة: إذا كنت تتحدث اذكر اللغة، فإن خدمات المساعدة اللغوية تتوافر لك بالمجان. اتصل برقم 1-800-400-7247
(رقم هاتف الصم والبكم: 711).

Tagalog (Tagalog – Filipino) PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tumawag sa 1-800-400-7247 (TTY: 711).

فارسی(Farsi) توجه: اگر به زبان فارسی گفتگو می کنید، تسهیلات زبانی بصورت رایگان برای شما
فراهم می باشد. با 1-800-400-7247 (TTY: 711) تماس بگیرید.

አማርኛ (Amharic) ማስታወሻ: የሚናገሩት ቋንቋ አማርኛ ከሆነ የትርጉም እርዳታ ድርጅቶች፣ በነጻ ሊያግዝዎት ተዘጋጀተዋል፡ ወደ ሚከተለው ቁጥር ይደውሉ 1-800-400-7247 (መስማት ለተሳናቸው: 711).

اُردُو(Urdu) خبردار: اگر آپ اردو بولتے ہیں، تو آپ کو زبان کی مدد کی خدمات مفت میں دستیاب ہیں ۔ کالکریں
1-800-400-7247 (TTY: 711).

Français (French) ATTENTION: Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le 1-800-400-7247 (ATS: 711).

Русский (Russian) ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните 1-800-400-7247 (телетайп: 711).

हिंदी (Hindi) ध्यान दें: यदि आप हिंदी बोलते हैं तो आपके लिए मुफ्त में भाषा सहायता सेवाएं उपलब्ध हैं। 1-800-400-7247 (TTY: 711) पर कॉल करें।

Deutsch (German) ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Rufnummer: 1-800-400-7247 (TTY: 711).

বাংলা (Bengali) লক্ষ্য করুনঃ যদি আপনি বাংলা, কথা বলতে পারেন, তাহলে নিঃখরচায় ভাষা সহায়তা পরিষেবা উপলব্ধ আছে। ফোন করুন ১-800-400-7247 (TTY: 711)।

Bàsɔ̀ɔ̀-wùɖù-po-nyɔ̀ (Bassa) Dè ɖɛ nià kɛ dyéɖé gbo: ɔ jǔ ké m̀ [Bàsɔ̀ɔ̀-wùɖù-po-nyɔ̀] jǔ ní, nìí, à wuɖu kà kò ɖò po-poɔ̀ ɓɛ́ìn m̀ gbo kpáa. Ɓá 1-800-400-7247 (TTY:711)

Igbo asusu (Ibo) Ige nti: O buru na asu Ibo asusu, enyemaka diri gi site na call 1-800-400-7247 (TTY: 711).

èdè Yorùbá (Yoruba) AKIYESI: Ti o ba nso ede Yoruba ofe ni iranlowo lori ede wa fun yin o. E pe ero ibanisoro yi 1-800-400-7247 (TTY: 711).