Piedmont Community Healthcare HMO, Inc.
Schedule of Benefits - Large Group - Centra Community HMO
Piedmont HMO Preferred 500/20/40

Benefits	In-Plan You Pay	Out-of-Plan You Pay
Annual Deductible		
Individual Unit - Medical per Participant	$500	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.	$500/person $1,000/family unit	Not Covered Not Covered
Annual Out-of-Pocket Maximum		
Individual Unit (includes medical and Rx coverage) per Participant	$2,500	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.	$2,500/person $5,000/family unit	Not Covered Not Covered
Office Visits*		
PCP (family, general, internal medicine, and pediatric physicians)	$20 Copayment	Not Covered
Telemedicine services - interactive virtual visits		
Piedmont Preferred Telemedicine Providers	$15 Copayment	Not Covered
All Other Telemedicine Service Providers	$15 Copayment	Not Covered
Retail Health Clinic	$20 Copayment	Not Covered
Mental Health/Substance Use Disorder office visits	$20 Copayment	Not Covered
Specialist (all other physicians and professionals)	$40 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*	20% of AC[1] after deductible	Not Covered
Allergy Testing	$40 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	20% of AC[1] after deductible	Not Covered
Outpatient Diagnostic Imaging Services & Tests (X-ray, etc.)	20% of AC[1] after deductible	Not Covered
Advanced Imaging Services (MRI, CT Scan, etc.) Office/Free-Standing	10% of AC[1] after deductible	Not Covered
Advanced Imaging Services (MRI, CT Scan, etc.) Outpatient Facility	20% 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)	20% of AC[1] after deductible	Not Covered
Postnatal office visit	$40 Copayment	Not Covered
ObGyn's Global fee (prenatal, postnatal, and delivery services)	20% of AC[1] after deductible	Not Covered
Inpatient and facility charges (including professional services)	20% of AC[1] after deductible	Not Covered
Hospital Services		
Inpatient/Facility and Services	20% of AC[1] after deductible	Not Covered
Outpatient and Facility testing, and Observation	20% of AC[1] after deductible	Not Covered
Off-Campus Outpatient Hospital Visits	20% of AC[1] after deductible	Not Covered
Mental Health/Substance Use Disorder (inpatient/outpatient/partial day)	20% of AC[1] after deductible	Not Covered
Medical/Surgical Expenses	20% of AC[1] after deductible	Not Covered
Emergency Room Services (including professional services)		
Emergency Room Facility Charge	$250 Copayment	$250 Copayment
Emergency Room Doctor and other Facility/Imaging Charges	0% of AC[1] after deductible	0% of AC[1] after deductible
Urgent Care	$40 Copayment	$40 Copayment
Ambulance	20% of AC[1] after deductible	Not Covered

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	Not Covered
Skilled Nursing Facility Care (100 days per admission limit)	20% of AC[1] after deductible	Not Covered
Private Duty Nursing (16 hours per year)	20% of AC[1] after deductible	Not Covered
Chiropractic/Osteopathic/Manipulation Therapy[4] (office setting)	$40 Copayment	Not Covered
Physical/Occupational Therapy[3] (office setting)	$40 Copayment	Not Covered
Speech Therapy[3] **(**office setting)	$40 Copayment	Not Covered
Cardiac Rehabilitation (office setting)	20% of AC[1] after deductible	Not Covered
Chemo/Radiation Therapy (office setting)	20% of AC[1] after deductible	Not Covered
Respiratory Therapy (office setting)	20% of AC[1] after deductible	Not Covered
Dialysis/Hemodialysis (office setting)	20% of AC[1] after deductible	Not Covered
Reference Labs	$0 Copayment	Not Covered
Home Health Care (100 visits per year)	20% of AC[1] after deductible	Not Covered
Durable Medical Equipment	20% of AC[1] after deductible	Not Covered
Prosthetic Device and Components	20% 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.