



**Piedmont Community HealthCare, Inc.**  
**Schedule of Benefits - Large Group - Virginia Expanded PPO**  
**Piedmont PPO Preferred 6000/35/60 VA Expanded**

Benefits	In-Plan You Pay	Out-of-Plan You Pay
<b>Annual Deductible</b> Individual Unit - Medical per Participant 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	\$12,000
	\$6,000/person \$12,000/family unit	\$12,000/person \$24,000/family unit
<b>Annual Out-of-Pocket Maximum</b> Individual Unit (includes medical and Rx coverage) per Participant 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	\$15,000
	\$7,500/person \$15,000/family unit	\$15,000/person \$30,000/family unit
<b>Office Visits*</b> <b>PCP</b> (family, general, internal medicine, and pediatric physicians) <b>Telemedicine services</b> - interactive virtual visits Piedmont Preferred Telemedicine Providers All Other Telemedicine Service Providers <b>Retail Health Clinic</b> <b>Mental Health/Substance Use Disorder</b> office visits <b>Specialist</b> (all other physicians and professionals) <b>Other services performed in office</b> (including but not limited to x-rays, diagnostic labs/tests, allergy serum and surgery) <b>Services requiring additional cost-sharing:</b> injectable and infused medications, labs sent from office to outpatient facilities, sleep studies, and off-campus outpatient hospital/facility visits* <b>Allergy Testing</b> <b>Allergy Injections</b>	\$35 Copayment \$0 Copayment \$30 Copayment \$35 Copayment \$35 Copayment \$60 Copayment Included with office visit Copayment 20% of AC <sup>1</sup> after deductible \$60 Copayment \$5 Copayment	40% of AC <sup>1</sup> after deductible 40% of AC <sup>1</sup> after deductible 40% of AC <sup>1</sup> after deductible 40% of AC <sup>1</sup> after deductible 40% of AC <sup>1</sup> after deductible 40% of AC <sup>1</sup> after deductible 40% of AC <sup>1</sup> after deductible 40% of AC <sup>1</sup> after deductible 40% of AC <sup>1</sup> after deductible
<b>Preventive Care</b> Routine physical exams (including testing), women's preventive care, routine well-child care, child and adult immunizations, screening mammogram/colonoscopy, other PPACA <sup>2</sup> covered preventive care services	\$0 Copayment	40% of AC <sup>1</sup> after deductible
<b>Diagnostic Mammogram</b> (to examine abnormalities)	\$100 Copayment	40% of AC <sup>1</sup> after deductible
<b>Diagnostic Colonoscopy</b>	20% of AC <sup>1</sup> after deductible	40% of AC <sup>1</sup> after deductible
<b>Outpatient Diagnostic Imaging Services &amp; Tests</b> (X-ray, etc.)	20% of AC <sup>1</sup> after deductible	40% of AC <sup>1</sup> after deductible
<b>Advanced Imaging Services</b> (MRI, CT Scan, etc.) Office/Free-Standing	10% of AC <sup>1</sup> after deductible	40% of AC <sup>1</sup> after deductible
<b>Advanced Imaging Services</b> (MRI, CT Scan, etc.) Outpatient Facility	20% of AC <sup>1</sup> after deductible	40% of AC <sup>1</sup> after deductible
<b>Maternity Care</b> Prenatal visits - Routine (including routine lab/diagnostic tests) Prenatal visits - Non-Routine (services outside of Global charge) Postnatal office visit ObGyn's Global fee (prenatal, postnatal, and delivery services) Inpatient and facility charges (including professional services)	\$0 Copayment 20% of AC <sup>1</sup> after deductible \$60 Copayment 20% of AC <sup>1</sup> after deductible 20% of AC <sup>1</sup> after deductible	40% of AC <sup>1</sup> after deductible 40% of AC <sup>1</sup> after deductible 40% of AC <sup>1</sup> after deductible 40% of AC <sup>1</sup> after deductible 40% of AC <sup>1</sup> after deductible
<b>Hospital Services</b> Inpatient/Facility and Services Outpatient and Facility testing, and Observation Off-Campus Outpatient Hospital Visits Mental Health/Substance Use Disorder (inpatient/outpatient/partial day)	20% of AC <sup>1</sup> after deductible 20% of AC <sup>1</sup> after deductible 20% of AC <sup>1</sup> after deductible 20% of AC <sup>1</sup> after deductible	40% of AC <sup>1</sup> after deductible 40% of AC <sup>1</sup> after deductible 40% of AC <sup>1</sup> after deductible 40% of AC <sup>1</sup> after deductible
<b>Medical/Surgical Expenses</b>	20% of AC <sup>1</sup> after deductible	40% of AC <sup>1</sup> after deductible
<b>Emergency Room Services</b> (including professional services) Emergency Room Facility Charge Emergency Room Doctor and other Facility/Imaging Charges	20% of AC <sup>1</sup> after deductible 20% of AC <sup>1</sup> after deductible	20% of AC <sup>1</sup> after deductible 20% of AC <sup>1</sup> after deductible
<b>Urgent Care</b>	\$60 Copayment	\$60 Copayment
<b>Ambulance</b>	20% of AC <sup>1</sup> after deductible	40% of AC <sup>1</sup> after deductible

Benefits	In-Plan You Pay	Out-of-Plan You Pay
<b>Rehabilitative/Habilitative Services<sup>3</sup></b> Inpatient/Outpatient Facility and Services	20% of AC <sup>1</sup> after deductible	40% of AC <sup>1</sup> after deductible
<b>Skilled Nursing Facility Care</b> (100 days per admission limit)	20% of AC <sup>1</sup> after deductible	40% of AC <sup>1</sup> after deductible
<b>Private Duty Nursing</b> (16 hours per year)	20% of AC <sup>1</sup> after deductible	40% of AC <sup>1</sup> after deductible
<b>Chiropractic/Osteopathic/Manipulation Therapy<sup>4</sup></b> (office setting)	\$60 Copayment	40% of AC <sup>1</sup> after deductible
<b>Physical/Occupational Therapy<sup>3</sup></b> (office setting)	\$60 Copayment	40% of AC <sup>1</sup> after deductible
<b>Speech Therapy<sup>3</sup></b> (office setting)	\$60 Copayment	40% of AC <sup>1</sup> after deductible
<b>Cardiac Rehabilitation</b> (office setting)	20% of AC <sup>1</sup> after deductible	40% of AC <sup>1</sup> after deductible
<b>Chemo/Radiation Therapy</b> (office setting)	20% of AC <sup>1</sup> after deductible	40% of AC <sup>1</sup> after deductible
<b>Respiratory Therapy</b> (office setting)	20% of AC <sup>1</sup> after deductible	40% of AC <sup>1</sup> after deductible
<b>Dialysis/Hemodialysis</b> (office setting)	20% of AC <sup>1</sup> after deductible	40% of AC <sup>1</sup> after deductible
<b>Reference Labs</b>	\$0 Copayment	40% of AC <sup>1</sup> after deductible
<b>Home Health Care</b> (100 visits per year)	20% of AC <sup>1</sup> after deductible	40% of AC <sup>1</sup> after deductible
<b>Durable Medical Equipment</b>	20% of AC <sup>1</sup> after deductible	40% of AC <sup>1</sup> after deductible
<b>Prosthetic Device and Components</b>	20% of AC <sup>1</sup> after deductible	40% of AC <sup>1</sup> after deductible
<b>Hospice</b>	\$0 Copayment	40% of AC <sup>1</sup> 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.

<sup>1</sup> AC is the allowable charge.

<sup>2</sup> PPACA is the Patient Protection and Affordable Care Act.

<sup>3</sup> 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.

<sup>4</sup> 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.