## Important Questions | Answers | Why This Matters:
--- | --- | ---
What is the overall deductible? | $6,000 Individual / $12,000 Family Unit in-Network  
$12,000 Individual / $24,000 Family Unit Out-of-Network | 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/](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** $6,550 Individual / $13,100 Family Unit; for **out-of-network providers** $13,100 Individual / $26,200 Family Unit | 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](http://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. To see a **specialist**, you don’t need a **referral** from this plan. You can see a **specialist** you choose without getting permission from this plan.

---

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

### Common Medical Event

<table>
<thead>
<tr>
<th>Services You May Need</th>
<th>Network Provider (You will pay the least)</th>
<th>Out-of-Network Provider (You will pay the most)</th>
<th>Limitations, Exceptions, &amp; Other Important Information</th>
</tr>
</thead>
<tbody>
<tr>
<td>Primary care visit to treat an injury or illness</td>
<td>25% coinsurance</td>
<td>40% coinsurance</td>
<td>*No cost share on any covered EHB service furnished or referred by the Indian Health Services, an Indian Tribe, Tribal Organization, or Urban Indian Organization.</td>
</tr>
<tr>
<td>Specialist visit</td>
<td>25% coinsurance</td>
<td>40% coinsurance</td>
<td>*See note above</td>
</tr>
<tr>
<td>Preventive care/screening/Immunization</td>
<td>No charge</td>
<td>40% coinsurance</td>
<td>You may have to pay for services that aren’t <strong>preventive</strong>. Ask your <strong>provider</strong> if the services you need are <strong>preventive</strong>. Then check what your <strong>plan</strong> will pay for. *See note above</td>
</tr>
</tbody>
</table>

### If you visit a health care provider’s office or clinic

- **Diagnostic test** (x-ray, blood work)
- Imaging (CT/PET scans, MRIs)
- **Generic drugs** (Tier 1)
  - **(Deductible Applies)**
  - 25% coinsurance (retail)
  - 25% coinsurance (mail order)
  - 25% coinsurance (retail)
  - 25% coinsurance (mail order) See Limitations

### If you have a test

- **Diagnostic mammogram/$100** copay. *See note above

### If you need drugs to treat your illness or condition

More information about **prescription drug coverage** is available at [www.pchp.net](http://www.pchp.net)

- **Preferred brand drugs** (Tier 2)
  - **(Deductible Applies)**
  - 25% coinsurance (retail)
  - 25% coinsurance (mail order)
  - 25% coinsurance (mail order) See Limitations

- **Non-preferred brand drugs** (Tier 3)
  - **(Deductible Applies)**
  - 50% coinsurance (retail)
  - 50% coinsurance (mail order)
  - 50% coinsurance (mail order) See Limitations

- **Specialty drugs, Preferred** (Tier 4)
  - **(Deductible Applies)**
  - 50% coinsurance (retail)
  - 50% coinsurance (mail order)

- **Specialty drugs, Non-Preferred** (Tier 5)
  - **(Deductible Applies)**
  - 50% coinsurance (retail)
  - 50% coinsurance (mail order)

Copays are per prescription. Covers up to a 30-day or 100 unit supply (retail prescription); Covers up to a 90-day or 300 unit supply (mail order prescription). This plan requires “mandatory” generic substitution if the FDA has determined the generic to be equivalent to the brand product, unless an In-Network provider requires brand name drugs. Prescriptions filled at an Out-of-Network pharmacy reimbursed up to the amount that would have been paid to an In-Network pharmacy (less copay, deductible).
<table>
<thead>
<tr>
<th>Common Medical Event</th>
<th>Services You May Need</th>
<th>Network Provider (You will pay the least)</th>
<th>Out-of-Network Provider (You will pay the most)</th>
<th>Limitations, Exceptions, &amp; Other Important Information</th>
</tr>
</thead>
<tbody>
<tr>
<td>If you have outpatient surgery</td>
<td>Facility fee (e.g., ambulatory surgery center)</td>
<td>25% coinsurance</td>
<td>40% coinsurance</td>
<td>Preauthorization is required. If you don't get preauthorization, benefits could be covered as Out-of-Network. *See note above</td>
</tr>
<tr>
<td></td>
<td>Physician/surgeon fees</td>
<td>25% coinsurance</td>
<td>40% coinsurance</td>
<td></td>
</tr>
<tr>
<td>If you need immediate medical attention</td>
<td>Emergency room care</td>
<td>40% coinsurance</td>
<td>40% coinsurance</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Emergency medical transportation</td>
<td>25% coinsurance</td>
<td>40% coinsurance</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Urgent care</td>
<td>25% coinsurance</td>
<td>40% coinsurance</td>
<td>*See note above</td>
</tr>
<tr>
<td>If you have a hospital stay</td>
<td>Facility fee (e.g., hospital room)</td>
<td>25% coinsurance</td>
<td>40% coinsurance</td>
<td>Preauthorization is required. If you don't get preauthorization, benefits could be covered as Out-of-Network. *See note above</td>
</tr>
<tr>
<td></td>
<td>Physician/surgeon fees</td>
<td>25% coinsurance</td>
<td>40% coinsurance</td>
<td></td>
</tr>
<tr>
<td>If you need mental health, behavioral health, or substance abuse services</td>
<td>Outpatient services</td>
<td>25% coinsurance</td>
<td>40% coinsurance</td>
<td>Pre-authorization required for any inpatient or outpatient facility services. Pre-authorization required for any services and office visits from Out-of-Network providers. Covered as Out-of-Network without pre-authorization. *See note above</td>
</tr>
<tr>
<td></td>
<td>Inpatient services</td>
<td>25% coinsurance</td>
<td>40% coinsurance</td>
<td></td>
</tr>
<tr>
<td>If you are pregnant</td>
<td>Office visits</td>
<td>25% coinsurance</td>
<td>40% coinsurance</td>
<td>Cost sharing does not apply to certain preventive services.</td>
</tr>
<tr>
<td></td>
<td>Childbirth/delivery professional services</td>
<td>25% coinsurance</td>
<td>40% coinsurance</td>
<td>Depending on the type of services, coinsurance may apply. Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound). *See note above</td>
</tr>
<tr>
<td></td>
<td>Childbirth/delivery facility services</td>
<td>25% coinsurance</td>
<td>40% coinsurance</td>
<td></td>
</tr>
<tr>
<td>If you need help recovering or have</td>
<td>Home health care</td>
<td>25% coinsurance</td>
<td>40% coinsurance</td>
<td>Limited to 100 visits/calendar year *See note above</td>
</tr>
</tbody>
</table>
| | Rehabilitation services | 25% coinsurance | 40% coinsurance | Physical/Occupational therapy or

*See note above
<table>
<thead>
<tr>
<th>Common Medical Event</th>
<th>Services You May Need</th>
<th>What You Will Pay Network Provider (You will pay the least)</th>
<th>Out-of-Network Provider (You will pay the most)</th>
<th>Limitations, Exceptions, &amp; Other Important Information</th>
</tr>
</thead>
<tbody>
<tr>
<td>other special health needs</td>
<td>Habilitation services</td>
<td>25% coinsurance</td>
<td>40% coinsurance</td>
<td>Speech therapy limited to 30 visits/yr each for rehabilitative or habilitative services. *See note above</td>
</tr>
<tr>
<td></td>
<td>Skilled nursing care</td>
<td>25% coinsurance</td>
<td>40% coinsurance</td>
<td>Limited to 100 visits/calendar year *See note above</td>
</tr>
<tr>
<td></td>
<td>Durable medical equipment</td>
<td>25% coinsurance</td>
<td>40% coinsurance</td>
<td>Pre-authorization required for costs in excess of $750. *See note above</td>
</tr>
<tr>
<td></td>
<td>Hospice services</td>
<td>25% coinsurance</td>
<td>40% coinsurance</td>
<td>Preauthorization is required. If you don’t get preauthorization, benefits could be reduced by 60% of the total cost of the service. *See note above</td>
</tr>
<tr>
<td>If your child needs dental or eye care</td>
<td>Children’s eye exam</td>
<td>No Charge</td>
<td>40% coinsurance</td>
<td>Limited to one routine eye exam per year for Participants up to age 19. *See note above</td>
</tr>
<tr>
<td></td>
<td>Children’s glasses</td>
<td>No Charge with limitations</td>
<td>40% coinsurance</td>
<td>Limited to one pair of standard glasses (lenses and frames), or one pair of contact lenses per year from a limited collection. *See note above</td>
</tr>
<tr>
<td></td>
<td>Children’s dental check-up</td>
<td>Not Covered</td>
<td>Not Covered</td>
<td>Dental check-up is Not Covered.</td>
</tr>
</tbody>
</table>

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 (except for pediatric vision benefits)
- Hearing aids
- Infertility Treatment
- Long Term Care
- Non-emergency care when traveling outside the U.S.
- Routine eye care (Adult)
- Routine Foot Care (unless you are under active treatment for a metabolic or peripheral vascular disease, such as diabetes
- 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 (total spinal manipulation / chiropractic services limited to 30 visits each per year for rehabilitative or habilitative services)
- Private-duty nursing (limited to 16 hours per year)
- Habilitation services

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 is: contact the plan at 1-800-400-7247. You may also contact your state insurance department, the U.S. Department of Labor, Employee Benefits Security Administration at 1-866-444-3272 or www.dol.gov/ebsa/consumerassistance.html, or the U.S. Department of Health and Human Services at 1-877-267-2323 x61565 or www.ccio.ems.gov. 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 at 1-800-400-7247 (434-947-4463 if local), or visit www.pchp.net. You may also contact the U.S. Department of Labor at 1-866-444-3272 or visit www.dol.gov/ebsa/healthreform; or call the Virginia Bureau of Insurance at 1-877-310-6560 or visit www.scc.virginia.gov/boi/omb. Additionally, a consumer assistance program can help you file your appeal. Contact the Virginia Bureau of Insurance, Office of Managed Care Ombudsman at 1-877-310-6560 or , www.scc.virginia.gov/boi/omb, or for assistance with complaints regarding the quality of health care services received, contact the Virginia Department of Health, Office of Licensure at 1-800-955-1819 or www.vdh.state.va.us/OLC/Complaint.

Does this plan provide Minimum Essential Coverage? Yes.
If you don’t have Minimum Essential Coverage for a month, you’ll have to make a payment when you file your tax return unless you qualify for an exemption from the requirement that you have health coverage for that month.

Does this plan meet Minimum Value Standards? Yes.
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:

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

Espanol si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-800-400-7247 (TTY: 1-877-295-1454).


To see examples of how this plan might cover costs for a sample medical situation, see the next section.
**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: $6,000
- Specialist copayment: 25%
- Hospital (facility) coinsurance: 25%
- Other coinsurance: 25%

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:** $12,800

**In this example, Peg would pay:**

<table>
<thead>
<tr>
<th>Cost Sharing</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Deductibles</td>
<td>$6,000</td>
</tr>
<tr>
<td>Copayments</td>
<td>$0</td>
</tr>
<tr>
<td>Coinsurance</td>
<td>$550</td>
</tr>
</tbody>
</table>

**What isn’t covered**

- Limits or exclusions: $60

**The total Peg would pay is:** $6,610

### Managing Joe’s type 2 Diabetes
(a year of routine in-network care of a well-controlled condition)

- The plan’s overall deductible: $6,000
- Specialist copayment: 25%
- Hospital (facility) coinsurance: 25%
- Other coinsurance: 25%

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:** $7,400

**In this example, Joe would pay:**

<table>
<thead>
<tr>
<th>Cost Sharing</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Deductibles*</td>
<td>$6,000</td>
</tr>
<tr>
<td>Copayments</td>
<td>$250</td>
</tr>
<tr>
<td>Coinsurance</td>
<td>$0</td>
</tr>
</tbody>
</table>

**What isn’t covered**

- Limits or exclusions: $60

**The total Joe would pay is:** $6,310

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

- The plan’s overall deductible: $6,000
- Specialist copayment: 25%
- Hospital (facility) coinsurance: 25%
- Other coinsurance: 25%

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:** $1,900

**In this example, Mia would pay:**

<table>
<thead>
<tr>
<th>Cost Sharing</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Deductibles*</td>
<td>$1,900</td>
</tr>
<tr>
<td>Copayments</td>
<td>$0</td>
</tr>
<tr>
<td>Coinsurance</td>
<td>$0</td>
</tr>
</tbody>
</table>

**What isn’t covered**

- Limits or exclusions: $0

**The total Mia would pay is:** $1,900

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Note: These numbers assume the patient does not participate in the plan’s wellness program. If you participate in the plan’s wellness program, you may be able to reduce your costs. For more information about the wellness program, please contact: 1-800-400-7247 or visit us at www.pchp.net.

*Note: This plan has other deductibles for specific services included in this coverage example. See “Are there other deductibles for specific services?” row above.

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

Piedmont Community Health Plan, on behalf of itself and its affiliates (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 Health Plan
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).

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

 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 전화해주십시오.

 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）。

 توجه: إذا كنت تتحدث اللغة العربية، خدمات المساعدة اللغوية متوفرة لك بالمجان. اتصل برقم 7247-400-800-1.

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

 خبردار: اگر به زبان فارسی گفتگو می کنید، تسهیلات زبانی بصورت رایگان برای شما مقدرو نمی باشد. BA (TTY: 711).

 أريحين: فارسی

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

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

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


 বলা বলা: এর মাধ্যমে আপনি বাংলা, ক্ষত্রিয়া বলতে পারেন, তাহলে সিধান্তগত ভাষা সহায়তা পরিষেবা উপলব্ধ আছে। ফোন করুন ১-৮০০-৪০০-৭২৪৭ (TTY: 711)।

 Bàssì-wùàtù-po-nyɔ̀ (Bassa) Dè dë nià kr dyëdë gbo: Ó jù kë m [Bàssì-wùàtù-po-nyɔ̀] jù nì, nìì, à wùdù kà kò dò po-òò bëin m gbo kpáà. Dá 1-800-400-7247 (TTY:711)

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

 èdè Yorùbá (Yoruba) AKIYEBI: 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).