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, 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?	**$4,000** Individual / **$8,000** Family Unit In-Network **$8,000** Individual / **$16,000** 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/.
Are there other deductibles for specific services?	Yes. Prescription drugs – **$250** individual, **$500** family In-Network **$500** individual, **$1,000** family Out-of-Network There are no other specific deductibles. Rx deductible does not apply to Tier 1 and Tier 2 drugs.	You must pay all of the costs for these services up to the specific deductible amount before this plan begins to pay for these services.
What is the out-of-pocket limit for this plan?	For network providers **$9,100** Individual / **$18,200** Family Unit For out-of-network providers **$18,200** Individual / **$36,400** 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 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 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	$45 copay/office visit; 20% coinsurance for other outpatient services; deductible does not apply	50% coinsurance	Allergy Injections (excluding serum) are a $5 copay. Telemedicine is a $0 copay for MD Live Telehealth and a $40 copay for all other Telemedicine.
	Specialist visit	$70 copay/visit; deductible does not apply	50% coinsurance	Specialist Telemedicine is $65 copay
	Preventive care/screening/ immunization	$0 copay	50% coinsurance	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)	Included with office visit copayment	50% coinsurance	Diagnostic mammogram $100 copay copay. Outpatient Diagnostic Test – 20% coinsurance; Imaging – 20% coinsurance Outpatient Facility; 10% coinsurance Office/Free-Standing
	Imaging (CT/PET scans, MRIs)	20% coinsurance	50% coinsurance	
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)	$15 copay/retail $38 copay/mail order	$15 copay/retail, $38 copay/mail order. See limitations.	Copays are per prescription. Covers up to a 31-day or 120 unit supply (retail prescription); Covers up to a 90-day or 360 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 are Not Covered unless that pharmacy has previously agreed in writing to accept reimbursement at rates for In-Network retail pharmacies.
	Preferred brand drugs (Tier 2)	$45 copay/retail. $113 copay/mail order	$45 copay/retail, $113 copay/mail order. See limitations.	
	Non-preferred brand drugs (Tier 3)	25% coinsurance/retail/ mail order	25% coinsurance/ mail order. See limitations.	
	Specialty drugs - Preferred (Tier 4) (Specialty Drugs must be purchased from the Pharmacy Benefit Manager's Specialty Pharmacy)(Specialty Drugs are not available for mail order)	25% coinsurance/retail.	Not Available	

For more information about limitations and exceptions, see the plan or policy document at pchp.net.

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Common Medical Event	Services You May Need	What You Will Pay Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	Limitations, Exceptions, & Other Important Information
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	20% coinsurance	50% coinsurance	Preauthorization is required. If you don't get preauthorization, benefits are covered as out of network.
	Physician/surgeon fees	20% coinsurance	50% coinsurance	----------None----------
If you need immediate medical attention	Emergency room care	$350 copay	$350 copay	Urgent Care – deductible does not apply.
	Emergency medical transportation	20% coinsurance	20% coinsurance	
	Urgent care	$70 copay/visit	$70 copay/visit	
If you have a hospital stay	Facility fee (e.g., hospital room)	20% coinsurance	50% coinsurance	Preauthorization is required. If you don't get preauthorization, benefits are covered as out of network.
	Physician/surgeon fees	20% coinsurance	50% coinsurance	
If you need mental health, behavioral health, or substance abuse services	Outpatient services	$45 copay/office visit and 20% coinsurance for other outpatient services	50% coinsurance	Preauthorization required for any inpatient or outpatient facility services. If you don't get preauthorization, benefits are covered as out of network.
	Inpatient services	20% coinsurance	50% coinsurance	
If you are pregnant	Office visits	20% coinsurance	50% coinsurance	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	20% coinsurance	50% coinsurance	
	Childbirth/delivery facility services	20% coinsurance	50% coinsurance	
If you need help recovering or have other special health needs	Home health care	20% coinsurance	50% coinsurance	Limited to 100 visits/benefit year
	Rehabilitation services	$45 copay / office visit and 20% coinsurance for other outpatient services	50% coinsurance	Physical/Occupational therapy or Speech therapy limited to 30 visits/year each for rehabilitative or habilitative services.
	Habilitation services	$45 copay / office visit and 20% coinsurance for other outpatient services	50% coinsurance	
	Skilled nursing care	20% coinsurance	50% coinsurance	Limited to 100 visits/benefit year

* For more information about limitations and exceptions, see the plan or policy document at pchp.net.

	Durable medical equipment	20% **coinsurance**	50% **coinsurance**	**Preauthorization** requirement is based on CPT code.
	Hospice services	20% **coinsurance**	50% **coinsurance**	**Preauthorization** is required. If you don't get **preauthorization**, benefits are Not Covered.
If your child needs dental or eye care	Children's eye exam	No Charge	50% **coinsurance**	One routine eye exam per benefit year.
	Children's glasses	No Charge	50% **coinsurance**	One pair of standard single vision, bifocal, trifocal or progressive lenses and one standard frame from a limited collection per benefit year, or one pair of standard contact lenses from a limited collection per benefit 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)
- Bariatric Surgery
- Cosmetic Surgery
- Dental Care (Adult) (except for accidental injury)
- Glasses
- Hearing aids (Adult)
- Infertility Treatment
- Long Term Care
- Non-emergency care when traveling outside the U.S.
- 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 benefit year for rehabilitative or habilitative services)
- Habilitation services
- Private-duty nursing (limited to 16 hours per year)
- Acupuncture-Medically Necessary (20 visit limit per benefit year)
- Hearing Aids (children age 18 or younger)

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: Virginia Bureau of Insurance at 1-800-552-7945 or bureauofinsurance@scc.virginia.gov. You may also contact the U.S. Department of Labor, Employee Benefits Security Administration at 1-866-444-3272 or **www.dol.gov/ebsa/healthreform**, or the U.S. Department of Health and Human Services at 1-877-267-2323 x61565 or **www.cciio.cms.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 on how 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. **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 the 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).

Korean 주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 1-800-400-7247 (TTY: 1-877-295-1454)번으로 전화해 주십시오.

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** **$4,000**
- **Specialist copayment** **$70**
- **Hospital (facility) coinsurance** **30%**
- **Other coinsurance** **30%**

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	$4,000
Copayments	$10
Coinsurance	$2,100
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	**$6,170**

Managing Joe's Type 2 Diabetes

(a year of routine in-network care of a well-controlled condition)

- **The plan's overall deductible** **$4,000**
- **Specialist copayment** **$70**
- **Hospital (facility) coinsurance** **30%**
- **Other coinsurance** **30%**

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	$0
Copayments	$1,800
Coinsurance	$0
What isn't covered	
Limits or exclusions	$20
The total Joe would pay is	**$1,820**

Mia's Simple Fracture

(in-network emergency room visit and follow up care)

- **The plan's overall deductible** **$4,000**
- **Specialist copayment** **$70**
- **Hospital (facility) coinsurance** **30%**
- **Other coinsurance** **30%**

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	$0
Copayments	$1,700
Coinsurance	$800
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$2,500**

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

* For more information about limitations and exceptions, see the **plan** or policy document at **pchp.net**.

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).

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

PIEDMONT COMMUNITY HEALTH PLAN

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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 7247 -400-800-1 (TTY: 711) رقم هاتف الصم والبكم.

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).

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

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

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

ह िंदी (Hindi) ध्यान दें: यहद आप ह िंदी बोलते तो आपके ललए मफ्त में भाषा स ंायता सेवा िंए उपलब्ध । 1-800-400-7247 (TTY: 711) पर कॉल करें ।

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

বাাংলা (Bengali) লক্ষ্য করুনঃ যদি আদিন বাাংলা, কথা বলতে দ াতেন, তাতেল িনঃতেচায় ভাষা স াতংয়া দতি েষবা দিলব্ধ আতে। ফ ান করুন ১-800- 400- 7247 (TTY: 711)।

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

Igbo asusu (Ibo) Ige nti: Oburu 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).