

Policy – Schedule of Benefits – Individual/Family Piedmont Bronze 9100 LCS

Benefit Year Deductible Individual (Includes Medical and Prescription Drug Coverage) 1 \$9,100 Not Covered Family (Includes Medical and Prescription Drug Coverage) 1 \$18,200 Not Covered Benefit Year Out-of-Pocket Maximum Individual (Includes Medical and Prescription Drug Coverage) \$19,100 Not Covered Family (Includes Medical and Prescription Drug Coverage) \$18,200 Not Covered Family (Includes Medical and Prescription Drug Coverage) \$18,200 Not Covered Family (Includes Medical and Prescription Drug Coverage) \$18,200 Not Covered United Maximum Benefit	Medical Benefits	In-Network, You Pay:	Out-of-Network, You Pay:		
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Diagnostic Imaging Services and Tests (X-ray, Ultrasound, EKG, EEG, etc.) Advanced Imaging Services (CT Scan, CTA Scan, MRI, PET Scan, etc.) Maternity Care Routine Prenatal Visits Global Maternity Charge From OB/GYN O% Coinsurance After Deductible Not Covered					
Advanced Imaging Services (CT Scan, CTA Scan, MRI, PET Scan, etc.) Maternity Care Routine Prenatal Visits Solution Services (CT Scan, CTA Scan, MRI, PET Scan, etc.) Mot Covered Not Covered		0% Coinsurance After Deductible	Not Covered		
Maternity Care Routine Prenatal Visits \$0 Copayment Not Covered Global Maternity Charge From OB/GYN 0% Coinsurance After Deductible Not Covered Not Covered Not Covered Not Covered Not Covered		0% Coinsurance After Deductible Not Covered			
Maternity Care Routine Prenatal Visits \$0 Copayment Not Covered Global Maternity Charge From OB/GYN 0% Coinsurance After Deductible Not Covered Not Covered Not Covered Not Covered Not Covered		ON Coincurance After Deductible	Not Court		
Routine Prenatal Visits \$0 Copayment Not Covered Global Maternity Charge From OB/GYN 0% Coinsurance After Deductible Not Covered		0% Coinsurance After Deductible	Not Covered		
Routine Prenatal Visits \$0 Copayment Not Covered Global Maternity Charge From OB/GYN 0% Coinsurance After Deductible Not Covered	Maternity Care				
Global Maternity Charge From OB/GYN 0% Coinsurance After Deductible Not Covered		\$0 Copayment	Not Covered		
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Medical Benefits	In-Network, You Pay:	Out-of-Network, You Pay:		
Vision Services				
Adult Vision (Annual Routine Eye Examination)	Not Covered			
Pediatric Vision ⁴	\$0 Copayment	Not Covered		
Nursing Facility, Hospice, Home Health Care, Therapy, and Other				
Skilled Nursing Facility Care (Limit of 100 Days per Admission)	0% Coinsurance After Deductible	Not Covered		
Hospice				
Home Health Care (Limit of 100 Visits per Benefit Year)	0% Coinsurance After Deductible	Not Covered		
Private Duty Nursing (Limit of 16 Hours per Benefit Year)				
Speech Therapy Office Visits ⁵	0% Coinsurance After Deductible	Not Covered		
Physical/Occupational Therapy Office Visits ⁵	0% Coinsurance After Deductible	Not Covered		
Chiropractic/Osteopathic/Manipulation Therapy ⁵	0% Coinsurance After Deductible Not Covered			
Rehabilitative/Habilitative Services - Inpatient/Outpatient Facility ⁵	0% Coinsurance After Deductible Not Covered			
Durable Medical Equipment	0% Coinsurance After Deductible Not Covered			
Prosthetic Devices/Services	0% Coinsurance After Deductible Not Covered			

Prescription Drug Benefits ⁶ (Out-of-Network Not Covered)	Retail/30-Day, You Pay:	Mail/90-Day, You Pay:
ACA Preventive Drugs	\$0 Copayment	\$0 Copayment
Tier 1 - Generic	0% Coinsurance After Deductible	0% Coinsurance After Deductible
Tier 2 - Preferred Brand Name ⁷	0% Coinsurance After Deductible	0% Coinsurance After Deductible
Tier 3 - Non-Preferred Brand Name 8	0% Coinsurance After Deductible	0% Coinsurance After Deductible
Tier 4 - Specialty	0% Coinsurance After Deductible	0% Coinsurance After Deductible

¹ Copayments do not count toward Your Benefit Year Deductible but do count toward Your Benefit Year Out-of-Pocket Maximum.

Please 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. Pediatric Dental benefits are NOT included in this plan; they are available separately on or off the Exchange.
- When preauthorization is the responsibility of an In-Network Provider, any reduction or denial of benefits for not obtaining a preauthorization should not affect the Insured.
- There is no cost sharing on any item or service that is an Essential Health Benefit furnished directly by the Indian Health Services, an Indian Tribe, Tribal Organization, or Urban Indian Organization, or through referral under contract health services.

² Amounts will accumulate for each family member until the Family Benefit Year Deductible amount is met. However, no individual family member will pay more than the Individual Benefit Year Deductible amount shown.

³ Amounts will accumulate for each family member until the Family Benefit Year Out-of-Pocket Maximum amount is met. However, no individual family member will pay more than the Individual Benefit Year Out-of-Pocket Maximum shown.

⁴ Coverage includes one routine eye exam per Benefit Year. Also covered, is 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. Coverage is only provided up to the end of the month the participant turns 19 years of age.

⁵ Limited to 30 visits for rehabilitative services and 30 visits for habilitative services. For more information on the visit limit for rehabilitative and habilitative services, please refer to the Rehabilitative and Habilitative Services subsection of Your Evidence of Coverage, located within Section V: What is Covered.

⁶ Outpatient Prescription Drugs, including Specialty Drugs, must be purchased from In-Network pharmacies, unless an Out-of-Network pharmacy or its intermediary has sent previous notification to Piedmont or the Pharmacy Benefit Manager (PBM) of its agreement to accept reimbursement for its services at rates applicable to participating In-Network pharmacies. You will only be required to make any copayment or other applicable charge that is consistently imposed for In-Network pharmacies. Also, generic contraceptive drugs and contraceptive drugs for which there is no generic equivalent are covered at 100% under Preventive Care.

⁷ Tier 2 insulin drug copayment will not exceed \$35 for a 30-day supply.

⁸ Tier 3 insulin drug copayment will not exceed \$50 for a 30-day supply.