PIEDMONT
COMMUNITY HEALTHCARE HMO, INC.

Policy – Schedule of Benefits – Individual/Family

Piedmont Bronze 5500 HSA OFF

Medical Benefits	In-Network, You Pay:	Out-of-Network, You Pay:
Benefit Year Deductible		
Individual (Includes Medical and Prescription Drug Coverage) [1]	$5,500	Not Covered
Family (Includes Medical and Prescription Drug Coverage) [1, 2]	$11,000	Not Covered
Benefit Year Out-of-Pocket Maximum		
Individual (Includes Medical and Prescription Drug Coverage)	$7,200	Not Covered
Family (Includes Medical and Prescription Drug Coverage) [3]	$14,400	Not Covered
Lifetime Maximum Benefit	No Lifetime Max	
Office Visits		
Preferred Telemedicine Provider	35% Coinsurance After Deductible	Not Covered
Primary Care - In Office/Telemedicine (Family, General, Internal Medicine, and Pediatric Physicians)	35% Coinsurance After Deductible	Not Covered
Mental Health/Substance Use Disorder In Office/Telemedicine	35% Coinsurance After Deductible	Not Covered
Specialist - In Office/Telemedicine (Includes All Other Physicians and Professionals)	35% Coinsurance After Deductible	Not Covered
Other Services Performed in Office (Including, but not limited to diagnostic imaging, labs, tests, and surgery.)	35% Coinsurance After Deductible	Not Covered
Allergy Injections	35% Coinsurance After Deductible	Not Covered
Preventive Care		
Routine Annual Physical Exams (Includes Testing)	$0 Copayment	Not Covered
Well Baby and Child Exams		
Women's Preventive Services		
Adult and Childhood Immunizations		
Screening Colonoscopy/Screening Mammogram		
Other Patient Protection and Affordable Care Act (ACA) Covered Preventive Care Services		
Hospital, Emergency Room, Urgent Care, and Ambulance Services		
Hospital/Facility Inpatient	35% Coinsurance After Deductible	Not Covered
Hospital/Facility Outpatient	35% Coinsurance After Deductible	Not Covered
Mental Health/Substance Use Disorder (Inpatient/Outpatient/Partial Day)	35% Coinsurance After Deductible	Not Covered
Medical/Surgical Expenses	35% Coinsurance After Deductible	Not Covered
Urgent Care	35% Coinsurance After Deductible	
Ambulance Service	35% Coinsurance After Deductible	
Emergency Room Services (Including Professional Services)	50% Coinsurance After Deductible	
Diagnostic, Imaging, and Testing Procedures		
Diagnostic Colonoscopy	35% Coinsurance After Deductible	Not Covered
Diagnostic Mammogram (To Examine Abnormalities)	35% Coinsurance After Deductible	Not Covered
Diagnostic Imaging Services and Tests (X-ray, Ultrasound, EKG, EEG, etc.)	35% Coinsurance After Deductible	Not Covered
Advanced Imaging Services (CT Scan, CTA Scan, MRI, PET Scan, etc.)	50% Coinsurance After Deductible	Not Covered
Maternity Care		
Routine Prenatal Visits	$0 Copayment	Not Covered
Global Maternity Charge From OB/GYN	35% Coinsurance After Deductible	Not Covered
Inpatient and Facility Charges	35% Coinsurance After Deductible	Not Covered

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)	35% Coinsurance After Deductible	Not Covered
Hospice	35% Coinsurance After Deductible	Not Covered
Home Health Care (Limit of 100 Visits per Benefit Year)		
Private Duty Nursing (Limit of 16 Hours per Benefit Year)		
Speech Therapy Office Visits [5]	35% Coinsurance After Deductible	Not Covered
Physical/Occupational Therapy Office Visits [5]	35% Coinsurance After Deductible	Not Covered
Chiropractic/Osteopathic/Manipulation Therapy [5]	35% Coinsurance After Deductible	Not Covered
Rehabilitative/Habilitative Services - Inpatient/Outpatient Facility [5]	35% Coinsurance After Deductible	Not Covered
Durable Medical Equipment	35% Coinsurance After Deductible	Not Covered
Prosthetic Devices/Services	30% 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	35% Coinsurance After Deductible	35% Coinsurance After Deductible
Tier 2 - Preferred Brand Name [7]	35% Coinsurance After Deductible	35% Coinsurance After Deductible
Tier 3 - Non-Preferred Brand Name [8]	50% Coinsurance After Deductible	50% Coinsurance After Deductible
Tier 4 - Specialty	50% Coinsurance After Deductible	50% Coinsurance After Deductible

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

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.