PIEDMONT
COMMUNITY HEALTHCARE HMO, INC.

# Policy – Schedule of Benefits – Individual/Family

## Piedmont Bronze 5500 HSA

| 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.