PIEDMONT
COMMUNITY HEALTHCARE HMO, INC.

Policy – Schedule of Benefits – Individual/Family

Piedmont Bronze 5500 ZCS

Medical Benefits	In-Network, You Pay:	Out-of-Network, You Pay:
Benefit Year Deductible		
Individual (Includes Medical and Prescription Drug Coverage)	$0	Not Covered
Family (Includes Medical and Prescription Drug Coverage)	$0	Not Covered
Benefit Year Out-of-Pocket Maximum		
Individual (Includes Medical and Prescription Drug Coverage)	$0	Not Covered
Family (Includes Medical and Prescription Drug Coverage)	$0	Not Covered
Lifetime Maximum Benefit	No Lifetime Max	
Office Visits		
Preferred Telemedicine Provider	$0 Copayment	Not Covered
Primary Care - In Office/Telemedicine (Family, General, Internal Medicine, and Pediatric Physicians)	$0 Copayment	Not Covered
Mental Health/Substance Use Disorder In Office/Telemedicine	$0 Copayment	Not Covered
Specialist - In Office/Telemedicine (Includes All Other Physicians and Professionals)	$0 Copayment	Not Covered
Other Services Performed in Office (Including, but not limited to diagnostic imaging, labs, tests, and surgery.)	0% Coinsurance	Not Covered
Allergy Injections	0% Coinsurance	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	$0 Copayment	Not Covered
Hospital/Facility Outpatient	$0 Copayment	Not Covered
Mental Health/Substance Use Disorder (Inpatient/Outpatient/Partial Day)	0% Coinsurance	Not Covered
Medical/Surgical Expenses	0% Coinsurance	Not Covered
Urgent Care	$0 Copayment	
Ambulance Service	0% Coinsurance	
Emergency Room Services (Including Professional Services)	$0 Copayment	
Diagnostic, Imaging, and Testing Procedures		
Diagnostic Colonoscopy	$0 Copayment	Not Covered
Diagnostic Mammogram (To Examine Abnormalities)	$0 Copayment	Not Covered
Diagnostic Imaging Services and Tests (X-ray, Ultrasound, EKG, EEG, etc.)	$0 Copayment	Not Covered
Advanced Imaging Services (CT Scan, CTA Scan, MRI, PET Scan, etc.)	$0 Copayment	Not Covered
Maternity Care		
Routine Prenatal Visits	$0 Copayment	Not Covered
Global Maternity Charge From OB/GYN	0% Coinsurance	Not Covered
Inpatient and Facility Charges	0% Coinsurance	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 [1]	$0 Copayment	Not Covered
Nursing Facility, Hospice, Home Health Care, Therapy, and Other		
Skilled Nursing Facility Care (Limit of 100 Days per Admission)	$0 Copayment	Not Covered
Hospice	0% Coinsurance	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 [2]	$0 Copayment	Not Covered
Physical/Occupational Therapy Office Visits [2]	$0 Copayment	Not Covered
Chiropractic/Osteopathic/Manipulation Therapy [2]	0% Coinsurance	Not Covered
Rehabilitative/Habilitative Services - Inpatient/Outpatient Facility [2]	0% Coinsurance	Not Covered
Durable Medical Equipment	$0 Copayment	Not Covered
Prosthetic Devices/Services	$0 Copayment	Not Covered

Prescription Drug Benefits [3] (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 Copayment	$0 Copayment
Tier 2 - Preferred Brand Name	$0 Copayment	$0 Copayment
Tier 3 - Non-Preferred Brand Name	$0 Copayment	$0 Copayment
Tier 4 - Specialty	$0 Copayment	$0 Copayment

[1] 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.

[2] 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.

[3] 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.