



LocalSelect Piedmont HSA Plans (Non-Grandfathered)							
		Piedmont HSA Preferred 1500/25 *		Piedmont HSA Preferred 2500/25 **		Piedmont HSA Preferred 3500/30 **	
		Piedmont HSA Complete 3000/30 **		Piedmont HSA Complete 5000/30 **			
Basics	Deductible - Individual In-Network	\$1,500	\$2,500	\$3,500	\$3,000	\$5,000	
	Deductible - Individual Out-of-Network	\$3,000	\$6,000	\$6,000	\$6,000	\$8,000	
	Deductible - Family In-Network	\$3,000	\$5,000	\$7,000	\$6,000	\$10,000	
	Deductible - Family Out-of-Network	\$6,000	\$12,000	\$12,000	\$12,000	\$16,000	
	Coinsurance - In-Network (%)	80/20	80/20	80/20	100/0	100/0	
	Coinsurance - Out-of-Network (%)	60/40	60/40	60/40	60/40	60/40	
	Maximum Out-of-Pocket - Individual In-Network	\$3,000	\$4,500	\$5,000	\$3,000	\$5,000	
	Maximum Out-of-Pocket - Family In-Network	\$6,000	\$9,000	\$10,000	\$6,000	\$10,000	
No Deductible Applies	Preventive Care Copays						
	Routine Physical Exams (including testing)	\$0	\$0	\$0	\$0	\$0	
	Annual GYN Exams	\$0	\$0	\$0	\$0	\$0	
	Routine Well-Child Care	\$0	\$0	\$0	\$0	\$0	
	Child and Adult Immunizations	\$0	\$0	\$0	\$0	\$0	
	Screening Mammogram / Screening Colonoscopy	\$0	\$0	\$0	\$0	\$0	
Other PPACA covered Preventive Care Services	\$0	\$0	\$0	\$0	\$0		
Once Deductible Is Met	Office Visits						
	PCP	20%	20%	20%	0%	0%	
	Mental Health / Substance Abuse	20%	20%	20%	0%	0%	
	Specialist	20%	20%	20%	0%	0%	
	Other Services Performed in Office	20%	20%	20%	0%	0%	
	Routine Allergy Injections	20%	20%	20%	0%	0%	
	Diagnostic Mammogram (to examine abnormalities)	20%	20%	20%	0%	0%	
	Maternity Care - Outpatient pre and postnatal Office Visits	20%	20%	20%	0%	0%	
	Maternity Care - Routine Lab/Diagnostic Tests	20%	20%	20%	0%	0%	
	Maternity Care - Inpatient Services/Delivery	20%	20%	20%	0%	0%	
	Emergency Room Services	20%	20%	20%	0%	0%	
	Hospital Expenses - Inpatient/Outpatient/Facility Testing	20%	20%	20%	0%	0%	
	Medical/Surgical Expenses	20%	20%	20%	0%	0%	
	Durable Medical Equipment (\$2000 Limit)	20%	20%	20%	0%	0%	
	Ground Ambulance (\$3000 Limit)	20%	20%	20%	0%	0%	
	Mental Health/Substance Abuse						
	Hospital - Inpatient/Outpatient/Partial Day Visits	20%	20%	20%	0%	0%	
Skilled Nursing Facility Care (100 day limit)	20%	20%	20%	0%	0%		
Home Health Care (90 day limit)	20%	20%	20%	0%	0%		
Hospice	20%	20%	20%	0%	0%		
Pharmacy	Once Deductible is Met						
	Retail	Mail Order (90-day supply)					
			Complete				 PIEDMONT COMMUNITY HEALTH PLAN
	\$15/\$30	\$30/\$60	Preferred				

* Aggregate Family Deductible and Out-of-Pocket Maximum
 ** Embedded Family Deductible and Out-of-Pocket Maximum

This is only a brief description of benefits for comparison purposes only. A complete description is provided through the appropriate Certificate of Coverage, Schedule of Benefits, and any Amendments to the policy.