SMITH HULSEY & BUSEY HEALTH BENEFIT PLAN **EPO Plan**
Medical Summary of Benefits **Effective July 1, 2020**

Refer to the Plan Document and Summary Plan Description for details of Coverage.

EPO Plan Benefits	CIGNA PPO Providers www.Cigna.com
Member Calendar Year Deductible	Benefits are not subject to a Calendar Year deductible.
Member Out-of-Pocket Maximum Once the Out-of-Pocket Maximum has been satisfied, no further medical plan copayments will apply for remainder of Calendar Year.	$4,000 per Individual / $8,000 per Family (accumulative) Out-of-Pocket expenses include medical plan Copayments. Prescription Drug Copayments, non-covered expenses, charges in excess of Reasonable & Customary charges & Pre-certification penalties DO NOT apply toward the Out-of-Pocket Maximum. Since Prescription Drug Copayments do not apply towards the Out-of-Pocket Maximum, they will continue to apply once the Out-of-Pocket Maximum has been met for the Calendar Year.
Lifetime Maximum Benefit	Unlimited.
Alcohol & Substance Abuse Treatment	**Inpatient Hospitalization:** 100% of covered expenses following $250 per day Inpatient Hospital Copayment; maximum expense of 5 (five) daily Copayments per confinement**.** **Outpatient Services:** 100% of covered expenses following $45 Copayment per visit.
Allergy Services	**Primary Care Physician Services:** 100% of covered expenses following $45 Copayment. **Specialist Services:** 100% of covered expenses following $75 Copayment. Note: Copayment will not apply if the PCP/Specialist does not bill the Plan for an office visit charge.
Ambulance Services	100% of covered expenses following $75 Copayment.
Birthing Center	100% of covered expenses following $250 per day Inpatient Hospital copayment; maximum expense of 5 (five) daily Copayments per confinement.
Colonoscopy Services	100% of covered expenses following $300 Copayment. Includes Routine / Diagnostic Colonoscopy Services.
Durable Medical Equipment	100% of covered expenses following $75 Copayment.
Emergency Room Services	100% of covered expenses following $500 Copayment per visit to Emergency Room. Copayment will be waived if patient is admitted into hospital directly from the Emergency Room.
Extended Care Facility	100% of covered expenses following $250 per day Inpatient Hospital Copayment; maximum expense of 5 (five) daily Copayments per confinement. Includes Rehabilitation Facility & Skilled Nursing Facility.
Home Health Care	100% of covered expenses following a $75 Copayment per Home Health Care visit.
Hospice Care	100% of covered expenses following $75 Copayment per visit. Includes Bereavement Counseling.
Inpatient Hospital Services	100% of covered expenses following $250 per day Inpatient Hospital Copayment; maximum expense of 5 (five) daily Copayments per confinement. Does not Include Physician Services.
Maternity Care	Initial diagnosis, office visit and global maternity charge is payable at 100% following $45 Copayment. Refer to Inpatient Hospital Services and Birthing Center benefit for services payable in connection with delivery. Dependent daughters covered for complications only.
Mental Health Services	**Inpatient Hospitalization:** 100% of covered expenses following a $250 per day Inpatient Hospital Copayment; maximum expense of 5 (five) daily Copayments per confinement. **Outpatient Services:** 100% of covered expenses following $45 Copayment per visit.
Outpatient Physician Office Visit Services / Inpatient Hospital Physician Visit	**Teladoc Visit:** $0 Member Copayment **Primary Care Physician Services:** 100% of covered expenses following $45 Copayment.* **Specialist Services:** 100% of covered expenses following $75 Copayment. *PCP= Internal Medicine, Family Practice, Pediatrics & Gynecology Note: Copayment will not apply if PCP/Specialist does not bill the Plan for office visit charge.
Outpatient Private Duty Nursing	100% of covered expenses following $75 Copayment per visit.
Outpatient Surgery	100% of covered expenses following $300 Copayment.
Outpatient X-Ray, Laboratory & Diagnostic Services	▪ Laboratory Services performed at free-standing lab: 100% of covered expenses. ▪ X-ray's (minor) performed at imaging center: 100% of covered expenses after $75 Copayment. ▪ Cat Scan, MRI, PET Scan (regardless where test is performed) and Lab or X-ray Services performed at a hospital: 100% of covered expenses following $200 Copayment per procedure.
Pre-Certification Requirements	**Pre-admission Certification is required for the following services:** Hospitalizations; Home Health Care; Durable Medical Equipment (over $500) MRI/CAT Scans; Hospice Care; Outpatient Surgical procedures (outside of a Physician's office) Extended Care Facility; Psychological Testing Dialysis; Cardiac Rehabilitation Emergency admissions must be approved within 48 hours. Failure to comply will reduce all eligible charges by the lesser of $2,500.00 or 50%.

EPO Plan Benefits	CIGNA PPO Providers www.Cigna.com	
Prescription Drug Benefits Retail Prescriptions (30 day supply maximum) Mail Order Prescriptions (Maintenance medications only; 90 day supply maximum)	**Retail Network Pharmacy:** ▪ Generic drugs: $20 Copayment ▪ Brand name drugs with NO Generic equivalent: $50 Copayment ▪ Brand name drugs with Generic equivalent: $75 Copayment **Mail Order Prescriptions:** ▪ Generic drugs: $40 Copayment ▪ Brand name drugs with NO Generic equivalent: $100 Copayment ▪ Brand name drugs with Generic equivalent: $150 Copayment **Specialty Pharmacy Program** (for certain high-cost drugs) 100% of covered expenses.	Prescriptions purchased from Non-Participating pharmacies or outside of prescription drug program are not eligible for reimbursement through the Plan.
Prosthetics / Orthotics	100% of covered expenses following $75 Copayment.	
Routine Well Adult Care (Age 17 and above) *Annual hearing and vision examination is for an annual examination only and does not include hearing aids, glasses, contact lenses or other related hardware.	100% of covered expenses; not subject to an office visit copayment. This routine benefit includes physician charges and related laboratory charges for annual routine preventive examinations and the preventive services outlined below: ▪ Immunizations. ▪ Annual hearing and vision examination.* ▪ Fasting lipoprotein profile (cholesterol screening). ▪ Annual Prostate Specific Antigen (PSA) screening. ▪ Fasting blood sugar screening (for diabetes mellitus). ▪ Bone Mineral Density (BMD) screening (once every 24 months for postmenopausal women). ▪ Blood pressure screening. ▪ Annual colorectal screening. ▪ Annual mammogram screening. ▪ Annual pelvic exam and Pap test. ▪ EKG.	
Routine Well Child Care (Birth through age 16)	100% of covered expenses; not subject to an office visit Copayment. Includes Office Visit charges, immunizations, laboratory blood tests & routine vision & hearing screenings.	
Second and Third Surgical Opinion	If required by the Medical Coordinator through the Utilization Review process, Benefits shall be payable at 100% of eligible charges.	
Spinal Manipulation	100% of covered expenses following $75 Copayment. Calendar Year maximum benefit of 31 visits.	
Therapy Services	100% of covered expenses following $45 Copayment for Physical Therapy, Occupational Therapy and Speech Therapy. Multiple therapy services performed by the same provider on the same date of service shall be subject to one Copayment. Neuromuscular Therapy is payable at 100% following $25 Copayment and is limited to 15 visits per Calendar Year.	
TMJ / Jaw Joint Services	100% of covered expenses following the applicable Copayment based upon type of service rendered. Benefits are not available when services are rendered by a Dentist.	
Transplant Benefit	100% of covered expenses following applicable Copayment based on type of service rendered.	
Urgent Care Facility Services	**Primary Care Physician Services:** 100% of covered expenses following $45 Copayment. **Specialist Services:** 100% of covered expenses following $75 Copayment. Refer to Emergency Room benefit for services rendered in Emergency Room at a hospital.	
Wig After Chemotherapy	100% of covered expenses following $75 Copayment.	
All Other Covered Medical Expenses	100% of covered expenses following the applicable copayment based upon the type of service rendered.	

Out-of-Area Benefits are available through the Plan and shall be payable at the PPO Provider level.

Questions regarding Coverage and Benefits should be directed to:

Preferred Benefit Administrators, Inc.,
PO Box 916188, Longwood, FL 32791-6188
Toll Free 888-524-2777
www.PreferredTPA.com

Important Notice to Plan All Participants

This group health plan believes this plan is a "grandfathered health plan" under the Patient Protection and Affordable Care Act (the Affordable Care Act). As permitted by the Affordable Care Act, a grandfathered health plan can preserve certain basic health coverage that was already in effect when that law was enacted. Being a grandfathered health plan means that your plan may not include certain consumer protections of the Affordable Care Act that apply to other plans, for example, the requirement for the provision of preventive health services without any cost sharing. However, grandfathered health plans must comply with certain other consumer protections in the Affordable Care Act, for example, the elimination of lifetime limits on benefits.

Questions regarding which protections apply and which protections do not apply to a grandfathered health plan and what might cause a plan to change from grandfathered health plan status can be directed to our Claims Administrator:

Preferred Benefit Administrators, Inc.
PO Box 916188, Longwood, FL 32791-6188
(407)786-2777 or (888)524-2777

You may also contact the Employee Benefits Security Administration, U.S. Department of Labor at 1-866-444-3272 or www.dol.gov/ebsa/healthreform. This website has a table summarizing which protections do and do not apply to grandfathered health plans.