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

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

Gold Plan Benefits	CIGNA PPO Providers www.Cigna.com	Non-PPO Providers
Member Calendar Year Deductible	$1,000 per individual $3,000 per family (accumulative)	$2,000 per individual $4,000 per family (accumulative)
	Calendar Year deductible does not include Prescription Drug Copayments, non-covered expenses or pre-certification penalties. PPO and Non-PPO deductibles shall combine together.	
Plan Coinsurance	80% of covered expenses after Calendar Year deductible is satisfied.	70% of covered expenses after Calendar Year deductible is satisfied.
Member Out-of-Pocket Maximum PPO and Non-PPO Out-of-Pocket Maximums shall combine together.	$4,000 per individual $8,000 per family (accumulative)	$6,000 per individual $9,000 per family (accumulative)
	Out-of-pocket expenses include the Calendar Year deductible and Coinsurance. 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.	
Lifetime Maximum Benefit	Unlimited.	
Alcohol & Substance Abuse Treatment	Inpatient Hospitalization and Outpatient Services: 80% Coinsurance; subject to Calendar Year deductible.	Inpatient Hospitalization and Outpatient Services:70% Coinsurance; subject to Calendar Year deductible.
Allergy Services	80% Coinsurance; subject to Calendar Year deductible.	70% Coinsurance; subject to Calendar Year deductible.
Ambulance Services	80% Coinsurance; subject to Calendar Year deductible.	70% Coinsurance; subject to Calendar Year deductible.
Birthing Center	80% Coinsurance; subject to Calendar Year deductible.	70% Coinsurance; subject to Calendar Year deductible.
Colonoscopy Services	80% Coinsurance; subject to Calendar Year deductible.	70% Coinsurance; subject to Calendar Year deductible.
	Includes Routine and/or Diagnostic Colonoscopy Services.	
Durable Medical Equipment	80% Coinsurance; subject to Calendar Year deductible.	70% Coinsurance; subject to Calendar Year deductible.
Emergency Room Services	80% Coinsurance; subject to the Calendar Year deductible.	70% Coinsurance following $25 per visit Emergency Room Copayment*; subject to the Calendar Year deductible.
	*Emergency Room copayment will be waived if patient is admitted into hospital from emergency room.	
Extended Care Facility	80% of facility's semiprivate room rate; subject to the Calendar Year deductible.	70% of facility's semiprivate room rate; subject to Calendar Year deductible.
	Includes Rehabilitation Facility & Skilled Nursing Facility.	
Home Health Care	80% Coinsurance; subject to Calendar Year deductible.	70% Coinsurance; subject to Calendar Year deductible.
Hospice Care Includes Bereavement Counseling	80% Coinsurance; subject to Calendar Year deductible.	70% Coinsurance; subject to Calendar Year deductible.
Inpatient Hospital Services Does not include Physician Services	80% of facility's Semiprivate Room Rate; subject to Calendar Year deductible.	70% of facility's Semiprivate Room Rate following a $100 inpatient admission deductible; subject to Calendar Year deductible. No more than 3 (three) inpatient admission deductibles shall apply per Calendar Year.
Maternity Care Dependent daughters covered for complications only	80% Coinsurance; subject to Calendar Year deductible.	70% Coinsurance; subject to Calendar Year deductible.
	Refer to Inpatient Hospital Services for benefits payable in connection with delivery in a Hospital.	
Mental Health Services	Inpatient Hospitalization and Outpatient Services: 80% Coinsurance; subject to Calendar Year deductible.	Inpatient Hospitalization and Outpatient Services: 70% Coinsurance; subject to Calendar Year deductible.
Outpatient Physician Office Visit Services / Inpatient Hospital Physician Visit	**Teladoc Visit:** $0 Member Copayment **All other Physician Visits:** 80% Coinsurance; subject to Calendar Year deductible.	70% Coinsurance; subject to Calendar Year deductible.

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Outpatient Private Duty Nursing	80% Coinsurance; subject to Calendar Year deductible.	70% Coinsurance; subject to Calendar Year deductible.
Outpatient Surgery	80% Coinsurance; subject to Calendar Year deductible.	70% Coinsurance; subject to Calendar Year deductible.
Outpatient X-Ray, Laboratory & Diagnostic Services	80% Coinsurance; subject to Calendar Year deductible.	70% Coinsurance; subject to Calendar Year deductible.
Pre-Admission Testing	100% of covered expenses; not subject to Calendar Year deductible. Pre-admission Testing must occur on outpatient basis within 7 (seven) days of inpatient hospital confinement to be payable under this benefit.	
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%.	
Prescription Drug Benefits Retail Prescriptions (30 day supply maximum) Mail Order Prescriptions (For 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) 80% of covered expenses; subject to Calendar Year deductible.	Prescriptions purchased from Non-Participating pharmacies or outside of the prescription drug program are not eligible for reimbursement through the Plan.
Prosthetics / Orthotics	90% Coinsurance; subject to Calendar Year deductible.	80% Coinsurance; subject to Calendar Year deductible.
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 eligible charges; not subject to the Calendar Year deductible.	
	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 eligible charges; not subject to the Calendar Year deductible. 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; not subject to the Calendar Year deductible.	
Spinal Manipulation	80% Coinsurance; subject to Calendar Year deductible and benefit maximum.	70% Coinsurance; subject to Calendar Year deductible and benefit maximum.
	Calendar Year maximum benefit of 31 visits.	
Therapy Services	80% Coinsurance; subject to Calendar Year deductible.	70% Coinsurance; subject to Calendar Year deductible.
	Benefits shall be payable for Physical Therapy, Speech Therapy and Occupational Therapy. Neuromuscular Therapy is limited to 15 visits per Calendar Year.	
TMJ / Jaw Joint Services (Excluded if rendered by Dentist)	80% Coinsurance; subject to Calendar Year deductible.	70% Coinsurance; subject to Calendar Year deductible.
Transplant Benefit	80% Coinsurance; subject to Calendar Year deductible.	70% Coinsurance; subject to Calendar Year deductible.
Urgent Care Facility Services	80% Coinsurance; subject to Calendar Year deductible.	70% Coinsurance; subject to Calendar Year deductible.
	Refer to Emergency Room benefit for services rendered in Emergency room department of hospital.	
All Other Covered Medical Expenses	80% Coinsurance; subject to Calendar Year deductible.	70% Coinsurance; subject to Calendar Year deductible.

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

407-786-2777 or 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.