SMITH HULSEY & BUSEY HEALTH BENEFIT PLAN **High Deductible Health Plan (HDHP)**
Medical Summary of Benefits **Effective July 1, 2020**

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

HDHP Benefits	CIGNA PPO Providers www.Cigna.com
Member Calendar Year Deductible	**$3,000 per individual / $6,000 per family (accumulative)** **Note:** The individual deductible applies to employees enrolling for single coverage. The Family deductible applies to Employees enrolling family members and must be met in full before any claims are payable. The total Family deductible may be met from claims by one or more enrolled family member.
Member Out-of-Pocket Maximum Once the Out-of-Pocket Maximum has been satisfied, no further medical plan copayments or prescription drug copayments will apply for the remainder of the Calendar Year.	**$4,000 per individual / $8,000 per family (accumulative)** Out-of-pocket expenses include the Calendar Year deductible, medical plan copayments and 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. **Note:** The individual Out-of-Pocket maximum applies to employees enrolling for single coverage. The Family Out-of-Pocket maximum applies to Employees enrolling family members and must be met in full before the Out-of-Pocket maximum is satisfied. The total Family Out-of-Pocket may be met from claims by one or more enrolled family member.
Lifetime Maximum Benefit	Unlimited.
Alcohol & Substance Abuse Treatment	**Inpatient Hospitalization:** After satisfying the Calendar Year deductible the Plan will pay 100% of covered expenses following $250 per day Inpatient Hospital copayment; maximum expense of 5 (five) daily Copayments per confinement**.** **Outpatient Services:** After satisfying the Calendar Year deductible the Plan will pay 100% of covered expenses following $45 Copayment per visit once the Calendar Year deductible has been satisfied.
Allergy Services	**Primary Care Physician Services:** After satisfying the Calendar Year deductible the Plan will pay 100% of covered expenses following $45 Copayment. **Specialist Services:** After satisfying the Calendar Year deductible the Plan will pay 100% of covered expenses following $75 Copayment. Note: After satisfying the Calendar Year deductible, a Copayment will not apply if the PCP/Specialist does not bill the Plan for an office visit charge.
Ambulance Services	After satisfying the Calendar Year deductible the Plan will pay 100% of covered expenses following $75 Copayment.
Birthing Center	After satisfying the Calendar Year deductible the Plan will pay 100% of covered expenses following $250 per day Inpatient Hospital Copayment; maximum expense of 5 daily Copayments per confinement.
Colonoscopy Services	After satisfying the Calendar Year deductible the Plan will pay 100% of covered expenses following $300 Copayment. Includes Routine and Diagnostic Colonoscopy services.
Durable Medical Equipment	After satisfying the Calendar Year deductible the Plan will pay 100% of covered expenses following $75 copayment.
Emergency Room Services	After satisfying the Calendar Year deductible the Plan will pay 100% of covered expenses following $500 Copayment per visit to the Emergency Room. Note: Emergency Room Copayment will be waived if the patient is admitted into the hospital from the emergency room.
Extended Care Facility	After satisfying the Calendar Year deductible the Plan will pay 100% of covered expenses following $250 per day Inpatient Hospital Copayment; maximum expense of 5 daily copayments per confinement. Includes Rehabilitation Facility & Skilled Nursing Facility.
Home Health Care	After satisfying the Calendar Year deductible the Plan will pay 100% of covered expenses following a $75 Copayment per Home Health Care visit.
Hospice Care	After satisfying the Calendar Year deductible the Plan will pay 100% of covered expenses following $75 Copayment per visit. Includes Bereavement Counseling.
Inpatient Hospital Services Does not include Physician Services	After satisfying the Calendar Year deductible the Plan will pay 100% of covered expenses following a $250 per day Inpatient Hospital copayment; maximum expense of 5 (five) daily Copayments per confinement.
Maternity Care Dependent daughters covered for complications only	Initial diagnosis, office visit and global maternity charge is payable at 100% following a $45 Copayment once the Calendar Year Deductible has been satisfied. Refer to Inpatient Hospital Services and Birthing Center Services for benefits payable in connection with delivery.

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Mental Health Services	**Inpatient Hospitalization:** After satisfying the Calendar Year deductible the Plan will pay 100% of covered expenses following $250 per day Inpatient Hospital copayment; maximum expense of 5 (five) daily Copayments per confinement. **Outpatient Services:** After satisfying the Calendar Year deductible the Plan will pay 100% of covered expenses following $45 Copayment per visit.
Outpatient Physician Office Visit Services / Inpatient Hospital Physician Visit	**Teladoc Visit:** $0 Member Copayment; not subject to Calendar Year deductible. **Primary Care Physician Services*:** After satisfying the Calendar Year deductible the Plan will pay 100% of covered expenses following 45 Copayment. **Specialist Services:** After satisfying the Calendar Year deductible the Plan will pay 100% of covered expenses following $75 Copayment. *PCP= Internal Medicine, Family Practice, Pediatrics & Gynecology Note: After satisfying the Calendar Year deductible, Copayment will not apply if the PCP/Specialist does not bill the Plan for office visit charge.
Outpatient Private Duty Nursing	After satisfying the Calendar Year deductible the Plan will pay 100% of covered expenses following $75 Copayment per visit.
Outpatient Surgery	After satisfying the Calendar Year deductible the Plan will pay 100% of covered expenses following $300 Copayment.
Outpatient X-Ray, Laboratory & Diagnostic Services	After satisfying the Calendar Year deductible the Plan will pay: ▪ Laboratory Services performed at a free-standing lab: 100% of covered expenses. ▪ X-ray's (minor) performed at imaging center: 100% of covered expenses after a $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 a $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%.
Prescription Drug Benefits Retail Prescriptions (30 day supply maximum) Mail Order Prescriptions (For Maintenance medications only; 90 day supply maximum)	**Retail Network Pharmacy:** After satisfying the Calendar Year deductible the following copayments shall apply: ▪ Generic drugs: $20 Copayment ▪ Brand name drugs with NO Generic equivalent: $50 Copayment ▪ Brand name drugs with Generic equivalent: $75 Copayment **Mail Order Prescriptions:** After satisfying the Calendar Year deductible the following copayments shall apply: ▪ 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; 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	After satisfying the Calendar Year deductible the Plan will pay 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 or 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)	After satisfying the Calendar Year deductible the Plan will pay 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 subject to the Calendar Year deductible.
Spinal Manipulation	After satisfying the Calendar Year deductible the Plan will pay 100% of covered expenses following $75 Copayment. Calendar Year maximum benefit of 31 visits.

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Therapy Services	After satisfying the Calendar Year deductible the Plan will pay 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 only be subject to one Copayment. Neuromuscular Therapy shall be payable at 100% following $25 Copayment once the Calendar Year deductible has been satisfied.
TMJ / Jaw Joint Services	After satisfying the Calendar Year deductible the Plan will pay 100% of covered expenses following the applicable Copayment based upon the type of service rendered. Benefits are not available when services are rendered by a Dentist.
Transplant Benefit	After satisfying the Calendar Year deductible the Plan will pay 100% of covered expenses following the applicable Copayment based upon the type of service rendered.
Urgent Care Facility Services	**Primary Care Physician Services:** After satisfying the Calendar Year deductible the Plan will pay 100% of covered expenses following a $45 Copayment. **Specialist Services:** After satisfying the Calendar Year deductible the Plan will pay 100% of covered expenses following a $75 Copayment. Refer to Emergency Room benefit for services rendered in the Emergency room of a hospital.
Wig After Chemotherapy	After satisfying the Calendar Year deductible the Plan will pay 100% of covered expenses following a $75 Copayment.
All Other Covered Medical Expenses	After satisfying the Calendar Year deductible the Plan will pay 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:

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