CITY OF MARTIN HEALTH BENEFIT PLAN
Medical Schedule of Benefits

Effective July 1, 2019

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

MEDICAL BENEFITS	Cigna PPO Network Providers www.Cigna.com	Non-PPO Providers
Member Benefit Year Deductible Benefit Year begins July 1st of each year and ends June 30th of the following year.	$1,000 per individual $2,000 per family (accumulative)	$2,000 per individual $4,000 per family (accumulative)
	▪ The Benefit Year deductible does not include pre-certification penalties or non-covered expenses. ▪ Charges by PPO providers will only apply toward the Deductible for PPO Network services. ▪ Charges by Non-PPO providers will only apply toward the Deductible for Non-PPO provider services.	
Plan Coinsurance	Plan pays 80% of covered expenses after the Benefit Year deductible has been satisfied.	Plan pays 60% of covered expenses after the Benefit Year deductible has been satisfied.
Member Out-of-Pocket Maximum	$2,800 per individual $5,600 per family (accumulative)	$5,600 per individual $11,200 per family (accumulative)
	▪ The Benefit Year Deductible & Member coinsurance will apply toward the Out-of-Pocket Maximum. ▪ Pre-certification penalties, non-covered expenses and charges in excess of Reasonable & Customary charges DO NOT apply toward the Out-of-Pocket Maximum. ▪ Charges billed by PPO Network providers will only apply toward the Out-of-Pocket Maximum for PPO Network services. ▪ Charges billed by Non-PPO providers will only apply toward Out-of-Pocket Maximum for Non-PPO provider services.	
Lifetime Maximum Benefit	Unlimited.	
Alcohol & Substance Abuse Treatment	Plan pays 80% Coinsurance; subject to Benefit Year deductible.	Plan pays 60% Coinsurance; subject to Benefit Year deductible.
	Inpatient Hospital admissions require pre-certification.	
Allergy Treatment	Plan pays 80% Coinsurance; subject to Benefit Year deductible.	Plan pays 60% Coinsurance; subject to Benefit Year deductible.
Ambulance Services	Plan pays 80% Coinsurance; subject to Benefit Year deductible.	
Birthing Center	Plan pays 80% Coinsurance; subject to Benefit Year deductible.	Plan pays 60% Coinsurance; subject to Benefit Year deductible.
Chiropractic Care (Spinal Manipulation)	Plan pays 80% Coinsurance; subject to Benefit Year deductible.	Plan pays 60% Coinsurance; subject to Benefit Year deductible.
	Benefit Year maximum benefit of 20 visits.	
Colonoscopy Services (Diagnostic)	Plan pays 80% Coinsurance; subject to Benefit Year deductible.	Plan pays 60% Coinsurance; subject to Benefit Year deductible.
	Refer to Routine Well Adult Care Benefit for routine colonoscopy services.	
Diabetic Education	Plan pays 80% Coinsurance; subject to Benefit Year deductible.	Plan pays 60% Coinsurance; subject to Benefit Year deductible.
	Benefit Year maximum of $500	
Durable Medical Equipment Includes diabetic monitors/kits	Plan pays 80% Coinsurance; subject to Benefit Year deductible.	Plan pays 60% Coinsurance; subject to Benefit Year deductible.
Emergency Room Services	Plan pays 80% Coinsurance; subject to Benefit Year deductible. Includes all medically necessary services rendered during the Emergency Room visit.	**Emergency Room services for Injuries and Life-Threatening Care (as defined in Plan):** Plan pays 80% Coinsurance; subject to Benefit Year deductible. Includes all medically necessary services rendered during the Emergency Room visit. **Non-Emergency visits to an Emergency Room:** Plan pays 60% Coinsurance; subject to Benefit Year deductible. Includes all medically necessary services rendered during the Emergency Room visit.
Extended Care Facility Includes Rehabilitation Facility & Skilled Nursing Facility	Plan pays 80% Coinsurance; subject to Benefit Year deductible.	Plan pays 60% Coinsurance; subject to Benefit Year deductible.
	Inpatient admissions require pre-certification.	

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Hearing Aids For Participants under age 18	Plan pays 80% Coinsurance; subject to Benefit Year deductible.	Plan pays 60% Coinsurance; subject to Benefit Year deductible.
	Limited to $1,000 per ear within a three (3) year Benefit period.	
Home Health Care	Plan pays 80% Coinsurance; subject to Benefit Year deductible.	Plan pays 60% Coinsurance; subject to Benefit Year deductible.
Hospice Care Includes Bereavement Counseling	Plan pays 100% of covered expenses; subject to Benefit Year deductible.	Plan pays 60% Coinsurance; subject to Benefit Year deductible.
Inpatient Hospital Services Includes Physician Services	Plan pays 80% Coinsurance; subject to Benefit Year deductible.	Plan pays 60% Coinsurance; subject to Benefit Year deductible.
	Inpatient Hospital admissions require pre-certification.	
Maternity Care	Plan pays 80% Coinsurance; subject to Benefit Year deductible.	Plan pays 60% Coinsurance; subject to Benefit Year deductible.
Mental Health Services	Plan pays 80% Coinsurance; subject to Benefit Year deductible.	Plan pays 60% Coinsurance; subject to Benefit Year deductible.
	Inpatient Hospital admissions require pre-certification.	
Outpatient Physician Office Visit Services	Plan pays 80% Coinsurance; subject to Benefit Year deductible.	Plan pays 60% Coinsurance; subject to Benefit Year deductible.
	Includes office visit charges, standard x-ray, laboratory & diagnostic services performed in the Physician's office during the office visit.	
Outpatient Surgery	Plan pays 80% Coinsurance; subject to Benefit Year deductible.	Plan pays 60% Coinsurance; subject to Benefit Year deductible.
	Includes all surgical procedures performed in a Physicians Office, Ambulatory Surgical Center or Outpatient Surgery in a Hospital.	
Outpatient X-Ray, Laboratory & Diagnostic Services	Plan pays 80% Coinsurance; subject to Benefit Year deductible.	Plan pays 60% Coinsurance; subject to Benefit Year deductible.
	Includes CT scans, MRI's, MRA's and PET scans in any location, including the Physician's office.	
Pre-Certification Requirements	Pre-admission certification for an elective non-emergency hospital admission is mandatory. Emergency admissions must be approved within 48 hours. Failure to obtain pre-admission certification will reduce the services that require pre-admission certification to 50% coinsurance to a maximum penalty of $2,500. Non-medically necessary services are not be payable by the Plan.	
Prescription Drug Benefits Retail Prescriptions (30 or 90 day supply maximum) Mail Order Prescriptions (90 day supply maximum)	**Retail Network Pharmacy (30 or 90 day supply):*** Plan pays 80% Coinsurance after the Benefit Year deductible is satisfied. **Mail Order Prescriptions:*** Plan pays 80% Coinsurance after the Benefit Year deductible is satisfied. **Specialty / Injectible Drugs:** Plan pays 80% Coinsurance after the Benefit Year deductible is satisfied. ***Mandatory Generic Program:** If there is a generic alternative for the prescription drug being filled and the Member chooses a brand name drug instead, regardless of how the prescription is written, the Member must pay the difference in cost between the generic and brand medication plus 20% Coinsurance amount for the generic medication.	Prescriptions purchased from Non-Participating Pharmacies are not eligible for reimbursement by the Plan.
Prosthetic & Orthotic Appliances	Plan pays 80% Coinsurance; subject to Benefit Year deductible.	Plan pays 60% Coinsurance; subject to Benefit Year deductible.
Rehabilitative Therapy Services	Plan pays 80% Coinsurance; subject to Benefit Year deductible.	Plan pays 60% Coinsurance; subject to Benefit Year deductible.
	The following types of Rehabilitative Therapy Service will be considered a covered expense: ▪ Physical Therapy ▪ Occupational Therapy ▪ Pulmonary Rehabilitation ▪ Speech Therapy ▪ Cardiac Rehabilitation	

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Routine Well Adult Care (Age 18 and above) *Annual hearing and vision examination is for an annual examination only and does not include hearing aids, glasses or other related hardware.	Plan pays 100% of eligible charges; not subject to the Benefit Year deductible.	Plan pays 60% Coinsurance; subject to Benefit Year deductible.
	This routine benefit includes physician charges and related laboratory charges for annual routine preventive examinations and the preventive services outlined below: ▪ Immunizations (except for occupation & international travel). ▪ Fasting lipoprotein profile (cholesterol screening). ▪ Annual Prostate Specific Antigen (PSA) screening. ▪ Fasting blood sugar screening (for diabetes mellitus). ▪ Annual colorectal screening. ▪ Annual hearing examination.* ▪ Annual vision examination.* ▪ Blood pressure screening. ▪ Colonoscopy and/or sigmoidoscopy screening. ▪ Bone Mineral Density (BMD) screening (once every 24 months). ▪ Annual mammogram screening. ▪ Annual pelvic exam and Pap test. ▪ FDA approved contraception methods and contraceptive counseling. ▪ Breastfeeding support, supplies (limit of one breast pump per pregnancy) and counseling. ▪ Screening and counseling for interpersonal and domestic violence. ▪ Counseling and screening for human immune-deficiency virus. ▪ Counseling for sexually transmitted infections. ▪ HPV DNA testing. ▪ Screening for gestational diabetes. **A complete list of covered ACA mandated routine services for women / adults is available at: https://www.healthcare.gov/coverage/preventive-care-benefits/**	
Routine Well Child Care (Birth through age 17)	Plan pays 100% of eligible charges; not subject to the Benefit Year deductible.	Plan pays 60% Coinsurance; subject to Benefit Year deductible.
	Includes Office Visit charges, immunizations, laboratory blood tests & routine vision & hearing screenings in accordance with the Affordable Care Act (ACA).	
Transplant Benefit	Plan pays 80% Coinsurance; subject to Benefit Year deductible.	Plan pays 60% Coinsurance; subject to Benefit Year deductible.
	Inpatient admissions require pre-certification.	
Voluntary Second and Third Surgical Opinion	Plan pays 100% of eligible charges; not subject to the Benefit Year deductible.	Plan pays 60% Coinsurance; subject to Benefit Year deductible.
All Other Covered Medical Expenses	Plan pays 80% Coinsurance; subject to Benefit Year deductible.	Plan pays 60% Coinsurance; subject to Benefit Year deductible.

Questions regarding Coverage and/or Preventive Care Benefits should be directed to:

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