PUBLIC TRUST ADVISORS HEALTH BENEFIT PLAN **Silver In-Network Only PPO Plan**
Medical Summary of Benefits **Effective January 1, 2021**

Refer to the Medical Plan Document and Summary Plan Description for details of Coverage.
Important Reminder: This Silver PPO Health Plan provides Coverage for services rendered ONLY by PPO Providers.

MEDICAL BENEFITS	Cigna PPO Network Providers www.Cigna.com
Member Calendar Year Deductible	$3,000 per individual / $6,000 per family (accumulative) The Calendar Year deductible does NOT include Medical Plan Co-payments, Prescription Drug Co-payments, pre-certification penalties, non-covered expenses or charges in excess of Reasonable & Customary charges. **Your Calendar Year Deductible will be reduced by $500 if you utilize a Medical Advocate Program (MAP) recommended hospital or surgical facility for inpatient hospital admissions or surgical procedures. Medical Advocate Program (MAP): 1-888-289-0700**
Coinsurance	Plan pays 70% of covered expenses.
Member Out-of-Pocket Maximum	$7,000 per individual / $14,000 per family (accumulative) Out-of-Pocket Maximum includes Medical Plan & Prescription Drug Co-payments, Calendar Year deductible and Member Coinsurance. Pre-certification penalties, non-covered expenses and charges in excess of Reasonable & Customary charges DO NOT apply toward the Out-of-Pocket Maximum.
Lifetime Maximum Benefit	Unlimited.
Alcohol & Substance Abuse Treatment Inpatient Hospital admission requires Pre-certification	**Inpatient / Partial Hospitalization:** 70% Coinsurance; subject to Calendar Year deductible. Your Calendar Year Deductible will be reduced by $500 if you use a Medical Advocate Program (MAP) recommended facility. **Outpatient Services:** Refer to Outpatient Physician Office Visit Services benefit.
Allergy Injections & Testing	70% Coinsurance; subject to Calendar Year deductible.
Ambulance Services	70% Coinsurance; subject to Calendar Year deductible.
Chiropractic Services / Spinal Manipulation	$35 Co-payment for first three (3) visits per Calendar Year. Additional visits payable at 70% Coinsurance; subject to Calendar Year deductible. Calendar Year maximum benefit of 30 visits.
Durable Medical Equipment & Supplies	70% Coinsurance; subject to Calendar Year deductible.
Emergency Room Services	70% of covered expenses following a $250 Co-payment; subject to Calendar Year deductible. Co-payment will be waived if admitted directly from Emergency Room to a Hospital.
Extended Care Facility Requires Pre-certification	70% Coinsurance; subject to Calendar Year deductible. Calendar Year maximum benefit of 100 days for Skilled Nursing Facility, Extended Care Facility or Inpatient Rehabilitation Facility.
Home Health Care	70% Coinsurance; subject to Calendar Year deductible. Calendar Year maximum benefit of 60 visits.
Hospice Care Requires Pre-certification	70% Coinsurance; subject to Calendar Year deductible.
Inpatient Hospital Services Includes Physician Services Requires Pre-certification	70% Coinsurance; subject to Calendar Year deductible. Your Calendar Year Deductible will be reduced by $500 if you use a Medical Advocate Program (MAP) recommended facility.
Maternity Care	**Initial Maternity Office Visit:** Refer to Outpatient Physician Office Visit Services benefit. **Pre-natal & Post-natal Care, Delivery & all Inpatient Hospital Services:** 70% Coinsurance; subject to Calendar Year deductible.
Mental Health Services Inpatient admission requires Pre-certification	**Inpatient / Partial Hospitalization:** 70% Coinsurance; subject to Calendar Year deductible. Your Calendar Year Deductible will be reduced by $500 if you use a Medical Advocate Program (MAP) recommended facility. **Outpatient Services:** Refer to Outpatient Physician Office Visit Services benefit.
Outpatient Imaging / X-Ray Services	**Diagnostic Imaging / X-Rays (not complex):** 70% Coinsurance; subject to Calendar Year deductible. **Complex Imaging Services:** (Includes but is not limited to CT scans, MRI's, MRA's, PET scans) Independent Imaging Facility: 100% of covered expenses following a $100 Co-payment; not subject to Calendar Year deductible. Outpatient Hospital: 70% Coinsurance; subject to Calendar Year deductible.
Outpatient Laboratory Services	70% Coinsurance; subject to Calendar Year deductible.

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Outpatient Physician Office Visit Services Includes office visit charges, x-ray / imaging, laboratory and diagnostic services performed in the Physician's office during the office visit. Refer to Outpatient Surgery benefit for surgical procedures performed during an office visit.	**Teladoc Health; General Medical Visit:** 100% of covered expenses; Co-payment waived. **Teladoc Health; Behavioral Health Visit:** 100% of covered expenses following a $35 Co-payment. **Primary Care Physician Office Visits / Convenience Care Clinic:** 100% of covered expenses following a $35 Co-payment; not subject to Calendar Year deductible. **Specialist Office Visit:** $35 Co-payment for first three (3) visits per Calendar Year. Additional visits payable at 70% Coinsurance; subject to Calendar Year deductible. **Urgent Care Provider:** 100% of covered expenses following a $50 Co-payment; not subject to Calendar Year deductible. Refer to Outpatient Laboratory Services benefit and Outpatient Imaging / X-Ray Services benefit for treatment rendered outside of the Physicians office.
Outpatient Surgery	70% Coinsurance; subject to Calendar Year deductible. Your Calendar Year Deductible will be reduced by $500 if you utilize a Medical Advocate Program (MAP) recommended surgical facility for outpatient surgical procedures.
Outpatient Therapy Services	$35 Co-payment for first three (3) visits per Calendar Year. Additional visits payable at 70% Coinsurance; subject to Calendar Year deductible. Calendar Year maximum benefit of 30 visits for each type of Therapy listed below: ▪ Physical Therapy (habilitative) ▪ Physical Therapy (rehabilitative) ▪ Speech Therapy (habilitative) ▪ Speech Therapy (rehabilitative) ▪ Occupational Therapy (habilitative) ▪ Occupational Therapy (rehabilitative) ▪ Acupuncture / Nerve Pathway Therapy & Massage Therapy
Pre-certification for Inpatient Hospital Admissions	Pre-admission certification is mandatory for inpatient Hospital Admissions. Emergency hospital admissions must be approved within 48 hours. Failure to comply will result in a $500 reduction of benefits due to pre-certification non-compliance.
Prescription Drug Benefits ▪ Retail Prescriptions (30 day supply maximum) ▪ Mail Order Prescriptions (90 day supply maximum)	**Retail Network Pharmacy Co-payments:** ▪ Generic medications: $10 ▪ Formulary Brand medications: $40 ▪ Non-Formulary Brand medications: $80 **Mail Order Prescription Co-payments:** ▪ Generic medications: $30 ▪ Formulary Brand medications: $120 ▪ Non-Formulary Brand medications: $240 **Specialty / Injectible Prescription:** $375 Co-pay per Rx; not subject to Calendar Year deductible.
Prosthetic Appliances	70% Coinsurance; subject to Calendar Year deductible.
Routine Colonoscopy	100% of covered expenses; not subject to Calendar Year deductible.
Routine Mammogram	100% of covered expenses; not subject to Calendar Year deductible.
Routine Well Adult Care (Age 18 and above)	100% of covered expenses; not subject to Calendar Year deductible. This routine benefit includes, but is not limited to, physician charges for an annual routine examination, routine x-rays and laboratory, immunizations and the routine services listed below: ▪ Immunizations. ▪ Fasting lipoprotein profile (cholesterol screening). ▪ Annual Prostate Specific Antigen (PSA) screening. ▪ Fasting blood sugar screening (for diabetes mellitus). ▪ Annual colorectal screening. ▪ Blood pressure screening. ▪ Obesity screening and counseling. ▪ Tobacco use screening and cessation interventions. ▪ ACA required prescription drugs. ▪ Bone Mineral Density (BMD) screening (once every 24 months). ▪ Women's Health Services to include pelvic exam and Pap test; screening for gestational diabetes; DNA Testing; HPV (Human Papillomavirus); counseling for sexually transmitted infections; counseling and screening for human immunodeficiency virus; screening and counseling for interpersonal and domestic violence; breastfeeding support, supplies and counseling; sterilization; and contraceptive methods and counseling. Limitations may apply. **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)	100% of covered expenses; not subject to Calendar Year deductible. Includes Office Visit charges, immunizations, laboratory blood tests, developmental screening, behavioral assessments, routine vision screening & hearing screening for newborns. **A complete list of covered ACA mandated routine services for children is available at: https://www.healthcare.gov/coverage/preventive-care-benefits/**
Transplant Benefit	70% Coinsurance; subject to Calendar Year deductible.
All Other Covered Medical Expenses	70% Coinsurance; subject to Calendar Year deductible.

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

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