McMinnville Electric System Health Benefit Plan
Medical Summary of Benefits
Effective January 1, 2019

TN HealthWorks
Sponsored by Public Entity Partners

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

MEDICAL BENEFITS	Cigna PPO Network Providers www.Cigna.com	Non-PPO Providers
Member Calendar Year Deductible	$500 per individual $1,000 per family (accumulative)	$1,500 per individual $3,000 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. PPO and Non-PPO deductibles shall NOT combine together.	
Plan Coinsurance	Plan pays 100% of covered expenses.	Plan pays 70% of Plan Allowable Rate. (Rate equals 125% of Medicare allowable)
Member Out-of-Pocket Maximum	$3,000 per individual $6,000 per family (accumulative)	$5,000 per individual $15,000 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. PPO and Non-PPO Out-of-Pocket Maximums shall NOT combine together.	
Lifetime Maximum Benefit	Unlimited.	
Alcohol & Substance Abuse Treatment Inpatient Hospital admission requires Pre-certification	**Inpatient / Partial Hospitalization:** 100% of covered expenses; subject to Calendar Year deductible. **Outpatient Services:** 100% of covered expenses following a $40 Co-payment; not subject to Calendar Year deductible.	70% Coinsurance; subject to Calendar Year deductible.
Allergy Injections & Testing	**Allergy Testing:** based on type of services performed and place services are rendered. **Allergy Injections:** 100% of covered expenses; subject to Calendar Year deductible.	70% Coinsurance; subject to Calendar Year deductible.
Ambulance Services	100% of covered expenses; subject to Calendar Year deductible.	**Emergency Ambulance Services:** 100% of covered expenses; subject to PPO Calendar Year deductible. **Non-Emergency Ambulance Services:** 70% Coinsurance; subject to Calendar Year deductible.
Chiropractic Services / Spinal Manipulation	100% of covered expenses following a $20 Co-payment; not subject to Calendar Year deductible.	70% Coinsurance; subject to Calendar Year deductible.
	Refer to Outpatient Therapy Services for Chiropractic Services limitations.	
Durable Medical Equipment & Supplies	70% Coinsurance; subject to Calendar Year deductible.	50% Coinsurance; subject to Calendar Year deductible.
Emergency Room Services	100% of covered expenses following a $150 Co-payment; not subject to Calendar Year deductible. Co-payment will be waived if admitted directly from Emergency Room to a Hospital. **Note: Non-emergency visits to the Emergency Room will not be considered a covered expense.**	
Extended Care Facility Requires Pre-certification	100% of covered expenses; subject to Calendar Year deductible.	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 Requires Pre-certification	100% of covered expenses; subject to Calendar Year deductible.	70% Coinsurance; subject to Calendar Year deductible.
	Calendar Year maximum benefit of 120 visits.	
Hospice Care Requires Pre-certification	100% of covered expenses; subject to Calendar Year deductible.	70% Coinsurance; subject to Calendar Year deductible.
Inpatient Hospital Services Includes Physician Services	100% of covered expenses; subject to Calendar Year deductible.	70% Coinsurance; subject to Calendar Year deductible.
Maternity Care	**Initial Maternity Office Visit / Pre-natal Care:** 100% of covered expenses; not subject to Calendar Year deductible. **Delivery & Post-natal Care:** 100% of covered expenses; subject to Calendar Year deductible.	70% Coinsurance; subject to Calendar Year deductible.

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Mental Health Services Inpatient admission requires Pre-certification	**Inpatient / Partial Hospitalization:** 100% of covered expenses; subject to Calendar Year deductible. **Outpatient Services:** 100% of covered expenses following a $40 Co-payment; not subject to Calendar Year deductible.	70% Coinsurance; subject to Calendar Year deductible.
Outpatient Imaging / X-Ray Services	**Diagnostic Imaging / X-Rays (not complex):** 100% of covered expenses; 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; subject to Calendar Year deductible. **Outpatient Hospital:** 100% of covered expenses; subject to Calendar Year deductible.	70% Coinsurance; subject to Calendar Year deductible.
Outpatient Laboratory Services	100% of covered expenses; subject to Calendar Year deductible.	70% Coinsurance; subject to Calendar Year deductible.
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.	**Primary Care Physician Office Visit / Walk-in Clinic / Convenience Care Clinic:** 100% of covered expenses following a $20 Co-payment; not subject to Calendar Year deductible. **Specialist Office Visit:** 100% of covered expenses following a $40 Co-payment; not subject to Calendar Year deductible. **Urgent Care Provider:** 100% of covered expenses following a $75 Co-payment; not subject to Calendar Year deductible*.	70% Coinsurance; subject to Calendar Year deductible*.
	***Note: Non-urgent use of an Urgent Care Provider shall not be considered a covered expense.** Refer to Outpatient Laboratory Services benefit and Outpatient Imaging / X-Ray Services benefit for treatment rendered outside of the Physicians office.	
Outpatient Surgery	100% of covered expenses; subject to Calendar Year deductible.	70% Coinsurance; subject to Calendar Year deductible.
Outpatient Therapy Services	100% of covered expenses following a $40 Co-payment; not subject to Calendar Year deductible.	70% Coinsurance; subject to Calendar Year deductible.
	Calendar Year combined maximum benefit of 60 visits for all therapy types listed below: Physical Therapy, Speech Therapy, Occupational Therapy and Chiropractic Services	
Pre-certification Requirements	Pre-admission certification is mandatory for Home Health Care services and inpatient Hospital Admissions. Emergency hospital admissions must be approved within 48 hours. Failure to comply will result in a $400 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:** ▪ Drugs on CVS Value Priced Generic List: $3 ▪ Generic medications not on CVS VPG list: $10 ▪ Formulary Brand medications: $35 ▪ Non-Formulary Brand medications: $60 **Mail Order Prescription Co-payments:** ▪ Drugs on CVS Value Priced Generic List: $6 ▪ Generic medications not on CVS VPG list: $20 ▪ Formulary Brand medications: $70 ▪ Non-Formulary Brand medications: $120 **Specialty / Injectible Prescription Co-payments:** ▪ Specialty Preferred drugs: 20% up to $250 ▪ Specialty Non-preferred drugs: 40% up to $500	Prescription drugs purchased from Non-Participating Pharmacies are not eligible for reimbursement by the Plan.
Prosthetic Appliances	100% of covered expenses; subject to Calendar Year deductible.	70% Coinsurance; subject to Calendar Year deductible.
Routine Colonoscopy (Age 50 and above)	100% of covered expenses; not subject to Calendar Year deductible.	70% Coinsurance; subject to Calendar Year deductible.
Routine Mammogram (Age 40 and above)	100% of covered expenses; not subject to Calendar Year deductible.	70% Coinsurance; subject to Calendar Year deductible.

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Routine Well Adult Care (Age 18 and above)	100% of covered expenses; not subject to Calendar Year deductible.	70% Coinsurance; 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. ▪ 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. ▪ Blood pressure screening. ▪ Obesity screening and counseling. ▪ Tobacco use screening and cessation interventions. **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.	70% Coinsurance; 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	100% of covered expenses; subject to Calendar Year deductible.	70% Coinsurance; subject to Calendar Year deductible.
Vision Examination Limited to 1 examination every 12 months	100% of covered expenses; not subject to Calendar Year deductible.	70% Coinsurance; subject to Calendar Year deductible.
All Other Covered Medical Expenses	100% of covered expenses; subject to Calendar Year deductible.	70% Coinsurance; subject to Calendar Year deductible.

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

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