LYKES INSURANCE HEALTH BENEFIT PLAN **In-Network Only / Co-Payment Plan**
Medical Schedule of Benefits **Effective January 1, 2019**

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

MEDICAL BENEFITS	Cigna PPO Network Providers www.Cigna.com
Member Calendar Year Deductible	**$1,350 per individual / $2,700 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
Plan Coinsurance	Plan pays 100% of covered expenses
Member Out-of-Pocket Maximum	**$6,350 per individual / $12,700 per family** (accumulative) Out-of-Pocket Maximum includes the Calendar Year deductible, Medical Plan Co-payments and Prescription Drug Co-payments. 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 / Partial Hospitalization:** 100% of covered expenses; subject to Calendar Year deductible. Inpatient confinement requires Pre-certification **Outpatient Treatment Services:** 100% of covered expenses following a $25 Co-payment.
Allergy Injections & Testing	100% of covered expenses following a $25 Co-payment per visit.
Ambulance Services	100% of covered expenses; subject to Calendar Year deductible.
Chiropractic Services	100% of covered expenses following a $25 Co-payment. Calendar Year maximum benefit of 6 visits.
Durable Medical Equipment & Supplies	100% of covered expenses; subject to Calendar Year deductible. DME is limited to the lesser of the purchase price or the total anticipated rental charges.
Emergency Room Services	**True Medical Emergency:** 100% of covered expenses following a $150 Co-payment. **Non-Medical Emergency:** 100% of covered expenses following a $500 Co-payment. Co-payment will be waived if admitted directly from Emergency Room to a Hospital.
Extended Care Facility Requires Pre-certification	100% of covered expenses; subject to Calendar Year deductible. Calendar Year maximum benefit of 20 days. Includes Rehabilitation Facility & Skilled Nursing Facility.
Home Health Care	100% of covered expenses; subject to Calendar Year deductible. Calendar Year maximum benefit of 40 visits (one per day).
Home Infusion Therapy	**Physician / Specialist Office:** 100% of covered expenses following a $25 Co-payment. **Outpatient Hospital:** 100% of covered expenses; subject to Calendar Year deductible.
Hospice Care	100% of covered expenses; subject to Calendar Year deductible. Requires Pre-certification.
Inpatient Hospital Services	100% of covered expenses; subject to Calendar Year deductible. Includes Physician and Hospital Services. Inpatient admissions require Pre-certification.
Maternity Care	**Pre-natal Care (global fee):** 100% of covered expenses; not subject to Calendar Year deductible. **Labor & Delivery:** 100% of covered expenses; subject to Calendar Year deductible. Includes one breast pump per Calendar Year payable at 100%; not subject to Calendar Year deductible.
Mental Health Services	**Inpatient / Partial Hospitalization:** 100% of covered expenses; subject to Calendar Year deductible. Inpatient confinement requires Pre-certification. **Outpatient Treatment Services:** 100% of covered expenses following a $25 Co-payment.
Orthopedic Shoes	100% of covered expenses; subject to Calendar Year deductible. Limited to 1 (one) pair of specifically molded and Medically Necessary shoes per Calendar Year.
Orthotics	100% of covered expenses; subject to Calendar Year deductible. Limited to one set of inserts every 24 months as prescribed by a Physician or Specialist.
Outpatient Imaging Services Includes CT scans, MRI's, MRA's, PET scans and nuclear cardiology	▪ **Freestanding Imaging Facility:** 100% of covered expenses; not subject to Calendar Year deductible. ▪ **Physician/Specialist Office:** 100% of covered expenses following $1,500 Co-payment per scan. ▪ **Outpatient Hospital:** 100% of covered expenses; subject to Calendar Year deductible.
Outpatient Laboratory & X-Ray Services	▪ **Freestanding Facility:** 100% of covered expenses; not subject to Calendar Year deductible. ▪ **Physician/Specialist Office:** 100% of covered expenses following $250 Co-payment per test. ▪ **Outpatient Hospital:** 100% of covered expenses; subject to Calendar Year deductible.

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Outpatient Physician Office Visit Services Includes office visit charges, surgical procedures and diagnostic services performed in the Physician's office.	▪ **Teladoc Visit:** $0 Co-payment. ▪ **Primary Care / Convenience Clinic:** 100% of covered expenses following a $25 Co-payment. ▪ **Specialist Office Visit:** 100% of covered expenses following a $25 Co-payment. ▪ **Urgent Care Provider:** 100% of covered expenses following a $25 Co-payment. Refer to Outpatient Laboratory & X-Ray Services and Outpatient Imaging Services to determine additional Benefits and/or Member cost sharing.
Outpatient Surgery	**Ambulatory Surgical Center:** 100% of covered expenses; not subject to Calendar Year deductible. **Outpatient Hospital:** 100% of covered expenses; subject to Calendar Year deductible.
Outpatient Therapy Services	100% of covered expenses following a $25 Co-payment. Calendar Year maximum of 12 visits each for Physical, Speech and Occupational 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 Co-pay ▪ Preferred Brand medications: $30 Co-pay ▪ Non-Preferred Brand medications: $65 Co-pay **Mail Order Prescription Co-payments:** ▪ Generic medications: $0 Co-pay ▪ Preferred Brand medications: $0 Co-pay ▪ Non-Preferred Brand medications: $0 Co-pay **Specialty / Injectible Prescriptions:** $300 Co-payment; not subject to Calendar Year deductible.
Prosthetic Appliances	100% of covered expenses; subject to Calendar Year deductible.
Routine Colonoscopy	100% of covered expenses; not subject to Calendar Year deductible. (Age 50 and above)
Routine Mammogram	100% of covered expenses; not subject to Calendar Year deductible. (Age 40 and above)
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. ▪ 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	100% of covered expenses; subject to Calendar Year deductible.
Vision Examinations	100% of covered expenses following a $25 Co-payment. One exam every two years for members age 6 and older; does not include glasses contact lenses.
All Other Covered Medical Expenses	100% of covered expenses; subject to Calendar Year deductible.

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

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