LYKES INSURANCE HEALTH BENEFIT PLAN **In-Network Only / HSA 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** **Note:** Family Coverage refers to an Employee plus one or more Dependents. If an Employee is enrolled for Family Coverage the Family deductible must be met before any claims are paid. The total Family deductible may be met by claims of one or more individuals. The Calendar Year deductible does NOT include, 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** **Note:** Family Coverage refers to an Employee plus one or more Dependents. The family Out-of-Pocket Maximum can be met by a combination of family members or by any single individual within the family. Once the family Out-of-Pocket Maximum is met, all family members will be considered as having met their Out-of-Pocket Maximum. The Out-of-Pocket Maximum includes the 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 / Partial Hospitalization:** 100% of covered expenses; subject to Calendar Year deductible. Inpatient confinement requires Pre-certification **Outpatient Treatment Services:** 100% of covered expenses; subject to Calendar Year deductible.
Allergy Injections & Testing	100% of covered expenses; subject to Calendar Year deductible.
Ambulance Services	100% of covered expenses; subject to Calendar Year deductible.
Chiropractic Services	100% of covered expenses; subject to Calendar Year deductible. 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; subject to Calendar Year deductible. **Non-Medical Emergency:** 80% of covered expenses; subject to Calendar Year deductible.
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; subject to Calendar Year deductible. **Outpatient Hospital:** 100% of covered expenses; subject to Calendar Year deductible.
Hospice Care	100% of covered expenses; subject to Calendar Year deductible. In-patient Hospice 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; 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; subject to Calendar Year deductible.
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; subject to Calendar Year deductible. ▪ **Physician/Specialist Office:** 100% of covered expenses; subject to Calendar Year deductible. ▪ **Outpatient Hospital:** 100% of covered expenses; subject to Calendar Year deductible.

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Outpatient Laboratory & X-Ray Services	▪ **Freestanding Facility:** 100% of covered expenses; subject to Calendar Year deductible. ▪ **Physician/Specialist Office:** 100% of covered expenses; subject to Calendar Year deductible. ▪ **Outpatient Hospital:** 100% of covered expenses; subject to Calendar Year deductible.
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; subject to Calendar Year deductible. ▪ **Specialist Office Visit:** 100% of covered expenses; subject to Calendar Year deductible. ▪ **Urgent Care Provider:** 100% of covered expenses; subject to Calendar Year deductible. 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; subject to Calendar Year deductible. **Outpatient Hospital:** 100% of covered expenses; subject to Calendar Year deductible.
Outpatient Therapy Services	100% of covered expenses; subject to Calendar Year deductible. 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 Coinsurance AFTER Calendar Year deductible is met:** ▪ Generic medications: 80% Coinsurance ▪ Preferred Brand medications: 80% Coinsurance ▪ Non-Preferred Brand medications: 80% Coinsurance **Mail Order Prescription Co-payments AFTER Calendar Year deductible is met::** ▪ Generic medications: $0 Co-pay ▪ Preferred Brand medications: $0 Co-pay ▪ Non-Preferred Brand medications: $0 Co-pay **Specialty / Injectible Prescriptions:** 100% of covered expenses; 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). ▪ Blood pressure screening. ▪ Obesity screening and counseling. ▪ Tobacco use screening and cessation interventions. ▪ 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. **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; subject to Calendar Year deductible. 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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