CITY OF GREEN COVE SPRINGS HEALTH BENEFIT PLAN **BRONZE EPO Plan**
Medical Schedule of Benefits **Effective October 1, 2020**

Refer to the Medical Plan Document and Summary Plan Description for details of Coverage.
Important Notice: This Plan Option DOES NOT include coverage for services rendered by Non-PPO Network Providers.

Medical Benefits	Cigna PPO Network Providers
Member Calendar Year Deductible	$2,000 per individual / $6,000 per family (accumulative)
	The Calendar Year deductible does not include Medical Co-payments, Prescription Drug Co-payments, pre-certification penalties, non-covered expenses or charges in excess of Reasonable & Customary charges.
Plan Coinsurance	Plan pays 80% of covered expenses
Member Out-of-Pocket Maximum	$5,500 per individual / $11,000 per family (accumulative)
	Out-of-Pocket Maximum includes the Calendar Year deductible, Medical & Prescription Drug Co-payments and 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 / Emergency Room:** 100% of covered expenses; not subject to Calendar Year deductible. Inpatient confinement requires Pre-certification. **Outpatient Services:** 100% of covered expenses; not subject to Calendar Year deductible.
Allergy Testing & Injections	Allergy Injections are payable at 100% of covered expenses following a $10 Co-payment per visit; not subject to Calendar Year deductible. Allergy Testing & Serum is payable following a $35 PCP or $65 Specialist Co-payment per visit; not subject to Calendar Year deductible.
Ambulance Services	80% Coinsurance; subject to Calendar Year deductible.
Autism Spectrum Disorders	80% Coinsurance; subject to Calendar Year deductible. Calendar Year maximum benefit of $36,000. Lifetime maximum benefit of $200,000.
Chiropractic Services / Spinal Manipulation	100% of covered expenses following a $65 Co-payment per visit; not subject to Calendar Year deductible. Calendar Year maximum of 26 visits; accumulates toward Outpatient Therapy maximum.
Durable Medical Equipment & Supplies	100% of covered expenses following a $500 Co-payment for motorized wheelchair. All other DME and supplies are payable at 100% of covered expenses; not subject to Calendar Year deductible. Excludes replacement of DME due to growth and/or age.
Emergency Room Services	**Emergency Room Facility Charges:** 100% of covered expenses following a $300 Co-payment for expenses charged by the Facility/Emergency Room; not subject to Calendar Year deductible. Co-payment will be waived if admitted to a Hospital directly from the Emergency Room. **Physician and Other Healthcare Professional Services:** 80% Coinsurance; subject to Calendar Year deductible.
Extended Care Facility Requires Pre-certification	80% Coinsurance; subject to Calendar Year deductible. Extended Care Facility includes Rehabilitation Hospital & Skilled Nursing Facility services. Calendar Year maximum of 60 days.
Home Health Care	100% of covered expenses; not subject to Calendar Year deductible. Calendar Year maximum of 20 visits.
Hospice Care	80% Coinsurance; subject to Calendar Year deductible. Inpatient Hospice requires Pre-certification.
Inpatient Hospital Services Requires Pre-certification	80% Coinsurance; subject to Calendar Year deductible and additional $100 per admission deductible. Physician/Surgeon charges shall be payable at 80% Coinsurance; subject to Calendar Year deductible.
Maternity Care	**Initial Maternity Office Visit:** 100% of covered expenses following a $65 Co-payment; not subject to Calendar Year deductible. **Pre-natal Care/Physician Delivery:** 80% Coinsurance; subject to Calendar Year deductible. Refer to Inpatient Hospital Services Benefit for Hospital benefits.
Mental Health Services	**Inpatient / Partial Hospitalization / Emergency Room:** 100% of covered expenses; not subject to Calendar Year deductible. Inpatient confinement requires Pre-certification. **Outpatient Services:** 100% of covered expenses; not subject to Calendar Year deductible.
Outpatient Imaging / X-Ray Services Pre-certification is required for Complex Imaging Services	**Diagnostic Imaging / X-Rays (not complex)**
	Independent Imaging Facility: 100% of covered expenses following a $50 Co-payment; not subject to Calendar Year deductible. **Outpatient Hospital:** 80% Coinsurance; subject to Calendar Year deductible.
	Complex Imaging Services (Includes but is not limited to CT scans, MRI's, MRA's, PET scans and nuclear cardiology in any location, including the Physician's office)
	Independent Imaging Facility: 100% of covered expenses following a $300 Co-payment; not subject to Calendar Year deductible. **Outpatient Hospital:** 80% Coinsurance; subject to Calendar Year deductible.
Outpatient Laboratory Services	**Independent Clinical Lab:** 100% of covered expenses; not subject to Calendar Year deductible. **Outpatient Hospital:** 80% Coinsurance; subject to Calendar Year deductible.

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Outpatient Physician Office Visit Services Includes office visit charges, standard x-ray, minor surgical procedures, laboratory and diagnostic services performed in the Physician's office during the office visit.	**Teladoc Health Visit:** $10 Co-payment **Physician E-Visit:** $10 Co-payment **Convenience Care Clinic:** $35 Co-payment **Primary Care Office Visit:** $35 Co-payment **Specialist Office Visit:** $65 Co-payment **Urgent Care Provider:** $75 Co-payment Calendar Year deductible does not apply to above noted visits.
	Refer to Outpatient Laboratory Services benefit and Outpatient Imaging / X-Ray Services benefit for treatment rendered outside of the Physicians office and for CT scans, MRI's, MRA's and PET scans in any location, including the Physician's office. Refer to Outpatient Surgery benefit for surgical procedures performed outside of a Physician's office.
Outpatient Surgery	**Ambulatory Surgical Center:** 100% of covered expenses following a $250 Co-payment; not subject to Calendar Year deductible. Physician/Surgeon charges shall be payable at 100% of covered expenses following a $65 Co-payment; not subject to Calendar Year deductible. **Outpatient Hospital:** 80% Coinsurance; subject to Calendar Year deductible (includes Physician / Surgeon services).
Outpatient Therapy Services	100% of covered expenses following a $65 Co-payment; not subject to Calendar Year deductible. Combined Calendar Year maximum of 35 visits for all rehabilitative therapy including Physical Therapy, Speech Therapy, Occupational Therapy, Cardiac Therapy and Chiropractic Treatment.
Pre-certification for Inpatient Hospital Admissions	Pre-admission certification is mandatory for all inpatient Hospital Admissions, Complex Imaging Services and Experimental / Investigational treatment. Emergency hospital admissions must be approved within 48 hours. Failure to comply will result in a penalty equaling the lesser of $500 or 20% of the allowed amount of the claim due to pre-certification non-compliance.
Prescription Drug Benefits Retail: 30 day supply Mail Order: 90 day supply Specialty / Injectible Drugs: 30 day supply	**Retail Network Pharmacy Co-payments:** Generic medications: $10 Co-pay Formulary Brand medications: $50 Co-pay Non-Formulary Brand medications: $80 Co-pay **Mail Order Prescription Co-payments:** Generic medications: $25 Co-pay Formulary Brand medications: $125 Co-pay Non-Formulary Brand medications: $200 Co-pay **Specialty / Injectible Prescription Co-pay:** Co-payments listed above will apply based on drug tier.
Prosthetic Appliances	80% Coinsurance; subject to Calendar Year deductible.
Routine Colonoscopy	100% of covered expenses; not subject to Calendar Year deductible. Age/frequency schedule apply.
Routine Mammogram	100% of covered expenses; not subject to Calendar Year deductible. Age/frequency schedule apply.
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	80% Coinsurance; subject to Calendar Year deductible. Refer to Inpatient Hospital Services Benefit for Hospital and Physician/Surgeon benefits.
All Other Covered Medical Expenses	80% Coinsurance; subject to Calendar Year deductible.

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

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