**ETC PALM BEACH HEALTH BENEFIT PLAN** **MID PLAN**
**Medical Schedule of Benefits** **Effective January 1, 2022**

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

| Medical Benefits | Cigna PPO Network Providers | Non-PPO Providers |
|---|---|---|
| **Member Calendar Year Deductible** | $3,000 per individual / $6,000 per family (accumulative) | |
| | The Calendar Year deductible does not include Medical or Prescription Drug Co-payments, pre-certification penalties, non-covered expenses or charges in excess of Reasonable & Customary charges. PPO & Non-PPO deductibles accumulate towards one another. | |
| **Plan Coinsurance** | Plan pays 80% of covered expenses | Plan pays 70% of covered Reasonable & Customary charges |
| **Member Out-of-Pocket Maximum** | $7,350 per individual<br>$14,700 per family (accumulative) | Unlimited; no maximum. |
| | 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. PPO & Non-PPO Out-of-Pocket Maximums accumulate towards one another. | |
| **Lifetime Maximum Benefit** | Unlimited | |
| **Alcohol & Substance Abuse Treatment**<br>Inpatient admission requires Pre-certification | **Outpatient Services:** $50 Co-payment<br>**Inpatient Services, Partial Hospitalization:** 80% Coinsurance; subject to Calendar Year deductible. | **Inpatient Services, Partial Hospitalization and Outpatient Services:** 70% Coinsurance; subject to Calendar Year deductible. |
| **Allergy Testing & Injections** | 100% of covered expenses following a $30 Co-payment per visit; not subject to Calendar Year deductible. | 70% Coinsurance; subject to Calendar Year deductible. |
| **Ambulance Services** | 100% of covered expenses following a $100 Co-payment. | $100 Co-payment plus 20% of allowable rate; not subject to Calendar Year deductible. |
| **Chiropractic Services / Spinal Manipulation**<br>Limit of 30 visits per Calendar year | 100% of covered expenses following a $50 Co-payment per visit; not subject to Calendar Year deductible. | 70% Coinsurance; subject to Calendar Year deductible. |
| **Durable Medical Equipment & Supplies** | 80% Coinsurance; subject to Calendar Year deductible. | 70% Coinsurance; subject to Calendar Year deductible. |
| | Excludes replacement of DME due to growth and/or age. | |
| **Emergency Room Services** | 100% of covered expenses following a $250 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. Includes Emergency Room facility charges, Physician and all other services. | |
| **Extended Care Facility**<br>Requires Pre-certification | 80% Coinsurance; subject to Calendar Year deductible. | 70% Coinsurance; subject to Calendar Year deductible. |
| | Extended Care Facility includes Rehabilitation Hospital & Skilled Nursing Facility services. | |
| **Home Health Care** | 80% Coinsurance; subject to Calendar Year deductible. | 70% Coinsurance; subject to Calendar Year deductible. |
| **Hospice Care** | 80% Coinsurance; subject to Calendar Year deductible. | 70% Coinsurance; subject to Calendar Year deductible. |
| **Inpatient Hospital Services**<br>Requires Pre-certification<br>Includes Physician charges | 80% Coinsurance; subject to Calendar Year deductible. | 70% Coinsurance; subject to Calendar Year deductible. |
| **Maternity Care** | **Initial Maternity Office Visit:** 100% of covered expenses following a $50 Co-payment. | |
| | **Pre-natal Care/Physician Delivery:** 80% Coinsurance; subject to Calendar Year deductible. | **Pre-natal Care/Physician Delivery:** 70% Coinsurance; subject to Calendar Year deductible. |
| **Mental Health Services**<br>Inpatient confinement requires Pre-certification | **Outpatient Services:** $50 Co-payment<br>**Inpatient Services, Partial Hospitalization:** 80% Coinsurance; subject to Calendar Year deductible. | **Inpatient Services, Partial Hospitalization & Outpatient Services:** 70% Coinsurance; subject to Calendar Year deductible. |
| **Outpatient Imaging / X-Ray Services** | 80% Coinsurance; subject to Calendar Year deductible. | 70% Coinsurance; subject to Calendar Year deductible. |
| | Includes Diagnostic & Complex Imaging in any location. | |
| **Outpatient Laboratory Services** | 80% Coinsurance; subject to Calendar Year deductible. | 70% Coinsurance; subject to Calendar Year deductible. |

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|---|---|---|
| **Outpatient Physician Office Visit Services** | **Teladoc Health Visit:** $0 Co-payment<br>**Primary Care Office Visit:** $30 Co-payment<br>**Specialist Office Visit:** $50 Co-payment<br>**Urgent Care Provider:** $60 Co-payment | **Primary Care Visit:** $30 Co-pay + 20%*<br>**Specialist Office Visit:** $50 Co-pay then 20%*<br>**Urgent Care Provider:** $60 Co-pay then 20%*<br>*20% of allowable rate; not subject to deductible. |
| | Refer to Outpatient Laboratory Services, Outpatient Imaging / X-Ray Services and Outpatient Surgery Benefit for benefits payable even if performed in Physician's office. | |
| **Outpatient Surgery** | 80% Coinsurance;<br>subject to Calendar Year deductible. | 70% Coinsurance;<br>subject to Calendar Year deductible. |
| **Outpatient Therapy Services** | 80% Coinsurance;<br>subject to Calendar Year deductible. | 70% Coinsurance;<br>subject to Calendar Year deductible. |
| | Includes Physical Therapy, Speech Therapy, Occupational Therapy and Cardiac Therapy. | |
| **Pre-certification for Inpatient Hospital Admissions** | Pre-admission certification is mandatory for all inpatient Hospital Admissions. Emergency hospital admissions must be approved within 48 hours. Failure to comply will result in a penalty of $250 due to pre-certification non-compliance. | |
| **Prescription Drug Benefits**<br>▪ Retail Prescriptions (30 day supply maximum)<br>▪ Mail Order Prescriptions (90 day supply maximum) | **Retail Network Pharmacy Co-payments:**<br>▪ Generic medications: $10 Co-payment<br>▪ Formulary Brand medications: $40 Co-payment<br>▪ Non-Formulary Brand medications: $60 Co-pay<br>**Mail Order Prescription Co-payments:**<br>▪ Generic medications: $20 Co-payment<br>▪ Formulary Brand medications: $80 Co-payment<br>▪ Non-Formulary Brand medications: $120 Co-pay<br>**Specialty / Injectible Prescriptions:**<br>30% Co-payment; not subject to deductible. | Prescriptions purchased from Non-Participating Pharmacies or outside of the Mail Order pharmacy program are not eligible for reimbursement from the Plan. |
| **Prosthetic Appliances** | 80% Coinsurance;<br>subject to Calendar Year deductible. | 70% Coinsurance;<br>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**<br>(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:<br>▪ Immunizations.<br>▪ Fasting lipoprotein profile (cholesterol screening).<br>▪ Annual Prostate Specific Antigen (PSA) screening.<br>▪ Fasting blood sugar screening (for diabetes mellitus).<br>▪ Annual colorectal screening.<br>▪ Blood pressure screening.<br>▪ Obesity screening and counseling.<br>▪ Tobacco use screening and cessation interventions.<br>▪ ACA required prescription drugs.<br>▪ Bone Mineral Density (BMD) screening (once every 24 months).<br>▪ 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.<br>**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**<br>(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.<br>**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;<br>subject to Calendar Year deductible. | 70% Coinsurance;<br>subject to Calendar Year deductible. |
| **Vision Examination**<br>Limited to one (1) exam annually | 80% Coinsurance;<br>subject to Calendar Year deductible. | 70% Coinsurance;<br>subject to Calendar Year deductible. |
| **All Other Covered Medical Expenses** | 80% Coinsurance;<br>subject to Calendar Year deductible. | 70% Coinsurance;<br>subject to Calendar Year deductible. |

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

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