ETC PALM BEACH HEALTH BENEFIT PLAN **HIGH 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	$500 per individual / $1,000 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 90% of covered expenses	Plan pays 80% of covered Reasonable & Customary charges
Member Out-of-Pocket Maximum	$3,000 per individual $6,000 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 Inpatient admission requires Pre-certification	**Outpatient Services:** $50 Co-payment **Inpatient Services, Partial Hospitalization:** 90% Coinsurance; subject to Calendar Year deductible.	**Inpatient Services, Partial Hospitalization and Outpatient Services:** 80% 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.	80% Coinsurance; subject to Calendar Year deductible.
Ambulance Services	100% of covered expenses following a $100 Co-payment.	$100 Co-payment plus 20%.
Chiropractic Services / Spinal Manipulation Limit of 30 visits per Calendar year	100% of covered expenses following a $50 Co-payment per visit; not subject to Calendar Year deductible.	80% Coinsurance; subject to Calendar Year deductible.
Durable Medical Equipment & Supplies	90% Coinsurance; subject to Calendar Year deductible.	80% 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 Requires Pre-certification	90% Coinsurance; subject to Calendar Year deductible.	80% Coinsurance; subject to Calendar Year deductible.
	Extended Care Facility includes Rehabilitation Hospital & Skilled Nursing Facility services.	
Home Health Care	90% Coinsurance; subject to Calendar Year deductible.	80% Coinsurance; subject to Calendar Year deductible.
Hospice Care	90% Coinsurance; subject to Calendar Year deductible.	80% Coinsurance; subject to Calendar Year deductible.
Inpatient Hospital Services Requires Pre-certification	90% Coinsurance; subject to Calendar Year deductible.	80% 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: 90% Coinsurance; subject to Calendar Year deductible.	**Pre-natal Care/Physician Delivery:** 80% Coinsurance; subject to Calendar Year deductible.
Mental Health Services Inpatient confinement requires Pre-certification	**Outpatient Services:** $50 Co-payment **Inpatient Services, Partial Hospitalization:** 90% Coinsurance; subject to Calendar Year deductible.	**Inpatient Services, Partial Hospitalization and Outpatient Services:** 80% Coinsurance; subject to Calendar Year deductible.
Outpatient Imaging / X-Ray Services Includes Diagnostic & Complex Imaging	**Physician Office / Non-Hospital Imaging Facility:** $60 Co-payment. **Hospital Facility:** 90% Coinsurance; subject to Calendar Year deductible.	**Physician Office / Non-Hospital Imaging Facility:** $60 Co-pay + 20% of allowable rate; not subject to Calendar Year deductible. **Hospital Facility:** 80% Coinsurance; subject to Calendar Year deductible.
Outpatient Laboratory Services	**Physician Office / Independent Lab:** $60 Co-payment. **Hospital Facility:** 90% Coinsurance; subject to Calendar Year deductible.	**Physician Office / Independent Lab:** $60 Co-pay + 20% of allowable rate; not subject to Calendar Year deductible. **Hospital Facility:** 80% Coinsurance; subject to Calendar Year deductible.

Medical Benefits	Cigna PPO Network Providers	Non-PPO Providers
Outpatient Physician Office Visit Services	**Teladoc Health Visit:** $0 Co-payment **Primary Care Office Visit:** $30 Co-payment **Specialist Office Visit:** $50 Co-payment **Urgent Care Provider:** $60 Co-payment	**Primary Care Visit:** $30 Co-pay + 20%* **Specialist Office Visit:** $50 Co-pay + 20%* **Urgent Care Provider:** $60 Co-pay + 20%* *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	90% Coinsurance; subject to Calendar Year deductible.	80% Coinsurance; subject to Calendar Year deductible.
Outpatient Therapy Services	90% Coinsurance; subject to Calendar Year deductible.	80% Coinsurance; 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 ▪ Retail Prescriptions (30 day supply maximum) ▪ Mail Order Prescriptions (90 day supply maximum)	**Retail Network Pharmacy Co-payments:** ▪ Generic medications: $10 Co-payment ▪ Formulary Brand medications: $40 Co-payment ▪ Non-Formulary Brand medications: $60 Co-pay **Mail Order Prescription Co-payments:** ▪ Generic medications: $20 Co-payment ▪ Formulary Brand medications: $80 Co-payment ▪ Non-Formulary Brand medications: $120 Co-pay **Specialty / Injectible Prescriptions:** 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	90% Coinsurance; subject to Calendar Year deductible.	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	90% Coinsurance; subject to Calendar Year deductible.	80% Coinsurance; subject to Calendar Year deductible.
Vision Examination Limited to one (1) exam annually	90% Coinsurance; subject to Calendar Year deductible.	80% Coinsurance; subject to Calendar Year deductible.
All Other Covered Medical Expenses	90% Coinsurance; subject to Calendar Year deductible.	80% Coinsurance; subject to Calendar Year deductible.

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

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