ESTERO BAY CHEVROLET HEALTH BENEFIT PLAN **PPO Plan 1000/80**
Medical Summary of Benefits **Effective October 1, 2022**

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

MEDICAL BENEFITS	Cigna PPO Network Providers www.Cigna.com	Non-PPO Providers
Member Calendar Year Deductible	$1,000 per individual $2,000 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. PPO and Non-PPO deductibles shall combine together.	
Coinsurance	Plan pays 80% of covered expenses.	Plan pays 60% of covered expenses.
Member Out-of-Pocket Maximum	$4,000 per individual $8,000 per family (accumulative)	
	Out-of-Pocket Maximum includes Medical Plan & Prescription Drug Co-payments, 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. PPO and Non-PPO Out-of-Pocket Maximums shall combine together.	
Lifetime Maximum Benefit	Unlimited.	
Alcohol & Substance Abuse Treatment Inpatient Hospital admission requires Pre-certification	**Inpatient / Partial Hospitalization:** 80% Coinsurance; subject to Calendar Year deductible. **Outpatient Services:** 100% of covered expenses following a $40 Co-payment; not subject to Calendar Year deductible.	**Inpatient / Partial Hospitalization:** 60% Coinsurance; subject to Calendar Year deductible. **Outpatient Services:** 60% Coinsurance after $40 Co-payment; not subject to Calendar Year deductible.
Allergy Injections, Testing and Treatment	**Testing & Injections:** 100% of covered expenses following a $40 Co-payment. **Allergy Serum:** 100% of covered expenses following a $100 Co-payment. Not subject to Calendar Year deductible.	**Testing & Injections:** 60% Coinsurance following $40 Co-payment. **Allergy Serum:** 60% Coinsurance following $100 Co-payment. Not subject to Calendar Year deductible.
Ambulance Services	100% of covered expenses following a $100 Co-payment; not subject to Calendar Year deductible.	60% Coinsurance following $100 Co-payment; not subject to Calendar Year deductible.
Chiropractic Services / Spinal Manipulation	100% of covered expenses following a $40 Co-payment; not subject to Calendar Year deductible.	60% Coinsurance after $40 Co-payment; not subject to Calendar Year deductible.
Durable Medical Equipment & Supplies	80% Coinsurance; subject to Calendar Year deductible.	60% Coinsurance; subject to Calendar Year deductible.
Emergency Room Services	100% of covered expenses following a $250 Co-payment; not subject to Calendar Year deductible. Co-payment waived if admitted directly from Emergency Room to Hospital.	
Extended Care Facility Requires Pre-certification	80% Coinsurance; subject to Calendar Year deductible.	60% Coinsurance; subject to Calendar Year deductible.
Home Health Care	80% Coinsurance; subject to Calendar Year deductible.	60% Coinsurance; subject to Calendar Year deductible.
Hospice Care	80% Coinsurance; subject to Calendar Year deductible.	60% Coinsurance; subject to Calendar Year deductible.
Inpatient Hospital Services Includes Physician Services	80% Coinsurance; subject to Calendar Year deductible.	60% Coinsurance; subject to Calendar Year deductible.
Maternity Care	**Initial Maternity Office Visit:** $40 Co-payment; not subject to Calendar Year deductible. **Pre-natal & Post-natal Care, Delivery & all Inpatient Hospital Services:** 80% Coinsurance; subject to Calendar Year deductible.	**Initial Maternity Office Visit:** 60% Coinsurance following $40 Co-payment; not subject to Calendar Year deductible. **Pre-natal & Post-natal Care, Delivery & all Inpatient Hospital Services:** 60% Coinsurance; subject to Calendar Year deductible.

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Mental Health Services Inpatient admission requires Pre-certification	**Inpatient / Partial Hospitalization:** 80% Coinsurance; subject to Calendar Year deductible. **Outpatient Services:** 100% of covered expenses following a $40 Co-payment; not subject to Calendar Year deductible.	**Inpatient / Partial Hospitalization:** 60% Coinsurance; subject to Calendar Year deductible. **Outpatient Services:** 60% Coinsurance after $40 Co-payment; not subject to Calendar Year deductible.
Outpatient Imaging / X-Ray Services	**Diagnostic Imaging / X-Rays (not complex):** 100% of covered expenses following a $60 Co-payment; not subject to Calendar Year deductible. **Complex Imaging Services:** (Includes but is not limited to CT scans, MRI's, MRA's, PET scans) Independent Imaging Facility: 100% of covered expenses following a $250 Co-payment; not subject to Calendar Year deductible. Outpatient Hospital: 80% Coinsurance; subject to Calendar Year deductible.	**Diagnostic Imaging / X-Rays (not complex):** 60% Coinsurance after $60 Co-payment; not subject to Calendar Year deductible. **Complex Imaging Services:** (Includes but is not limited to CT scans, MRI's, MRA's, PET scans) Independent Imaging Facility: 60% Coinsurance following a $250 Co-payment; not subject to Calendar Year deductible. Outpatient Hospital: 60% Coinsurance; subject to Calendar Year deductible.
Outpatient Laboratory Services	100% of covered expenses following a $60 Co-payment; not subject to Calendar Year deductible.	60% Coinsurance after $60 Co-payment; not subject to Calendar Year deductible.
Outpatient Physician Office Visit Services ***Co-payment applies only to Physician office visit charge.** Refer to Outpatient Imaging / X-ray Services, Outpatient Laboratory & Outpatient Surgery categories for services performed in the Physician's office during the office visit.	**Teladoc and Virtual Office Visits:** 100% of covered expenses; Co-payment waived. **Primary Care Physician Office Visit / Convenience Care Clinic:** 100% of covered expenses following a $20 Co-payment.* **Specialist Office Visit:** 100% of covered expenses following a $40 Co-payment.* **Urgent Care Provider:** 100% of covered expenses following a $60 Co-payment.* Office Visit charge not subject to Calendar Year deductible.	**Primary Care Physician Office Visit / Convenience Care Clinic:** 60% Coinsurance following a $20 Co-payment.* **Specialist Office Visit:** 60% Coinsurance following a $40 Co-payment.* **Urgent Care Provider:** 60% Coinsurance following a $60 Co-payment.* Office Visit charge not subject to Calendar Year deductible.
Outpatient Surgery	80% Coinsurance; subject to Calendar Year deductible.	60% Coinsurance; subject to Calendar Year deductible.
Outpatient Therapy Services	100% of covered expenses following a $40 Co-payment; not subject to Calendar Year deductible.	60% Coinsurance following a $40 Co-payment; not subject to Calendar Year deductible.
	Includes Physical, Speech, Occupational and Cardiac/Pulmonary 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 $250 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) If Generic is available and brand is purchased, member pays the brand Co-pay PLUS difference in the cost between generic and brand drug. This does not apply if "Dispense as Written" is prescribed by Physician.	**Retail Network Pharmacy Co-payments:** ▪ Generic medications: $0 ▪ Formulary Brand medications: $30 ▪ Non-Formulary Brand medications: $60 **Mail Order Prescription Co-payments:** ▪ Generic medications: $10 ▪ Formulary Brand medications: $60 ▪ Non-Formulary Brand medications: $120 **Specialty / Injectible Prescription:** $250 Co-payment for 30 day prescription. $500 Co-payment for 60-90 day prescription. Not subject to Calendar Year deductible.	Prescription drugs purchased from Non-Participating Pharmacies are not eligible for reimbursement by the Plan.
Prosthetic Appliances	80% Coinsurance; subject to Calendar Year deductible.	60% Coinsurance; subject to Calendar Year deductible.
Routine Colonoscopy	100% of covered expenses; not subject to Calendar Year deductible.	
Routine Mammogram	100% of covered expenses; not subject to Calendar Year deductible.	

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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	80% Coinsurance; subject to Calendar Year deductible.	60% Coinsurance; subject to Calendar Year deductible.
Vision Examinations Limited to one (1) vision examination each Calendar Year	100% of covered expenses following a $40 Co-payment; not subject to Calendar Year deductible. Co-payment waived for children under the age of 5.	60% Coinsurance following a $40 Co-payment; not subject to Calendar Year deductible. Co-payment waived for children under the age of 5.
All Other Covered Medical Expenses	80% Coinsurance; subject to Calendar Year deductible.	60% Coinsurance; subject to Calendar Year deductible.

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

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