Stop Loss Provided By:

PPO 6550/70

SERVICES	PPO PROVIDERS	NON-PPO PROVIDERS
Plan Year Deductible (Embedded)	$6,550 per Individual $13,100 per Family	Not Covered
Coinsurance	Plan pays 70%	Not Covered
Out-of-Pocket Maximum	$7,350 per Individual $14,700 per Family	Not Covered
Preventative Care Provisions	No Deductible, No Copay as required under the law	Not Covered
Professional Outpatient Office Visits (includes Primary Care, Specialist, and Mental Health and Substance Abuse physicians)		
First 3 office visits per Plan Year: Copay includes office visit charge, In-office Surgery, Lab and X-ray (but not Advanced Imaging), allergy testing, and allergy treatment	$30 Copay per visit; $0 if www.1800md.com (1-800-530-8666) used	Not Covered
After first 3 visits per Plan Year:	70% after Deductible	
Diagnostic Testing		
Inpatient Lab, X-rays	70%, no Deductible	Not Covered
Doctors Office - Lab, X-rays	Refer to **Professional Outpatient Office Visits**	Not Covered
Outpatient Lab, X-rays	$50 Copay, then 70% no Deductible	Not Covered
All Advanced Imaging (e.g., MRI, MRA, PET, CT)	$300 Copay, then 70% no Deductible	Not Covered
Inpatient Hospital Services		
Medical Services and Facility	70% after Deductible	Not Covered
Anesthesiologist & Surgeon Fees (Assistants at 20% of Primary)		
Mental Health & Substance Abuse		
Outpatient Surgical & Diagnostic		
Medical Services	70% after Deductible	Not Covered
Facility Charges		
Emergency Services		
Hospital Emergency Room	$250 Copay for facility and $250 Copay for physician; then 70%, no Deductible. Copays waived if admitted directly to the Hospital from the Emergency Room.	Covered as if In-Network
Urgent Care Visits	$50 Copay for the first visit; visits thereafter are 70% after Deductible	Not Covered
Ambulance - Ground	70% after Deductible	Covered as if In-Network
Ambulance - Air	70% after Deductible; Limit $7,500 maximum per trip for air ambulance	Covered as if In-Network
Prescription Drugs* - Generic Non-Specialty/ Formulary/Non-Formulary/Specialty Drugs	No Cost first $600 Generic. Otherwise, after Deductible $20/$50/$80/50%; See Note for Mail-order.	Not Covered
Supplemental Services		
Home Health	70% after Deductible; Limit 100 Visits per Plan Year	Not Covered
Occupational Therapy	70% after Deductible; Limit 20 Visits per Plan Year	Not Covered
Physical Therapy	70% after Deductible; Limit 20 Visits per Plan Year	Not Covered
Speech Therapy	70% after Deductible; Limit 20 Visits per Plan Year	Not Covered
Private Duty Nursing	70% after Deductible; Limit 10 Visits per Plan Year	Not Covered
Skilled Nursing	70% after Deductible; Limit 60 Days per Plan Year	Not Covered
Epidural Injections	70% after Deductible; Limit 10 Visits per Plan Year	Not Covered
Non-Surgical Treatment of the Spine	70% after Deductible; Limit $1,000 per Plan Year	Not Covered
Hospice Care	70% after Deductible	Not Covered
TMJ	70% after Deductible; $1,000 Lifetime Maximum Benefit	Not Covered
Allergy Treatment		
Testing and Injections	Refer to **Professional Outpatient Office Visits**	Not Covered
Serum		
Durable Medical Equipment	70% after Deductible	Not Covered

Network Providers have agreed to accept the Maximum Allowable Charge (MAC) as payment in full. Non-Network providers are not covered except in the case of an Emergency, at which time, they will be covered under In-Network benefits. Please refer to your Summary Plan Description (SPD) for details. **The SPD is the final determination of all benefits.**

* Prescription Drugs - You pay the difference if a generic is available, even if doctor requested otherwise. Drugs subject to Cigna programs for Prior Authorization, Step Therapy and Exclusive Specialty. Copays shown are per 30-day prescription, mail-order copay is two times for a 60 or more day supply.
Pre-Certification Penalty: Certain procedures or medical care require pre-certification in order to qualify for full benefits. Failure to pre-certify will result in a $250 penalty per service, procedure or confinement. Please refer to the Pre-Certification section in your SPD for details.

Please Note: This schedule applies as indicated in the SPD. *This schedule must be read in conjunction with the entire Summary Plan Description and has no full meaning by itself.*

Stop Loss Provided By:

PPO 6550/70 - Health Plan Options	
Plan Year Deductible	An individual with family coverage will only be required to meet the individual deductible amount before the coinsurance begins. Deductible does not apply to Preventive Care Provisions.
Coinsurance	Coinsurance is the share of the cost of a covered service, calculated as a percent of the allowed amount of the service.
Out-of-Pocket Maximum	All allowed deductibles, coinsurance, copayments and pre-certification penalties apply to the Out-of-Pocket Maximum. An individual with family coverage will only be required to meet the individual out-of-pocket maximum.
Preventative Care Provisions	In-Network charges for preventive care services coverage are at no cost sharing. Out-of-Network preventive care is not covered. Cost sharing may apply if a specific service is for non-preventive care (even if billed in conjunction with preventive care services). Although not required under the law, this plan pays for Prostatic/Testicular exams.
Professional Outpatient Office Visits	These charges are billed by the physician for time spent with the patient. Office visits do not include charges for diagnostic, surgical, or medical procedures performed by the physician.
Primary Care	
Specialist	
Mental Health	Mental Health and Substance Abuse coverage excludes counseling for behavioral disorders.
Substance Abuse	
Independent Diagnostic Testing Facility	These charges are billed by an independent facility, separate from any charges billed by the requesting physician.
X-rays & Adv. Imaging (e.g., MRI, MRA, PET, CT)	
Independent Clinical Labs - Blood Work	
Outpatient Surgical & Diagnostic	Includes outpatient services, miscellaneous medical procedures & supplies, diagnostic & therapeutic procedures and surgery at a physician's office, freestanding surgery center, or hospital (when approved).
Medical Services	
Facility Charges	
Emergency Services	Urgent care visits include charges for diagnostic (except advanced imaging), surgical or medical procedures.
Hospital Emergency Room	
Urgent Care Visits	
Ambulance - Ground	
Ambulance - Air	
Prescription Drugs	If generics are available and a brand name is purchased, then the covered person must pay the copay PLUS the difference in the cost between the generic and brand-name drug. In the case of the integrated drug plan, the plan will reimburse only up to the cost of the generic equivalent.
Short-Term Rehabilitation Services	Includes therapies performed in the provider's office or non-hospital based facility only.
TMJ	There is a lifetime benefit for these services.