Stop Loss Provided By:

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DEGREES HEALTH

TRU FREEDOM 6550-70/30

PLAN BENEFITS	
Physician Office Visits - Primary Care (PCP) and Specialty Care (SCP) Physician You Chose Your Physician; Copay includes office visit charge, In-office Surgery, Lab and X-ray (but not Advanced Imaging), allergy testing, and allergy treatment, mental health and substance abuse outpatient visits.	FOR THE FIRST THREE VISITS You pay $30 per visit copay, then Plan pays 100%; Visits 4 and therafter are AFTER the deductible and You pay 30% then the Plan pays 70%
Telehealth Services www.1800md.com (1-800-530-8666) Board Certified Physcians, diagnosis, treatment and prescriptions thru telephone and video consultations available 24 hours a day, 7 days a week. 70% of all urgent care and emergency room visits are unnecessary and expensive.	You pay $0 per consultation, Plan pays 100%
Urgent Care Visit All Services including Lab and X-ray, diagnostics (except advanced imaging), surgical or medical procedures.	FOR THE FIRST THREE VISITS You pay $30 per visit copay, then Plan pays 100%; Visits 4 and therafter are AFTER the deductible and You pay 30% then the Plan pays 70%
Preventative Care	Plan Pays 100% no copay, no deductible
Preventative Services	Plan Pays 100% no copay, no deductible
Immunizations	Plan Pays 100% no copay, no deductible
PPACA Women's Health Includes contraceptive devices and surgical services such as tubal ligation (except reversals).	Plan Pays 100% no copay, no deductible
Coinsurance	After the Plan Deductible, You pay 30% Plan pays 70%
Plan Year Deductible (Embedded) - Benefits for an individual within a family are paid once the individual deductible has been met. Copays always apply before plan deductible and coinsurance.	$6,550 Individual $13,100 Family
Out-of-Pocket Annual Maximum - Medical copays apply towards the out-of-pocket maximums. Medical deductibles apply towards the out-of-pocket maximums.	$7,350 Individual $14,700 Family
Lifetime Maximum	Unlimited Per Individual

Hospital Emergency Room (ER) All services rendered apply to ER including Lab and X-ray.	You pay per visit $250 copay for facility plus $250 for physician (copays waived if admitted), then You pay 30%, Plan pays 70%
Ambulance - Ground	After the Plan Deductible, You pay 30% Plan pays 70%
Ambulance - Air	After the Plan Deductible, Plan pays 70% Limit $7,500 maximum per trip for air ambulance
Office Surgery - PCP	Refer to Physician Office Visits
Office Surgery - SCP	Refer to Physician Office Visits
Other Office Services - Lab, X-ray	Refer to Physician Office Visits
Independent Facility - Lab, X-rays See Independent Facility Advanced Imaging below.	No Deductible, After a $50 copay You pay 30% Plan pays 70%
Independent Facility Advanced Imaging (e.g., MRI, MRA, PET, CT, Nuclear Medicine)	No Deductible, After a $300 copay You pay 30% Plan pays 70%
Allergy Treatment	Refer to Physician Office Visits
Durable Medical Equipment Includes external prosthetic appliances	After the Plan Deductible, You pay 30% Plan pays 70%
TMJ Temporomandibular joint dysfunction	After the Plan Deductible, Plan pays 70% Limit $1,000 maximum lifetime benefit

HOSPITAL SERVICES	
Inpatient Hospital Services Preadmission Certification REQUIRED unless an emergency	After the Plan Deductible, You pay 30% Plan pays 70%
Inpatient Lab & X-ray	No Deductible, You pay 30% Plan pays 70%
Inpatient Advanced Imaging (e.g., MRI, MRA, PET, CT)	No Deductible, After a $300 copay You pay 30% Plan pays 70%
Inpatient Professional Services For services performed by surgeons, radiologists, pathologists, hospital based physicians and anesthesiologists (assistants at 20% of primary)	After the Plan Deductible, You pay 30% Plan pays 70%
Outpatient Hospital/Facility Services	After the Plan Deductible, You pay 30% Plan pays 70%
Outpatient Professional Services For services performed by surgeons, radiologists, pathologists, hospital based physicians and anesthesiologists	After the Plan Deductible, You pay 30% Plan pays 70%
Skilled Nursing Facility 60 days per Plan year maximum	After the Plan Deductible, You pay 30% Plan pays 70%
Hospice Care	After the Plan Deductible, You pay 30% Plan pays 70%
Home Health Care 100 visits per Plan year maximum	After the Plan Deductible, You pay 30% Plan pays 70%
Private Duty Nursing 10 visits per Plan year maximum	After the Plan Deductible, You pay 30% Plan pays 70%
Epidural Injections 10 visits per Plan year maximum	After the Plan Deductible, You pay 30% Plan pays 70%
MENTAL HEALTH AND SUBSTANCE ABUSE DISORDER	
Inpatient Mental Health Includes residential treatment	After the Plan Deductible, You pay 30% Plan pays 70%
Inpatient Substance Abuse Includes residential treatment	After the Plan Deductible, You pay 30% Plan pays 70%
Outpatient Mental Health	Refer to Physician Office Visits
Outpatient Substance Abuse	Refer to Physician Office Visits
THERAPY SERVICES	
Outpatient Physical Therapy 20 visits per Plan year maximum	After the Plan Deductible, You pay 30% Plan pays 70%
Outpatient Speech Therapy 20 visits per Plan year maximum	After the Plan Deductible, You pay 30% Plan pays 70%
Outpatient Occupational Therapy 20 visits per Plan year maximum	After the Plan Deductible, You pay 30% Plan pays 70%
Non-Surgical Treatment of the Spine/Chiropractic Services	After the Plan Deductible, Plan pays 70% Limit $1,000 maximum per Plan year
Prescription Drugs* - Generic/Formulary/Non-Formulary/Specialty	No Cost first $600 Generic. Otherwise, after Deductible $20/$50/$80/50%; 2 time Mail-order. SEE NOTE.
SAVINGS FOR YOU AND YOUR FAMILY.	

No out-of-network increased deductibles, coinsurance and copays.
Freedom to choose your physician, hospital and treatment throughout the United States.
Freedom to choose the prescription drug benefits that accomodates your needs.
Your employer has partnered with a Third Party Administrator to help combat rising healthcare costs by paying hospitals and doctors what is fair and reasonable for health care services, that is known as reference based reimbursement (RBR). Now, when you visit a facility or hospital, the claim will be audited and fairly-priced by removing errors and determining what is a fair market value.
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.

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 $400 penalty per service, procedure or confinement. Please refer to the Pre-Certification section in your SPD for details.
Emergency Admissions Penalty: In the case of an Emergency Admission, the member must call the toll-free number listed on the medical identification card within 48 hours after admission or on the next regular business day after the start of treatment, if later. Failure to call will result in a $250 penalty per occurence. This penatly will not count toward the plan deductible or towards the Out-of-pocket limit.
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.
Copayments - Copayment, if any, does not apply towards deductibles or coinsurance but does apply to maximum out-of-pocket limits.
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.
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.
Mental Health and Substance Abuse coverage - These benefits exclude counseling for behavioral disorders.
Therapies - Physical, Occupational and Speech Therapy covered if performed in provider's office or non-hospital based facility only.
Outpatient Hospital/Facility Services - These include miscellaneous medical procedures & supplies, diagnostic & therapeutic procedures and surgery at a freestanding surgery center, or outpatient hospital (when approved).
* **Prescription Drugs** - You pay the difference if a generic is available, even if doctor requested otherwise. Copays shown are per prescription, mail-order copay is two times for a 90-day supply. 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.