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%	
Out-of-Pocket Maximum (Non-PPO providers do not satisfy the PPO provider Out-of-Pocket)	$7,150 per Individual $14,300 per Family	
Preventive Care Provisions	No Deductible, No Copay	Not Covered
Professional Outpatient Office Visits		
Primary Care, Specialist, Mental Health and Substance Abuse, Allergy Treatments		Not Covered
First 3 office visits includes Surgery, In-Office Lab and X-ray (but not Advanced Imaging)	$25 Copay per visit	
After first 3 visits	70% After the Deductible	
Diagnostic Testing		
In Doctors Office - First 3 Visits - Lab, X-rays	Included as Part of Office Visit	Not Covered
All Other Lab, X-rays	70% after $50 Copay; No deductible	Not Covered
All Advance Imaging (e.g., MRI, MRA, PET, CT)	70% after $300 Copay; No deductible	Not Covered
Inpatient Hospital Services	70% after Deductible	Not Covered
Medical Services and Facility		
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	70% after a $250 Facility and $250 Physician Emergency Room Copays	Covered as if In-Network
Urgent Care Visits	$50 Copay for first visit; all other visits 70% after deductible	Not Covered
Ambulance - Ground	70% after Deductible	Covered as if In-Network
Ambulance - Air	70% after Deductible up to $7,500 per Plan Year for accidents only	Covered as if In-Network
Prescription Drugs* - Generic Non-Specialty/ Formulary/Non-Formulary/Specialty	No Cost first $600 Generic. Otherwise, After Deductible $0/$40/$80/30% up to $500 max copays; 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
Chronic Pain Treatment Program	70% after Deductible; Limit 10 Visits per Plan Year	Not Covered
Manipulative Therapy	70% after Deductible; Limit 20 Visits 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	70% after Deductible unless during the first 3 office visit benefits	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.*

PPO 6550/70 - Health Plan Options *PLEASE REFER TO THE NETWORK PROVIDER INFORMATION ON THE FRONT PAGE OF THIS SUMMARY OF BENEFITS*	
Plan Year Deductible	An individual within 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 costs 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 within family coverage will only be required to meet the individual out-of-pocket maximum.
Preventive 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).
Professional Outpatient Office Visits	These charges are billed by the physician for time spent with the patient. The first 3 Office Visits DO include charges for diagnostic, surgical, or medical procedures performed in the office by the physician. All other visits and charges are subject to the deductible, coinsurance or copays. Mental Health and Substance Abuse coverage excludes Behavioral Health counselling.
Primary Care (In-office Xray/Blood work Incl.)	
Specialist	
Mental Health	
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, 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 the 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.