MEDICAL SCHEDULE OF BENEFITS

Benefit Period: July 1 – June 30

MEDICAL BENEFITS-PPO PLAN	PREFERRED PROVIDER	NONPREFERRED PROVIDER
Deductible per benefit period		
Individual	$500	$1,000
Family (embedded)	$1,500	$3,000
Deductible does share between preferred and nonpreferred		
Generally, each ***covered person*** must pay all of the costs from providers up to the deductible amount before the ***Plan*** begins to pay. **Embedded family deductible**: Any number of covered family members may help to satisfy the family deductible, but no family member will incur more than the individual deductible amount.		
Out-of-Pocket Expense Limit per benefit period (includes deductible, ***coinsurance***, and ***copays***)		
Individual	$3,500	$7,000
Family (embedded)	$10,500	$21,000
Out-of-pocket expense limit does share between preferred and nonpreferred		
The out-of-pocket expense limit is the most the ***covered person*** could pay in a year for ***covered expenses***. The ***Plan*** will pay the designated percentage of ***covered expenses*** until the out-of-pocket expense limits are reached; at which time the ***Plan*** will pay 100% of the remainder of ***covered expenses*** for the rest of the benefit period unless stated otherwise. **Embedded family out-of-pocket expense limit:** Any number of covered family members may help to satisfy the family out-of-pocket expense limit, but no family member will incur more than the individual out-of-pocket expense limit. The following charges do not apply to the out-of-pocket expense limit and are never paid at 100%: • expenses not covered by the ***Plan*** • expenses in excess of amounts covered by the ***Plan*** • expenses in excess of ***customary and reasonable amount*** • expenses incurred as a result of failure to obtain pre-certification		
Standard *coinsurance* paid by the *Plan*	80%	60%

MEDICAL BENEFITS-PPO PLAN	PREFERRED PROVIDER	NONPREFERRED PROVIDER
Acupuncture	Not covered	Not covered
Allergy Services		
Allergy testing, injections and serum	80% after deductible	60% after deductible
Specialist	80% after deductible	60% after deductible
Ambulance		
Land	80% after deductible	***Preferred Provider*** benefit applies
Air	80% after deductible	***Preferred Provider*** benefit applies
Applied Behavior Analysis Therapy (ABA)	80% after deductible	60% after deductible
Bereavement Counseling	80% after deductible	60% after deductible
Birthing Center	80% after deductible	60% after deductible
Blood *(Blood storage and transfusions)*	80% after deductible	60% after deductible
Cardiac Rehabilitation		
Facility	80% after deductible	60% after deductible
Physician	80% after deductible	60% after deductible
Chemotherapy		
Facility	80% after deductible	60% after deductible
Physician	80% after deductible	60% after deductible
Chiropractic Care Office visits, spinal manipulation, adjustments and x-rays	80% after deductible	60% after deductible
	Maximum: 30 visits per plan year	
Diagnostic Services – Major *(such as MRI, CT Scan, PET Scan)*	Independent Lab/Freestanding Facility 80% after deductible Physician's Office: See **Office Visit & Other Services**	Independent Lab/Freestanding Facility 60% after deductible Physician's Office: See **Office Visit & Other Services**
Diagnostic Services – Minor		
Laboratory and X-ray services		
Independent Lab/Freestanding Facility	80% after deductible	60% after deductible
Other diagnostic services	80% after deductible	60% after deductible
Dialysis Therapy or Treatment		
Facility	80% after deductible	60% after deductible
Physician	80% after deductible	60% after deductible

MEDICAL BENEFITS-PPO PLAN	PREFERRED PROVIDER	NONPREFERRED PROVIDER
Durable Medical Equipment	80% after deductible	60% after deductible
Emergency Services – (for an ***emergency***)		
Facility (***copay*** waived if admitted or due to an ***accident***)	80% after deductible and $150 ***copay***	***Preferred Provider*** benefit applies
Physician	80% after deductible	***Preferred Provider*** benefit applies
Emergency Services – (not for an ***emergency***)		
Facility	80% after deductible and $150 ***copay***	***Preferred Provider*** benefit applies
Physician	80% after deductible	***Preferred Provider*** benefit applies
Hearing		
Routine Exam	Not Covered	Not Covered
Hearing Aids	Not Covered	Not Covered
Cochlear Implants/Bone Anchored Hearing Aids *(Medically Necessary)*	80% after deductible	60% after deductible
Home Health Care		
Home health care visits	80% after deductible	60% after deductible
Home health care supplies & services	80% after deductible	60% after deductible
IV therapy	80% after deductible	60% after deductible
Hospice Care		
Inpatient	80% after deductible	60% after deductible
Outpatient	80% after deductible	60% after deductible
Hospital – Inpatient		
Facility	80% after deductible	60% after deductible
Physician/Surgeon	80% after deductible	60% after deductible
Anesthesia, Radiology, Pathology, Lab	80% after deductible	60% after deductible
	Maximum: Inpatient Rehabilitation is limited to 60 days per plan year and is combined with Skilled Nursing.	
Hospital – Outpatient & Ambulatory Surgical Facility		
Facility	80% after deductible	60% after deductible
Physician/Surgeon	80% after deductible	60% after deductible
Anesthesia, Radiology, Pathology, Lab	80% after deductible	60% after deductible

MEDICAL BENEFITS-PPO PLAN	PREFERRED PROVIDER	NONPREFERRED PROVIDER
Infertility Services		
Diagnostic testing to determine infertility	Based on service provided	Based on service provided
Medications and treatments	Not Covered	Not Covered
	Maximum: $5,000 lifetime	
Infusion Therapy		
Facility	80% after deductible	60% after deductible
Physician	80% after deductible	60% after deductible
Office Visit & Other Services (one ***copay*** per provider per date of service)		
Office visit		
Primary care physician (includes outpatient visits for ***mental and nervous disorders*** and ***substance use disorder***)	$25 ***copay*** deductible waived	60% after deductible
Specialist	$50 ***copay*** deductible waived	60% after deductible
Surgery		
Primary care physician	80% after deductible	60% after deductible
Specialist	80% after deductible	60% after deductible
X-ray, lab, minor diagnostics & advanced imaging *(MRIs, CT & PET scans)*		
Primary care physician	$25 ***copay*** deductible waived	60% after deductible
Specialist	$50 ***copay*** deductible waived	60% after deductible
Other services		
Primary care physician	80% after deductible	60% after deductible
Specialist	80% after deductible	60% after deductible
Orthotics	80% after deductible	60% after deductible
Podiatry Services	Based on service provided	Based on service provided
Pregnancy		
Pre-natal and post-natal care	80% after deductible	60% after deductible
Delivery	80% after deductible	60% after deductible
Private Duty Nursing *(Medically Necessary)*		
Inpatient	Not Covered	Not Covered
Outpatient	80% after deductible	60% after deductible
Prostheses	80% after deductible	60% after deductible

MEDICAL BENEFITS-PPO PLAN	PREFERRED PROVIDER	NONPREFERRED PROVIDER
Radiation Therapy		
Facility	80% after deductible	60% after deductible
Physician	80% after deductible	60% after deductible
Respiratory Therapy		
Facility	80% after deductible	60% after deductible
Physician	80% after deductible	60% after deductible
Retail Clinic Visits	$50 ***copay*** deductible waived	60% after deductible
Routine Preventive Care/Wellness Benefits - Routine Office Visits, - Periodic Screening Exams, - Routine Gyn Exam/Pap Smear, - Routine Mammogram - Routine Colonoscopy - Routine Prostate Exam - Routine Immunizations	100% up to maximum combined benefit of $500 per ***covered person*** per plan year, then 80% after deductible	60% after deductible
Routine Well-Childcare	Office Visit: 100% deductible waived Immunizations: $25 ***copay*** deductible waived	60% after deductible
Second Surgical Opinion	80% after deductible	60% after deductible
Skilled Nursing Facility	80% after deductible	60% after deductible
	Maximum: 60 days per plan year combined with Inpatient Rehabilitation	
Telemedicine		
Primary care physician (includes outpatient visits for ***mental and nervous disorders*** and ***substance use disorder***)	$25 ***copay*** deductible waived	60% after deductible
Specialist	$50 ***copay*** deductible waived	60% after deductible
Temporomandibular Joint Syndrome (TMJ) Treatment *(Includes intraoral orthotics, prosthetics and therapy)* Orthodontia services not covered	Based on service provided	Based on service provided
Therapy Services *(Physical, speech and occupational)*		
Facility	80% after deductible	60% after deductible
Physician	80% after deductible	60% after deductible
	Maximum: 30 visits combined for physical and occupational therapy per plan year. Speech therapy limited to 30 visits per plan year.	

MEDICAL BENEFITS-PPO PLAN	PREFERRED PROVIDER	NONPREFERRED PROVIDER
Transplants (Organ or Tissue) *(pre-certification required)* • Expenses for services that are payable under the Specific Employer Transplant Program.	Contact Cigna LifeSOURCE at 1.800.668.9682 for benefit information-authorization of services, and participation in the Cigna Life SOURCE network.	
Urgent Care Center		
Visit	$30 ***copay*** deductible waived	60% after deductible
All other services	100% deductible waived	60% after deductible
Vision – Routine Services	Not Covered	Not Covered
Weight Loss Services		
Surgical treatment	Not Covered	Not Covered
Non-surgical treatment and programs	Not Covered	Not Covered
Wigs *(Required due to chemotherapy)*	80% after deductible	60% after deductible
	Maximum: Limited to one (1) wig lifetime	
All Other C*overed Expenses*	80% after deductible	60% after deductible

PRE-CERTIFICATION REQUIREMENTS – *Covered expenses incurred* for any of the following services shall be reduced by twenty-five percent (25%) if pre-certification is not obtained.

Pre-certification is required for the following services. Refer to *Claim Filing Procedure, Pre-Service Claim Procedure, Filing a Pre-Service Claim* for more information:

- Acute Care- (Services rendered in the hospital setting not included in any other inpatient pre-cert category)
- Routine and high-risk maternity (routine only if inpatient stay exceeds federal requirements)
- Long term acute care
- ***Skilled nursing facility***
- Rehabilitation
- Detox
- IP ***mental and nervous disorders/ substance use disorder hospital***
- IP ***mental and nervous disorders/ substance use disorder*** residential
- Transplants - Adult or pediatric, living or cadaveric donors for heart, heart/lung, intestinal, liver, pancreas, pancreatic islet cell, multivisceral solid organ transplants; preparation for and including allogeneic/autologous hematopoietic/bone marrow transplants; transplant-related travel and lodging
- Diagnostic radiology-CT scans, MRI/MRA, myocardial perfusion imaging, PET scans, cardiac blood pool imaging and cardiac tests including diagnostic cardiac catheterizations and stress echocardiograms
- ***Durable medical equipment***- Seat lifts, TENS, pumps, wheelchairs, power operated vehicles, speech generating devices, insulin infusion pump, osteogenesis stimulators, neuromuscular stimulators
- ***Home Health Care*** (home nursing care) - Registered nurse, licensed practical nurse or aid in the home
- Home infusion therapy - Home infusion therapy for immunotherapy, continuous medications, hydration, total parenteral nutrition, pain management
- ***Outpatient*** procedures (not otherwise categorized) - Facial reconstruction, varicose vein treatment, breast reconstruction or reduction, blepharoplasty, rhinoplasty
- Speech Therapy – Treatment and services of speech, language and voice. Can also be performed in the home setting.
- Therapeutic radiology - Brachytherapy, proton beam therapy, radiotherapy.

PRESCRIPTION DRUG PROGRAM SCHEDULE OF BENEFITS

Benefit Period: July 1 – June 30

PRESCRIPTION DRUG PROGRAM BENEFITS -PPO PLAN	**PARTICIPATING PHARMACY**	**NONPARTICIPATING PHARMACY**
The ***Plan*** will pay the designated percentage of ***covered expenses*** and will apply the applicable ***copay***.		
Retail Pharmacy (34-day supply)		
Generic	$10 ***copay***	Not Covered
Formulary Brand Name	$30 ***copay***	Not Covered
Non-Formulary Brand Name	$60 ***copay***	Not Covered
Retail Pharmacy (90-day supply)		
Generic	$25 ***copay***	Not Covered
Formulary Brand Name	$75 ***copay***	Not Covered
Non-Formulary Brand Name	$150 ***copay***	Not Covered
Mail Order Pharmacy (90-day supply)		
Generic	$25 ***copay***	Not Covered
Formulary Brand Name	$75 ***copay***	Not Covered
Non-Formulary Brand Name	$150 ***copay***	Not Covered
Specialty Drugs (30 -day supply)	Generic: $10 ***copay*** Formulary Brand Name: $30 ***copay*** Non-Formulary Brand Name: $60 ***copay***	Not Covered
If the ***covered person*** selects a brand drug when a generic equivalent is available, the ***covered person*** is responsible for the brand ***copay*** plus the cost difference between the generic and brand equivalent. If a ***nonparticipating pharmacy*** is used, the ***covered person*** will be responsible for the entire cost of the prescription. **Specialty Drugs** must be purchased through the specialty pharmacy.		