Stop Loss Provided By:

Nationwide® | United Advantage Agency™

HDHP 3500/100		
SERVICES	***PPO PROVIDERS***	***NON-PPO PROVIDERS***
Plan Year Deductible (Embedded)	$3,500 per Individual $7,000 per Family	$10,000 per Individual $20,000 per Family
Coinsurance	Plan pays 100%	Plan pays 80%
Out-of-Pocket Maximum (Non-PPO providers do not satisfy the PPO provider Out-of-Pocket)	$3,500 per Individual $7,000 per Family	$15,000 per Individual $30,000 per Family
Preventative Care Provisions	No Deductible, No Copay as required under the law	Not Covered
Professional Outpatient Office Visits		
Primary Care	100% after Deductible; $0 Before Deductible if www.1800md.com (1-800-530-8666) used	80% after Deductible
Specialist		
Mental Health		
Substance Abuse		
Diagnostic Testing		
Doctors Office - Lab, X-rays & Imaging	100% after Deductible	80% after Deductible
Independent Facility - Lab, X-rays & Imaging (e.g., MRI, MRA, PET, CT)	100% after Deductible	80% after Deductible
Inpatient Hospital Services	100% after Deductible	80% after Deductible
Medical Services and Facility		
Anesthesiologist & Surgeon Fees (Assistants at 20% of Primary)		
Mental Health & Substance Abuse		
Outpatient Surgical & Diagnostic		
Medical Services	100% after Deductible	80% after Deductible
Facility Charges		
Emergency Services		
Hospital Emergency Room	100% after Deductible	Covered as if In-Network
Urgent Care Visits	100% after Deductible	80% after Deductible
Ambulance - Ground	100% after Deductible	100% after Deductible
Ambulance - Air	100% after Deductible; Limit $7,500 maximum per trip for air ambulance	100% after Deductible; Limit $7,500 maximum per trip for air ambulance
Prescription Drugs* - Generic/Formulary/Non-Formulary/Specialty	After Deductible $20/$50/$80/50%; 2 times Mail-order; SEE NOTE	Not Covered
Supplemental Services		
Home Health	100% after Deductible; Limit 100 Visits per Plan Year	80% after Deductible; Limit 100 Visits per Plan Year
Occupational Therapy	100% after Deductible; Limit 20 Visits per Plan Year	80% after Deductible; Limit 20 Visits per Plan Year
Physical Therapy	100% after Deductible; Limit 20 Visits per Plan Year	80% after Deductible; Limit 20 Visits per Plan Year
Speech Therapy	100% after Deductible; Limit 20 Visits per Plan Year	80% after Deductible; Limit 20 Visits per Plan Year
Private Duty Nursing	100% after Deductible; Limit 10 Visits per Plan Year	80% after Deductible; Limit 10 Visits per Plan Year
Skilled Nursing	100% after Deductible; Limit 60 Days per Plan Year	80% after Deductible; Limit 60 Days per Plan Year
Epidural Injections	100% after Deductible; Limit 10 Visits per Plan Year	80% after Deductible; Limit 10 Visits per Plan Year
Non-Surgical Treatment of the Spine	100% after Deductible; $1,000 per Plan Year	80% after Deductible; $1,000 per Plan Year
Hospice Care	100% after Deductible	80% after Deductible
TMJ	100% after Deductible; $1,000 Lifetime Maximum Benefit	80% after Deductible; $1,000 Lifetime Maximum Benefit
Allergy Treatment		
Testing and Injections	100% after Deductible	80% after Deductible
Serum		
Durable Medical Equipment	100% after Deductible	80% after Deductible

Network Providers have agreed to accept the Maximum Allowable Charge (MAC) as payment in full. However, when you receive services from Non-Network providers, you are responsible for any amounts over UCR, i.e., the reimbursement level is either the 50 percentile of Usual, Customary, Reasonable charges or 150% of Medicare Allowed). Non-Network providers may charge considerably higher amounts. Therefore, if the billed amount exceeds the UCR, your provider may bill you for the difference. It is best to utilize network providers whenever possible. These amounts over the UCR, while the responsibility of the Covered Person, do not apply toward deductible or out-of-pocket maximums. 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 prescription, mail-order copay is two times for a 90-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.*

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HDHP 3500/100 - 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. Eligible claims incurred in the PPO Network apply to the Out-of-Network deductible; however, the Out-of-Network eligible claims do NOT apply to the PPO Network deductible.
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. Eligible claims incurred in the PPO Network apply to the Out-of-Network Out-of-Pocket Maximum; however, the Out-of-Network eligible claims do NOT apply to the PPO Network 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, 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.