Stop Loss Provided By:

Nationwide® | United Advantage Agency™

DEGREES HEALTH

MEC - Minimum Essential Coverage - Copay Plan

SERVICES	*PPO PROVIDERS*	*NON-PPO PROVIDERS*
Plan Year Deductible (Embedded)	None	None
Coinsurance	Plan pays 100%	Plan pays 100%
Out-of-Pocket Maximum (Non-PPO providers do not satisfy the PPO provider Out-of-Pocket)	None	Not Covered
Preventative Care Provisions	No Deductible, No Copay as required under the law	Covered as PPO only if PPO provider is not available within a 50-mile radius
Professional Outpatient Office Visits		
Primary Care	$25 Copay per visit; Limit 3 visits per Plan Year	Not Covered
Specialist	$50 Copay per visit; Limit 3 visits per Plan year	Not Covered
Mental Health	$25 Copay per visit; Limit 3 visits per Plan Year	Not Covered
Substance Abuse	$25 Copay per visit; Limit 3 visits per Plan Year	Not Covered
Diagnostic Testing		
Doctors Office - Lab, X-rays & Imaging	$25 Copay per visit; Limit 3 visits per Plan Year, combined with visit limit for Professsional Outpatient Office Visits	Not Covered
Independent Facility - X-rays & Imaging (e.g., MRI, MRA, PET, CT)	Not Covered	Not Covered
Inpatient Hospital Services		
Medical Services and Facility	Not Covered	Not Covered
Anesthesiologist & Surgeon Fees (Assistants at 20% of Primary)		
Mental Health & Substance Abuse		
Outpatient Surgical & Diagnostic		
Medical Services	Not Covered	Not Covered
Facility Charges		
Emergency Services		
Hospital Emergency Room	Not Covered	Not Covered
Urgent Care Visits	Not Covered	Not Covered
Ambulance - Ground	Not Covered	Not Covered
Ambulance - Air	Not Covered	Not Covered
Prescription Drugs*	Only if required under the law for preventive care*, otherwise, a discount program is provided	Covered as PPO only if PPO provider is not available within a 50-mile radius
Supplemental Services		
Home Health	Not Covered	Not Covered
Occupational Therapy	Not Covered	Not Covered
Physical Therapy	Not Covered	Not Covered
Speech Therapy	Not Covered	Not Covered
Private Duty Nursing	Not Covered	Not Covered
Skilled Nursing	Not Covered	Not Covered
Epidural Injections	Not Covered	Not Covered
Non-Surgical Treatment of the Spine	Not Covered	Not Covered
Hospice Care	Not Covered	Not Covered
TMJ	Not Covered	Not Covered
Allergy Treatment		
Testing and Injections	Not Covered	Not Covered
Serum	Not Covered	Not Covered
Durable Medical Equipment	Not Covered	Not Covered

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.*

MEC - Minimum Essential Coverage	
Plan Year Deductible	None
Coinsurance	Plan Pays 100%
Out-of-Pocket Maximum	None
Preventative Care Provisions	In-Network charges for preventive care services coverage are at no cost sharing. Out-of-Network preventive care is not covered, unless an In-Network provider is not available. Services for non-preventive care will not be covered (even if billed in conjunction with preventive care services), unless a PPO provider is not available within a 50-mile radius. 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 (ONLY the office visit charge is covered by this copay). All other services rendered during the office visit (except diagnositic testing in an office) are not included in the copay and are not covered. Visits are limited to 3 per plan year for all types of physicians (PCP,Specialist, and Mental Health providers) and combined with the limit for diagnostic testing in an office. If diagnostic testing is done in the office and an office visit is billed, 2 copays will apply, but it only counts as 1 visit towards the 3 visit maximum.
Primary Care	
Specialist	
Mental Health	
Substance Abuse	
Independent Diagnostic Testing Facility	Not Covered
X-rays & Adv. Imaging (e.g., MRI, MRA, PET, CT)	
Independent Clinical Labs - Blood Work	
Outpatient Surgical & Diagnostic	Not Covered
Medical Services	
Facility Charges	
Emergency Services	Not Covered
Hospital Emergency Room	
Urgent Care Visits	
Ambulance - Ground	
Ambulance - Air	
*** Prescription Drugs**	Only those prescriptions required by law are covered, e.g., FDA approved contraceptives and Aspirin to prevent CVO.
Short-Term Rehabilitation Services	Not Covered
TMJ	Not Covered