Stop Loss Provided By:

breckpoint®
LEAD TOGETHER

United Advantage Agency™

Zero Deductible 60% Coinsurance

SERVICES	PPO PROVIDERS	NON-PPO PROVIDERS
Plan Year Deductible (Embedded)	$0 per Individual $0 per Family	$10,000 per Individual $20,000 per Family
Coinsurance	Plan Pays 60%	Plan pays 40%
Out-of-Pocket Maximum (Non-PPO providers do not satisfy the PPO provider Out-of-Pocket)	$7,350 per Individual $14,700 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	$45 Copay per visit; $0 if www.1800md.com (1-800-530-8666) used	40%
Specialist	$90 Copay per visit	
Mental Health	$45 Copay per visit	
Substance Abuse	$45 Copay per visit	
Diagnostic Testing		
Doctors Office - Lab, X-rays & Imaging	No Charge	40%
Independent Facility - Lab, X-rays & Imaging (e.g., MRI, MRA, PET, CT)	$425 Copay	40%
Inpatient Hospital Services		No out of network Treated as RBR with in network Deductibles and copays
Medical Services and Facility	$1,750 Copay per day/visit fo up to 3 days	
Anesthesiologist & Surgeon Fees (Assistants at 20% of Primary)	no charge	
Mental Health & Substance Abuse	$1,750 Copay per day/visit fo up to 3 days	
Outpatient Surgical & Diagnostic		
Medical Services	No Charge	No out of network Treated as RBR
Facility Charges	$1,750 Copay per day/visit fo up to 3 days	
Emergency Services		
Hospital Emergency Room	$425 Copay per visit	No out of network Treated as RBR
Urgent Care Visits	$125 Copay per visit	40%
Ambulance - Ground	60%	40%
Ambulance - Air	60%; Limit $7,500 maximum per trip for air ambulance	40%; Limit $7,500 maximum per trip for air ambulance
Prescription Drugs* - Generic/Formulary/Non-Formulary/Specialty	$20/$50/$80/50%; 2 times Mail-order; SEE NOTE	Not Covered
Supplemental Services		
Home Health	$90 Copay per Visit; 100 Visits per Plan Year	40%; Limit 100 Visits per Plan Year
Occupational Therapy	$90 Copay per Visit; 20 Visits per Plan Year	40%; Limit 20 Visits per Plan Year
Physical Therapy	$90 Copay per Visit; 20 Visits per Plan Year	40%; Limit 20 Visits per Plan Year
Speech Therapy	$90 Copay per Visit; 20 Visits per Plan Year	40%; Limit 20 Visits per Plan Year
Private Duty Nursing	$90 Copay per Visit; 10 Visits per Plan Year	40%; Limit 10 Visits per Plan Year
Skilled Nursing	$90 Copay per Visit; 60 Visits per Plan Year	40%; Limit 60 Days per Plan Year
Epidural Injections	60%; Limit 10 Visits per Plan Year	40%; Limit 10 Visits per Plan Year
Non-Surgical Treatment of the Spine	60%; $1,000 per Plan Year	40%; $1,000 per Plan Year
Hospice Care	60%	40%
TMJ	60%; $1,000 Lifetime Maximum Benefit	40%; $1,000 Lifetime Maximum Benefit
Allergy Treatment		
Testing and Injections	60%	40%
Serum		
Durable Medical Equipment	No Charge	40%

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

* 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 $400 penalty per service, procedure or

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 $400 penalty per occurence. This penatly will not count toward the plan deductible or towards the Out-of-pocket

Copayments- Copayment does not apply towards deductibles or coinsurance but does apply to maximum out-of-pocket limits

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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Zero Deductible 40% Coinsurance	
Plan Year Deductible	No 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.