

**Comparison of Medical Plans
CIGNA Open Access and CIGNA POS**

Services Covered	CIGNA Open Access In-Network	CIGNA POS In-Network	CIGNA Open Access Out-Of-Network	CIGNA POS Out-Of-Network
Annual Deductible Amount for injury, illness, or maternity	\$300 / individual \$600 / family	None	\$500 / individual \$1,000 / family	\$200 / individual \$400 / family
Out-of-Pocket Annual Limit (excludes deductible)	\$1,500 / individual \$3,000 / family	\$1,000 / individual \$2,000 / family	\$4,500 / individual \$9,000 / family	\$3,000 / individual \$6,000 / family
Pre-Existing Conditions	N/A	N/A	N/A	N/A
Maximum Lifetime Benefit	\$2,000,000 (combined in- and out-of-network maximum)	Unlimited	\$2,000,000 (combined in- and out-of-network maximum)	\$2,000,000 lifetime (in- and out-of-network combined)

Physician Care

Primary Care Office Visit Specialist Office Visit	Covered 100% after \$15 copay Covered 100% after \$30 copay	Covered 100% after \$10 copay	Covered 60% of R&C* after deductible	Covered 80% of R&C* after deductible
Physician and Surgeon Services in Hospital	Covered 90% after plan deductible	Covered 100%	Covered 60% of R&C* after deductible	Covered 80% of R&C* after deductible
Maternity Office Visits	Covered 100% after one-time physician's office visit copay	Covered 100% after one-time physician's office visit copay	Covered 60% of R&C* after deductible	Covered 80% of R&C* after deductible
Maternity Delivery (Physician charges)	Covered 90% after plan deductible	Covered 100%	Covered 60% of R&C* after deductible	Covered 80% of R&C* after deductible
Preventive Health Services: -Well Baby Care -Routine Physical Exams -Routine Gynecological Exams -Routine Mammogram -Hearing Aid Benefits	Covered 100% after: \$15 copay (including immunizations) \$15 primary care office copay \$30 physician's office copay, if physician used is contracted as specialist \$15 physician's office copay, if physician used is contracted as primary care physician No charge (no referral needed) \$750 maximum every 36 months	Covered 100% after: \$10 copay (including immunizations) \$10 copay \$10 copay No charge (no referral needed) Not covered	Not covered Not covered Not covered Covered 60% of R&C* after deductible Not covered	Not covered Not covered Not covered Covered 80% of R&C* after deductible Not covered

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Outpatient Laboratory and X-Ray: All charges billed by an independent facility.	Covered 100%	Covered 100%	Covered 60% of R&C* after deductible	Covered 80% of R&C* after deductible
Home Health Care (skilled visits only)	Covered 100%	Covered 100%; up to 60 days per calendar year, in- and out-of-network combined	Covered 60% of R&C* after deductible for up to 60 days per calendar year, reduced by any in-network days.	Covered 80% of R&C* after deductible, up to 60 days per calendar year, in- and out-of-network combined
Chiropractic Care (when medically appropriate)	Covered 100% after \$30 copay; 25 visit limit per year	Covered 100% after \$10 copay per visit; 25 visit limit per year. No referral required.	Not covered	Not covered
Substance Abuse: -Outpatient <u>Effective 1/1/2010 substance abuse is paid the same as any other medical condition.</u>	\$30 copay per visit for individual therapy;	\$10 copay per visit for individual therapy; <u>35 visit limit per calendar year in and out of network combined - until 1/1/2010, then visit limit is removed</u>	Covered 60% of R&C* after deductible <u>35 visit limit per calendar year reduced by any in network visits - until 1/1/2010, then visit limit is removed</u>	Covered 80% R&C* after deductible <u>35 visit limit per calendar year in and out of network combined – until 1/1/2010, then visit limit is removed</u>
Mental Health Service: -Outpatient <u>Effective 1/1/2010 mental health is paid the same as any other medical condition.</u>	\$30 copay per visit for individual therapy; \$15 copay per visit for group therapy	\$10 copay per visit for individual therapy; \$10 copay per visit for group therapy <u>35 visit limit per calendar year reduced by any in network visits - until 1/1/2010, then visit limit is removed</u>	Covered 60% of R&C* after deductible <u>35 visit limit per calendar year reduced by any in network visits - until 1/1/2010, then visit limit is removed</u>	Covered 80% of R&C* after deductible <u>35 visit limit per calendar year in and out of network combined – until 1/1/2010, then visit limit is removed</u>

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Physician Services in Emergency Room	Covered 100%	Covered 100%	Covered 100%	Covered 100%
Durable Medical Equipment	Covered 100%	Covered 100%, maximum of \$3,500 per calendar year	Covered 60% of R&C* after deductible	Not covered
<p>Infertility Treatment</p> <p>Physician office visit, test, counseling</p> <p>Surgical Treatment: Includes procedures for correction of infertility (in vitro fertilization, artificial insemination, GIFT, ZIFT, etc.)</p> <p>Limited coverage; lifetime maximum \$20,000</p>	<p>\$30 copay per office visit, then covered 100%</p> <p>Inpatient and outpatient facility same as inpatient and outpatient hospital</p> <p>Physician services 90% after plan deductible</p>	Not covered	60% of R&C* after plan deductible	Not covered
<p>External Prosthetic Devices – <u>Requires approval by Healthplan</u> (Coverage for external prosthetic appliances and devices is limited to the most appropriate and cost effective alternative as determined by the utilization review physician. Covers initial purchase and fitting of any physician ordered or prescribed external prosthetic devices which are to be used as replacements or substitutes for missing body parts and are necessary for the alleviation or correction of sickness, injury, or congenital defects.)</p>	Covered 90% after deductible and \$100 copay	Covered 100% after \$200 deductible; maximum of \$1,000 per calendar year	Covered 60% of R&C* after deductible	Not covered

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Hospital Care

Services Covered	CIGNA Open Access In-Network	CIGNA POS In-Network	CIGNA Open Access Out-Of-Network	CIGNA POS Out-Of-Network
<p>Inpatient Services: Semi-private room, operating room, x-ray, and laboratory services Includes stand-alone facilities such as Birthing Center</p>	Covered 90% after deductible and \$250 copay per admission	Covered 100%, no copay	Covered 60% of R&C* after deductible and \$500 copay per admission	Covered 80% of R&C* after deductible
<p>Outpatient Services: Operating Room, Recovery Room, Procedure Room, and Treatment</p>	Covered 90% after deductible and \$150 copay per visit	Covered 100%	Covered 60% of R&C* after deductible and \$300 copay per visit	Covered 80% of R&C* after deductible
<p>Organ Transplant Coverage</p> <p>Inpatient Facility</p> <p>Travel Benefit</p>	<p>Covered 90% after deductible and \$250 copay at approved facilities</p> <p>\$10,000 per transplant per lifetime available when using an approved facility</p>	<p>Covered 100% at approved facilities</p> <p>\$10,000 per transplant per lifetime available when using an approved facility</p>	<p>Covered 60% of R&C* after deductible</p> <p>Not covered</p>	<p>Not covered</p> <p>Not covered</p>
<p>Emergency Room Services</p> <p>Ambulance Services</p>	<p>Covered 100% after \$100 copay per visit if true emergency (waived if admitted)</p> <p>Covered 100% if true emergency, otherwise, not covered</p>	<p>Covered 100% after \$50 copay if true emergency (waived if admitted)</p> <p>Covered 100% if true emergency; otherwise, not covered</p>	<p>Covered 100% after \$100 copay per visit if true emergency (waived if admitted)</p> <p>Covered 100% if true emergency; otherwise, not covered</p>	<p>Covered 100% after \$50 copay if true emergency (waived if admitted)</p> <p>Covered 100% if true emergency; otherwise, not covered</p>

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Urgent Care Facility	Covered 100% after \$50 copay per visit	Covered 100% after \$25 copay per visit	Covered 100% after \$50 copay per visit	Covered 100% after \$25 copay per visit
Inpatient Mental Health <u>Effective 1/1/2010 mental health is paid the same as any other medical condition.</u>	Covered 90% after deductible and \$250 copay per admission <u>20 days per calendar year in and out of network combined – until 1/1/2010 then day limit is removed</u>	Covered 100%, no copay <u>20 days per calendar year in and out of network combined – until 1/1/2010 then day limit is removed</u>	Covered 60% of R&C* after deductible- (effective 1/1/2010 \$500 copay per admission also applies) <u>20 days per calendar year in and out of network combined – until 1/1/2010 then day limit is removed</u>	Covered 80% of R&C* after deductible <u>20 days per calendar year in and out of network combined – until 1/1/2010 then day limit is removed</u>
Inpatient Substance Abuse <u>Effective 1/1/2010 substance abuse is paid the same as any other medical condition.</u>	Covered 90% after deductible and \$250 copay per admission <u>Limited to 2 admissions per lifetime and 100 days per lifetime in and out of network combined – until 1/1/2010 then limit is removed</u>	Covered 100%, no copay <u>20 days per calendar year in and out of network combined – until 1/1/2010 then day limit is removed</u>	Covered 60% of R&C* after deductible- (effective 1/1/2010 \$500 copay per admission also applies) <u>Limited to 2 admissions per lifetime and 100 days per lifetime in and out of network combined – until 1/1/2010 then limit is removed</u>	Covered 80% of R&C* after deductible <u>20 days per calendar year in- and out of network combined – until 1/1/2010 then day limit is removed</u>
Maternity – Inpatient	Covered 90% after deductible and \$250 copay for mother (includes child)	Covered 100%	Covered 60% of R&C* after deductible	Covered 80% of R&C* after deductible
Skilled Nursing Facility	Covered 90% after deductible for up to 60 days per calendar year in- and out-of-network combined	Covered 100%, maximum of 60 days per calendar year in- and out-of-network combined	Covered 60% of R&C* after deductible for up to 60 days per calendar year in- and out-of-network combined	Covered 80% of R&C* after deductible; maximum 60 days per calendar year in- and out-of-network combined
Hospice Care – Inpatient and Outpatient	Same as inpatient hospital Covered 100%, no copay	Covered 100%, no copay	Covered 60% of R&C* after deductible	Covered 80% of R&C* after deductible
Outpatient (short-term) rehabilitation (includes speech, occupational, physical and cardiac rehabilitation)	Covered 100% (180 days per year for all conditions for in- and out-of-network combined)	Covered 100% after \$10 copay per visit; 20 days limit per calendar year for in- and out-of-network combined	Covered 60% of R&C* after deductible (180 days per year for all conditions for in- and out-of-network combined)	Covered 80% of R&C* after deductible; maximum of 20 days per member for short-term therapy only for in- and out-of-network combined

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- 1) In-network copays will not apply toward the in- or out-of-network annual deductibles.
- 2) All out-of-network inpatient hospitalizations and outpatient surgeries must be pre-certified. Failure to do so will result in denied claims.
- 3) Hospital stays not deemed medically necessary will be disapproved.
- 4) Neither plan will cover non-cancerous skin tag removal or bariatric surgery (gastric bypass).
- 5) Both plans will cover rhinoplasty, breast reductions, varicose veins and blepharoplasty surgery (removal of excessive eyelid tissue) if medically necessary. Prior health plan approval is required.

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Prescription Drugs

Services Covered	CIGNA Open Access In-Network	CIGNA POS In-Network	CIGNA Open Access Out-Of-Network	CIGNA POS Out-Of-Network
Retail Prescription Drugs – up to 30-day supply	\$150 deductible Generic: 20% (minimum \$10 copay) after deductible Brand: 30% (minimum \$10 copay) after deductible If actual cost is under \$10, then you pay actual cost	Generic: \$5 copay for a 30-day supply Preferred Brand: \$15 copay for a 30-day supply Non-preferred Brand: \$35 copay for a 30-day supply	50% of cost after \$150 deductible	80% after \$200 deductible
Mail Order – Home Delivery	Generic: \$15 copay for up to a 90-day supply Brand: \$35 copay for up to a 90-day supply	Generic: \$5 copay for each 30-day supply (\$15 for 90 days) Preferred Brand: \$15 copay for each 30-day supply (\$45 for 90 days) Non-preferred Brand: \$35 copay for each 30-day supply (\$105 for 90 days)	Not covered	Not covered

Pharmacy benefits for the CIGNA Open Access and CIGNA POS are through Medco.

Certain drugs may require a prior authorization in order to receive the prescription or the full quantity your doctor prescribes. For a listing of the brand names or categories that currently require prior authorization, you may refer to the Benefits homepage or contact Medco at 1-800-685-8869.

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Vision Plan

Services Covered	CIGNA Open Access In-Network	CIGNA POS In-Network	CIGNA Open Access Out-Of-Network	CIGNA POS Out-Of-Network
Exam every 12 months Lenses every 12 months: Single vision Bifocal Trifocal Polycarbonate for dependent children	Covered in full Covered in full Covered in full Covered in full Covered in full	Covered in full Covered in full Covered in full Covered in full Covered in full	Exam \$29.75 Single Vision \$21.25 Bifocals \$34.00 Trifocals \$46.75	Exam \$29.75 Single Vision \$21.25 Bifocals \$34.00 Trifocals \$46.75
Frames every 24 months	Covered up to \$120 Plus, 20% off amount exceeding \$120	Covered up to \$120 Plus, 20% off amount exceeding \$120	Frame \$38.25	Frame \$38.25
or				
Contact Lens every 12 months	Covered up to \$120, allowance applies to the cost of contacts and contact lens exam Plus, 15% off cost of contact lens exam OR Eligible members may take advantage of VSP Contact Lens Care program, in which Contact Lens Exam and up to 4 boxes (6 mo. supply) are covered in full	Covered up to \$120, allowance applies to the cost of contacts and contact lens exam Plus, 15% off cost of contact lens exam OR Eligible members may take advantage of VSP Contact Lens Care program, in which Contact Lens Exam and up to 4 boxes (6 mo. supply) are covered in full	Elective Contacts \$105	Elective Contacts \$105
Lens Options	20% discount on lens enhancements and upgrades	20% discount on lens enhancements and upgrades		
Additional Discounts	20% discount on additional prescription glasses and sunglasses Laser vision correction services are provided at a reduced cost through VSP network doctors and contracted laser surgery centers	20% discount on additional prescription glasses and sunglasses Laser vision correction services are provided at a reduced cost through VSP network doctors and contracted laser surgery centers		

Vision benefits for the CIGNA Open Access & CIGNA POS are through VSP.

Every attempt has been made to ensure the accuracy of this summary. However, its contents are not legally binding nor should it be considered as a substitute for the actual contract language, company policies, or Book of Benefits.