

**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 (effective 1/1/2011)	Unlimited	Unlimited	Unlimited	Unlimited

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 90% after deductible co-insurances & 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:	Covered 100% after:	Covered 100% after:		
-Well Baby Care	\$15 copay (including immunizations)	\$10 copay (including immunizations)	Not covered	Not covered
-Routine Physical Exams	\$15 primary care office copay	\$10 copay	Not covered	Not covered
-Routine Gynecological Exams	\$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	\$10 copay	Not covered	Not covered
-Routine Mammogram	No charge (no referral needed)	No charge (no referral needed)	Covered 60% of R&C* after deductible	Covered 80% of R&C* after deductible
-Hearing Aid Benefits	\$750 maximum every 36 months	Not covered	Not covered	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	\$30 copay per visit	\$10 copay per visit	Covered 60% of R&C* after deductible	Covered 80% R&C* after deductible
Mental Health Service: -Outpatient	\$30 copay per visit	\$10 copay per visit	Covered 60% of R&C* after deductible	Covered 80% of R&C* after deductible

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Physician Services in Emergency Room	Covered 100%	Covered 100%	Covered 100%	Covered 100%
Durable Medical Equipment - R&C* applies	Covered 100%	Covered 100%	Covered 60% 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 & copays	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.) - R&C* applies</p>	Covered 90% after deductible and \$100 copay	Covered 100% after \$200 deductible	Covered 60% 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
Inpatient Services: Semi-private room, operating room, x-ray, and laboratory services Includes stand-alone facilities such as Birthing Center	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
Outpatient Services: Operating Room, Recovery Room, Procedure Room, and Treatment	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
Organ Transplant Coverage				
Inpatient Facility	Covered 90% after deductible and \$250 copay at approved facilities	Covered 100% at approved facilities	Covered 60% of R&C* after deductible and \$500 copay	Not covered
Travel Benefit	\$10,000 per transplant per lifetime available when using an approved facility	\$10,000 per transplant per lifetime available when using an approved facility	Not covered	Not covered
Emergency Room Services	Covered 100% after \$100 copay (waived if admitted)	Covered 100% after \$50 copay (waived if admitted)	Covered 100% after \$100 copay (waived if admitted)	Covered 100% after \$50 copay (waived if admitted)
Ambulance Services	Covered 100% if true emergency, otherwise, not covered	Covered 100% if true emergency; otherwise, not covered	Covered 100% if true emergency; otherwise, not covered	Covered 100% if true emergency; otherwise, not covered

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Services Covered	CIGNA Open Access In-Network	CIGNA POS In-Network	CIGNA Open Access Out-Of-Network	CIGNA POS Out-Of-Network
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	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
Inpatient Substance Abuse	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
Maternity – Inpatient	After initial visit Covered 90% after deductible and \$250 copay for mother (includes child)	Covered 100%	Covered 60% of R&C* after deductible and \$500 copay	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	Inpatient: Covered 90% after \$250 per admission & deductible Outpatient: Covered 100%,	Covered 100%, no copay	Inpatient: Covered 60% of R&C* after per admission copay & deductible Outpatient: Covered 60% of R&C*	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) Requires prior health plan approval and determined to be medical necessary treatment for coverage of rhinoplasty, breast reductions, varicose veins and blepharoplasty surgery (removal of excessive eyelid tissue).

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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 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	Covered up to \$120, allowance applies to the cost of contacts and contact lens exam Plus, 15% off cost of contact lens exam	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.