

THE POWER OF CHOICE

**CBIA**  **HEALTH CONNECTIONS**

# POS \$20 & POS \$20 OA

CIGNA, CONNECTICARE, HEALTH NET, OXFORD

For groups with  
**3-50**  
employees

	In Network	Out-of-Network
<b>Access</b>	Available as Gated or Open Access	
<b>Benefit Year</b>	CIGNA - Contract Year; ConnectiCare, Health Net, Oxford - Calendar Year	
<b>Deductible</b>	N/A	\$750 indiv./\$2,250 family
<b>Coinsurance</b>	N/A	70/30% after deductible
<b>Maximum Out-of-Pocket</b> — based on approved charges (including deductible)	N/A	\$3,750 indiv./\$11,250 family
<b>Coinsurance Limit</b> (applies to out-of-network only, not including deductible or in-network co-payments)	N/A	\$3,000 individual; \$9,000 family (indiv. coinsurance limit is determined by member paying 30% of approved charges totaling \$10,000)
<b>Hospital Inpatient</b>		
Hospital Services: Semi-private room & board, medications, and related hospital services (includes inpatient services for mental/nervous and substance abuse)	Covered in full after \$500 per admission co-pay	70/30% after deductible
<b>Outpatient Medical Services</b>		
Routine Physical Exams (adults and children based on schedules)	\$20 per visit	No coverage, except for well-child care through age 6
Medical Office Visits — includes office visits associated w/ mental/nervous and substance abuse	\$20 per visit	70/30% after deductible
Routine OB/GYN Exam — 1 visit annually	\$20 per visit	Not covered
Routine Mammography (subject to age limitations)	Covered in full	Not covered
Routine Vision Exam: 1 exam/24 mo.	\$20 per visit except Oxford covers to max. of \$50 on a reimbursement basis only; CIGNA members must use VSP provider	Not covered; except Oxford offers coverage same as in-network
Immunizations	\$20 per visit	Not covered
Diagnostic X-ray & Lab	Covered in full	70/30% after deductible
Same Day Surgery (doctor's office or other facility)	\$20 doctor's office; \$100 outpatient facility	70/30% after deductible
<b>Other Services</b>		
Physical Therapy: Includes physical, speech and occupational. Prior authorization required. (Allowable treatments varies by carrier.)	\$20 per visit	70/30% after deductible
Prescription Drugs (Retail) (MAC-C is co-pay only) See formularies for each health plan company.	Three-tier co-pay: Generic/Preferred Brand*/Non-Preferred Brand \$10/\$20/\$40	Not covered. Member must use participating pharmacy
Mail-order Pharmacy	2x retail co-pay for up to a 90-day supply.	Not available unless member uses in-network vendor
Urgent Care (includes walk-in centers)	\$50 per visit	70/30% after deductible
Emergency Room Services	\$50 if not admitted to hospital	\$50 if not admitted to hospital
Ambulance Services	Covered in full when medically necessary	Covered in full when medically necessary
<b>Lifetime Maximum</b>	Unlimited	\$1,000,000

\*Information relative to "Preferred Brand" drugs may be found on each health plan's Web site or by contacting each health plan's Member Services Department.

The services described in this brochure are only an overview of the entire benefit package. For a more detailed plan description prior to enrolling, please contact the health plan company that interests you. Health plan company phone numbers can be obtained from your employer. Services provided by the health plan company under the benefit plan you select will be fully described in the proof of coverage document you'll receive once you are enrolled in the program. The benefits are subject to various limitations, exclusions and conditions as fully described in each health plan company's Certificate of Coverage. The services identified are covered as described only when they are provided based on the guidelines of the program; in other words, when they are provided, prescribed or directed by the health plan company you have selected (except in cases of emergencies).