

	In-Network	Out-of-Network
Access		Open Access
Benefit Year		Contract Year
Deductible	\$1,500 individual plan deductible \$3,000 family plan deductible*	\$3,000 individual plan deductible \$6,000 family plan deductible*
	*Note: For Family coverage, the CIGNA plan requires that the family plan deductible must be met completely prior to any member of the family becoming eligible for benefits after the deductible.	
Coinsurance	20%	40%
Coinsurance Limit (not including deductible or in-network co-payments)	\$3,500 individual/\$7,000 family (individual coinsurance limit is determined by member paying 20% of approved charges totaling \$17,500)	\$7,000 individual/\$14,000 family (individual coinsurance limit is determined by member paying 40% of approved charges totaling \$17,500)
Maximum Out-of-Pocket —based on approved charges (including deductible)	\$5,000 individual (2X family)	\$10,000 individual (2X family)
Hospital Inpatient		
Hospital Services: Semi-private room & board, medications, and related hospital services (includes inpatient services for mental/nervous and substance abuse)	20% after plan deductible	40% after plan deductible
Outpatient Medical Services		
Routine Physical Exams (adults and children based on schedules)	Covered in full	40% after plan deductible
Medical Office Visits—includes office visits associated with mental/nervous and substance abuse	20% after plan deductible	40% after plan deductible
Routine OB/GYN Exam—1 visit annually	Covered in full	40% after plan deductible
Routine Mammography (subject to age limitations)	Routine/preventive services covered in full	40% after plan deductible
Routine Colonoscopy (subject to age limitations)	Routine/preventive services covered in full	40% after plan deductible
Routine Vision Exam	Covered in full One exam per contract year	Not covered
Immunizations	Covered in full	40% after plan deductible
Diagnostic X-ray	20% after plan deductible	40% after plan deductible
Laboratory	Covered in full as part of routine physical exam; otherwise subject to deductible	40% after plan deductible
Outpatient Surgery (doctor's office or other facility)	20% after plan deductible	40% after plan deductible
Other Services		
Physical Therapy: Includes physical, speech and occupational. Prior authorization required.	20% after plan deductible	40% after plan deductible
Prescription Drugs (Retail) (MAC-A mandatory generic)* See formularies for each health plan company.	30% after plan deductible	50% after plan deductible
Mail-order Pharmacy	30% after plan deductible	50% after plan deductible
Urgent Care (includes walk-in centers)	20% after plan deductible	40% after plan deductible
Emergency Room Services	20% after plan deductible	20% after in-network plan deductible
Ambulance Services	20% after plan deductible	20% after in-network plan deductible
Lifetime Maximum	Unlimited	Unlimited

* Generic substitution required when available. If member purchases brand drug when a generic is available, the member pays the difference in cost between brand and generic.

The services described 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).