Loudoun County Government Group Health Plan Comparison—2024

Description of Service	Cigna Open Access Plus High		Cigna Open Access Plus		CIGNA Choice HSA/HRA	
	In-Network	Out-of-Network	In-Network	Out-of-Network	In-Network	Out-of-Network
Employer-funded HSA/HRA	None	None	None	None	$1,000/single $2,000/family	$1,000/single $2,000/family
Annual Deductible[1]	None	$1,500/person $4,500/family	$250/person $750/family	$1,500/person $4,500/family	$1,600/person $3,200/family	$2,500/person $5,000/family
Out-of-Pocket (OOP) Maximum	$4,000/person $8,000/family	$5,000/person $15,000/family	$4,000/person $8,000/family	$5,000/person $15,000/family	$6,450/person $12,900/family	$ 6,450/person $12,900/family
Referrals Required	No	No	No	No	No	No
Physician Services	**[1] after deductible**			**[3] actual charge if less**		
Convenience Care Clinic	$20 copay	20% [1]	$20 copay	30% [1]	10% [1]	30% [1]
Physician Office Visit	$20 copay	20% [1]	$20 copay	30% [1]	10% [1]	30% [1]
Specialist Office Visit	$35 copay	20% [1]	$35 copay	30% [1]	10% [1]	30% [1]
Telehealth Services	$20 copay	N/A	$20 copay	N/A	10% [1]	N/A
Maternity Care Services	$20/$35 copay 1st visit	20% [1]	$20/$35 copay	30%[1]	10% [1]	30% [1]
Lab Work & X– Rays	Covered in Full	20% [1]	10% [1]	30% [1]	10% [1]	30% [1]
Allergy Injections	$20/$35 copay	20%[1, 3]	$20/$35 copay	30% [1, 3]	10% [1]	30% [1]
Preventive Care Benefits	**[1] after deductible**					
Physician Office Visit	**Covered in Full**	**20% [1]**	**Covered in Full**	**30%[1]**	**Covered in Full**	**30%[1]**
Well Baby/Child Care	**Covered in Full**	**20% [1]**	**Covered in Full**	**30%[1]**	**Covered in Full**	**30%[1]**
Immunizations	**Covered in Full**	**20% [1]**	**Covered in Full**	**30%[1]**	**Covered in Full**	**30%[1]**
Emergency Services	**[1] after deductible**		**[2] applies to in-network OOP maximum**			
Urgent Care Centers	$35 copay[2]		$35 copay[2]		10%[1]	10% [1]
Emergency Room	$150 per visit[2]		$150 per visit[2]		10%[1]	10% [1]
Hospital Inpatient & Outpatient	**[1] after deductible**					
Semi-Private Room	$100 copay	$200 copay then 20% [1]	$100 copay then 10% [1]	$200 copay then 30% [1]	10% [1]	30% [1]
Professional Services	Covered in Full	20% [1]	10% [1]	30% [1]	10% [1]	30% [1]
Outpatient Surgical Procedures (Facility)	$50 copay	$100 copay then 20% [1]	$50 copay then10% [1]	$100 copay then 30% [1]	10% [1]	30% [1]
Professional Fees	Covered in Full	20% [1]	10% [1]	30% [1]	10% [1]	30% [1]
Mental Health / Substance Abuse	**[1] after deductible**					
Inpatient Days	$100 copay	$200 copay then 20% [1]	$100 copay then 10% [1]	$200 copay then 30% [1]	10% [1]	30% [1]
Outpatient Visits	$35 copay	20% [1]	$35 copay	30%[1]	10% [1]	30% [1]
Express Scripts - Pharmacy Benefits - 30 day supply		**[1] after deductible**		**[4] after manual claim reimbursement**		
Generic	$7 copay	$7 copay [4]	$7 copay	$7 copay [4]	10% [1]	10% [1, 4]
Brand Name Formulary	$28 copay	$28 copay [4]	$28 copay	$28 copay [4]	25% [1]	25% [1, 4]
Non-Formulary Brand	$50 copay	$50 copay [4]	$50 copay	$50 copay [4]	40% [1]	40% [1, 4]

Questions?

Contact Benefits Help Line at 703-777-0517 or benefits@loudoun.gov.

Dental Benefits

Description of Service	In-Network		Out-of-Network	General Plan Information
	PPO	Premier		
Annual Deductible	$50	$50	$50	Limit of 3 per family per calendar year
Annual Benefit Maximum	$2,000	$2,000	$2,000	Per enrollee, per calendar year
Orthodontic Lifetime Maximum	$1,500	$1,500	$1,500	Per enrollee, for subscriber and covered dependent
Diagnostic & Preventive Care / Prevention First –*Cleanings twice in a calendar year*	100%	100%	80%	Oral exams and cleanings, fluoride applications, bitewing x-rays, space maintainers, sealants *These services are exempt from the deductible and annual maximum.)
Basic Dental Care *(after deductible)*	80%	80%	60%	Fillings, stainless steel crown, oral surgery, denture repair and recommendation of crowns, endodontic services, periodontal services
Major Dental Care *(after deductible)*	80%	80%	50%	Prosthodontics / dentures/ bridges, crowns
Orthodontic Benefits	50%	50%	50%	
Right Start 4 Kids Dental Program	100%	100%	Not covered	Coverage for diagnostic, preventive, basic and major services, with no deductible, up to annual maximum

Vision Benefits

Description of Service	In-Network			Out-of-Network
Examination - *Once in a calendar year*	$15 copay			Up to $35 reimbursement
Lenses - *Once in a calendar year*	Fashion $0 copay	Designer $0 copay	Premier $25 copay	Up to $25 — Single Vision Up to $40 — Bifocals
Materials - *Once in a calendar year*	$130 wholesale allowance			Up to $35 reimbursement
Contact Lenses - *Once in a calendar year*	$15 exam plus $130 max allowance			Up to $35 exam Up to $95 lenses
Contact Lenses (Medically Necessary) *Once in a calendar year*	Covered in full after $15 copay			Up to $210

This summary is for informational purposes only and should not be construed as a final representation of benefit coverage. In case of any conflict between this summary and the County's official summary plan description, provisions of the summary plan description will govern. Refer to the county intranet located at Pay & Benefits Portal / Benefits & Wellness / Health Plan Benefits.