

Pre-65 Group—Health Plan Comparison

Group Retiree Medical Plans - Plan Year 2019

Description of Service	Cigna Point-of-Service		Cigna Open Access Plus		CIGNA Choice HRA	
	In-Network	Out-of-Network	In-Network	Out-of-Network	In-Network	Out-of-Network
Employer-funded 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	\$1,500/person \$3,000/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	Yes	No	No	No	No	No
Physician Services	¹ after deductible		³ actual charge if less			
Convenience Care Clinic	\$20 copay	N/A	\$20 copay	N/A	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 1 st 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 then 10% 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
Outpatient Intensive Visits	\$50 copay	\$50 copay then 20%	\$50 copay	\$50 copay then 30%	10% ¹	30% ¹
Express-Scripts	Pharmacy Benefits – 30 day supply		¹ after deductible			
Generic	\$7	20% (of maximum allowable charges)	\$7	30% (of maximum allowable charges)	10% ¹	10% ¹
Brand Name Formulary	\$28	20% (of maximum allowable charges)	\$28	30% (of maximum allowable charges)	25% ¹	25% ¹
Non-Formulary Brand	\$50	20% (of maximum allowable charges)	\$50	30% (of maximum allowable charges)	40% ¹	40% ¹