

Pre-65 Group—Health Plan

Group Retiree Medical Plans - Plan Year 2020

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 co- pay	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	\$2 8	20% (of maximum allowable charges)	\$2 8	30% (of maximum allowable charges)	25% 1	25% ¹
Non-Formulary Brand	\$5 0	20% (of maximum allowable charges)	\$5 0	30% (of maximum allowable charges)	40% 1	40% ¹