

SUMMARY COMPARISON OF MEDICAL PLANS 2009

<u>BENEFIT HIGHLIGHTS:</u>	<u>CIGNA OPEN ACCESS PLUS</u>		<u>HMO IL and Blue Advantage HMO</u>	<u>CIGNA NETWORK POS</u>	
	<u>OUT-OF-NETWORK</u>	<u>IN-NETWORK</u>	<u>IN-NETWORK</u>	<u>IN-NETWORK</u>	<u>OUT-OF-NETWORK</u>
<u>HOSPITAL IN-PATIENT</u>	Pre-admission certification is required. You must call Member Services for approval or penalty applies.	Pre-admission certification is required. Your in-network provider must call Member Services for approval or penalty applies.	Primary care physician must approve hospital stay. \$250 Copay, 100%	Primary care physician must approve hospital stay. \$200 Copay, 100%	Pre-admission certification is required. You must call Member Services for approval or penalty applies.
In-patient Room & Board (semi-private)	80% subject to deductible	90% subject to deductible	100%	100%	70% subject to deductible
In-patient Ancillary Charge	80% subject to deductible	90% subject to deductible	100%	100%	70% subject to deductible
Out-patient Emergency Hospital Charges	80% Subject to deductible	90% Subject to Deductible	\$75 co-payment, 100% provided you follow HMO emergency procedure described in each HMO literature.	\$100 co-payment, 100% provided that you follow the POS emergency procedure described in POS literature.	The healthplan's definition of emergency will be paid at the in-network level regardless of provider, otherwise 70% subject to deductible.
Out-patient Emergency Doctor Charges	80% Subject to deductible	90% Subject to deductible	100% provided that you follow the HMO or POS emergency procedure described in each plan's literature.		The healthplan's definition of emergency will be paid at the in-network level regardless of provider, otherwise 70% subject to deductible.
<u>SURGERY</u>					
In-patient	80% Subject to deductible	90% Subject to deductible	100%	100%	70% Subject to deductible
Out-patient	80% Subject to deductible	90% Subject to deductible	\$50 Copay, 100%	\$100 Copay, 100%	70% Subject to deductible
<u>PHYSICIAN CHARGES</u>					
Hospital Visits	80% Subject to deductible	90% Subject to deductible	100%	100%	70% Subject to deductible
Office Visits	80% Subject to deductible	\$20 Copay, 100%, \$30 Copay Specialist *	\$15 Copay, 100% PCP, \$25 Copay Specialist *	\$20 Copay, 100% \$30 Copay Specialist *	70% Subject to deductible
Chiropractor	80% Subject to deductible	\$30 Copay, 100%	\$25 Copay, need referral from PCP	\$30 Copay, 100%	70% Subject to deductible

* The specialist copay will not apply to the following physician speciality types: internal medicine, general practitioner, family practice, pediatrician, optometrist, and obstetrician/gynecologist (OB/GYN). Under Cigna Open Access Plus and Point of Service Plan: if your OB/GYN provider is listed as a PCP in the provider directory, you will pay a PCP copayment. If your OB/GYN

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doctor is listed as a specialist, you will pay the specialist copayment. You do not need a referral to visit an OB/GYN.

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	OUT-OF-NETWORK	IN-NETWORK	IN-NETWORK	IN-NETWORK	OUT-OF-NETWORK	
<u>DIAGNOSTIC X-RAY & LAB TEST</u>						
Billed by Dr. Office	80% Subject to deductible	\$20 co-pay, 100%	100%	100%	70% Subject to deductible	
Billed by other than Dr. Office	80% Subject to deductible	90% Subject to deductible	100%	100%	70% Subject to deductible	
<u>NEWBORN</u>						
Hospital Nursery	80% Subject to deductible	90% Subject to deductible	100%	100%	70% Subject to deductible	
Well Baby Care (Office Visit)	Not Covered	\$20 Copay, 100% to age 2	\$15 Copay, 100%	\$20 Copay, 100%	Not Covered	
<u>MENTAL HEALTH</u>						
	** Maximum number of days or visits applies to the combination of in and out of network benefits.			** Maximum number of days or visits applies to the combination of in and out of network benefits.		
Hospital In-Patient	80%, Subject to deductible 45 days per calendar year** Precertification required	90% Subject to deductible, 45 days per calendar year**	\$250 copay, 100%, 20 days per calendar year	\$200 copay, 100%, 45 days per calendar year**	70% subject to the deductible; 45 days per calendar year** Precertification required	
Office Visits	80%, subject to deductible, 60 visits per year**	\$30 Copay, 100%, 60 visits per year **	\$25 copay 20 visits per calendar year	\$30 copay 60 visits per year**	70% subject to the deductible; 60 visits per year**	
<u>SUBSTANCE ABUSE</u>						
	** Maximum number of days or visits applies to the combination of in and out of network benefits.			** Maximum number of days or visits applies to the combination of in and out of network benefits.		
Hospital In-patient	80%, subject to deductible, 45 days calendar per year** Precertification required	90% Subject to deductible, 45 days per calendar year**	\$250 Copay, 100%, 20 days per calendar year	\$200 copay, 100%, 30 days per calendar year**	70% subject to the deductible; 30 days per calendar year** Precertification required	

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	OUT-OF-NETWORK	IN-NETWORK	IN-NETWORK	IN-NETWORK	OUT-OF-NETWORK	
<u>Continued - SUBSTANCE ABUSE</u>						
	** Maximum number of days or visits applies to the combination of in and out of network benefits.			** Maximum number of days or visits applies to the combination of in and out of network benefits.		
Office Visits	80%, subject to the deductible, 35 visits per year.**	\$30 copay, 100%, 35 visits per year. **	\$25 copay 20 visits per calendar year.	\$30 copay 60 visits per year **	70% subject to the deductible, 60 visits per year **	
<u>PRESCRIPTION DRUGS</u>		Retail: 100% after copay on covered prescriptions, must use approved pharmacy. Mail Order: 100% after copay. Copay is two times the tier the prescription drug falls under.				
	80% subject to the RX deductible of \$50	<u>Open Access Plus in-network:</u> \$10 copay, generic \$20 copay, preferred brand \$40 copay, non-preferred brand Mail order 90 day supply (see above)	<u>HMO IL:</u> \$10 copay generic \$20 copay brand name formulary \$35 copay brand name non-formulary <u>Blue Advantage:</u> \$10 copay generic \$15 copay brand name formulary \$30 copay brand name non-formulary Mail order 90 day supply (see above)	<u>Cigna POS in-network:</u> \$10 copay, generic \$20 copay, preferred brand \$40 copay, non-preferred brand Mail order 90 day supply (see above)	70% subject to the RX deductible of \$50	
<u>ROUTINE SERVICES</u>						
Annual Physical Exam	Not Covered	\$20 copay, 100% to \$750	\$15 Copay,100%	\$20 Copay,100%	Not covered	
Immunizations & Inoculations	Not Covered	See well baby care	\$15 Copay,100%	\$20 Copay,100%	Not covered	
Eye Exams	Not Covered	Not Covered	\$15 Copay, 100% every 12 months	\$10 Copay, 100% every 24 months	Not covered	
Discounts on Glasses	Not Covered	Not Covered	\$75 allowance every 24 months	Not Covered	Not Covered	
Hearing Exams	Not Covered	Not Covered	\$15 Copay,100%	\$30 Copay,100%	Not covered	

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	OUT-OF-NETWORK	IN-NETWORK	IN-NETWORK	IN-NETWORK	OUT-OF-NETWORK
<u>MAJOR MEDICAL</u>					
Deductible (YOU PAY)	\$550 per person 3 per family per calendar year Cross Accumulated	\$300 per person 3 per family per calendar year	N/A	N/A	\$350 per person 3 per family per calendar year
Lifetime Maximum Benefit	\$2,000,000 per person - Cross Accumulated		Unlimited	Unlimited	\$2,000,000 per person
OUT OF POCKET LIMIT (You pay per year)	\$3,000 per person \$9,000 per family Excludes Deductable Cross Accumulated	\$1,500 per person \$4,500 per family	\$1,500 per person \$3,000 per family (Excludes copays for prescription drugs, vision, durable medical equipment, and prosthetics)	Copayments where applicable.	\$3,000 per person \$6,000 per family Excludes Deductable
Dependent Child	Coverage continues to age 19, to age 23 if full-time student		Coverage continues to age 19, to age 23 if full-time student		Coverage continues to age 19, to age 23 if full-time student
<u>EXCLUSIONS & LIMITATIONS</u>	All services must be medically necessary and are subject to carrier plan rules and limitations. Consult the CIGNA Group Insurance Certificate and HMO Contracts and/or booklets for specifics.				

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