MEDICAL BENEFITS	HDHP / HSA	Mid Plan	Buy Up
	Cigna	Cigna	Cigna
Deductible			
Preferred Network	$2,600 Ind./ $5,200 Fam.	$500 Ind./ $1,000 Fam.	$250 Ind./ $500 Fam.
In-Network	$2,600 Ind./ $5,200 Fam.	$1,000 Ind./ $2,000 Fam.	$500 Ind./ $1,000 Fam.
Non-Network	$5,200 Ind. /$10,600 Fam.	$5,000 Ind. / $10,000 Fam.	$2,000 Ind./ $4,000 Fam.
Out Of Pocket Max	Includes Ded. / Coins. / Copays	Includes Ded. / Coins. / Copays	Includes Ded. / Coins. / Copays
In-Network	$5,000 Ind./ $10,000 Fam.	$3,500 Ind./ $6,000 Fam.	$2,000 Ind./ $4,000 Fam.
Non-Network	$10,000 Ind. / $20,000 Fam.	$15,000 Ind./ $30,000 Fam.	$10,000 Ind./ $20,000 Fam.
Coinsurance			
Preferred Network	10%	10%	10%
In-Network	20%	20%	20%
Non-Network	40%	40%	40%
Lifetime Max	Unlimited	Unlimited	Unlimited
Preventive Care			
In-Network	$0 - No Cost Sharing	$0 - No Cost Sharing	$0 - No Cost Sharing
Non-Network	$150 Copay, then Ded/Coins	Ded./ 40%	Ded./ 40%
Physician Office Visit			
Preferred Network	Ded./ 10%	0 to 19 = $0 Copay / >19 = $10Copay	0 to 19 = $0 Copay / >19 = $10 Copay
In-Network Dep. Child Age 0-19	Ded./ 20%	0 to 19 = $0 Copay	0 to 19 = $0 Copay
In-Network	Ded./ 20%	$25 Copay	$25 Copay
Non-Network	$150 Copay, then Ded/Coins	Ded./ 40%	Ded./ 40%
Specialist Office Visit			
Preferred Network	Ded./ 10%	0 to 19 = $0 Copay / >19 = $10 Copay	0 to 19 = $0 Copay / >19 = $10 Copay
In-Network Dep. Child Age 0-19	Ded./ 20%	0 to 19 = $0 Copay	0 to 19 = $0 Copay
In-Network	Ded./ 20%	$50 Copay	$40 Copay
Non-Network	Ded./ 20%	Ded./ 40%	Ded./ 40%
Basic Lab & Radiology			
Preferred Network	Ded./ 10%	10%*	10%*
In-Network	Ded./ 20%	20%*	20%*
Non-Network	Ded./ 40%	Ded./ 40%	Ded./ 40%
Emergency Room			
In-Network	Ded./ 20%	$150 Copay, then Ded/Coins	$150 Copay, then Ded/Coins
Non-Network	Ded./ 40%	$150 Copay, then Ded/Coins	$150 Copay, then Ded/Coins
Urgent Care			
Preferred Network	Ded./ 10%	$25 Copay	$20 Copay
In-Network	Ded./ 20%	$50 Copay	$40 Copay
Non-Network	$150 Copay, then Ded/Coins	Ded./ 40%	Ded./ 40%
Major Lab & Radiology (MRI / CT / PET)	Prior Auth Required	Prior Auth Required	Prior Auth Required
Preferred Network	Ded./ 10%	Ded./ 10%	Ded./ 10%
In-Network	Ded./ 20%	Ded./ 20%	Ded./ 20%
Non-Network	Ded./ 40%	Ded./ 40%	Ded./ 40%
In-Patient Hospital			
Preferred Network	Ded./ 10%	Ded./ 10%	Ded./ 10%
In-Network	Ded./ 20%	Ded./ 20%	Ded./ 20%
Non-Network	Ded./ 40%	Ded./ 40%	Ded./ 40%
Out-patient Surgery			
Preferred Network	Ded./ 10%	Ded./ 10%	Ded./ 10%
In Network	Ded./ 20%	Ded./ 20%	Ded./ 20%
Non-Network	Ded./ 40%	Ded./ 40%	Ded./ 40%
Rehabilitative Therapy PT / OT / ST			
Preferred Network	Ded./ 10%	Ded./ 10%	Ded./ 10%
In-Network	$25 Copay	$25 Copay	$25 Copay
Non-Network	Ded./ 40%	Ded./ 40%	Ded./ 40%
Prescriptions	Deductible then:		
Network Retail Pharmacy	$10/$40/$80/20%	$10/$35/$60/15%	$10/$25/$50/15%
Network Mail Order / 90 Retail Now	$25/$87.50/$150	$20/$70/$120	$20/$50/$100
Preventive Generics	N/A	$0 Copay	$0 Copay
CDHP Preventive Drug List	Deductible Waived; $0 Cost	N/A	N/A
Step Therapy / Mandatory Generic	Step Therapy GF / Mandatory Generic	Step Therapy GF / Mandatory Generic	Step Therapy GF / Mandatory Generic
Note: This is a brief summary and not intended to be a contract.		*Covered under Office Visit Copay when service occurs in office visit setting; Covered under coinsurance when procedure occurs in outpatient or independent lab.	*Covered under Office Visit Copay when service occurs in office visit setting; Covered under coinsurance when procedure occurs in outpatient or independent lab.