

Medical Plan Highlights (limited)

<i>Medical Plan Highlights</i>	Network (HMO)	OAPIN	Network POS	
Annual deductibles and maximums	In-network Only	In-network Only	In-network	Out-of-network
<p>Plan year deductible After each family member meets his or her individual deductible, the plan will pay his or her claims, less any coinsurance amount. After the family deductible has been met, each individual's claims will be paid by the plan, less any coinsurance amount.</p>	<p>Employee \$0 Employee and family \$0</p>	<p>Employee \$0 Employee and family \$0</p>	<p>Employee \$0 Employee and family \$0</p>	<p>Per Individual \$500</p>
<p>Pre-existing Condition Limitation</p>	<p>Not Applicable</p>	<p>Not Applicable</p>	<p>Not Applicable</p>	<p>Not Applicable</p>
<p>Plan year out-of-pocket maximum The amount you pay for any services counts towards both your in-network and out-of-network out-of-pocket maximums</p>	<p>Employee \$2,500 Employee and family \$5,000</p>	<p>Employee \$2,500 Employee and family \$5,000</p>	<p>Employee \$2,500 Employee and family \$5,000</p>	<p>Employee \$3,000 Employee and family \$6,000</p>

Pharmacy out-of-pocket maximum Retail and Home Delivery copays apply to the Pharmacy out-of-pocket maximum	Employee \$3,850 Employee and family \$7,700	Employee \$3,850 Employee and family \$7,700	Employee \$3,850 Employee and family \$7,700
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This booklet is a summary of plan provisions related to the various Group Insurance policies issues. In the event of a conflict between this summary and the applicable Group Insurance policy and/or certificate, the policy and/or certificate shall dictate the insurance and coverage provisions, exclusions, all limitations and terms of coverage. In accordance with the provisions of ADA, this document may be requested in an alternative format. If you have any questions or would like to receive additional benefit plan materials, please contact your Group Insurance office or representative.

<i>Medical Plan Highlights</i>	Network (HMO)		OAPIN		Network POS	
Benefits	In-network Only		In-network Only		In-network	Out-of-network
Physician services						
Office visit	Primary Care Physician You pay \$20 per visit Specialists You pay \$40 per visit		Primary Care Physician You pay \$20 per visit Specialists You pay \$40 per visit		Primary Care Physician You pay \$20 per visit Specialists You pay \$40 per visit You pay 30% Plan pays 70% after the deductible is met	
Preventive care						
Routine preventive care Includes well-baby, well-child, well-woman and adult preventive care Immunizations are covered at no charge.	No charge		No charge		No charge Out-of-network preventive care including immunizations for children to age 16 are covered at plan coinsurance with no deductibles.	

Preventive Mammogram, PSA, Pap Smear Includes charges for the procedure itself and the professional reading charge.	No charge	No charge	No charge	You pay 30% Plan pays 70% after the deductible is met
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Benefits	In-network Only	In-network Only	In-network	Out-of-network
Lab and X-ray				
Lab and X-ray Physician's Office, Independent Lab, Outpatient Facility	No charge	Physician's Office - Primary Care Physician, you pay \$20 per visit Specialists, you pay \$40 per visit Independent Lab, Outpatient Facility - No charge *Radiology not applicable at Independent Lab	No charge	You pay 30% Plan pays 70% after the deductible is met
Advanced radiological imaging MRI, MRA, CT Scan, PET Scan, etc. Inpatient facility	No charge	No charge	No charge	You pay 30% Plan pays 70% after the deductible is met

Advanced radiological imaging MRI, MRA, CT Scan, PET Scan, etc. Outpatient facility Physician's office	You pay a per scan copay of \$150, then no charge	You pay a per scan copay of \$150, then no charge	You pay a per scan copay of \$150, then no charge	You pay 30% Plan pays 70% after the deductible is met
Emergency and urgent care services				
Hospital emergency room Including radiology, pathology and physician charges ER Copay waived if admitted Inpatient copays applies	No charge after \$200 per visit copay	No charge after \$200 per visit copay	No charge after \$200 per visit copay	
Inpatient Professional Services For services performed by surgeons, radiologists, pathologists and anesthesiologists	No charge	No charge	No charge	You pay 30% Plan pays 70% after the deductible is met

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Benefits	In-network Only	In-network Only	In-network	Out-of-network
Urgent care services <i>Please note urgent care CANNOT give a referral for an MRI, for advanced radiology imaging services or for specialists</i>	No charge after \$25 per visit copay	No charge after \$25 per visit copay	No charge after \$25 per visit copay	
Convenience Care Centers	You pay \$20 per visit	You pay \$20 per visit	You pay \$20 per visit	You pay 30% Plan pays 70% after the deductible is met
Inpatient hospital facility services				
Semi-private room and board and other non-physician services Inpatient room and board, pharmacy, x-ray, lab, operating room, surgery, etc. Private room stays may result in extra charges for the patient.	\$350 copay per admission, then No charge (Plan pays 100%)	\$350 copay per admission, then No charge (Plan pays 100%)	\$350 copay per admission, then No charge (Plan pays 100%)	\$500 deductible per admission, then You pay 30% Plan pays 70% after the deductible is met

Inpatient Professional Services For services performed by surgeons, radiologists, pathologists and anesthesiologists	No charge	No charge	No charge	You pay 30% Plan pays 70% after the deductible is met
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Outpatient services				
Outpatient surgery (facility charges) Non-surgical treatment procedures are not subject to the facility copay	\$150 copay per visit, then Plan pays 100%	\$150 copay per visit, then Plan pays 100%	\$150 copay per visit, then Plan pays 100%	You pay 30% Plan pays 70% after the deductible is met

Physical, occupational, cognitive and speech therapy Unlimited days for all therapies combined per plan year	You pay \$40 copay per visit	You pay \$40 copay per visit	You pay \$40 copay per visit	You pay 30% Plan pays 70% after the deductible is met
Includes cardiac rehabilitation, physical therapy, speech therapy, occupational therapy, spinal manipulation services (includes chiropractors), pulmonary rehabilitation and cognitive therapy				

Maternity Care Services

Physician's office – Initial Visit to confirm pregnancy	Primary Care Physician You pay \$20 per visit Specialists You pay \$40 per visit	Primary Care Physician You pay \$20 per visit Specialists You pay \$40 per visit	Primary Care Physician You pay \$20 per visit Specialists You pay \$40 per visit	You pay 30% Plan pays 70% after the deductible is met
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Physician's office – Subsequent prenatal visits, postnatal visits, and physician's delivery charges (i.e. global maternity fee)	No charge	No charge	No charge	You pay 30% Plan pays 70% after the deductible is met

Delivery – Facility (inpatient Hospital, Birthing Center)	\$350 copay per admission, then No charge (Plan pays 100%)	\$350 copay per admission, then No charge (Plan pays 100%)	\$350 copay per admission, then No charge (Plan pays 100%)	\$500 deductible per admission, then You pay 30% Plan pays 70% after the deductible is met
Special Services				
Skilled nursing facility, rehabilitation hospital and other facilities 90 days per plan year	No charge	No charge	No charge	\$500 deductible per admission, then You pay 30% Plan pays 70% after the deductible is met
Hospice Inpatient services Outpatient services	No charge	No charge	No charge	You pay 30% Plan pays 70% after the deductible is met

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Benefits	In-network Only	In-network Only	In-network	Out-of-network

Durable medical equipment Unlimited plan year maximum	No charge	No charge	No charge	\$200 Deductible then No charge
External prosthetic appliances (EPA) Unlimited plan year maximum	No charge	No charge	No charge	You pay 30% Plan pays 70%
Mental health and substance abuse services				
Inpatient services Unlimited days per plan year	\$350 copay per admission, then No charge (Plan pays 100%)	\$350 copay per admission, then No charge (Plan pays 100%)	\$350 copay per admission, then No charge (Plan pays 100%)	\$500 deductible per admission, then You pay 30% Plan pays 70% after the deductible is met
Outpatient physician's office services Unlimited visits per plan year This includes group therapy mental health and intensive outpatient	You pay \$40 copay per visit	You pay \$40 copay per visit	You pay \$40 copay per visit	You pay 30% Plan pays 70% after the deductible is met

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Prescription Plan Highlights

Prescription Plan Highlights	Network (HMO)	OAPIN	Network POS	
Benefits	In-network only	In-network only	In-network	Out-of-network
Special Services				

<p>CIGNA Pharmacy three-tier copay plan Self administered Injectable and optional Injectable drugs – excludes infertility drugs</p> <p>Note: Effective 01/01/13, as a result of health care reform certain categories of drugs and other products have been included in the preventive care services coverage. The coverage emphasizes the prevention of disease and meeting the unique health care needs of women. For a list of specific products and prescriptions medications (as well as specific over-the-counter medications) which will be available at no cost please review the information please contact Cigna for more information.</p>	<p>Retail (30 day supply) You pay: Generic \$20 Preferred Brand \$50 Non-Preferred Brand \$70</p>	<p>Retail (30 day supply) You pay: Generic \$20 Preferred Brand \$50 Non-Preferred Brand \$70</p>	<p>Retail (30 day supply) You pay: Generic \$20 Preferred Brand \$50 Non-Preferred Brand \$70</p>	<p>Retail - You pay 30% Plan pays 70%</p>
	<p>Home Delivery (90 day supply) You pay: Generic \$40 Preferred Brand \$100 Non-Preferred Brand \$140</p>	<p>Home Delivery (90 day supply) You pay: Generic \$40 Preferred Brand \$100 Non-Preferred Brand \$140</p>	<p>Home Delivery (90 day supply) You pay: Generic \$40 Preferred Brand \$100 Non-Preferred Brand \$140</p>	<p>Home Delivery - Not covered</p>

Pharmacy out-of-pocket maximum Retail and Home Delivery copays apply to the Pharmacy out-of-pocket maximum	Employee \$3,850 Employee and family \$7,700	Employee \$3,850 Employee and family \$7,700	Employee \$3,850 Employee and family \$7,700	
Prescription smoking cessation drugs & OTC with a prescription	Covered - no copay applied	Covered - no copay applied	Covered - no copay applied	Not covered

Note: The CIGNA Prescription Drug List is available on www.myCigna.com to help you determine the cost of your prescribed medication.

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