

Benefit Provision		Cigna HMO	UnitedHealthcare PPO		UnitedHealthcare HDHP with H.S.A.	
		<i>In-Network Coverage Only</i>	<i>In-Network</i>	<i>Out-of-Network</i>	<i>In-Network</i>	<i>Out-of-Network</i>
Plan Deductible (These work differently for HMO, PPO and HDHP Plans. Refer to the Benefits website for more information.)	Single	\$350 Facility Deductible	\$350 Annual Deductible	\$700 (one way accumulation)	\$1,250 (cross accumulation)	\$2,500 (cross accumulation)
	Family	\$700 Facility Deductible	\$700 Annual Deductible	\$1,400 (one way accumulation)	\$2,500 (cross accumulation)	\$5,000 (cross accumulation)
Standard Percent of Co-Insurance		N/A	10%	30%	10%	30%
Out-of-Pocket Maximum (Refer to the Benefits website for more information)	Single	\$1,600	\$3,000	\$6,000	\$2,000 (cross accumulation)	\$4,000 (cross accumulation)
	Family	\$3,200	\$6,000	\$12,000	\$4,000 (cross accumulation)	\$8,000 (cross accumulation)
Pre-Existing Condition Limitation		None	None		None	
Preventive Care		\$0 (FREE)	\$0 (FREE)	Covered in-network only	\$0 (FREE) no deductible	Covered in-network only
Primary Care Physician		\$30	\$40	30% after deductible	10% after deductible	30% after deductible
Convenience Care Clinic Visit		\$20	\$30	30% after deductible	10% after deductible	30% after deductible
Specialty Care Physician - CCN/Non-CCN / Tier 1		\$45* / \$70**	\$55* / \$70**	30% after deductible	10% after deductible	30% after deductible
Advanced Radiological Imaging: CAT, PET, MRI, MRA Scans and nuclear cardiac studies		\$100/type of scan/day***	\$100/type of scan/day*** plus 10% co-insurance	30% after deductible ***	10% after deductible	30% after deductible
Allergy Injections - CCN/Non-CCN / Tier 1		\$13* / \$28**	\$18* / \$33**	30% after deductible	10% after deductible	30% after deductible
Independent Lab and X-ray Facility		\$0	\$0	30% after deductible	10% after deductible; no deductible if preventive	30% after deductible
Inpatient Hospital Facility Services (including delivery)		\$250, after deductible	10% after deductible	30% after deductible	10% after deductible	30% after deductible
Inpatient and Outpatient Professional Services (Surgeon, Anesthesiologist)		\$0	10% after deductible	30% after deductible	10% after deductible	30% after deductible
Outpatient Hospital Facility Services		\$125 after deductible	10% after deductible	30% after deductible	10% after deductible	30% after deductible
Pre- & Post-Natal Exams (after pregnancy has been confirmed)		\$30/\$45*/\$70**, waived after 1st visit	\$40/\$55*/\$70** to confirm pregnancy; 10% all other related services	30% after deductible	10% after deductible	30% after deductible
Urgent Care		\$75, waived if admitted to hospital	\$75, waived if admitted to hospital	\$75, waived if admitted to hospital	10% after deductible	10% after deductible
Emergency Room		\$200, waived if admitted to hospital	\$200, waived if admitted to hospital	\$200, waived if admitted to hospital	10% after deductible	10% after deductible
Ambulance		\$0	10% after deductible	10% after deductible	10% after deductible	10% after deductible
Durable Medical Equipment/Medical Supplies No annual limit (co-pay/co-insurance applies to each item)		\$75 DME; \$0 consumable supplies	10% after deductible	30% after deductible	10% after deductible	30% after deductible
External Prosthetics		\$0	10% after deductible	30% after deductible	10% after deductible	30% after deductible
Chiropractic Services; limited to 24 visits/year (combined in and out-of-network for UnitedHealthcare PPO and UnitedHealthcare HDHP with H.S.A.)		\$30	\$40	30% after deductible	10% after deductible	30% after deductible
Pulmonary Rehab, Physical, Speech, Occupational and Cognitive Therapy, 60 visits combined/yr. (combined in and out-of-network for UnitedHealthcare PPO and UnitedHealthcare HDHP with H.S.A.)		\$45	\$55	30% after deductible	10% after deductible	30% after deductible
Cardiac Rehab; 36 visits/year (combined in and out-of-network for UnitedHealthcare PPO and UnitedHealthcare HDHP with H.S.A.)		\$45	\$55	30% after deductible	10% after deductible	30% after deductible
Alternative Medicine; 20 visits/year \$60 credit for supplies/products when prescribed by Alternative Medicine Provider		\$30	\$40	Covered in-network only	10% after deductible	Covered in-network only
Bariatric Surgery (1 year waiting period from initial employment)		\$1,000 co-pay after deductible; in addition to Inpatient Hospital Facility Services	\$1,000 co-pay after deductible; in addition to Inpatient Hospital Facility Services	Covered in-network only	10% after deductible	Covered in-network only

For more detail, review the plan summaries on the Benefits Home Page under the Open Enrollment tab, or under the Medical Section tab.

*You pay lower co-pays when you use a specialist with the Cigna Care Network (CCN) or the UnitedHealthcare Premium Tier 1 designation.

**You pay higher co-pays when you use a specialist without the CCN or UHC Tier 1 designation. Not all specialties are included. When the specialty is not included in the CCN or UHC Tier 1, the higher Non-CCN or Non-UHC Tier 1 co-pay applies except for therapy & rehabilitation.

***Does not apply to inpatient facility services; subject to applicable place of service co-insurance & plan deductible; associated ancillary charges are subject to the the applicable place of service co-insurance & deductible.