Plan Type Plan Type	**Anthem BCBS BlueCard PPO 100**		**CIGNA OAP PPO 100**	
	Network	**Out of Network**	**Network**	**Out of Network**
Annual Medical Deductible	$0 per person $0 per family	$500 per person $1000 per family	$0 per person $0 per family	$500 per person $1,000 per family
Annual Maximum Out of Pocket	$2,000 per person $4,000 per family	$4,000 per person $8,000 per family	$2,000 per person $4,000 per family	$4,000 per person $8,000 per family
Preventive Care				
Preventive Services & Well Child Care	$0 copay	50% co-insurance	$0 co-pay	50% coinsurance
Physicians Services				
Office Visit	$30 copay	50% coinsurance	$30 copay	50% coinsurance
Diagnosis Services (outpatient)	$0 copay	50% coinsurance	$0 copay	50% coinsurance
Specialist Care	$45 copay	50% coinsurance	$45 copay	50% coinsurance
Hospital Services				
Inpatient Services (including inpatient maternity services)	$250 copay	50% coinsurance	$250 copay	50% coinsurance
Outpatient Surgery	$200 copay	50% coinsurance	$200 copay	50% coinsurance
Emergency Room Care	$250 copay	$250 copay	$250 copay	$250 copay
Ambulance Services	$0 copay	$0 copay	$0 copay	$0 copay
Mental Health/Substance Abuse				
Outpatient Services	$30 copay Services through Anthem	30% coinsurance Services through Anthem	$30 copay Services through CIGNA	30% coinsurance Services through CIGNA
Inpatient Services	$250 copay Services through Anthem	50 % coinsurance Services through Anthem	$250 copay Services through CIGNA	50 % coinsurance Services through CIGNA
Other medical services				
Durable Equipment	$0 copay	50% coinsurance	$0 copay	50% coinsurance
Home Healthcare	$0 copay	50% coinsurance	$0 copay	50% coinsurance
Outpatient Therapy	$30 copay PCP $45 copay specialist (includes hearing/speech, physical and occupational & 60 visits per year per each type of therapy)	50% coinsurance (includes hearing/speech, physical and occupational & 60 visits per year per each type of therapy)	$30 copay PCP $45 copay specialist (includes hearing /speech, physical and occupational 60 visits per year per each type of therapy)	50% coinsurance
Skilled Nursing/Acute Rehab Facility	0 co-pay	50% coinsurance	$0 copay	50% coinsurance
Urgent Care Services	$50 copay	$50 copay	$50 copay	$50 copay

Plan Type Plan Type	**Anthem BCBS BlueCard PPO 80**		**CIGNA OAP PPO 80**	
	Network	**Out of Network**	**Network**	**Out of Network**
Annual Medical Deductible	$1,000 per person $2,000 per family	$2,000 per person $4,000 per family	$1,000 per person $2,000 per family	$2,000 per person $4,000 per family
Annual Maximum Out of Pocket	$3,500 per person $7,000 per family	$7,000 per person $14,000 per family	$3,500 per person $7,000 per family	$7,000 per person $14,000 per family
Preventive Care				
Preventive Services & Well Child Care	$0 copay	50% coinsurance	$0 copay	50% coinsurance
Physicians Services				
Office Visit	$30	50% coinsurance	$30 copay	50% coinsurance
Diagnosis Services (outpatient)	20% coinsurance	50% coinsurance	20% coinsurance	50% coinsurance
Specialist Care	$45 copay	50% coinsurance	$45 copay	50% coinsurance
Hospital Services				
Inpatient Services (including inpatient maternity services)	20% coinsurance	50% coinsurance	20% coinsurance	50% coinsurance
Outpatient Surgery	20% coinsurance	50% coinsurance	20% coinsurance	50% coinsurance
Emergency Room Care	$250 copay	$250 copay	$250	$250
Ambulance Services	20% coinsurance	20% coinsurance	20% coinsurance	20% coinsurance
Mental Health/Substance Abuse				
Outpatient Services	$30 copay Services through Anthem	30% coinsurance Services through Anthem	$30 copay Services through CIGNA Behavioral	30% coinsurance Services through CIGNA Behavioral
Inpatient Services	20% coinsurance Services through Anthem	50 % coinsurance Services through Anthem	20% coinsurance Services through CIGNA Behavioral	50 % coinsurance Services through CIGNA Behavioral
Other medical services				
Durable Equipment	20% coinsurance	50% coinsurance	20% coinsurance	50% coinsurance
Home Healthcare	20% coinsurance	50% coinsurance	20% coinsurance	50% coinsurance
Outpatient Therapy	$30 copay PCP $45 copay specialist (includes hearing/speech, physical and occupational & 60 visits per year per each type of therapy)	50% coinsurance (includes hearing/speech, physical and occupational & 60 visits per year per each type of therapy)	$30 copay PCP $45 copay specialist (includes hearing/ speech, physical and occupational 60 visits per year per each type of therapy)	50% coinsurance (includes hearing/speech, physical and occupational & 60 visits per year per each type of therapy)
Skilled Nursing/Acute Rehab Facility	20% coinsurance	50% coinsurance	20% coinsurance	50% coinsurance
Urgent Care Services	$50 copay	$50 copay	$50 copay	$50 copay

Plan Type	ANTHEM CDHP20/HSA	ANTHEM CDHP20/HSA	CIGNA CDHP20/HSA	CIGNA CDHP20/HSA
	Network	**Out of Network**	**Network**	**Out of Network**
Annual Deductible	$2,700 per person $5,450 per family (includes medical & prescriptions)	$3,000 per person $6,000 per family (includes medical & prescriptions	2,700 per person $5,450 per family (includes medical & prescriptions)	$3,000 per person $6,000 per family (includes medical & prescriptions
Annual Maximum Out of Pocket	$4,200 per person $8,450 per family	$7,000 per person $13,000 per family	$4,200 per person $8,450 per family	$7,000 per person $13,000 per family
Preventive Care				
Preventive Services & Well Child Care	$0 copay	45% coinsurance	$0 copay	45% coinsurance
Physicians Services				
Office Visit	20% coinsurance	45% coinsurance	20% coinsurance	45% coinsurance
Diagnosis Services (outpatient)	20% coinsurance	45% coinsurance	20% coinsurance	45% coinsurance
Specialist Care	20% coinsurance	45% coinsurance	20% coinsurance	45% coinsurance
Hospital Services				
Inpatient Services (including inpatient maternity services)	20% coinsurance	45% coinsurance	20% coinsurance	45% coinsurance
Outpatient Surgery	20% coinsurance	45% coinsurance	20% coinsurance	45% coinsurance
Emergency Room Care	20% coinsurance	20% coinsurance	20% coinsurance	20% coinsurance
Ambulance	20% coinsurance	20% coinsurance	20% coinsurance	20% coinsurance
Mental Health/Substance Abuse				
Outpatient Services	20% coinsurance	45% coinsurance	20% coinsurance	45% coinsurance
Inpatients Services	20% coinsurance	45% coinsurance	20% coinsurance	45% coinsurance
Other medical services				
Durable Equipment	20% coinsurance	45% coinsurance	20% coinsurance	45% coinsurance
Home Healthcare	20% coinsurance	45% coinsurance	20% coinsurance	45% coinsurance
Outpatient Therapy	20% coinsurance (includes hearing/speech, physical and occupational & 60 visits per year per each type of therapy)	45% coinsurance (includes hearing/speech, physical and occupational & 60 visits per year per each type of therapy)	20% coinsurance (includes hearing/speech, physical and occupational & 60 visits per year per each type of therapy)	45% coinsurance (includes hearing/speech, physical and occupational & 60 visits per year per each type of therapy
Skilled Nursing/Acute Rehab Facility	20% coinsurance	45% coinsurance	20% coinsurance	45% coinsurance
Urgent Care Services	20% coinsurance	20% coinsurance	20% coinsurance	20% coinsurance

Plan Type	**Prescription Drug Benefits managed by Express Scripts**		
	Standard	**Standard**	**CDHP-20/HSA**
	Retail	**Home Delivery**	
Annual Prescription Deductible (in-network)	None	None	$2,700 per person $5,450 per family (combined with medical deductible)
Tier 1: Generic	Up to a $10 copay	Up to a $25 copay	You pay 15% after deductible
Tier 2: Preferred Brand Name	Up to a $40 copay	Up to a $100 copay	You pay 25% after deductible
Tier 3: Non-Preferred Brand Name	Up to a $80 copay	Up to a $200 copay	You pay 50% after deductible
Dispensing Limits Per Copayment	Up to a 30-day supply	Up to a 90-day supply	Up to a 30-day supply (retail) or 90-day supply (mail order)

	Vision Benefits Managed by EYEMED	**Network**	**Out-of-Network**
Eye Examinations		$0 copay	Plan pays up to 30% for ophthalmologists and optometrists
Lenses (eligible once every calendar year)		$10 copay	Plan pays up to: $32 for single vision $46 for bifocal $57 for bifocal
	Lens Options		
Standard Progressive (add-on to bifocal)		Up to $75 copay	Plan pays up to $46
UV Coating		Up to $15 copay	You are responsible for the cost of any lens options that you elect from out-of-network providers
Tint Solid and gradient		Up to $15 copay	You are responsible for the cost of any lens options that you elect from out-of-network providers
Standard scratch resistance		Up to $15 copay	You are responsible for the cost of any lens options that you elect from out-of-network providers
Standard Polycarbonate		$0 copay	You are responsible for the cost of any lens options that you elect from out-of-network providers
Standard Antireflective Coating		Up to $45 copay	You are responsible for the cost of any lens options that you elect from out-of-network providers
Disposable		20% off retail price	You are responsible for the cost of any lens options that you elect from out-of-network providers
Frames (eligible once every calendar year)		$150 Allowance, 20% off balance over$150	Plan pays up to $47
	Contact lenses		
Conventional		$150 Allowance, 15% off balance over $150	Plan pays up to $100
Disposable		$150 Allowance, the you pay balance over $150	Plan pays up to $100

This chart is a general description and is provided for informational purposes only. It should not be viewed as an offer of coverage. In the event of a conflict between this chart and the official Plan documents, the official Plan documents will govern.