

Medical Benefits At-A-Glance

The following is only a summary, some benefits may have further limitations or exclusions.

	CIGNA Open Access Plan		Presbyterian My Care ²
	In-Network	Out of Network	Active
Annual deductible	None	\$1,000 ind. \$2,000 family	None
Annual out-of-pocket costs	\$1,500 individual, \$3,000 family	\$3,000 ind. \$6,000 family	Twice your annual premium
Lifetime maximum	Unlimited		Unlimited
Physician services			
Office visit	\$15 co-pay per visit	50% after plan deductible ³	\$20 co-pay per visit
Specialist visit	\$25 co-pay per visit		\$30 co-pay per visit
Allergy testing	\$25 co-pay per visit	50% after plan deductible	You pay 20%
Injections	\$25 co-pay per visit, \$15 co-pay if PCP	50% after plan deductible ³	Included in office visit co-pay
Infertility services	\$25 co-pay per visit, \$15 co-pay if PCP	50% after plan deductible ³	You pay 50%
Gynecological exam	\$25 co-pay per visit, \$15 co-pay if PCP	50% after plan deductible ³	\$20 co-pay
Pre and post natal care	\$25 co-pay per initial visit, no charge for all other routine visits	50% after plan deductible ³	\$20 co-pay per visit up to \$200 per pregnancy
Diagnostic X-ray			
MRI	\$75 co-pay ¹	50% after \$150 per procedure deductible and plan deductible ^{1 3}	\$125 co-pay per test
Cat Scans	\$75 co-pay ¹	50% after plan deductible ^{1 3}	\$75 co-pay per test
Cardiac Cath	\$150 co-pay ¹	50% after plan deductible ^{1 3}	\$200 co-pay per test
X-Ray and Laboratory	No charge	50% after plan deductible ³	No charge
Urgent care	\$25 co-pay urgent, \$15 co-pay non appointment care	50% after plan deductible ³	Participating provider: \$25 co-pay Non-participating provider: \$50 co-pay
Emergency room	\$75 co-pay, waived if admitted	50% after plan deductible ³	\$75 co-pay per visit, waived if admitted
Ambulance	No charge	50% after plan deductible ³	\$50 co-pay (ground), \$100 co-pay (air)
Hospital			
Inpatient	\$250 co-pay per admission ¹	50% after \$500 per admit deductible and plan deductible ^{1 3}	\$150 co-pay per day up to \$450 per admission ¹
Outpatient	\$150 co-pay ¹	50% after \$250 per admit deductible and plan deductible ^{1 3}	\$150 co-pay per visit ¹
Speech, physical, occupational therapy Outpatient	\$20 co-pay per visit (60 visits per calendar year combined includes acupuncture) ¹	50% after plan deductible ^{1 3}	\$30 co-pay per visit ¹ (2 months per condition)
Acupuncture	See speech therapy	50% after plan deductible ³	\$30 co-pay per visit (20 visits per calendar year, medical necessity)
Durable medical equipment	No charge (up to \$1,000 per calendar year) ^{*1}	50% after plan deductible ^{1 3}	You pay 50% ¹
Chiropractic	See speech therapy	50% after plan deductible ^{1 3}	\$30 co-pay per visit (18 visits per calendar year, medical necessity)
Home Health Care	No charge (100 visits max per calendar year) ^{*1}	50% after plan deductible ^{1 3}	No charge ¹
Hospice	No charge ¹	50% after plan deductible ^{1 3}	\$150 co-pay per day up to \$450 per admission ¹
Skilled nursing care	No charge (60 days per calendar year) ^{*1}	50% after plan deductible ^{1 3}	\$150 co-pay per day up to \$450 per admission (60 days per calendar year) ¹
Dialysis	\$150 co-pay per admission	50% after plan deductible ^{1 3}	You pay 20% per visit
Mental Health			
Inpatient	\$250 co-pay per admission ¹	50% after \$500 per admit deductible and plan deductible ^{1 3}	\$150 co-pay per day up to \$450 per admission ¹
Outpatient	\$25 co-pay per visit	50% after plan deductible ³	\$30 co-pay per visit ¹
Substance Abuse			
Inpatient	\$50 co-pay per day (30-day max per calendar year) ^{*1}	50% after \$50 per day deductible and plan deductible ^{1 3}	Detox: \$150 co-pay per day up to \$450 per admission ^{1,3*} Rehab: 25% co-pay per admission ^{1,3*}
Outpatient	\$25 co-pay for first 2 visits, \$25 thereafter (20 visit max per calendar year) [*]	50% after plan deductible ³	\$30 co-pay per visit ¹ (30 visits per calendar year)
Prescription drugs			
Retail	Generic \$10, brand \$35, non-preferred or brand name with generic equivalent 50%	In-network coverage only	Generic \$10, brand \$35, non-preferred \$55 (30 days up to the maximum dosing recommended by the manufacturer) When generic available but chooses brand, \$10 plus difference in cost
Mail Order	Generic \$20, brand \$70, non-preferred or brand name with generic equivalent 50%	In-network coverage only	Generic \$20, brand \$87.50, non-preferred \$165 (90 days up to the maximum dosing recommended by the manufacturer) When generic available but chooses brand, \$20 plus difference in cost

¹ Prior authorization/benefit certification applies.

² Pending Department of Insurance approval.

³Benefits are limited to reasonable and customary charges. You are responsible for any balance due above reasonable and customary charges.

For a more complete description please refer to each plan's member certificate, schedule of benefits or group subscriber agreement.

Presbyterian My Care ²		
Family	Independent	
	Network	Out-of-Network
None	None	\$500 individual, \$1,500 family
Twice your annual premium	Twice your annual premium	\$6,000 individual, \$18,000 family
Unlimited	Unlimited	\$2 million
\$25 co-pay (adult), \$10 co-pay (child)	\$25 co-pay per visit	You pay 40%
\$35 co-pay (adult), \$20 co-pay (child)	\$35 co-pay per visit	You pay 40%
You pay 20%	You pay 20%	You pay 40%
Included in office visit co-pay	Included in office visit co-pay	You pay 40%
You pay 50%	You pay 50%	Not covered
\$25 co-pay (adult), \$10 co-pay (child)	\$25 co-pay	You pay 40%
\$25 co-pay per visit up to \$250 per pregnancy	\$25 co-pay per visit up to \$250 per pregnancy	You pay 40%
\$200 co-pay per test (adult) \$100 co-pay per test (child)	\$125 co-pay per test	You pay 40% ^{1,4}
\$125 co-pay per test (adult) \$75 co-pay per test (child)	\$75 co-pay per test	You pay 40% ^{1,4}
\$300 co-pay per test (adult) \$175 co-pay per test (child)	\$200 co-pay per test	You pay 40% ^{1,4}
No charge	No charge	You pay 40% ^{1,4}
Participating provider: \$35 co-pay (adult), \$20 co-pay (child), Non-participating provider: \$45 (adult), \$30 co-pay (child)	\$35 co-pay	\$45 co-pay no deductible
\$75 co-pay per visit, waived if admitted	\$75 co-pay per visit, waived if admitted	\$75 co-pay per visit no deductible
\$50 co-pay (ground), \$100 co-pay (air)	\$50 co-pay (ground), \$100 co-pay (air)	\$50 co-pay (ground), \$100 co-pay (air)
\$150 co-pay per day up to \$450 per admission (adult) ¹ \$100 co-pay per day up to \$300 per admission (child) ¹	\$150 co-pay per day up to \$450 per admission ¹	You pay 40% ^{1,4}
\$200 co-pay per visit (adult), \$100 co-pay per visit (child) ¹	\$125 co-pay per visit ¹	You pay 40% ^{1,4}
\$35 co-pay per visit (adult), \$20 co-pay per visit (child) (2 months per condition)	\$35 co-pay per visit (2 months per condition)	You pay 40% ^{1,4} (2 months per condition) Speech therapy not covered out-of-network
\$35 co-pay (adult), \$20 co-pay (child); (20 visits per calendar year, medical necessity)	\$35 co-pay per visit (20 visits per calendar year, medical necessity)	You pay 40%
You pay 50% ¹	You pay 50% ¹	You pay 50% ^{1,4}
\$35 co-pay (adult), \$20 co-pay (child) (18 visits per calendar year, medical necessity)	\$35 co-pay per visit (18 visits per calendar year, medical necessity)	You pay 40%
No charge ¹	No charge ¹	You pay 40% ^{1,4}
\$150 co-pay per day up to \$450 per admission (adult) \$100 co-pay per day up to \$300 per admission (child) ¹	\$150 co-pay per day up to \$450 per admission ¹	You pay 40% ^{1,4}
\$150 co-pay per day up to \$450 per admission (adult) \$100 co-pay per day up to \$300 per admission (child) (60 days per calendar year) ¹	\$150 co-pay per day up to \$450 per admission ¹	You pay 40% ^{1,4}
You pay 20% per visit	You pay 20% per visit	You pay 40%
\$150 co-pay per day up to \$450 per admission (adult) ¹ \$100 co-pay per day up to \$300 per admission (child) ¹	\$150 co-pay per day up to \$450 per admission ¹	You pay 40% ^{1,4}
\$35 co-pay (adult), \$20 co-pay (child) per visit ¹	\$35 co-pay per visit ¹	You pay 40% ^{1,4}
Detox: \$150 co-pay per day up to \$450 per admission (adult) ¹ ; \$100 co-pay per day up to \$300 per admission (child) ¹ ; Rehab: 25% co-pay per admission ^{1*}	Detox: \$150 co-pay per day up to \$450 per admission ¹ ; Rehab: 25% co-pay per admission ^{1,4*}	You pay 40% ^{1,4}
\$35 co-pay per visit (adult) ¹ ; \$20 co-pay per visit (child) ¹ (30 visits per calendar year)	\$35 co-pay per visit ¹ (30 visits per calendar year)	You pay 40% ^{1,4}
Generic \$10, brand \$30, non-preferred \$50 (30 days up to the maximum dosing recommended by the manufacturer) When generic available but chooses brand \$10 plus difference in cost	Generic \$10, brand \$30, non-preferred \$50 (30 days up to the maximum dosing recommended by the manufacturer) When generic available but chooses brand \$10 plus difference in cost	Not covered unless an emergency outside service area (deductible doesn't apply)
Generic \$20, brand \$75, non-preferred \$150 (90 days up to the maximum dosing recommended by the manufacturer) When generic available but chooses brand \$20 plus difference in cost	Generic \$20, brand \$75, non-preferred \$150 (90 days up to the maximum dosing recommended by the manufacturer) When generic available but chooses brand \$20 plus difference in cost	Not covered

⁴ A 15% penalty applies if benefit certification is not obtained.

*20 visits and 1 episode per calendar year, 3 episodes per lifetime.