Introducing our premium Affinity Healthcare Plans

Proposed Plan Comparison Summary Fall 2019.
Consult Plan Certificates and Summary of Benefits & Coverage (SBC) for details.
These are highlights only, discrepancies will be governed by the plan document.

(Plans not Grandfathered)

	CIGNA Premium 500 PPO	CIGNA Preferred 1000 PPO	CIGNA Silver 3000 HSA PPO	CIGNA Bronze Lvl II 5000 HSA EPO
Website:	**In Network [2]**	**In Network [2]**	**In Network [2]**	**In Network [2]**
Deductible				
Individual	$500	$1,000	$3,000	$5,000
Family	$1,500	$3,000	$6,000	$10,000
Out-of-Pocket Maximum - Annual				
Individual	$1,000 [1]	$2,000 [1]	$3,000 [1]	$6,250 [1]
Family	$3,000 [1]	$6,000 [1]	$6,000 [1]	$12,500 [1]
Physician Services (office/facility)	$10/10%*	$20/15%*	0%*	$60/$60*
Routine Care (not subject to deductible)	$0	$0	$0	$0
Outpatient Labs - non hospital	0%	0%	0%*	30%*
Urgent Care	$20	$30	0%*	$60*
Emergency Room Care (waived if admitted)	$100*	$150	$100*	$300*
Hospital Inpatient Room & Care	$100* x 3 days	$150* x 3 days	0%*	30%*
Hospital expenses - Lab/X-ray/CT/MRI/MRA/PET	10%*	15%*	0%*	30%*
Outpatient / Ambulatory Surgery	$100*	$150*	0%*	30%*
CT/MRI/MRA/PET Scan - non hospital	0%	0%	0%*	30%*
Ambulance Services (Emergency Only)	$150*	$200*	0%*	30%*
	Some services may require pre-certification	*Some services may require pre-certification*		
Prescription Card In-network benefits only	**Mandatory Generic Only - Preventive Prescription Services as defined by PPACA. In order for preventive medications to be covered at 100%, a prescription is required from your physician, including over-the counter (OTC) drugs.**			
Deductible	None	None	Same as Medical	Same as Medical
Out-of-Pocket Max. Indv/Fam	$5,850 / $10,700	$4,850 / $7,700	Same as Medical	Same as Medical
Preventive Generic	$0	$0	$0	$0
Generic	$10	$20	$25*	$15*
Preferred Brand	$20	$30	$50*	$50*
Non-Preferred Brand	$35	$45	$75*	$65*
Mail Order Prescriptions	2 x copay for 90 day	2 x copay for 90 day	2 x copay for 90 day	2 x copay for 90 day
Lifetime Maximum	Unlimited	Unlimited	Unlimited	Unlimited
EE Only	$447.20	$432.64	$382.72	$326.56
EE+ SP	$893.36	$865.28	$765.44	$653.12
EE +CH(ren)	$826.80	$800.80	$708.24	$604.24
EE + Family	$1,340.56	$1,297.92	$1,148.16	$979.68

* after meeting calendar year deductible.

[1] Pharmacy out-of-pocket benefits separate.

2 For PPO Non-Participating Providers, the member will be responsible for the deductible, copayments, and coinsurance, as well as any amounts exceeding the Reasonable & Allowed amount. Any amounts in excess of the Reasonable & Allowed amount payable to Providers DO NOT apply to the Annual Deductible NOR the Annual Out-of-Pocket Maximum.

PPO = Preferred Provider Organization provides benefits for contracted (in-network) and non contracted (out-of-network) providers. Out-of-network benefits provided are lower than in-network providers and participants are subject to balance billing. For best benefits, use network contracted providers.

EPO = Exclusive Provider Organization provides benefits for contracted (in-network) providers only. There is no coverage for out-of-network providers, except for emergency care.