WORLD



				RBP				
IN-NETWORK BENEFITS	1000 CLASSIC	1500 CLASSIC	2500 CLASSIC	3500 CLASSIC	5000 CLASSIC	3500 HSA	5000 HSA	7350
Plan Design	PPO Classic	PPO HSA	PPO HSA	PPO				
Deductible Individual / Family	\$1,000/\$2,000	\$1,500/\$3,000	\$2,500/\$5,000	\$3,500/\$7,000	\$5,000/\$10,000	\$3,500/\$7000	\$5,000 / \$10,000	\$7,350/\$14,700
Coinsurance Plan Pays /Member Pays	80%/20%	80%/20%	80%/20%	80%/20%	80%/20%	80%/20%	80%/20%	100%
Out-of-Pocket Maximum Individual / Family	\$5,000/\$10,000	\$7,350 / \$14,700	\$7,350 / \$14,700	\$7,350 / \$14,700	\$7,350 / \$14,700	\$6,550/\$13,100	\$6,550/\$13,100	\$7,350/\$14,700
Routine Preventive Services (Non Diagnostic)	No Member Cost Sharing Deductible Waived							
Inpatient Hospital (patient responsibility)	Facility: 20% no ded. Professional: 20% after ded.	Facility: 20% after ded. Professional: 20% after ded.	Facility: 20% no ded. Professional: 20% after ded.	Facility: 0%; dedutible waived Professional: 0% after ded.				
Out Patient Services Surgical Services (Procedure & Anesthesia)	Facility: 20% no ded. Professional: 20% after ded.	Facility: 20% after ded. Professional: 20% after ded.	Facility: 20% no ded. Professional: 20% after ded.	Facility: 0%; dedutible waived Professional: 0% after ded.				
Free Standing Lab & Diagnostic Services (Lab & x-ray)	Facility: 0%; dedutible waived Professional: 0% after ded.							
Complex Diagnositc Services (CT Scan, MRI, Ultra Sound, PET, Nuclear Medicine)	Facility: 20% no ded. Professional: 20% after ded.	Facility: 20% after ded. Professional: 20% after ded.	Facility: 20% no ded. Professional: 20% after ded.	Facility: 0%; dedutible waived Professional: 0% after ded.				
Emergency Room	Facility: 20% no ded. Professional: 20% after ded.	Facility: 20% after ded. Professional: 20% after ded.	Facility: 20% no ded. Professional: 20% after ded.	Facility: 0%; dedutible waived Professional: 0% after ded.				
Urgent Care	\$40 Copay	\$80 Copay	\$80	\$90 Copay	\$90 Copay	20% after deductible	20% after deductible	\$100 Copay
Primary Care / Specialist	\$20/\$40	\$40/\$80	\$40/\$80	\$45/\$90	\$45/\$90	20% after deductible	20% after deductible	\$50/\$100 Copay
Telemedicine	\$0 Copay							

WORLD



				RBP				
Prescription Drug Deductible Retail (31 Days) Mail Order (90 Days)	In-Network None \$15/\$45/\$85 \$45/\$90/\$150	In-Network None \$15/\$45/\$85 \$45/\$90/\$150	In-Network None \$15/\$45/\$85 \$45/\$90/\$150	In-Network None \$15/\$65/\$100 \$45/\$90/\$150	In-Network None \$15/\$65/\$100 \$45/\$90/\$150	In-Network None Drug Discount Card Drug Discount Card	In-Network None Drug Discount Card Drug Discount Card	In-Network None Drug Discount Card Drug Discount Card
NON-NETWORK SERVICES	1000 CLASSIC	1500 CLASSIC	2500 CLASSIC	3500 CLASSIC	5000 CLASSIC	3500 HSA	5000 HSA	7350
Coinsurance Plan Pays/Member Pays	60%/40%	60%/40%	60%/40%	60%/40%	60%/40%	60%/40%	50%/50%	60%/40%
Deductible Individual/Family	\$2,000/\$4,000	\$3,000/\$6,000	\$5,000/\$10,000	\$7,000/\$14,000	\$7,000/\$14,000	\$7,000/\$14,000	\$10,000/\$20,000	\$14,700/\$29,400
Out of Pocket Maximum Individual/Family	\$10,000/\$20,000	\$20,000/\$40,000	\$20,000/\$40,000	\$20,000/\$40,000	\$20,000/\$40,000	\$20,000/\$40,000	\$13,100/\$20,000	\$14,700/\$29,400

CIGNA NETWORK								
IN-NETWORK BENEFITS	1000	1500	2500	3500	5000	3500 HSA	5000 HSA	7350
Plan Design	PPO	PPO	PPO	PPO	PPO	PPO HSA	PPO HSA	PPO
Deductible Individual / Family	\$1,000/\$2000	\$1,500/\$3,000	\$2,500/\$5,000	\$3,500/\$7,000	\$5,000/\$10,000	\$3,500/\$7,000	\$5,000 / \$10,000	\$7,350/\$14,700
Coinsurance Plan Pays /Member Pays	80%/20%	80%/20%	80%/20%	80%/20%	80%/20%	80%/20%	80%/20%	100%
Out-of-Pocket Maximum Individual / Family	\$5,000/\$10,000	\$7,350 / \$14,700	\$7,350 / \$14,700	\$7,350 / \$14,700	\$7,350 / \$14,700	\$6,550/\$13,100	\$6,550/\$13,100	\$7,350/\$14,700
Routine Preventive Services (Non Diagnostic)	No Member Cost Sharing Deductible Waived	No Member Cost Sharing Deductible Waived	No Member Cost Sharing Deductible Waived					
Inpatient Hospital (patient responsibility)	Facility: 20% no ded. Professional: 20% after ded.	Facility: 20% after ded. Professional: 20% after ded.	Facility: 20% no ded. Professional: 20% after ded.	Facility: 0%; dedutible waived Professional: 0% after ded.				

WORLD



CIGNA NETWORK Facility: 0%; **Out Patient Services** Facility: 20% no ded. Facility: 20% after ded. Facility: 20% no ded. dedutible waived **Surgical Services** Professional: 20% Professional: 0% (Procedure & Anesthesia) after ded. Facility: 0%; deductible waived Free Standing Lab & Diagnostic deductible waived Services (Lab & x-ray) Professional: 0% after ded. Facility: 0%; Facility: 20% no ded. Facility: 20% no ded. Facility: 20% no ded. Facility: 20% after ded. **Complex Diagnositc Services** Facility: 20% no ded. Facility: 20% no ded. Facility: 20% no ded. dedutible waived (CT Scan, MRI, Ultra Sound, Professional: 20% Professional: 0% PET, Nuclear Medicine) after ded. Facility: 0%; Facility: 20% no ded. Facility: 20% after ded. Facility: 20% no ded. dedutible waived **Emergency Room** Professional: 20% Professional: 0% after ded. **Urgent Care** \$40 Copay \$80 Copay \$80 Copay \$90 Copay \$90 Copay 20% after deductible 20% after deductible \$100 Copay 20% after deductible **Primary Care / Specialist** \$20/\$40 Copay \$40/\$80 Copay \$40/\$80 Copay \$45/\$90 Copay \$45/\$90 Copay 20% after deductible \$50/\$100 Copay Telemedicine \$0 Copay **Prescription Drug** In-Network In-Network In-Network In-Network In-Network In-Network In-Network In-Network Deductible None None None None None None None None Retail (31 Days) \$15/\$45/\$85 \$15/\$45/\$85 \$15/\$45/\$85 \$15/\$65/\$100 \$15/\$65/\$100 Drug Discount Card Drug Discount Card Drug Discount Card Mail Order (90 Days) \$45/\$90/\$150 \$45/\$90/\$150 \$45/\$90/\$150 \$45/\$90/\$150 \$45/\$90/\$150 Drug Discount Card Drug Discount Card Drug Discount Card 1500 **5000 CLASSIC** 3500 HSA 5000 HSA **NON-NETWORK SERVICES** 1000 2500 3500 7350 Coinsurance 60%/40% 60%/40% 60%/40% 60%/40% 60%/40% 60%/40% 60%/40% 50%/50% Plan Pays/Member Pays **Deductible** \$2,000/\$4000 \$3,000/\$6000 \$5,000/\$10,000 \$7,000/\$14,000 \$7,000/\$14,000 \$7,000/\$14,000 \$10,000/\$20,000 \$14,700/\$29,400 Individual/Family **Out of Pocket Maximum** \$10,000/\$20,000 \$14,700/\$29,400 \$14,700/\$29,400 \$14,700/\$29,400 \$14,700/\$29,400 \$20,000/\$40,000 \$20,000/\$40,000 \$14,700/\$29,400 Individual/Family

NOTE: Precertification is required for all in-hospital admissions, chemotherapy, diagnostic testing and outpatient surgery. Penalty may apply for not obtaining precertification.

This comparison describes the plan in an easy understood manner and presented as a matter of general information. The contents are not to be accepted as a substitute for the provision of the plan.