

# Medical Insurance: OAP – PBA Plan At-A-Glance

The Summary of Benefits and Coverage (SBC), provided in addition to this Employee Benefits Highlights Booklet, is your primary source of information regarding your Cigna medical plans. The information contained in this Booklet regarding your medical plans is intended to supplement your SBC and accompanying definitions. If any information in this booklet unintentionally conflicts with the SBC or accompanying definitions, the SBC information prevails. If you have any additional questions regarding the plan please contact Cigna's Customer Service at (800) 244-6224.

Network	Open Access Plus (OAP)	
Calendar Year Deductible (CYD)	In Network	Out of Network
Individual	\$500	\$600
2 Member Family	\$1,000	\$1,200
3 or More Member Family	\$1,500	\$1,800
Coinsurance (When Applicable)	In Network	Out of Network
Member Responsibility	20%	40%
Out-of-Pocket Maximum	In Network	Out of Network
Individual	\$1,500	\$3,000
2 Member Family	\$3,000	\$6,000
3 or More Member Family	\$4,500	\$9,000
What Applies to the Out-of-Pocket Maximum	Copays, Deductible & Coinsurance (excludes Rx Copays)	
Physician Office Visits	In Network	Out of Network**
Primary Care Physician (PCP)	\$20 Copay	40% After CYD
Specialists (No Referral Required)	\$30 Copay	40% After CYD
Diagnostic Services	In Network	Out of Network**
Clinical Lab (Blood Work) at Independent Facility	No Charge	40% After CYD
X-rays at Independent Facility	No Charge	40% After CYD
Advanced Imaging (MRI, PET, CAT, MRA) Independent Facility	\$75 Copay Per Scan	40% After CYD
Hospital	In Network	Out of Network**
Inpatient Hospital	20% After CYD	40% After CYD
Outpatient Hospital	20% After CYD	40% After CYD
Physician Services at Outpatient Hospital or Surgical Center	20% After CYD	40% After CYD
Emergency Room (Waived if Admitted)	\$150 Copay	
Urgent Care Facility	\$50 Copay	
Mental Health / Alcohol & Substance Abuse	In Network	Out of Network**
Inpatient	20% After CYD	40% After CYD
Outpatient Facility	No Charge	40% After CYD
Physician Office Visit	\$30 Copay	40% After CYD
Prescription Drugs (Rx)	In Network	Out of Network**
Tier 1 – Generic	\$5 Copay	Not Covered
Tier 2 – Preferred Brand Name	40% of Cost, \$20 Minimum & \$50 Maximum	
Tier 3 – Non-Preferred Brand Name	60% of Cost, \$35 Minimum & \$85 Maximum	
Tier 4 – Self Administered Injectables / Specialty Drugs	\$200 Copay	
Mail-Order Program (90 Day Supply)	2x Retail Copay	

*Calendar Year Deductible (CYD) must be met before any co-insurance applies.*

## \*\*Out-Of-Network Balance Billing

For information regarding out-of-network balance billing that may be charged by an out-of-network provider for services rendered, please refer to the Out-of-Network Benefits section on the Summary of Benefits and Coverage (SBC).