

Open Access Plus Plan L

Plan-at-a-Glance


**CIGNA HealthCare
of Arizona**

	In-Network	Out-of-Network
Primary Care Physician Services:		
Office Visits	\$20 Copay	60% after deductible
Preventative Care, Including Immunizations (birth thru age 2)	\$20 Copay	Not Covered
Immunizations (Birth through age 2)	No Charge	Not Covered
Adult Preventive Care	\$20 Copay	Not Covered
Well Child Care, Including Immunizations (Age 3 and Above)	\$20 Copay	Not Covered
Immunizations (Age 3 and above)	No Charge	Not Covered
Lab and X-ray In Physicians Office	\$20 Copay	60% after deductible
Specialty Physician Services:		
Office Visits	\$40 Copay	60% after deductible
Referral Physician Services	\$40 Copay	60% after deductible
Allergy Testing and Treatment	\$40 Copay	60% after deductible
Well Woman OB/GYN Visit	\$20/40 Copay	Not Covered
Lab and X-ray in Specilaists Office	\$40 Copay	60% after deductible
Routine Mammogram, PSA, PAP Smear		
Performed at (Physician's/Specialists Office)	\$20/\$40 Copay	60% after deductible
If billed by separate O/P Diagnostic Facility	90% after deductible	60% after deductible
Pre and Postnatal Exams		
Initial Visit	\$20 Copay	60% after deductible
Subsequent Prenatal/Postnatal Visits (Physician's Global Maternity Fee)	90% after deductible	60% after deductible
MRI / CT / PET Scans		
	\$200 Copay plan deductible, then 90%	\$400 Copay plan deductible, then 60%
Inpatient Hospital Services		
Operating and Recovery Room	90% after deductible	60% after deductible
Physician and Surgeon Charges	90% after deductible	60% after deductible
Newborn Delivery Charges	90% after deductible	60% after deductible
Diagnostic and Therapeutic Lab and X-ray Services	90% after deductible	60% after deductible
Drugs and Medications	90% after deductible	60% after deductible
Operating and Recovery Room	90% after deductible	60% after deductible
Hemodialysis	90% after deductible	60% after deductible
Radiation and Chemotherapy	90% after deductible	60% after deductible
Outpatient Hospital Services		
Operating and Recovery Room	90% after deductible	60% after deductible
Physician Services	90% after deductible	60% after deductible
Laboratory and X-ray	90% after deductible	60% after deductible
Hemodialysis	90% after deductible	60% after deductible
Radiation and Chemotherapy	90% after deductible	60% after deductible
Emergency Care		
Participating Physician's Office	\$20/40 Copay \$150 Copay*	\$20/40 Copay \$150 Copay*
Hospital Emergency Room, Outpatient Facility, or Non-Participating Physician's Office		
Urgent Care Facility	\$75 Copay*	\$75 Copay*
Ambulance	90% after deductible	90% after deductible
- Ground		
- Air		
*no charge after per visit copay and plan deductible		
Other Health Care Facilities (Skilled Nursing and Rehabilitation)		
Maximum of 60 days per contract year.	90% after deductible	60% after deductible
Home Health Care		
	90% after deductible	60% after deductible

Outpatient Short Term Rehabilitation		
Maximum of 20 visits (including Chiro)	\$40 Copay	60% after deductible
Family Planning		
Tests, counseling	\$20/40 Copay	60% after deductible
Surgical sterilization procedures (vasectomy, tubal ligation):		
- Inpatient Facility Services	90% after deductible	60% after deductible
- Outpatient Facility Charge	90% after deductible	60% after deductible
- Surgery in Physician's/Specialists Office	\$20/\$40 Copay	60% after deductible
Infertility		
Office Visit	Not covered	Not Covered
Treatment / surgery	Not covered	Not Covered
Exclusions (where allowed by state):		
- Inpatient Facility Services		
- Outpatient Facility Charge		
- Costs connected with collection, preparation, storage of sperm, for artificial insemination, including donor fees.		
EPA		
\$1,000 calendar year maximum	\$200 ded, then plan deductible, then 90%	\$200 ded, then plan deductible, then 90%
DME Outpatient		
\$700 per year maximum	90% after plan deductible	60% after plan deductible
Diabetic equipment/appliances will be covered as DME but will not be applied to DME maximum		
Mental Health		
Inpatient Copay	\$500 per admission copay plan deductible, then 90%	\$500 per admission copay plan deductible, then 60%
Inpatient Days	25 MH&SA Combined	25 MH&SA Combined
Outpatient Individual Copay	\$40 Copay	60% after deductible
Outpatient Group Copay	\$20 Copay	60% after deductible
Outpatient Visits	20 MH&SA Combined	20 MH&SA Combined
Substance Abuse		
Inpatient Copay	\$500 per admission copay plan deductible, then 90%	\$500 per admission copay plan deductible, then 60%
Inpatient Days	25 MH&SA Combined	25 MH&SA Combined
Outpatient Individual Copay	\$40 Copay	60% after deductible
Outpatient Group Copay	\$20 Copay	60% after deductible
Outpatient Visits	20 MH&SA Combined	20 MH&SA Combined
Prescription Drugs (with O/C, no O/F)		
Generic/Preferred Brand/Non-Preferred Brand	\$15/\$35/\$60	Not Covered
Mail Order Drugs (3x - \$5)	\$40/\$100/\$175	Not Covered
Out of Pocket Limits		
	\$2,500	\$5,000
Deductible		
	\$250	\$1,500
Lifetime Maximum		
	\$2,000,000	\$2,000,000

- Other 1/1/05 exclusions apply as well (bariatric supply, abdnoplasty, TMJ,...)
- Family deductible and OOP maximum are 2X individual levels
- Out of Pocket Does NOT include deductible
- O/C = Oral Contraceptives, O/F = oral fertility drugs