

**Open Access Plus Plan N**

Plan-at-a-Glance


**CIGNA HealthCare  
of Arizona**

	In-Network	Out-of-Network
<b>Primary Care Physician Services:</b>		
Office Visits	\$25 Copay	50% after deductible
Preventative Care, Including Immunizations (birth thru age 2)	\$25 Copay	Not Covered
Immunizations (Birth through age 2)	No Charge	Not Covered
Adult Preventive Care	\$25 Copay	Not Covered
Well Child Care, Including Immunizations (Age 3 and Above)	\$25 Copay	Not Covered
Immunizations (Age 3 and above)	No Charge	Not Covered
Lab and X-ray in Physicians Office	\$25 Copay	50% after deductible
<b>Specialty Physician Services:</b>		
Office Visits	\$50 Copay	50% after deductible
Referral Physician Services	\$50 Copay	50% after deductible
Allergy Testing and Treatment	\$50 Copay	50% after deductible
Well Woman OB/GYN Visit	\$25/50 Copay	Not Covered
Lab and X-ray in Specilaists Office	\$50 Copay	50% after deductible
<b>Routine Mammogram, PSA, PAP Smear</b>		
Performed at (Physician's/Specialists Office)	\$25/\$50 Copay	50% after deductible
If billed by separate O/P Diagnostic Facility	70% after deductible	50% after deductible
<b>Pre and Postnatal Exams</b>		
Initial Visit	\$25/50 Copay	50% after deductible
Subsequent Prenatal/Postnatal Visits (Physician's Global Maternity Fee)	70% after deductible	50% after deductible
<b>MRI / CT / PET Scans</b>		
	\$200 Copay plan deductible, then 70%	\$400 Copay plan deductible, then 50%
<b>Inpatient Hospital Services</b>		
Operating and Recovery Room	70% after deductible	50% after deductible
Physician and Surgeon Charges	70% after deductible	50% after deductible
Newborn Delivery Charges	70% after deductible	50% after deductible
Diagnostic and Therapeutic Lab and X-ray Services	70% after deductible	50% after deductible
Drugs and Medications	70% after deductible	50% after deductible
Operating and Recovery Room	70% after deductible	50% after deductible
Hemodialysis	70% after deductible	50% after deductible
Radiation and Chemotherapy	70% after deductible	50% after deductible
<b>Outpatient Hospital Services</b>		
Operating and Recovery Room	70% after deductible	50% after deductible
Physician Services	70% after deductible	50% after deductible
Laboratory and X-ray	70% after deductible	50% after deductible
Hemodialysis	70% after deductible	50% after deductible
Radiation and Chemotherapy	70% after deductible	50% after deductible
<b>Emergency Care</b>		
Participating Physician's Office	\$25/50 Copay \$200 Copay*	\$25/50 Copay \$200 Copay*
Hospital Emergency Room, Outpatient Facility, or Non-Participating Physician's Office		
Urgent Care Facility	\$100 Copay*	\$100 Copay*
Ambulance	70% after deductible	70% after deductible
- Ground		
- Air		
*no charge after per visit copay and plan deductible		
<b>Other Health Care Facilities (Skilled Nursing and Rehabilitation)</b>		
Maximum of 60 days per contract year.	70% after deductible	50% after deductible
<b>Home Health Care</b>		
	70% after deductible	50% after deductible

<b>Outpatient Short Term Rehabilitation</b>		
Maximum of 20 visits (including Chiro)	\$50 Copay	50% after deductible
<b>Family Planning</b>		
Tests, counseling	\$25/50 Copay	50% after deductible
Surgical sterilization procedures (vasectomy, tubal ligation):		
- Inpatient Facility Services	70% after deductible	50% after deductible
- Outpatient Facility Charge	70% after deductible	50% after deductible
- Surgery in Physician's/Specialists Office	\$25/\$50 Copay	50% after deductible
<b>Infertility</b>		
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.		
<b>EPA</b>		
\$1,000 calendar year maximum	\$200 ded, then plan deductible, then 70%	\$200 ded, then plan deductible, then 90%
<b>DME Outpatient</b>		
\$700 per year maximum	70% after deductible	50% after plan deductible
Diabetic equipment/appliances will be covered as DME but will not be applied to DME maximum		
<b>Mental Health</b>		
Inpatient Copay	\$500 per admission copay plan deductible, then 70%	\$500 per admission copay plan deductible, then 50%
Inpatient Days	25 MH&SA Combined	25 MH&SA Combined
Outpatient Individual Copay	\$50 Copay	50% after deductible
Outpatient Group Copay	\$25 Copay	50% after deductible
Outpatient Visits	20 MH&SA Combined	20 MH&SA Combined
<b>Substance Abuse</b>		
Inpatient Copay	\$500 per admission copay plan deductible, then 70%	\$500 per admission copay plan deductible, then 50%
Inpatient Days	25 MH&SA Combined	25 MH&SA Combined
Outpatient Individual Copay	\$50 Copay	50% after deductible
Outpatient Group Copay	\$25 Copay	50% after deductible
Outpatient Visits	20 MH&SA Combined	20 MH&SA Combined
<b>Prescription Drugs (with O/C, no O/F)</b>		
Generic/Preferred Brand/Non-Preferred Brand	\$20/\$40/\$60	Not Covered
Mail Order Drugs (3x - \$5)	\$55/\$115/\$175	Not Covered
<b>Out of Pocket Limits</b>		
	\$3,000	\$9,000
<b>Deductible</b>		
	\$1,000	3,000
<b>Lifetime Maximum</b>		
	\$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