

Point of Service (POS) Plan K 30/1000/80%

Plan-at-a-Glance



**CIGNA HealthCare
of Arizona**

	In-Network	Out-of-Network
Primary Care Physician Services:		
Office Visits	\$30 Copay	50% after deductible
Preventative Care	\$30 Copay	Not Covered
Adult Medical Care	\$30 Copay	Not Covered
Adult Physical Exams	\$30 Copay	Not Covered
Well Child Care	\$30 Copay	Not Covered
Routine Immunizations and Injections	\$30 Copay	Not Covered
Vision and Hearing Screening (for members age 17 and under)	\$30 Copay	Not Covered
Lab and X-ray	No Charge	50% after deductible
Specialty Physician Services:		
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 Visit - (1/Year)	\$50 Copay	Not Covered
Lab and X-ray	No Charge	50% after deductible
Pre and Postnatal Exams		
Initial Visit	\$50 Copay	50% after deductible
Subsequent Prenatal/Postnatal Visits (Physician's Global Maternity Fee)	80% after deductible	50% after deductible
Inpatient Hospital Services		
Operating and Recovery Room	80% after deductible	50% after deductible
Physician and Surgeon Charges	80% after deductible	50% after deductible
Newborn Delivery Charges	80% after deductible	50% after deductible
Diagnostic and Therapeutic Lab and X-ray Services	80% after deductible	50% after deductible
Drugs and Medications	80% after deductible	50% after deductible
Operating and Recovery Room	80% after deductible	50% after deductible
Hemodialysis	80% after deductible	50% after deductible
Radiation and Chemotherapy	80% after deductible	50% after deductible
Outpatient Hospital Services		
Operating and Recovery Room	80% after deductible	50% after deductible
Physician Services	80% after deductible	50% after deductible
Laboratory and X-ray	80% after deductible	50% after deductible
Hemodialysis	80% after deductible	50% after deductible
Radiation and Chemotherapy	80% after deductible	50% after deductible
Emergency Care		
Participating Physician's Office	\$30/\$50 Copay	\$30/\$50 Copay
Hospital Emergency Room, Outpatient Facility, or Non-Participating Physician's Office, or other Urgent Care Facility	\$100 Copay	\$100 Copay
Ambulance		
- Ground	No Charge	No Charge
- Air	No Charge	No Charge
Other Health Care Facilities (Skilled Nursing and Rehabilitation)		
<i>Maximum of 60 days per contract year.</i>	80% after deductible	50% after deductible
Home Health Care		
<i>Maximum of 20 visits per contract year.</i>	No Charge	50% after deductible
Outpatient Short Term Rehabilitation		
<i>Maximum of 60 consecutive days per condition.</i>	\$50 Copay	50% after deductible

Family Planning		
Tests, counseling	\$50 Copay	50% after deductible
Surgical sterilization procedures (vasectomy, tubal ligation):		
- Inpatient Facility Services	80% after deductible	50% after deductible
- Outpatient Facility Charge	\$50 Copay	50% after deductible
- Surgery in Physician's Office	\$50 Copay	50% 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.		
DME Outpatient		
\$200 Per Contract Year Deductible	\$200 Ded/\$700 Max	\$200 Ded/\$700 Max
\$700 Per Contract Year Maximum	\$200 Ded/\$700 Max	\$200 Ded/\$700 Max
All Other Covered Services		
	No Charge	50% after deductible
Mental Health		
Inpatient Copay	\$50 Copay Per Day	Not Covered
Inpatient Days	8 MH&SA Combined	Not Covered
Outpatient Individual Copay	\$50 Copay	Not Covered
Outpatient Group Copay	\$25 Copay	Not Covered
Outpatient Visits	25 MH&SA Combined	Not Covered
Substance Abuse		
Inpatient Copay	\$100 Copay Per Day	Not Covered
Inpatient Days	8 MH&SA Combined	Not Covered
Outpatient Individual Copay	\$50 Copay	Not Covered
Outpatient Group Copay	\$25 Copay	Not Covered
Outpatient Visits	25 MH&SA Combined	Not Covered
Prescription Drugs		
Generic/Preferred Brand/Non-Preferred Brand	\$20/\$40/\$60	Not Covered
Out of Pocket Limits		
	\$3,000/\$6,000	\$6,000/\$12,000
Deductible		
	\$1,000/\$2,000	\$3,000/\$6,000
Lifetime Maximum		
	Unlimited	Unlimited