2023 Plan Comparison Highlight

kcFED

Medical Plan Comparison

Covered Services	Cigna CHP w/ HSA		CIGNA PPO 80 w/ Deductible		CIGNA PPO 90		CIGNA PPO 100	
	In-Network	Out-of-Network*	In-Network	Out-of-Network*	In-Network	Out-of-Network*	In-Network	Out-of-Network*
Annual deductible	$1,500/Individual	$2,000/Individual	$300/Individual	$600/Individual	None	$300/Individual	None	$300/Individual
	$3,000/Individual + 1 or more	$4,000/Individual + 1 or more	$600/Family	$1,200/Family		$600/Family		$600/Family
Preventive Care (routine physicals, immunizations, etc.)	Plan pays 100%; bypasses deductible	Plan pays 60% after deductible	$0 copay	60% covered after deductible	$0 copay	70% covered after deductible	$0 copay	70% covered after deductible
Office Visit Copay	Plan pays 80% after deductible	Plan pays 60% after dedcutible	$20 Generalist $30 Specialist	60% covered after deductible	$15 Generalist $25 Specialist	70% covered after deductible	$15 Generalist $25 Specialist	70% covered after deductible
Coinsurance	Plan pays 80% after deductible	Plan pays 60% after deductible	Plan pays 80% after deductible	Plan pays 60% after deductible	90% covered	70% covered after deductible	100% covered	70% covered after deductible
Annual out-of-pocket maximum**	$3,000/Individual	$5,000/Individual	$3,000/Individual	$5,000/Individual	$1,000/Individual	$2,000/Individual	N/A	$2,000/Individual
	$6,000/Individual + 1 or more	$10,000/Individual + 1 or more	$6,000/Family	$10,000/Family	$2,000/Family	$4,000/Family		$4,000/Family
Lifetime coverage limit	Unlimited	Unlimited	Unlimited	Unlimited	Unlimited	Unlimited	Unlimited	Unlimited

*Out-of-network benefits are based on 300 percent of the Medicare reimbursement amount for the service.
** Plan year deductible is included in the annual out-of-pocket maximum. Once you reach the out-of-pocket maximum, the Plan pays 100% of Plan allowable charges. All copayments are excluded from the annual out-of-pocket maximum.

Prescription Drug Coverage (included with medical plans, you do not pay a separate premium for prescription drug coverage)

When You Purchase:	At a network retail pharmacy (up to a 30-day supply)	Through the *CVS Caremark Mail Service Pharmacy* (mail service for up to a 90-day supply)
Generic Drugs	$7 copayment per prescription	$14 copayment per prescription
Preferred Brand-Name drugs	20% of the cost of the drug, up to a $40 maximum per prescription	15% of the cost of the drug, up to a $80 maximum per prescription
Non-Preferred Brand-Name drugs	30% of the cost of the drug, up to a $60 maximum per prescription	25% of the cost of the drug, up to a $120 maximum per prescription
Speciality drugs must be ordered through the CVS Speciality Pharmacy	Specialty drugs ordered through the CVS Specialty Pharmacy may be picked up at a local CVS retail pharmacy or delivered to your home, work or other designated location	15% of the cost of the drug, up to a $80 maximum per prescription
Annual Out-of-Pocket Maximum	$2,000 per individual / $4,000 per family (separate from the Medical Plan out-of-pocket maximum)*	
Additional Retail Copayment for Maintenance Medications	After three consecutive fills at a retail pharmacy, if you do not purchase your maintenance medication through the *CVS Caremark Mail Service Pharmacy* , you will pay an additional $25 per prescription. Note: This additional copayment does not count toward your annual out-of-pocket maximum.	

***Important Note about the Consumer Health Plan (CHP) w/ HSA Presciption Drug Coverage: If you enroll in the Consumer Health Plan with HSA your prescirption drug coverage will be subject to the CHP dedcutible. This means that you pay the full cost (CVS Caremark's negotiated rate) for your prescription drugs until your deductible is met with the exception of prescriptions that are for preventative care, which are availalbe at no cost from in-network pharmacies. Enrollment in the CHP Plan with HSA also means that you will have a combined annual out-of-pocket maximum for medical and prescription drug expenses. The other Medical Plan options have seperate out-of-pocket maximums for medical and presciption drug coverage.**

Dental Plan Comparison

Covered Service		CIGNA DHMO	CIGNA Standard PPO	CIGNA Premier PPO
Annual Deductible (You pay)		None	$25/Individual $50/Family	None
Annual maximum benefits payable (excludes orthodontia and major oral surgery)		N/A	$1,000 per person	$2,500 per person
Diagnostic/Preventative services (Plan pays)		100%	100%	100%
Basic Services (Plan pays)		Patient charge outlined in schedule	70% after deductible	90%
Major Services (Plan pays)		Patient charge outlined in schedule	50% after deductible (implants not covered)	60%
Major Surgery (Plan pays)		Patient charge outlined in schedule	70% after deductible	90%
Orthodontia (children & adults)		Maximum benefit of 24 months of treatment; children and adults - check with plan for lifetime limits	Not Covered	50% up to lifetime benefit of $2,500 per person; children and adults

Preventative Services are not subject to the Anual Benefit Maximum. For out-of-network benefits with the Standard or Premier PPO plans, coinsurance percentages are applied to reasonable and customary (R&C) charges. Any charges in excess of R&C, annual and/or lifetime maximums or charges for services not covered by the Plan are the participant's responsibility. There are no out-of-network benefits with the DHMO plan.

Vision Services Plan (VSP)

Covered Service		In-Network	Out-of-Network Reimbursement
WellVision Exam Every calendar year		Plan pays 100% after $20 copayment	Reimbursement up to $50 after $20 copayment
Prescription Glasses		$25 Copyment	After $25 Copayment
Lenses Every calendar year		Anti reflective coating, all progressive lens, polycarbonate lenses, tints/photochromic lenses, high-index lenses, scratch-resistant coating, UV protection. Average 35 - 40% off other lens options not listed above after $25 copayment	Reimbursement for up to:$50 for single vision, $75 for lined bifocal or pregressives, $100 for lined trifocal, $125 for lenticular. Additional options are nto covered unless specified
Frames Every other calendar year (every calendar year for children under age of 18)		Up to $200 allowance at regular in-network providers Up to $110 allowance at Costco, Walmart & Sam's Club 20% discount for frames exceeding the allowance (excludes Costco, Walmart & Sam's Club)	Reimbursement up to $70
Contact Lenses (in lieu of lenses and/or frames; includes disposables; every year for medically necessary)		» $200 allowance for elective contacts and contact lens exam (fitting and evaluation) » 15% off cost (before allowance is applied) of contact lens exam (fitting and evaluation); $0 copayment	Up to $210 for medically necessary contacts Up to $105 for elective contacts and contact lens exam (fitting and evaluation)