



## 2012 Medical Plan Comparison Chart – Pre-65 Retirees

	Aetna POS 90		CIGNA POS 90 Tri-State Only		UHC POS 90		CIGNA POS 100 Tri-State Only		UHC POS 100		CIGNA Plan B*
	In-network	Out-of-network*	In-network	Out-of-network*	In-network	Out-of-network*	In-network	Out-of-network*	In-network	Out-of-network*	
Physician Office Visits	\$30 copay	60% after deductible	\$30 copay	60% after deductible	\$30 copay	60% after deductible	\$30 copay	60% after deductible	\$30 copay	60% after deductible	80% after deductible
Preventive Care	100% no copay	Not covered	100% no copay	Not covered	100% no copay	Not covered	100% no copay	Not covered	100% no copay	Not covered	Not covered
<b>Annual Deductible and Coinsurance</b>											
Annual Deductible:	\$200 Per Person	\$600 Per Person	\$200 Per Person	\$600 Per Person	\$200 Per Person	\$600 Per Person	None	\$600 Per Person	None	\$600 Per Person	Individual: \$250 Family: \$500
Co-insurance (% Paid by CU)	90% after deductible	60% after deductible	90% after deductible	60% after deductible	90% after deductible	60% after deductible	100%	60% after deductible	100%	60% after deductible	80% after deductible
<b>Out of Pocket Maximum</b>											
Individual Family	\$1,500 \$3,000	\$3,500 \$7,000	\$1,500 \$3,000	\$3,500 \$7,000	\$1,500 \$3,000	\$3,500 \$7,000	None	\$3,500 \$7,000	None	\$3,500 \$7,000	\$1,250 \$2,500
<b>Out of Network Reimbursement</b>											
Precertification required for most services	N/A	60% after deductible; reimbursement based on 150% of Medicare maximum allowable charge	N/A	60% after deductible; reimbursement based on 150% of Medicare maximum allowable charge	N/A	60% after deductible; reimbursement based on 150% of Medicare maximum allowable charge	N/A	60% after deductible; reimbursement based on 150% of Medicare maximum allowable charge	N/A	60% after deductible; reimbursement based on 150% of Medicare maximum allowable charge	N/A
Lifetime Maximum	Unlimited	Unlimited	Unlimited	Unlimited	Unlimited	Unlimited	Unlimited	Unlimited	Unlimited	Unlimited	Unlimited
<b>Hospital Services ** Precertification required for all services</b>											
Inpatient Care **	90% after deductible	60% after deductible	90% after deductible	60% after deductible	90% after deductible	60% after deductible	\$500 copay per admission	60% after deductible	\$500 copay per admission	60% after deductible	Room & board: 100% after deductible Surgeon: 80% after deductible
Outpatient Care (including, surgery lab & radiology)	90% after deductible	60% after deductible	90% after deductible	60% after deductible	90% after deductible	60% after deductible	100% \$150 copay	60% after deductible	100% \$150 copay	60% after deductible	Surgery, Surgeon's fees and non-surgical: 80% after deductible
Emergency Room <i>Copay waived if admitted</i>	\$150 copay	\$150 copay	\$150 copay	\$150 copay	\$150 copay	\$150 copay	\$150 copay	\$150 copay	\$150 copay	\$150 copay	80% after deductible
<b>Mental Health &amp; Substance Abuse ** Precertification required for all services</b>											
Inpatient **	90% after deductible	60% after deductible	90% after deductible	60% after deductible	90% after deductible	60% after deductible	\$500 copay per admission	60% after deductible	\$500 copay per admission	60% after deductible	100% after deductible



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	In-network	Out-of-network*	In-network	Out-of-network*	In-network	Out-of-network*	In-network	Out-of-network*	In-network	Out-of-network*	
Outpatient Care **	\$30 copay Annual maximum 60 visits	60% after deductible Combined annual maximum 60 visits	\$30 copay Annual maximum: 60 visits	60% after deductible Combined annual maximum: 60 visits	\$30 copay Annual maximum: 60 visits	60% after deductible Combined annual maximum: 60 visits	\$30 copay Annual maximum: 60 visits	60% after deductible Combined annual maximum: 60 visits	\$30 copay Annual maximum: 60 visits	60% after deductible Combined annual maximum: 60 visits	80% after deductible Annual limit: 60 visits
<b>Vision Care</b>											
Routine Eye Exam	100% after \$30 copay; covered once every 2 calendar years	Not covered	\$30 copay (VSP Network)	Not covered	Not covered	Not covered	\$30 copay	Not covered	Not covered	Not covered	Not covered
Eyeglasses and Lenses	\$100 allowance per calendar year Additional discounts off retail hardware (e.g., 40% off eyeglass frames) at participating providers. Call Aetna for details.	Not covered	<b>Allowance available once every 24 months (VSP Network)</b> Single lenses: \$20 Bifocal lenses: \$30 Trifocal lenses: \$40 Lenticular lenses: \$75 Contact lenses: \$75 Frames: \$30	Not covered	Not covered	Not covered	<b>Allowance available once every 24 mos. (VSP Network)</b> Single lenses: \$20 Bifocal lenses: \$30 Trifocal lenses: \$40 Lenticular lenses: \$75 Contact lenses: \$75 Frames: \$30	Not covered	Not covered	Not covered	Not covered
<b>Prescription Drugs</b>	<b>From Medco</b>		<b>From Medco</b>		<b>From Medco</b>		<b>From Medco</b>		<b>From Medco</b>		<b>From Medco</b>
Retail Pharmacy (Up to 30-day supply)	\$10 generic \$25 single-source brand (product not available in generic) \$45 multi-source brand (choice between generic and brand available)		\$10 generic \$25 single-source brand (product not available in generic) \$45 multi-source brand (choice between generic and brand available)		\$10 generic \$25 single-source brand (product not available in generic) \$45 multi-source brand (choice between generic and brand available)		\$10 generic \$25 single-source brand (product not available in generic) \$45 multi-source brand (choice between generic and brand available)		\$10 generic \$25 single-source brand (product not available in generic) \$45 multi-source brand (choice between generic and brand available)		\$10 generic \$25 single-source brand (product not available in generic) \$45 multi-source brand (choice between generic and brand available)
Home Delivery (Up to 90-day supply)	\$15 generic \$50 single-source brand (product not available in generic) \$90 multi-source brand (choice between generic and brand)		\$15 generic \$50 single-source brand (product not available in generic) \$90 multi-source brand (choice between generic and brand)		\$15 generic \$50 single-source brand (product not available in generic) \$90 multi-source brand (choice between generic and brand)		\$15 generic \$50 single-source brand (product not available in generic) \$90 multi-source brand (choice between generic and brand)		\$15 generic \$50 single-source brand (product not available in generic) \$90 multi-source brand (choice between generic and brand)		\$15 generic \$50 single-source brand (not available in generic) \$90 multi-source brand (choice between generic and brand)



- The percentage charges that will be considered for reimbursement are 150% of the Medicare allowable charge.