ORNL COMPARISON OF MEDICAL PLANS FOR 2009
CIGNA OPEN ACCESS AND CIGNA POS

This comparison is intended as a guide to highlight differences between the medical plans. For additional information, consult the plan descriptions in the Medical Section of Your Book of Benefits.

PLAN DESIGN FEATURES

COVERED SERVICES	OPEN ACCESS IN-NETWORK	POS IN-NETWORK	OPEN ACCESS OUT-OF-NETWORK	POS OUT-OF-NETWORK
Annual Deductible *For injury, illness or maternity*	$300 per individual $600 per family	None	$500 per individual $1,000 per family	$200 per individual $400 per family
Coinsurance is the portion of covered health care costs for which an insured person has a financial responsibility, usually according to a fixed percentage. For example, 90%/10% plan coinsurance means the plan pays 90% of your covered costs (such as costs for physician and surgeon services in a hospital) and you are responsible for paying the remaining 10% after you meet the deductible and co-pays. Coinsurance amounts apply to your out-of-pocket maximum.			*In-network co-pays will not apply toward the in or out-of-network annual deductibles.*	
Out-of-Pocket Annual Maximum	$1,500 per individual $3,000 per family	$1,000 per individual $2,000 per family	$4,500 per individual $9,000 per family	$3,000 per individual $6,000 per family
Maximum Lifetime Benefit	$2,000,000 *(combined in- and out-of-network maximum)*	Unlimited	$2,000,000 *(combined in- and out-of-network maximum)*	$2,000,000 *(combined in- and out-of-network maximum)*
Annual Reinstatement	$5,000 *(combined in- and out-of-network)*	N/A	$5,000 *(combined in- and out-of-network)*	N/A
Any benefits you receive reduce your lifetime maximum. For each year, the Open Access plan provides an Annual Reinstatement that automatically increases your maximum by the amount of benefits paid, up to $5,000. This calculation will be done when a member approaches the lifetime maximum.				
Pre-Existing Condition Exclusion Period	N/A	N/A	N/A	N/A
Primary Care Physician (PCP)	Not Required	Required	N/A	N/A
PCP Referral	Not Required	Required	N/A	N/A
Provider Network	Tennessee Seamless Network	Tennessee Seamless Network	N/A	N/A
Guesting (eligible to participate in an out-of-state CIGNA network)	Yes *(if CIGNA guesting is available)*	Yes *(if CIGNA guesting is available)*	Yes – out-of-network benefits apply for services out of the guested network	Yes – out-of-network benefits apply for services out of the guested network

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*R&C – Reasonable and customary charges in your geographic area for similar services

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PHYSICIAN SERVICES PROVIDED IN AN OFFICE SETTING

COVERED SERVICES	OPEN ACCESS IN-NETWORK	POS IN-NETWORK	OPEN ACCESS OUT-OF-NETWORK	POS OUT-OF-NETWORK
Primary Care Physician Office Visit Specialist Office Visit	Covered 100% after $15 co-pay Covered 100% after $30 co-pay	Covered 100% after $10 co-pay Covered 100% after $10 co-pay	Covered 60% of R&C* after annual deductible	Covered 80% of R&C* after annual deductible
Maternity Office Visits	Covered 100% after a one-time physician's office visit co-pay	Covered 100% after a one-time physician's office visit co-pay	Covered 60% of R&C* after annual deductible	Covered 80% of R&C* after annual deductible
Allergy Treatment/Injections Allergy Serum (dispensed by the physician in the office)	No charge for injections. Co-pay applies for physician visit. No charge	No charge for injections. Co-pay applies for physician visit. No charge	Covered 60% of R&C* after annual deductible	Covered 80% of R&C* after annual deductible
In-network preventive health services (well baby care, periodic health assessments, routine gynecological exams, and routine mammograms) are covered 100% after co-pay; these services are not covered out-of-network.				
Well Baby Care	Covered 100% after $15 co-pay *(Includes immunizations)*	Covered 100% after $10 co-pay *(Includes immunizations)*	Not covered	Not covered
Routine Physical Exams	Covered 100% after $15 primary care office co-pay *The annual deductible and hospital/facility charges may apply depending on where services are obtained.*	Covered 100% after $10 co-pay	Not covered	Not covered
Routine Gynecological Exams	Covered 100% after: $15 co-pay, if physician used is contracted as primary care physician $30 co-pay, if physician used is contracted as specialist	Covered 100% after $10 co-pay	Not covered	Not covered
Routine Mammogram	No charge; no referral needed	No charge; no referral needed	Covered 60% of R&C* after annual deductible	Covered 80% of R&C* after annual deductible

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INPATIENT HOSPITAL SERVICES

COVERED SERVICES	OPEN ACCESS IN-NETWORK	POS IN-NETWORK	OPEN ACCESS OUT-OF-NETWORK	POS OUT-OF-NETWORK
Inpatient Services: *Includes stand alone facilities such as a Birthing Center* - Operating room; x-ray and laboratory services; room and board	Covered 90% after annual deductible and $250 co-pay per admission. Covered at hospital's negotiated rate for semi-private room	Covered 100%; no co-pay	Covered 60% of R&C* after annual deductible and $500 co-pay per admission	Covered 80% of R&C* after annual deductible
	Hospital stays not deemed medically necessary will be disapproved.		*You must have all out-of-network inpatient hospitalizations pre-certified through CIGNA. Failure to do so will result in denied claims.*	
Physician and Surgeon Services in Hospital	Covered 90% after annual deductible	Covered 100%	Covered 60% of R&C* after annual deductible	Covered 80% of R&C* after annual deductible
Maternity *Inpatient charges*	Covered 90% after annual deductible and $250 hospital co-pay per admission (includes newborn)	Covered 100%	Covered 60% of R&C* after annual deductible	Covered 80% of R&C* after annual deductible
Maternity Delivery *Physician charges*	Covered 90% after annual deductible	Covered 100%	Covered 60% of R&C* after annual deductible	Covered 80% of R&C* after annual deductible
Mental Health - Inpatient CIGNA Behavioral Health Network	Covered 90% after annual deductible and $250 co-pay per admission; 20 days per calendar year in- and out-of-network combined	Covered 100%; 20 days per calendar year in-and out-of-network combined	Covered 60% of R&C* after annual deductible; 20 days per calendar year in- and out-of-network combined	Covered 80% of R&C*after annual deductible; 20 days per calendar year in- and out-of-network combined
Substance Abuse - Inpatient	Covered 90% after annual deductible and $250 co-pay per admission; Limited to 2 admissions per lifetime and 100 days per lifetime in- and out-of-network combined	Covered 100%; 20 days per calendar year in-and out-of-network combined	Covered 60% of R&C* after annual deductible; Limited to 2 admissions per lifetime and 100 days per lifetime in- and out-of-network combined	Covered 80% of R&C* after annual deductible; 20 days per calendar year in- and out-of-network combined

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COVERED SERVICES	OPEN ACCESS IN-NETWORK	POS IN-NETWORK	OPEN ACCESS OUT-OF-NETWORK	POS OUT-OF-NETWORK
Skilled Nursing Facility	Covered 90% after annual deductible; for up to 60 days per calendar year in- and out-of-network combined	Covered 100%; for up to 60 days per calendar year, in- and out-of-network combined	Covered 60% of R&C* after annual deductible; for up to 60 days per calendar year in- and out-of-network combined	Covered 80% of R&C* after annual deductible; for up to 60 days per calendar year, in- and out-of-network combined

Neither the Open Access nor the POS plan will cover bariatric surgery (gastric bypass) or non-cancerous skin tag removal.

OUTPATIENT HOSPITAL/FACILITY SERVICES

COVERED SERVICES	OPEN ACCESS IN-NETWORK	POS IN-NETWORK	OPEN ACCESS OUT-OF-NETWORK	POS OUT-OF-NETWORK
Outpatient Services: - Outpatient surgery 1. Outpatient Facility 2. Physician's Office	Covered 90% after annual deductible and $150 co-pay per visit	1. Covered 100% 2. Covered 100% after $10 office visit co-pay	Covered 60% of R&C* after annual deductible and $300 co-pay per visit *All out-of-network outpatient surgeries must be pre-certified through CIGNA. Failure to do so will result in denied claims.*	Covered 80% of R&C* after annual deductible
Outpatient Laboratory and Radiology Services received from: - Outpatient department of In-Network Hospital - Contracted independent facility (please see list of contracted facilities) - Doctor's office - Advanced Radiology Services such as MRI, PET, MRA, CAT – must be pre-certified and pre-authorized	Covered 90% after deductible Covered 100% Covered 100% Covered 100%	Covered 100%; no co-pay	Covered 60% of R&C* after annual deductible	Covered 80% of R&C* after annual deductible

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COVERED SERVICES	OPEN ACCESS IN-NETWORK	POS IN-NETWORK	OPEN ACCESS OUT-OF-NETWORK	POS OUT-OF-NETWORK
Emergency Room Services (not covered if not a true Emergency) Ambulance Services (not covered if not a true Emergency)	Covered 100% after $100 co-pay per visit if true emergency (waived if admitted) Covered at 100% if true emergency	Covered 100% after $50 co-pay per visit if true emergency (waived if admitted) Covered 100% if true emergency	Covered 100% after $100 co-pay per visit if true emergency (waived if admitted) Covered at 100% if true emergency	Covered 100% after $50 co-pay per visit if true emergency (waived if admitted) Covered 100% if true emergency
Physician Services in Emergency Room	Covered 100%	Covered 100%	Covered 100%	Covered 100%
Urgent Care Facility	Covered 100% after $50 co-pay per visit	Covered 100% after $25 co-pay per visit	Covered 100% after $50 copay per visit	Covered 100% after $25 copay per visit
Short-term rehabilitation – Outpatient Includes physical, speech, occupational, and cardiac therapy	Covered 100%; 180 days per calendar year for all conditions, in- and out-of-network combined	Covered 100% after $10 co-pay per visit; 20 day limit per calendar year, in- and out-of-network combined	Covered 60% of R&C* after annual deductible; 180 days per calendar year for all conditions, in- and out-of-network combined	Covered 80% of R&C* after annual deductible; 20 day limit per calendar year, in- and out-of-network combined
Mental Health – Outpatient	$30 co-pay per visit for individual therapy $15 co-pay per visit for group therapy No visit limit	Covered 100% after $10 co-pay per visit (individual or group therapy); 35 visit limit per calendar year, in- and out-of-network combined	Covered 60% of R&C* after annual deductible; up to 35 visits per year, reduced by any in-network visits	Covered 80% of R&C* after annual deductible; 35 visit limit per calendar year in- and out-of-network combined
Substance Abuse – Outpatient	$30 co-pay per visit for individual therapy $15 co-pay per visit for group therapy No visit limit	Covered 100% after $10 co-pay per visit (individual or group therapy); 35 visit limit per calendar year, in- and out-of-network combined	Covered 60% of R&C* after annual deductible; up to 35 visits per year, reduced by any in-network visits	Covered 80% of R&C* after annual deductible; 35 visit limit per calendar year in- and out-of-network combined

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VISION PLAN - Services Provided by VSP

COVERED SERVICES	OPEN ACCESS & POS IN-NETWORK	OPEN ACCESS & POS OUT-OF-NETWORK
Vision Services	No charge for yearly exam No charge for lenses every 12 months : single vision, bifocal, trifocal or polycarbonate (for dependent children) Frames allowance of up to $120 plus 20% off excess of $120 every 24 months; **OR** Contact lens every 12 months covered up to $120; allowance applies to cost of contacts and contact lens exam plus 15% off cost of contact exam. Eligible members may elect VSP Contact Lens Care Program for contact lens exam and initial supply of lenses.	Allowance of up to: Exam $29.75 Single Vision 21.25 Bifocals 34.00 Trifocals 46.75 Frame 38.75 Elective Contacts 105.00
Lens options	20% discount on lens enhancements and upgrades	
Additional Discounts	20% discount on additional prescription glasses and sunglasses. Laser vision correction services at reduced cost through VSP network doctors and contracted laser surgery centers	

OTHER SERVICES

COVERED SERVICES	OPEN ACCESS IN-NETWORK	POS IN-NETWORK	OPEN ACCESS OUT-OF-NETWORK	POS OUT-OF-NETWORK
Chiropractic Care *When medically appropriate*	Covered 100% after $30 co-pay; 25 visit limit per year	Covered 100% after $10 co-pay per visit with PCP referral; 25 visit limit per year	Not covered	Not covered
Hearing Aid Benefits	$750 maximum every 36 months	Not covered	Not covered	Not covered
COVERED SERVICES	OPEN ACCESS IN-NETWORK	POS IN-NETWORK	OPEN ACCESS OUT-OF-NETWORK	POS OUT-OF-NETWORK

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External Prosthetic Devices *Requires approval by Health Plan; limited coverage applies*	Covered 90% after annual deductible and $100 co-pay	Covered 100% after $200 deductible; maximum of $1,000 per calendar year	Covered 60% of R&C* after annual deductible	Not covered
	Coverage is limited to the most appropriate and cost-effective alternative as determined by the utilization review physician. Covers initial purchase and fitting of any physician-ordered or –prescribed external prosthetic devices that are to be used as replacements or substitutes for missing body parts and are necessary for the alleviation or correction of sickness, injury, or congenital defects.			
Durable Medical Equipment *Same network providers for each plan*	Covered 100%	Covered 100%; maximum of $3,500 per calendar year	Covered 60% of R&C* after annual deductible	Not covered
Infertility Treatment: - Physician office visit, test, counseling - Surgical Treatment: Includes procedures for correction of infertility (invitro fertilization, artificial insemination, GIFT, ZIFT, etc.)	$30 co-pay per office visit, then covered 100% Inpatient and outpatient facility same as inpatient and outpatient hospital benefits Physician services covered 90% after annual deductible *Limited coverage; lifetime maximum is $20,000*	Not covered	60% of R&C* after annual deductible *Limited coverage; lifetime maximum is $20,000*	Not covered
Organ Transplant Coverage: - Inpatient Facility - Travel Benefit	Covered 90% after annual deductible and $250 co-pay at approved facilities $10,000 lifetime maximum per transplant; available when using an approved facility	Covered 100% at approved facilities $10,000 lifetime maximum per transplant; available when using an approved facility	Covered 60% of R&C* after annual deductible Not covered	Not covered
Home Health Care *Skilled visits only*	Covered 100%	Covered 100%; up to 60 days per calendar year, in- and out-of-network combined	Covered 60% of R&C* after annual deductible; up to 60 days per calendar year, reduced by any in-network visits	Covered 80% of R&C* after annual deductible; up to 60 days per calendar year, in- and out-of-network combined

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COVERED SERVICES	OPEN ACCESS IN-NETWORK	POS IN-NETWORK	OPEN ACCESS OUT-OF-NETWORK	POS OUT-OF-NETWORK
Hospice Care: - Inpatient - Outpatient	 Same as inpatient hospital Covered 100%; no co-pay	Covered 100%; no co-pay	Covered 60% of R&C* after annual deductible	Covered 80% of R&C* after annual deductible
Optimal Health / Disease Management	Yes	Yes	N/A	N/A
MyCIGNA.com, Healthy Rewards Program, Healthy Baby Program, 24-hour Health Information Line	Yes	Yes	N/A	N/A

Important Note:
This information describes only certain highlights of the company's medical plans. *It does not supersede the actual provisions of the applicable plan documents, which in all cases are the final authority. Company plans, programs, practices or processes may be amended, changed, or terminated by the company at any time without prior notice to, or consent by, participants. This notice does not constitute a contract of employment between the company and any individual, or an obligation by the company to maintain any particular benefit program, practice or policy.*

PRESCRIPTION DRUGS – provided by MEDCO

COVERED SERVICES	OPEN ACCESS IN-NETWORK	POS IN-NETWORK	OPEN ACCESS OUT-OF-NETWORK	POS OUT-OF-NETWORK
Retail Prescription Drugs *Up to a 30-day supply*	$150 pharmacy deductible per individual Generic: 20% (minimum $10 co-pay) after deductible Brand: 30% (minimum $10 co-pay) after deductible If actual cost is under $10, you pay actual cost	Generic: $5 co-pay Preferred Brand: $15 co-pay Non-preferred Brand: $35 co-pay	50% after $150 pharmacy deductible	80% after $200 pharmacy deductible
Mail Order– Home Delivery *Up to a 90-day supply*	Generic: $15 co-pay for up to a 90-day supply Brand: $35 co-pay for up to a 90-day supply	Generic: $5 co-pay for each 30-day supply ($15 for a 90-day supply) Preferred Brand: $15 co-pay for each 30-day supply ($45 for a 90-day supply) Non-preferred Brand: $35 co-pay for each 30-day supply ($105 for a 90-day supply)	Not covered	Not covered
Note: Medications such as Viagra are not covered under the CIGNA POS plan.				

EXAMPLES OF PRESCRIPTION DRUG COSTS

	RETAIL PHARMACY				***MAIL ORDER / HOME DELIVERY***		
Plan	**Number of Retail Prescriptions Per Month for 12 Months**	**Retail Charges for 30-day Supply**	**Total Annual Retail Cost**		**Number of Mail Order Prescriptions**	**Mail Order Charges for 90-day Supply**	**Total Annual Mail Order Cost**
Open Access	2 Generic Drugs ($10 co-pay each) 2 Brand Drugs ($20 co-pay each)	$20 $40	$720		2 Generic Drug co-pays 2 Brand Drug co-pays	$30 $70	$400
POS	2 Generic Drug co-pays 1 Preferred Brand Drug co-pay 1 Non-preferred Brand Drug co-pay	$10 $15 $35	$720		2 Generic Drug co-pays 1 Preferred Brand Drug co-pay 1 Non-preferred Brand Drug co-pay	$30 $45 $105	$720