

# ORNL COMPARISON OF MEDICAL PLANS FOR 2013 FOR SALARIED EMPLOYEES CIGNA CHOICE FUND and OPEN ACCESS PLUS

*This comparison is intended as a guide to highlight differences between the medical plans. For additional information, consult the applicable plan documents, which in all cases are the final authority.*

COVERED SERVICES	CHOICE FUND IN-NETWORK	OPEN ACCESS PLUS IN-NETWORK	CHOICE FUND OUT-OF-NETWORK	OPEN ACCESS PLUS OUT-OF-NETWORK
<b>PLAN DESIGN FEATURES</b>				
Annual Deductible	Individual coverage: \$1,500 All other coverage levels: \$3,000 <i>(Includes Medical &amp; Rx)</i>	None	Individual coverage: \$2,500 All other coverage levels: \$5,000 <i>(Includes Medical &amp; Rx)</i>	\$200 per individual \$400 per family <i>(Medical only)</i>
<p><b>Coinsurance</b> 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. Coinsurance amounts apply to your out-of-pocket maximum.</p>			<p><i>In-network co-pays will not apply toward the in or out-of-network annual deductibles.</i></p>	
Out-of-Pocket Annual Maximum <i>(Includes Plan Deductible)</i>	Individual coverage: \$2,500 All other coverage levels \$5,000 <i>(Includes Medical &amp; Rx)</i>	N/A	Individual coverage: \$5,000 All other coverage levels: \$10,000 <i>(Includes Medical &amp; Rx)</i>	\$3,000 per individual \$6,000 per family <i>(Medical only)</i>
<p>The <b>Out of Pocket maximum</b> is the most you will pay during the calendar year, based on your coverage level. Once you meet the maximum, the plan pays 100% of your covered costs. Plan deductibles contribute towards your out of pocket maximum. In-network and out-of-network amounts are separate and do not cross accumulate.</p>				
Maximum Lifetime Benefit	Unlimited	Unlimited	Unlimited	Unlimited
Pre-Existing Condition Limitations	N/A	N/A	N/A	N/A
Primary Care Physician (PCP)	Not Required	Not Required	N/A	N/A
PCP Referral	Not Required	Not Required	N/A	N/A
Provider Network	Cigna National Network	Cigna National Network	N/A	N/A

COVERED SERVICES	CHOICE FUND IN-NETWORK	OPEN ACCESS PLUS IN-NETWORK	CHOICE FUND OUT-OF-NETWORK (Based on R&C*)	OPEN ACCESS PLUS OUT-OF-NETWORK (Based on R&C*)
<b>PHYSICIAN SERVICES</b>				
Office Visit <ul style="list-style-type: none"> <li>Primary Care Physician</li> <li>Specialist</li> </ul>	You pay 10% Plan pays 90% after the plan deductible is met	You pay \$20 per visit You pay \$35 per visit	You pay 30% Plan pays 70% after the plan deductible is met	You pay 20% Plan pays 80% after the plan deductible is met
Physician Services (hospital) <ul style="list-style-type: none"> <li>In hospital visits and consultations</li> <li>Inpatient</li> <li>Outpatient</li> </ul>	You pay 10% Plan pays 90% after the plan deductible is met	Plan pays 100%	You pay 30% Plan pays 70% after the plan deductible is met	You pay 20% Plan pays 80% after the plan deductible is met
Surgery (in a physician's office)	You pay 10% Plan pays 90% after the plan deductible is met	Plan pays 100% after office visit copay: PCP: \$20 per visit Specialist: \$35 per visit	You pay 30% Plan pays 70% after the plan deductible is met	You pay 20% Plan pays 80% after the plan deductible is met
Allergy Treatment/Injections  Allergy Serum (dispensed by the physician in the office)	You pay 10% Plan pays 90% after the plan deductible is met	Plan pays 100%	You pay 30% Plan pays 70% after the plan deductible is met	You pay 20% Plan pays 80% after the plan deductible is met
<b>PREVENTIVE CARE</b>				
<ul style="list-style-type: none"> <li>Preventive Care: Includes well-baby, well-child, well-woman, and adult preventive care.</li> <li>Includes routine immunizations</li> </ul>	Plan pays 100%	Plan pays 100%	Not covered	Not covered
Mammogram, PSA, Pap Smear and Maternity Screening	Plan pays 100%	Plan pays 100%	You pay 30% Plan pays 70% after the plan deductible is met	You pay 20% Plan pays 80% after the plan deductible is met

COVERED SERVICES	CHOICE FUND IN-NETWORK	OPEN ACCESS PLUS IN-NETWORK	CHOICE FUND OUT-OF-NETWORK (Based on R&C*)	OPEN ACCESS PLUS OUT-OF-NETWORK (Based on R&C*)
<b>INPATIENT HOSPITAL SERVICES</b>				
Inpatient Services: - Operating room; pharmacy, x-ray and laboratory services; semi-private room and board	You pay 10% Plan pays 90% after the plan deductible is met	Plan pays 100% after \$250 copay per admission	You pay 30% Plan pays 70% after the plan deductible is met	You pay 20% Plan pays 80% after the plan deductible is met
<i>Hospital stays not deemed medically necessary will be disapproved.</i>				
<i>You must have all out-of-network inpatient hospitalizations and outpatient surgeries pre-certified through CIGNA. Failure to do so will result in denied claims.</i>				
Physician and Surgeon Services in Hospital	You pay 10% Plan pays 90% after the plan deductible is met	Plan pays 100%	You pay 30% Plan pays 70% after the plan deductible is met	You pay 20% Plan pays 80% after the plan deductible is met
<b>OUTPATIENT SERVICES</b>				
Outpatient Services: - Outpatient surgery 1. Outpatient Facility 2. Physician's Office	You pay 10% Plan pays 90% after the plan deductible is met	Plan pays 100% after copay:  PCP: \$20 per visit Specialist: \$35 per visit	You pay 30% Plan pays 70% after the plan deductible is met	You pay 20% Plan pays 80% after the plan deductible is met
<i>All out-of-network outpatient surgeries must be pre-certified through CIGNA. Failure to do so will result in denied claims.</i>				
Short-term rehabilitation – Outpatient Includes physical, speech, occupational, cognitive, pulmonary, and cardiac therapy	You pay 10% Plan pays 90% after the plan deductible is met  <i>180 days per calendar year for all conditions</i>	Plan pays 100% after copay: PCP: \$20 per visit Specialist: \$35 per visit  <i>20 days per calendar year for all conditions</i>	You pay 30% Plan pays 70% after the plan deductible is met  <i>180 days per calendar year for all conditions</i>	You pay 20% Plan pays 80% after the plan deductible is met  <i>20 days per calendar year for all conditions</i>
<i>Day limits apply to both in- and out-of-network visits Therapy days, provided as part of an approved Home Health Care plan, accumulate to the outpatient short term rehab therapy maximum.</i>				
Chiropractic Care <i>When medically appropriate</i> -Limited to 25 days per calendar year	You pay 10% Plan pays 90% after the plan deductible is met	Plan pays 100% after copay: PCP:\$20 per visit Specialist: \$35 per visit	Not Covered	Not Covered

COVERED SERVICES	CHOICE FUND IN-NETWORK	OPEN ACCESS PLUS IN-NETWORK	CHOICE FUND OUT-OF-NETWORK (Based on R&C*)	OPEN ACCESS PLUS OUT-OF-NETWORK (Based on R&C*)
<b>LAB AND X-RAY</b>				
Outpatient Laboratory and Radiology Services received from: - Outpatient hospital facility - Independent facility - Doctor's office - Advanced Radiology Services such as MRI, PET, MRA, CAT – must be pre-certified and pre-authorized	You pay 10% Plan pays 90% after the plan deductible is met	Plan pays 100%	You pay 30% Plan pays 70% after the plan deductible is met	You pay 20% Plan pays 80% after the plan deductible is met
<b>EMERGENCY AND URGENT CARE SERVICES</b>				
Emergency Room Services -Includes radiology, pathology, and physician charges  Ambulance Services <i>Note: Non-emergency transportation (e.g. from hospital back home) is generally not covered</i>	You pay 10% Plan pays 90% after the plan deductible is met	You pay a \$75 copay, then Plan pays 100%  <i>Copay waived if admitted, then inpatient hospital charges would apply</i>  Plan pays 100%	You pay 10% Plan pays 90% after the plan deductible is met  <i>Out-of-network services are covered at the in-network rate</i>	You pay a \$75 copay, then Plan pays 100%  Plan pays 100%  <i>Out-of-network services are covered at the in-network rate</i>
Urgent Care Facility  <i>Out-of-network services are covered at the in-network rate</i>	You pay 10% Plan pays 90% after the plan deductible is met	You pay a \$25 copay, then Plan pays 100%	You pay 10% Plan pays 90% after the plan deductible is met	You pay a \$25 copay, then Plan pays 100%
Convenience Care	You pay 10% Plan pays 90% after the plan deductible is met	You pay a \$20 copay, then Plan pays 100%	You pay 30% Plan pays 70% after the plan deductible is met	You pay 20% Plan pays 80% after the plan deductible is met

COVERED SERVICES	CHOICE FUND IN-NETWORK	OPEN ACCESS PLUS IN-NETWORK	CHOICE FUND OUT-OF-NETWORK (Based on R&C*)	OPEN ACCESS PLUS OUT-OF-NETWORK (Based on R&C*)
<b>OTHER HEALTH CARE SERVICES</b>				
Maternity Care Services Covers maternity for employee and all dependents <ul style="list-style-type: none"> <li>Initial visit to confirm pregnancy</li> <li>All subsequent routine prenatal visits, postnatal visits and delivery</li> <li>Delivery (Inpatient Hospital, Birthing Center)</li> </ul>	You pay 10% Plan pays 90% after the plan deductible is met	Plan pays 100% after copay for initial visit: PCP: You pay \$20 Specialist: You pay \$35  Delivery: \$250 copay per admission, then Plan pays 100%	You pay 30% Plan pays 70% after the plan deductible is met	You pay 20% Plan pays 80% after the plan deductible is met
Infertility Treatment: - Physician office visit, test, counseling - Surgical Treatment: Includes procedures for correction of infertility (in vitro fertilization, artificial insemination, GIFT, ZIFT, etc.)	You pay 10% Plan pays 90% after the deductible is met <i>\$20,000 lifetime maximum            In and out of network combined</i>	Not Covered	You pay 30% Plan pays 70% after the plan deductible is met <i>\$20,000 lifetime maximum            In and out of network combined</i>	Not Covered
Durable Medical Equipment -Unlimited calendar year maximum	You pay 10% Plan pays 90% after the plan deductible is met	Plan pays 100%	You pay 30% Plan pays 70% after the plan deductible is met	You pay 20% Plan pays 80% after the plan deductible is met

COVERED SERVICES	CHOICE FUND IN-NETWORK	OPEN ACCESS PLUS IN-NETWORK	CHOICE FUND OUT-OF-NETWORK (Based on R&C*)	OPEN ACCESS PLUS OUT-OF-NETWORK (Based on R&C*)
External Prosthetic Appliances (EPA) Unlimited calendar year maximum <i>Requires approval by Health Plan; limited coverage applies</i>	You pay 10% Plan pays 90% after the plan deductible is met	Plan pays 100% after the EPA annual deductible is met  An additional \$200 calendar year EPA annual deductible is applied in addition to regular calendar year plan deductible to both in-network and out-of-network services	You pay 30% Plan pays 70% after the plan deductible is met	You pay 20% Plan pays 80% after the EPA annual and the plan deductibles are met
<i>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.</i>				
Hearing Aid Benefits	You pay 10% Plan pays 90% after the plan deductible is met \$750 maximum per 36 consecutive months	Not Covered	Not Covered	Not Covered
Organ Transplant Coverage: <ul style="list-style-type: none"> <li>• Inpatient Facility</li> </ul>	-Inpatient covered at 100% at Lifesource center, otherwise covered 90% after plan deductible is met.  Physician Services: Covered at 100% at Lifesource center; otherwise 90% after plan deductible is met.	-Inpatient: Covered at 100% at Lifesource center after plan's \$250 inpatient per admission copay, otherwise same as plan's inpatient hospital facility benefit  Physician services: Covered at 100% at Lifesource center; otherwise 100% after plan deductible	You pay 30% Plan pays 70% after the plan deductible is met	Not Covered
<ul style="list-style-type: none"> <li>• Travel Benefit</li> </ul>	Travel maximum \$10,000 per transplant (only available if using Lifesource facility)	Travel maximum \$10,000 per transplant (only available if using Lifesource facility)		

COVERED SERVICES	CHOICE FUND IN-NETWORK	OPEN ACCESS PLUS IN-NETWORK	CHOICE FUND OUT-OF-NETWORK (Based on R&C*)	OPEN ACCESS PLUS OUT-OF-NETWORK (Based on R&C*)
<p>Dental Care—Limited to charges for a continuous course of dental treatment started within 6 months of an injury to sound, natural teeth</p> <ol style="list-style-type: none"> <li>Physician's Office visit</li> <li>Inpatient Facility</li> <li>Outpatient Facility</li> <li>Physician's Services</li> </ol>	<p>You pay 10% Plan pays 90% after the plan deductible is met</p>	<ol style="list-style-type: none"> <li>Plan pays 100% copay for visit: PCP: \$20 Specialist: \$35</li> <li>\$250 copay per admission Then you pay 10% Plan pays 90% after the plan deductible is met</li> <li>Plan pays 100%</li> <li>Plan pays 100%</li> </ol>	<p>You pay 10% Plan pays 90% after the plan deductible is met</p>	<p>You pay 20% Plan pays 80% after the plan deductible is met</p>
<p>Temporomandibular Joint Disorder (TMJ) (surgical &amp; non-surgical treatment)</p> <p>Excludes appliances and orthodontic treatment. Subject to medical necessity</p> <ol style="list-style-type: none"> <li>Physician's Office visit</li> <li>Inpatient Facility</li> <li>Outpatient Facility</li> <li>Physician's Services</li> </ol>	<p>You pay 10% Plan pays 90% after the plan deductible is met</p>	<ol style="list-style-type: none"> <li>Plan pays 100% copay for visit: PCP: \$20 Specialist: \$35</li> <li>\$250 copay per admission Then you pay 10% Plan pays 90% after the plan deductible is met</li> <li>Plan pays 100%</li> <li>Plan pays 100%</li> </ol>	<p>You pay 30% Plan pays 70% after the plan deductible is met</p>	<p>You pay 20% Plan pays 80% after the plan deductible is met</p>
<p>Bariatric Surgery (Subject to medical necessity &amp; clinical guidelines)</p> <p><i>Neither the Open Access Plus nor the Choice Fund plan will cover non-cancerous skin tag removal. Both plans will cover rhinoplasty, breast reductions, varicose veins and blepharoplasty surgery (removal of excessive eyelid tissue) if medically necessary. Prior health plan approval is required.</i></p>	<p>You pay 10% Plan pays 90% after the plan deductible is met</p>	<p>PCP: You pay \$20 per visit Specialist You pay \$35 per visit</p> <p>Inpatient facility: \$250 copay per admission, then plan pays 100% Outpatient: Plan pays 100%</p>	<p>You pay 30% Plan pays 70% after the plan deductible is met</p>	<p>You pay 20% Plan pays 80% after the plan deductible is met</p>

COVERED SERVICES	CHOICE FUND IN-NETWORK	OPEN ACCESS PLUS IN-NETWORK	CHOICE FUND OUT-OF-NETWORK (Based on R&C*)	OPEN ACCESS PLUS OUT-OF-NETWORK (Based on R&C*)
Healthways / 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
<b><i>Mental Health and Substance Abuse Services</i></b>				
Inpatient Mental Health CIGNA Behavioral Health Network -Unlimited days per calendar year	You pay 10% Plan pays 90% after the plan deductible is met	\$250 copay per admission, then Plan pays 100%	You pay 30% Plan pays 70% after the plan deductible is met	You pay 20% Plan pays 80% after the plan deductible is met
Outpatient Mental Health -Unlimited visits per calendar year -This includes individual, group therapy mental health and intensive outpatient mental health	You pay 10% Plan pays 90% after the plan deductible is met	Primary care physician You pay \$20 per visit  Specialist You pay \$35 per visit	You pay 30% Plan pays 70% after the plan deductible is met	You pay 20% Plan pays 80% after the plan deductible is met
Inpatient Substance Abuse -Unlimited days per calendar year	You pay 10% Plan pays 90% after the plan deductible is met	\$250 copay per admission, then Plan pays 100%	You pay 30% Plan pays 70% after the plan deductible is met	You pay 20% Plan pays 80% after the deductible is met
Outpatient Substance Abuse -Unlimited visits per calendar year -This includes individual and intensive outpatient substance abuse treatment	You pay 10% Plan pays 90% after the plan deductible is met	Primary care physician You pay \$20 per visit  Specialist You pay \$35 per visit	You pay 30% Plan pays 70% after the plan deductible is met	You pay 20% Plan pays 80% after the plan deductible is met

COVERED SERVICES	CHOICE FUND IN-NETWORK	OPEN ACCESS PLUS IN-NETWORK	CHOICE FUND OUT-OF-NETWORK (Based on R&C*)	OPEN ACCESS PLUS OUT-OF-NETWORK (Based on R&C*)
<b>OTHER HEALTH CARE FACILITIES</b>				
Home Health Care Skilled visits only	You pay 10% Plan pays 90% after the plan deductible is met  Unlimited days per calendar year, in-network	Plan pays 100%  60 days per calendar year	You pay 30% Plan pays 70% after the plan deductible is met  60 days per calendar year in- and out-of-network combined	You pay 20% Plan pays 80% after the plan deductible is met  60 days per calendar year in- and out-of-network combined
Skilled Nursing Facility <i>60 days per calendar year, in and out of network combined</i>	You pay 10% Plan pays 90% after the plan deductible is met	Plan pays 100%	You pay 30% Plan pays 70% after the plan deductible is met	You pay 20% Plan pays 80% after the plan deductible is met
Hospice Care: - Inpatient - Outpatient	You pay 10% Plan pays 90% after the plan deductible is met	Plan pays 100%	You pay 30% Plan pays 70% after the plan deductible is met	You pay 20% Plan pays 80% After the plan deductible is met

COVERED SERVICES	CHOICE FUND & OPEN ACCESS PLUS IN-NETWORK	CHOICE FUND & OPEN ACCESS PLUS OUT-OF-NETWORK
<b>VISION PLAN- Services Provided by VSP</b>		
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; <b>OR</b> 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.	Allowance of up to: Exam \$45.00 Single Vision \$30.00 Bifocals \$50.00 Trifocals \$65.00 Frame \$70.00 <b>OR</b> 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	

COVERED SERVICES	CHOICE FUND IN-NETWORK	OPEN ACCESS PLUS IN-NETWORK	CHOICE FUND OUT-OF-NETWORK	OPEN ACCESS PLUS OUT-OF-NETWORK
<b>PRESCRIPTION DRUGS – provided by EXPRESS SCRIPTS</b>				
Retail Prescription Drugs <i>Up to a 30-day supply</i>	<p>Member pays 100% until meets overall plan deductible of \$1500 individual / \$3000 all other coverage levels</p> <p>Then 20% coinsurance</p> <p>Generic: 20% (minimum \$10 / maximum \$75) after deductible</p> <p>Preferred Brand: 20% (minimum \$25 / maximum \$150) after deductible</p> <p>Non-Preferred Brand: 20% (minimum \$40/ maximum \$250) after deductible</p> <p>If actual cost is under the minimum, you pay actual cost</p>	<p>Generic: \$5 co-pay</p> <p>Preferred Brand: 30% coinsurance (minimum \$20 / maximum \$100)</p> <p>Non-preferred Brand: 30% coinsurance (minimum \$40 / maximum \$200)</p> <p>If actual cost is under the minimum, you pay actual cost</p>	50% after plan deductible is met	80% after \$200 pharmacy deductible
Mail Order– Home Delivery <i>Up to a 90-day supply</i>	<p>Member pays 100% until meets overall plan deductible of \$1500 individual / \$3000 all other coverage levels</p> <p>Then 20% coinsurance</p> <p>Generic: 20% (minimum \$20 / maximum \$150) after deductible</p> <p>Preferred Brand: 20% (minimum \$60/ maximum \$300) after deductible</p> <p>Non-Preferred Brand: 20% (minimum \$100/ maximum \$500) after deductible</p> <p>If actual cost is under the minimum, you pay actual cost</p>	<p>Generic: \$12 co-pay</p> <p>Preferred Brand: 30% coinsurance (minimum \$50 / maximum \$200)</p> <p>Non-preferred Brand: 30% coinsurance (minimum \$100 / maximum \$400)</p> <p>If actual cost is under the minimum, you pay actual cost</p>	Not covered	Not covered

**Note 1:** Certain drugs may require a prior authorization in order to receive the prescription or the full quantity your doctor prescribes. Some medications may have a quantity limit. For a listing of the brand names or categories that currently require prior authorization, see the Prior Authorization List

**Note 2:** Certain contraceptive items identified by the Plan as preventive care are covered in full and are not subject to copayments or coinsurance.

EXAMPLES OF PRESCRIPTION DRUG COSTS		
Choice Fund: Retail Brand Preferred (Tier 2) Coinsurance Examples		
DRUG COST	20% COINSURANCE	MEMBER PAYS
\$60	\$12	\$25 (minimum payment)
\$150	\$30	\$30 (20% of covered cost)
\$800	\$160	\$150 (maximum payment)
Open Access Plus: Retail Brand Preferred (Tier 2) Coinsurance Examples		
DRUG COST	30% COINSURANCE	MEMBER PAYS
\$60	\$18	\$20 (minimum payment)
\$150	\$45	\$45 (30% of covered cost)
\$400	\$120	\$100 (maximum payment)

**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.***