Loudoun County Government Group Health Plan Comparison—2023

Description of Service	Cigna Point-of-Service		Cigna Open Access Plus		CIGNA Choice HSA/HRA	
	In-Network	Out-of-Network	In-Network	Out-of-Network	In-Network	Out-of-Network
Employer-funded HSA/HRA	None	None	None	None	$1,000/single $2,000/family	$1,000/single $2,000/family
Annual Deductible[1]	None	$1,500/person $4,500/family	$250/person $750/family	$1,500/person $4,500/family	$1,500/person $3,000/family	$2,500/person $5,000/family
Out-of-Pocket (OOP) Maximum	$4,000/person $8,000/family	$5,000/person $15,000/family	$4,000/person $8,000/family	$5,000/person $15,000/family	$6,450/person $12,900/family	$ 6,450/person $12,900/family
Referrals Required	Yes	No	No	No	No	No
Physician Services	**[1] after deductible**			**[3]actual charge if less**		
Convenience Care Clinic	$20 copay	N/A	$20 copay	N/A	10% [1]	30% [1]
Physician Office Visit	$20 copay	20% [1]	$20 copay	30% [1]	10% [1]	30% [1]
Specialist Office Visit	$35 copay	20% [1]	$35 copay	30% [1]	10% [1]	30% [1]
Telehealth Services	$20 copay	N/A	$20 copay	N/A	10% [1]	N/A
Maternity Care Services	$20/$35 copay 1st visit	20% [1]	$20/$35 copay	30% [1]	10% [1]	30% [1]
Lab Work & X– Rays	Covered in Full	20% [1]	10% [1]	30% [1]	10% [1]	30% [1]
Allergy Injections	$20/$35 copay	20%[1, 3]	$20/$35 copay	30% [1, 3]	10% [1]	30% [1]
Preventive Care Benefits	**[1] after deductible**					
Physician Office Visit	**Covered in Full**	**20% [1]**	**Covered in Full**	**30%[1]**	**Covered in Full**	**30%[1]**
Well Baby/Child Care	**Covered in Full**	**20% [1]**	**Covered in Full**	**30%[1]**	**Covered in Full**	**30%[1]**
Immunizations	**Covered in Full**	**20% [1]**	**Covered in Full**	**30%[1]**	**Covered in Full**	**30%[1]**
Emergency Services	**[1] after deductible**		**[2]applies to in-network OOP maximum**			
Urgent Care Centers	$35 copay[2]		$35 copay[2]		10%[1]	10% [1]
Emergency Room	$150 per visit[2]		$150 per visit[2]		10%[1]	10% [1]
Hospital Inpatient & Outpatient	**[1] after deductible**					
Semi-Private Room	$100 copay	$200 copay then 20% [1]	$100 copay then 10% [1]	$200 copay then 30% [1]	10% [1]	30% [1]
Professional Services	Covered in Full	20% [1]	10% [1]	30% [1]	10% [1]	30% [1]
Outpatient Surgical Procedures (Facility)	$50 copay	$100 copay then 20% [1]	$50 copay then10% [1]	$100 copay then 30% [1]	10% [1]	30% [1]
Professional Fees	Covered in Full	20% [1]	10% [1]	30% [1]	10% [1]	30% [1]
Mental Health / Substance Abuse	**[1] after deductible**					
Inpatient Days	$100 copay	$200 copay then 20% [1]	$100 copay then 10% [1]	$200 copay then 30% [1]	10% [1]	30% [1]
Outpatient Visits	$35 copay	20% [1]	$35 copay	30%[1]	10% [1]	30% [1]
Express-Scripts	**Pharmacy Benefits – 30 day supply**				**[1] after deductible**	
Generic	$7	20% (of maximum allowable charges)	$7	30% (of maximum allowable charges)	10% [1]	10% [1]
Brand Name Formulary	$28	20% (of maximum allowable charges)	$28	30% (of maximum allowable charges)	25% [1]	25% [1]
Non-Formulary Brand	$50	20% (of maximum allowable charges)	$50	30% (of maximum allowable charges)	40% [1]	40% [1]

Questions?

Contact Benefits Help Line at 703-777-0517 or benefits@loudoun.gov.

Dental Benefits

Description of Service	In-Network		Out-of-Network	General Plan Information
	PPO	Premier		
Annual Deductible	$50	$50	$50	Limit of 3 per family per calendar year
Annual Benefit Maximum	$2,000	$2,000	$2,000	Per enrollee, per calendar year
Orthodontic Lifetime Maximum	$1,500	$1,500	$1,500	Per enrollee, for subscriber and covered dependent
Diagnostic & Preventive Care / Prevention First –*Cleanings twice in a calendar year*	100%	100%	80%	Oral exams and cleanings, fluoride applications, bitewing x-rays, space maintainers, sealants . *These services are exempt from the deductible and annual maximum)
Basic Dental Care *(after deductible)*	80%	80%	60%	Fillings, stainless steel crown, oral surgery, denture repair and recommendation of crowns, endodontic services, periodontal services
Major Dental Care *(after deductible)*	80%	80%	50%	Prosthodontics / dentures/ bridges, crowns
Orthodontic Benefits	50%	50%	50%	
Right Start 4 Kids Dental Program	100%	100%	Not covered	Coverage for diagnostic, preventive, basic and major services, with no deductible

Vision Benefits

Description of Service	In-Network			Out-of-Network
Examination - *Once per 12 months*	$15 copay			Up to $35 reimbursement
Lenses - *Once per 12 months*	Fashion $0 copay	Designer $0 copay	Premier $25 copay	Up to $25 — Single Vision Up to $40 — Bifocals
Materials - *Once per 12 months*	$130 wholesale allowance			Up to $35 reimbursement
Contact Lenses - *Once per 12 months*	$15 exam plus $130 max allowance			Up to $35 exam Up to $95 lenses
Contact Lenses (Medically Necessary) -*Once per 12 months*	Covered in full after $15 copay			Up to $210

This summary is for informational purposes only and should not be construed as a final representation of benefit coverage. In case of any con-flict between this summary and the County's official summary plan description, provisions of the summary plan description will govern. Refer to the county intranet located at Pay & Benefits Portal / Benefits & Wellness / Health Plan Benefits.