Pre-65 Group—Health Plan Comparison

Group Retiree Medical Plans - Plan Year 2023

Description of Service	Cigna Point-of-Service		Cigna Open Access Plus		CIGNA Choice HRA	
	In-Network	Out-of-Network	In-Network	Out-of-Network	In-Network	Out-of-Network
Employer-funded 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 co-pay	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]
Outpatient Intensive Visits	$50 copay	$50 copay then 20%	$50 copay	$50 copay then 30%	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]

Dental Benefits - Plan Year 2023

Plan Benefit	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
Description of Services				**[1]After deductible**
Diagnostic & Preventive Care/Prevention First *2 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[1]	80%	80%	60%	*Fillings, stainless steel crown, oral surgery, denture repair and recommendation of crowns, endodontic services, periodontic services*
Major Dental Care[1]	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

Davis Vision Benefits - Plan Year 2023 (pre-65 only)

Description of Service	In-Network			Out-of-network
Examination - *Once per 12 months*	$15 copay			Up to $35 reimbursement
Frames - *Once per 12 months*	Fashion $0 copay	Designer $0 copay	Premier $25 copay	Up to $25 Single Vision Up to $40 Bifocals
	or $130 retail allowance			
Lenses - *Once per 12 months*	$15 copay			Up to $35 reimbursement
Contact Lenses - *Once per 12 months*	$15 copay (Davis Collection), or $130 retail allowance			Up to $35 exam Up to $95 lenses

How much will my coverage cost in 2023?

1. **Are you Medicare eligible or not?**
2. **Find your years of service on the premium chart (pages 9-10).**
3. **Select the number of individuals to be covered.**
4. **For pre & post families, add the premiums together.**

Contact Benefits:
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loudoun.gov/retiree