

**SUMMARY COMPARISON OF MEDICAL PLANS**

**October 1, 2006-December 31, 2007**

<b>HOW BENEFITS ARE PAID:</b>	<b>CIGNA OPEN ACCESS PLUS</b>		<b>HMO IL/ Blue Advantage HMO</b>	<b>CIGNA NETWORK POS</b>	
	<b>OUT-OF-NETWORK</b>	<b>IN-NETWORK</b>	<b>IN-NETWORK</b>	<b>IN-NETWORK</b>	<b>OUT-OF-NETWORK</b>
<b>HOSPITAL IN-PATIENT</b>	Pre-admission certification is required. You must call Intracorp for approval or penalty applies.	Pre-admission certification is required. Your in-network provider must call Intracorp for approval or penalty applies.	Primary care physician must approve hospital stay. \$250 Copay, 100%	Primary care physician must approve hospital stay. \$150, Copay, 100%	Pre-admission certification is required. You must call Member Services for approval or penalty applies.
<b>In-patient Room &amp; Board (semi-private)</b>	80% subject to deductible	90% subject to deductible	100%	100%	70% subject to deductible
<b>In-patient Ancillary Charge</b>	80% subject to deductible	90% subject to deductible	100%	100%	70% subject to deductible
<b>Out-patient Emergency Hospital Charges</b>	80% Subject to deductible	90% Subject to Deductible	\$75 co-payment, 100% provided that you follow the HMO's emergency procedure described in each HMO's literature.	\$100 co-payment, 100% provided that you follow the POS', emergency procedure described in each POS' literature.	See explanation below*
<b>Out-patient Emergency Doctor Charges</b>	80% Subject to deductible	90% Subject to deductible	100% provided that you follow the HMO's emergency procedure described in each HMO's literature.		See explanation below*
<b><u>SURGERY</u></b>					
<b>In-patient</b>	80% Subject to deductible	90% Subject to deductible	100%	100%	70% Subject to deductible
<b>Out-patient</b>	80% Subject to deductible	90% Subject to deductible	\$50 Copay, 100%	\$75 Copay, 100%	70% Subject to deductible
<b><u>PHYSICIAN CHARGES</u></b>					
<b>Hospital Visits</b>	80% Subject to deductible	90% Subject to deductible	100%	100%	70% Subject to deductible
<b>Office Visits</b>	80% Subject to deductible	\$15 Copay, 100%	\$15 Copay, 100% PCP, \$25 Copay Specialist **	\$15 Copay, 100%	70% Subject to deductible
<b>Chiropractor</b>	80% Subject to deductible	\$15 Copay, 100%	\$25 Copay, need referral from PCP	\$20 Copay, 100%	70% Subject to deductible

\* The healthplan's definition of emergency will be paid at the in-network level regardless of provider, otherwise 70% subject to the deductible.

\*\* The specialist copay will not apply to the following physician speciality types: internal medicine, general practitioner, family practice, pediatrician, optometrist, mental health provider, and dependency provider, and obstetrician/gynecologist.

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	<b><u>OUT-OF-NETWORK</u></b>	<b><u>IN-NETWORK</u></b>	<b><u>IN-NETWORK</u></b>	<b><u>IN-NETWORK</u></b>	<b><u>OUT-OF-NETWORK</u></b>
<b><u>DIAGNOSTIC X-RAY &amp; LAB TEST</u></b>					
<b>Billed by Dr. Office</b>	80% Subject to deductible	\$15 co-pay, 100%	100%	100%	70% Subject to deductible
<b>Billed by other than Dr. Office</b>	80% Subject to deductible	90% Subject to deductible	100%	100%	70% Subject to deductible
<b><u>NEWBORN</u></b>					
<b>Hospital Nursery</b>	80% Subject to deductible	90% Subject to Deductible	100%	100%	70% Subject to deductible
<b>Well Baby Care (Office Visit)</b>	Not Covered	\$15 Copay, 100% to age 2	\$15 Copay, 100%	\$15 Copay, 100%	Not Covered
<b><u>MENTAL ILLNESS</u></b>					
<b>Hospital In-Patient</b>	80%, Subject to deductible 45 days per calendar year*	90% Subject to deductible, 45 days per calendar year*	\$250 Copay, 100%, 20 days per calendar year	\$25 per day copayment, 100%, 45 days*	70% subject to the deductible; 45 days*
<b>Office Visits</b>	80%, subject to deductible, 35 visits per year*	\$15 Copay, 100%, 35 visits per year *	\$20 copay 20 visits per calendar year	\$15 copay 35 visits per year*	70% subject to the deductible; 35 visits per year*
<b><u>ALCOHOL &amp; DRUG ABUSE</u></b>					
<b>Hospital In-patient</b>	80%, subject to deductible, 30 days calendar per year*	90% Subject to deductible, 30 days per calendar year*	\$250 Copay, 100%, 20 days per calendar year	\$25 per day copayment, 100%, 30 days*	70% subject to the deductible; 30 days*

\* The maximum number of days or visits applies to the combination of in and out of network benefits.

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	<b>OUT-OF-NETWORK</b>	<b>IN-NETWORK</b>	<b>IN-NETWORK</b>	<b>IN-NETWORK</b>	<b>OUT-OF NETWORK</b>
<b><u>Cont. Drug &amp; Alcohol &amp; Drug Abuse</u></b>					
<b>Office Visits</b>	80%, subject to the deductible, 30 visits per year.*	90%,subject to the deductible, 30 visits per year. *	\$20 copay 20 visits per calendar year.	\$15 copay 60 visits per year *	70% subject to the deductible, 60 visits per year *
<b><u>PRESCRIPTION DRUGS</u></b>	80% subject to the RX deductible of \$50	100% AFTER COPAYMENT ON COVERED PRESCRIPTIONS ONLY. MUST USE APPROVED PHARMACY.			70% subject to the RX deductible of \$50
		\$10 copay, generic \$20 copay, preferred brand \$40 copay, non-preferred brand **(Mail Order 90 day supply)	HMO IL & BI. Adv. - \$10 copay, generic HMO IL \$20 / BI. Adv. \$15 copay, brand name formulary HMO IL \$35/ BI. Adv. \$30 copay, brand name non-formulary **(Mail Order 90 day supply)	\$10 copay, generic \$20 copay, preferred brand \$40 copay, non-preferred **(Mail Order 90 day supply)	
<b><u>ROUTINE SERVICES</u></b>					
<b>Annual Physical Exam</b>	Not Covered	\$15 copay,100% to \$300	\$15 Copay,100%	\$15 Copay,100%	Not covered
<b>Immunizations &amp; Inoculations</b>	Not Covered	See well baby care	\$15 Copay,100%	\$15 Copay,100%	Not covered
<b>Eye Exams</b>	Not Covered	Not Covered	\$15 Copay,100% every 12 months	\$15 Copay, 100% every 24 months	Not covered
<b>Discounts on Glasses</b>	Not Covered	Not Covered	\$75 allowance every 24 months	Not Covered	Not Covered
<b>Hearing Exams</b>	Not Covered	Not Covered	\$15 Copay,100%	\$15 Copay,100%	Not covered

\* The maximum number of days or visits applies to the combination of in and out of network benefits.

\*\* Two times the copay of the tier the prescription drug falls under.

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	<b>OUT-OF-NETWORK</b>	<b>IN-NETWORK</b>	<b>IN-NETWORK</b>	<b>IN-NETWORK</b>	<b>OUT-OF-NETWORK</b>
<b><u>MAJOR MEDICAL</u></b>					
<b>Deductible (YOU PAY)</b>	\$500 per person 3 per family per calendar year  Cross Accumulated	\$250 per person 3 per family per calendar year	N/A	N/A	\$300 per person 3 per family per calendar year
<b>Lifetime Maximum Benefit</b>	\$2,000,000 per person - Cross Accumulated		Unlimited	Unlimited	\$2,000,000 per person
<b>OUT OF POCKET LIMIT (You pay per year)</b>	\$3,000 per person \$9,000 per family Cross Accumulated	\$1,500 per person \$4,500 per family	\$1,500 per person \$3,000 per family *	Copayments where applicable.	\$3,000 per person \$6,000 per family
<b>Dependent Child</b>	19/23 full-time student		19/23 full-time student		19/23 full-time student
<b><u>EXCLUSIONS &amp; LIMITATIONS</u></b>	All benefits must be medically necessary and are subject to carrier plan rules and limitations. Consult the CIGNA Group Insurance Certificate and HMO Contracts and/or booklets for specifics.				

\*Excludes copayments for prescription drugs, vision, durable medical equipment, and prosthetics.

**THIS COMPARISON ONLY HIGHLIGHTS THE PLANS. DETAILED DESCRIPTIONS ARE AVAILABLE FROM THE BENEFITS OFFICE. SHOULD THERE BE A DISCREPANCY BETWEEN THIS COMPARISON AND THE CIGNA AND HMO CONTRACTS, THE TERMS OF THE CONTRACTS WILL GOVERN.**