Type of Service	Preferred-Basic	ActiveCare HD	Preferred-Enhanced	ActiveCare Primary+
Provider Network	**Cigna Open Access / PCA**	**BCBS POS / CVS Caremark**	**Cigna Open Access / PCA**	**BCBS HMO / CVS Caremark**
PCP/Referral Required	No	No	No	Yes
Coverage Area	Nationwide	Nationwide	Nationwide	Statewide
Deductible (per plan year) In-Network Out-of-Network	$3,000 individual / $6,000 family $6,000 individual / $12,000 family	**$3,000 individual / $6,000 family** $5,500 employee only / $11,000 family	$1,500 individual / $3,000 family $4,000 individual / $8,000 family	$1,200 individual / $3,600 family N/A
Out-of-Pocket Maximum In-Network Out-of-Network (per plan year; includes medical and prescription drug deductibles, copays and coinsurance)	$6,650 individual / $13,300 family $12,700 individual / $25,400 family (the individual out-of-pocket max only includes covered expenses incurred by that individual)	**$7,000 individual / $14,000 family** $20,250 individual / $40,500 family (the individual out-of-pocket max only includes covered expenses incurred by that individual)	$5,000 individual / $10,000 family $8,000 individual / $16,000 family	$6,900 individual / $13,800 family N/A
Coinsurance Participant pays after deductible Out-of-Network	20% 40% of allowed amount	**30%** **50% of allowed amount**	10% 40% of allowed amount	20% N/A
Office Visit Copay Participant pays	20% after ded	30% after ded	$35 copay for primary $35 copay for specialist	$30 copay for primary $70 copay for specialist
Diagnostic Lab Participant pays **(preauthorization may apply)**	20% after ded	30% after ded	$35 at Office/Independent Lab 10% after ded at outpatient facilities	$0 at Office/Independent Lab 20% after ded at outpatient facilities
Preventive Care	Plan pays 100%	Plan pays 100%	Plan pays 100%	Plan pays 100%
Virtual Health Care	Plan pays 100%	$30 consultation fee (applies to ded and out-of-pocket max)	Plan pays 100%	Plan pays 100%
High-Tech Radiology (CT scan, MRI, nuclear medicine) Participant pays	20% after ded	30% after ded	10% after ded $250 copay only at free standing	20% after ded
Inpatient Hospital In-Network Out-of-Network	20% after ded 40% after ded preauthorization recommended	30% after ded 50% after ded ($500 max per day) preauthorization required	10% after ded 40% after ded preauthorization recommended	20% after ded N/A preauthorization required
Urgent Care Centers	20% after ded	30% after ded	$75 copay per visit	$50 copay per visit
Emergency Room (true emergency use) Participant pays	20% after ded	30% after ded	$150 copay	20% after ded
Outpatient Surgery Participant pays	20% after ded	30% after ded	10% after ded	20% after ded
Mental or Behavior Health, or Substance Abuse Outpatient Services Inpatient Services	20% after ded 20% after ded	30% after ded 30% after ded	$35 copay 10% after ded	$30 copay 20% after ded
Vision Examination (one per plan year, performed by an ophthalmologist or optometrist)	Plan pays 100%	30% after ded	Plan pays 100%	$70 copay
Prescription Drugs Drug deductible (per plan year)	Subject to plan year ded	Subject to plan year ded	$0	$0 for generic drugs $200 per person for brand-name drugs
Retail Short-Term (up to 31 day supply) Participant pays · Tier 1-Generic · Tier 2-Preferred Brand · Tier 3-Non-Preferred Generic & Brand	20% after ded 20% after ded 20% after ded	20% after ded1 25% after ded 50% after ded	$10 copay $30 copay $50 copay	$15 copay 25% coinsurance 50% coinsurance
Mail Order and Retail-Plus (60-90 day supply) Participant pays · Tier 1-Generic · Tier 2-Preferred Brand · Tier 3-Non-Preferred Brand	20% after ded 20% after ded 20% after ded	20% after ded (ded and coinsurance waived for certain generic preventive drugs.) 25% after ded 50% after ded	$25 copay $75 copay $125 copay	$45 copay 25% after drug ded 50% coinsurance
Specialty Drugs Participant pays	20% after ded	20% after ded 30 day supply limit/fill	50% to max $1500	20% after ded 31 day supply limit/fill