

**CIGNA Healthcare**  
**Options I, II, & III**  
 Effective January 1, 2011

**Medical Benefit Summary for State of Wyoming – Employees’ Group Insurance**

<b>GENERAL SERVICES</b>	<b>WYOMING PROVIDERS</b> (Providers in network reimbursed at 85%; non-network providers reimbursed 80%)	<b>OUTSIDE WYOMING</b> (network providers reimbursed at 80%; non-network providers reimbursed at 60%)
<b>Physician Visit</b>	85% / 80% after calendar year deductible	80% / 60% after calendar year deductible
<b>Coinsurance</b>	85% / 80%	80% / 60%
<b>Calendar Year Deductible</b> <ul style="list-style-type: none"> <li>The amount of allowable out-of-pocket expenses that must be paid by the member prior to benefits being paid.</li> </ul>	\$350 / \$700 ind/family plan Option I \$750 / \$1,500 ind/family plan Option II \$2,000 / \$4,000 ind/family plan Option III	\$350 / \$700 ind/family plan Option I \$750 / \$1,500 ind/family plan Option II \$2,000 / \$4,000 ind/family plan Option III
<b>Wellness Care</b> <ul style="list-style-type: none"> <li>Immunizations</li> <li>Routine physicals</li> <li>Basic gynecological care</li> <li>Lab &amp; X-ray charges for preventive care are paid at 100% regardless of provider and subject to maximum allowable cost</li> <li>Colonoscopy – Paid at 100% once every five years regardless of provider and subject to maximum allowable cost.</li> <li>Please see <a href="http://healthierwy.org">healthierwy.org</a> for ways to receive a discount on your health insurance premium</li> </ul>	100% (1) evidence-based items or services that have in effect a rating of “A” or “B” in the current recommendations of the United States Preventive Services Task Force; (2) immunizations that have in effect a recommendation from the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention with respect to the Covered Person involved; (3) for infants, children, and adolescents, evidence-informed preventive care and screenings provided for in the comprehensive guidelines supported by the Health Resources and Services Administration; (4) for women, such additional preventive care and screenings not described in (1) as provided for in comprehensive guidelines supported by the Health Resources and Services Administration.  You can view the specific recommendations on the HealthCare.gov website ( <a href="http://www.healthcare.gov/center/regulations/prevention/recommendations.html">http://www.healthcare.gov/center/regulations/prevention/recommendations.html</a> ).	
<b>Pharmacy Plan</b>	\$10 Generic    \$20 Brand    \$50 Non-Formulary    \$80 Specialty	
<b>Durable Medical Equipment</b>	85% / 80% after calendar year deductible	80% / 60% after calendar year deductible
<b>Lab &amp; X-ray Services</b> <ul style="list-style-type: none"> <li>Reimbursed based on network status of referring physician</li> </ul>	85% / 80% after calendar year deductible	80% / 60% after calendar year deductible
<b>Emergency Room Care</b>	85% / 80% after calendar year deductible	80% / 60% after calendar year deductible
<b>Calendar Year Out-of-Pocket</b>	Individual: \$2,000 + deductible Family: \$4,000 + deductible	<u>In network:</u> Individual: \$2,000+deductible Family: \$4,000+ deductible <u>Out of Network:</u> Individual: \$4,000 + deductible Family: \$8,000 + deductible
<b>PPO Out of Area Services</b>	Services rendered outside of any PPO geographic area are paid at 80% of maximum allowable cost, subject to the deductible and out-of-pocket.	

<b>HOSPITAL SERVICES</b>		
<b>Inpatient Hospital Services</b> • Requires pre-certification	85% / 80% after calendar year deductible	80% / 60% after calendar year deductible
<b>Skilled Nursing Facility Care</b> • Required pre-certification		
<b>Outpatient Hospital Services</b> • Outpatient Surgery • Including anesthesia • Requires pre-certification Ambulatory Surgery	85% / 80% after calendar year deductible	80% / 60% after calendar year deductible
<b>Hospice Care</b>	100% no deductible	100% no deductible
<b>Home Health Care</b>	100%	100%
<b>Office Surgery</b>	85% / 80% after calendar year deductible	80% / 60% after calendar year deductible
<b>MENTAL HEALTH AND CHEMICAL DEPENDENCY SERVICES</b>		
<b>Inpatient</b> • Requires pre-certification	85% / 80% after calendar year deductible	80% / 60% after calendar year deductible
<b>Outpatient</b>	85% / 80% after calendar year deductible	80% / 60% after calendar year deductible
<b>THERAPY SERVICES</b>		
<b>Outpatient Physical Therapy, Speech Therapy, Hearing Therapy and Occupational Therapy combined benefit</b>	85% / 80% after calendar year deductible	80% / 60% after calendar year deductible
<b>Spinal Adjustment Therapy</b>	85% / 80% after calendar year deductible	80% / 60% after calendar year deductible
<b>ADDITIONAL SERVICES</b>		
<b>Family Planning</b> • Tubal Ligations and Vasectomies • Requires pre-certification if non-office • Includes infertility testing for diagnosis only	85% / 80% after calendar year deductible	80% / 60% after calendar year deductible

All services are subject to eligibility and Plan provisions at time of service, including but not limited to maximum allowable cost.  
**This is an outline of the benefits available; see the benefit booklet for details of the program.**