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Medical Comparison Chart
July 1, 2021 - June 30, 2022

	CIGNA / Allegiance PPO/OAP		CIGNA / Allegiance HDHP (HSA Eligible)		Kaiser DHMO	Kaiser HDHP (HSA Eligible)
	In Network	**Out-of-Network**	**In Network**	**Out-of-Network**	**In-Network Only**	**In-Network Only**
Type Of Plan	Preferred Provider Option		Preferred Provider Option		Health Maintenance Organization	Health Maintenance Organization
Out-Of-Network Coverage	N/A	Yes Limited to Reasonable and Customary	N/A	Yes Limited to Reasonable and Customary	Only For Emergency Care Limited to Reasonable and Customary	Only For Emergency Care Limited to Reasonable and Customary
Plan Year Deductible	Individual $1,500 Family $3,000	Individual $3,000 Family $6,000	Individual $3,000 Family $6,000	Individual $6,000 Family $12,000	Individual $250 Family $500	Individual $3,000 Family $6,000
	If you have dependent coverage, the single deductible is met on a per covered person basis, never to exceed the family deductible for all covered persons in the family.		If you have dependent coverage, the single deductible is met on a per covered person basis, never to exceed the family deductible for all covered persons in the family.		If you have dependent coverage, the single deductible is met on a per covered person basis, never to exceed the family deductible for all covered persons in the family.	If you have dependent coverage, the single deductible is met on a per covered person basis, never to exceed the family deductible for all covered persons in the family.
Plan Year Out-of-Pocket Maximum	Individual $4,000 Family $8,000	Individual $16,000 Family $32,000	Individual $5,000 Family $10,000	Individual $20,000 Family $40,000	Individual $2,000 Family $4,500	Individual $5,000 Family $10,000
	Deductible and Copays Included		Deductible, Copays and Coinsurance Included		Deductible, Copays and Coinsurance Included	Deductible, Copays and Coinsurance Included
Lifetime Maximum	Unlimited		Unlimited		Unlimited	Unlimited
Dependent Eligibility	End of the Month in Which the Child Turns Age 26		End of the Month in Which the Child Turns Age 26		End of the Month in Which the Child Turns Age 26	End of the Month in Which the Child Turns Age 26
Service Availability	CIGNA PPO Network Physicians and Hospitals	Any Physician Any Facility	CIGNA PPO Network Physicians and Hospitals	Any Physician Any Facility	* Kaiser Permanente Colorado Medical Group	* Kaiser Permanente Colorado Medical Group
Office Visit	$30 Copay	Deductible Applies; Paid at 60%	Deductible Applies; Paid at 80%	Deductible Applies; Paid at 60%	$30 Copay Per Visit Per Visit; 20% Coinsurance for Office-administered Drugs up to Out-of-pocket Max	Deductible Applies; Paid at 80%
Specialist Office Visit	$60 Copay	Deductible Applies; Paid at 60%	Deductible Applies; Paid at 80%	Deductible Applies; Paid at 60%	$60 Copay Per Visit Per Visit; 20% Coinsurance for Office-administered Drugs up to Out-of-pocket Max	Deductible Applies; Paid at 80%
Preventive Care	Covered at 100%	Deductible Applies; Paid at 60%	Covered at 100%	Deductible Applies; Paid at 60%	Covered at 100%	Covered at 100%
Infertility Office Visit (Diagnosis Only)	Deductible Applies; Paid at 80%	Deductible Applies; Paid at 60%	Deductible Applies; Paid at 80%	Deductible Applies; Paid at 60%	Covered at 50%	Not Covered

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	In Network	Out-of-Network	In Network	Out-of-Network	In-Network Only	In-Network Only
Prescription Drugs Retail	15% Generic Max $75 Pref Brand Max $125 Non-Pref Brand Max $175 30-day Supply _____ 20% Specialty/Injectible Max $250	Not Covered	Preventive Drug List: Not Subject to Deductible Generic Covered at 100% Pref Brand $30 All Other Prescriptions: Deductible Applies, Paid at 80% 30-day Supply	Not Covered	Preventive Drug List: Covered at 100% Generic $20 Brand $40 30-day Supply _____ 20% Coinsurance for Specialty Drugs Including Self-administered Injectibles (does not include insulin) Up to a Maximum of $250, Per Drug Dispensed/Per Prescription	Preventive Drug List: Not Subject to Deductible Deductible Applies Generic $15 Pref Brand $30 Non-Pref Brand 50% 30-day Supply _____ 20% Coinsurance for Specialty Drugs Including Self-administered Injectibles (does not include insulin) Per Drug Dispensed/Per Prescription
Prescription Drugs Mail Order	15% Generic Max $187.50 Pref Brand Max $312.50 Non-Pref Brand Max $437.50 90-day Supply _____ 20% Specialty/Injectible Max $625	N/A	Preventive Drug List: Not Subject to Deductible Generic Covered at 100% Pref Brand $60 All Other Prescriptions: Deductible Applies, Paid at 80% 90-day Supply	N/A	Generic $40 Brand $80 90-day Supply 20% Coinsurance for Specialty Drugs Including Self-administered Injectibles (does not include insulin) Up to a Max of $500, Per Drug Dispensed/Per Prescription	Deductible Applies Generic $30 Pref Brand $60 Non-Pref Brand 50% (Copays and Coinsurance Apply Towards Out-of-pocket Maximum) 90-day Supply 20% Coinsurance for Specialty Drugs Including Self-administered Injectibles (does not include insulin) Per Drug Dispensed/Per Prescription
Inpatient Hospital	Deductible Applies; Paid at 80%	Deductible Applies; Paid at 60%	Deductible Applies; Paid at 80%	Deductible Applies; Paid at 60%	Paid at 80%	Deductible Applies; Paid at 80%
Outpatient Surgical Procedures	Deductible Applies; Paid at 80%	Deductible Applies; Paid at 60%	Deductible Applies; Paid at 80%	Deductible Applies; Paid at 60%	$500 Copay Per Visit	Deductible Applies; Paid at 80%
Routine Laboratory and X-ray	Deductible Applies; Paid at 80%	Deductible Applies; Paid at 60%	Deductible Applies; Paid at 80%	Deductible Applies; Paid at 60%	No Copay Therapeutic X-ray $30 Copay Per Visit	Deductible Applies; Paid at 80%

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MRI, CAT, and PET Scans	Deductible Applies; Paid at 80%	Deductible Applies; Paid at 60%	Deductible Applies; Paid at 80%	Deductible Applies; Paid at 60%	$200 Copay Per Scan (waived if hospitalized)	Deductible Applies; Paid at 80%
Emergency	$250 Copay Per Visit	Care Provided at In-Network Level if the Condition Meets the Definition of an Emergency	Deductible Applies; Paid at 80%	Care Provided at In-Network Level if the Condition Meets the Definition of an Emergency	$300 Copay Per Visit	Deductible Applies; Paid at 80%
Urgent Care	$50 Copay Per Visit	Deductible Applies; Paid at 60%	Deductible Applies; Paid at 80%	Deductible Applies; Paid at 60%	$75 Copay After Hours (Non-Kaiser Facility Emergency Claims Limited to Reasonable and Customary Charges)	Deductible Applies; Paid at 80%
Hearing Aids	Covered Every Three Years; Deductible Applies; Paid at 80%		Covered Every Three Years; Deductible Applies; Paid at 80%		Not Covered	Not Covered
Mental Health Inpatient	Deductible Applies; Paid at 80%	Deductible Applies; Paid at 60%	Deductible Applies; Paid at 80%	Deductible Applies; Paid at 60%	Paid at 80%	Deductible Applies; Paid at 80%
Mental Health Outpatient	$50 Co-pay Per Visit	Deductible Applies; Paid at 60%	Deductible Applies; Paid at 80%	Deductible Applies; Paid at 60%	$30 Copay Per Visit	Deductible Applies; Paid at 80%
Outpatient Group Therapy	Deductible Applies; Paid at 80%	Deductible Applies; Paid at 60%	Deductible Applies; Paid at 80%	Deductible Applies; Paid at 60%	$15 Copay Per Visit	Deductible Applies; Paid at 80%
Physical, Occupational and Speech Therapy	Deductible Applies; Paid at 80% 60-visit Maximum Per Plan Year for All Therapies Combined	Deductible Applies; Paid at 60% 60-visit Maximum Per Plan Year for All Therapies Combined	Deductible Applies; Paid at 80% 60-visit Maximum Per Plan Year for All Therapies Combined	Deductible Applies; Paid at 60% 60-visit Maximum Per Plan Year for All Therapies Combined	$30 Copay Per Visit For Each Therapy (i.e. Physical, occupational and speech therapy). There will be a 20-visit Limit Per Therapy Per Year	Deductible Applies; Paid at 80% For Each Therapy (i.e. Physical, occupational and speech therapy). There will be a 20-visit Limit Per Therapy Per Year
Chiropractic Care	$60 Copay Per Visit 60-visit Maximum Per Plan Year for All Therapies Combined	Deductible Applies; Paid at 60% 60-visit Maximum Per Plan Year for All Therapies Combined	Deductible Applies; Paid at 80% 60-visit Maximum Per Plan Year for All Therapies Combined	Deductible Applies; Paid at 60% 60-visit Maximum Per Plan Year for All Therapies Combined	$30 Copay Per Visit 30-visit Maximum Per Plan Year	Not Covered
Referral required for specialist care	No		No		Yes	Yes
Prior authorization required for surgical procedures	Yes		Yes		Yes	Yes
Medical Video Visits (Teledoc, Telemedicine)	Teladoc.com: 1-800-835-2362 $15 per consult 24/7/365 Access to a Doctor		Teladoc.com: 1-800-835-2362 $45 per consult 24/7/365 Access to a Doctor		E-Visit: 24/7 Medical Advice No cost	

* Denver metro area - Kaiser physicians and facilities. Colorado Springs area - Kaiser network of private practice physicians.

Disclaimer: This document is a summary for comparison purposes only. It is not intended to replace the legal plan documents, which describe the plan benefits in full. For complete plan information, please refer to the summary plan description for the plan you have chosen.