

2020-2021 Medical Plan Comparison Chart

Benefit Provision		Cigna HMO	UnitedHealthcare PPO		Cigna HDHP with H.S.A. UnitedHealthcare HDHP with H.S.A. ⁵ Employer Contribution to H.S.A. \$500 Individual / \$1,000 Family ¹	
		In-Network Coverage Only	In-Network	Out-of-Network	In-Network	Out-of-Network
Plan Deductible (Each Plan works differently. See the Benefits website for more information.)	Individual	\$350 Facility Deductible	\$750 Annual Deductible	\$1,500	\$1,500	\$3,000
	Family	\$700 Facility Deductible	\$1,500 Annual Deductible	\$3,000	\$3,000	\$6,000
Standard Percent of Coinsurance		N/A	15%	50%	15%	50%
Out-of-Pocket Maximum (OOP Max) - Medical/Behavioral Health (See the Benefits website for more information)	Individual	\$1,600	\$3,500	\$7,000	\$3,275	\$6,550
	Family	\$3,200	\$7,000	\$14,000	\$6,550	\$13,100
Out-of-Pocket Maximum (OOP Max) - Prescription (See the Benefits website for more information)	Individual	\$1,500	\$1,500	N/A	Included in Medical OOP Max	Included in Medical OOP Max
	Family	\$3,000	\$3,000			
Preventive Care		\$0 (FREE)	\$0 (FREE)	Covered In-Network only	\$0 (FREE) no deductible	Covered In-Network only
Telehealth		\$0 (FREE)	\$0 (FREE)	Covered In-Network only	15% after deductible	Covered In-Network only
Convenience Care Clinic Visit		\$10	\$20	50% after deductible	15% after deductible	50% after deductible
Primary Care Physician (PCP)		\$30	\$25 ² / \$45 ³	50% after deductible	15% after deductible	50% after deductible
Specialty Care Physician - CCD/Non-CCD & Tier 1 / Non-Tier 1		\$45 ² / \$70 ³	\$55 ² / \$70 ³	50% after deductible	15% after deductible	50% after deductible
Chiropractic Services; limited to 24 visits/days per year		\$30	\$40	Covered In-Network only	15% after deductible	Covered In-Network only
Allergy Injections		\$30	\$40	50% after deductible	15% after deductible	50% after deductible
Inpatient Hospital Facility & Professional Services		\$250 after deductible	15% after deductible	50% after deductible	15% after deductible	50% after deductible
Outpatient Lab and X-Ray Facility		\$0	15% / 25% after deductible ⁵	50% after deductible	15% / 25% after deductible ⁵	50% after deductible
Outpatient Advanced Radiology: CAT, PET, MRI, MRA Scans and Nuclear Cardiac Studies		\$0 after deductible ⁴	15% / 25% after deductible ⁵	50% after deductible	15% / 25% after deductible ⁵	50% after deductible
Outpatient Surgery & Professional Services		\$150 after deductible	15% / 25% after deductible ⁵	50% after deductible	15% / 25% after deductible ⁵	50% after deductible
Pre- & Post-Natal Exams (after pregnancy has been confirmed)		\$30 / \$45 ² / \$70 ³ waived after 1st visit	\$25 / \$55 ² or \$45 / \$70 ³ to confirm pregnancy; 15% other related services after deductible	50% after deductible	15% after deductible	50% after deductible
Urgent Care		\$75, waived if admitted to hospital	\$75, waived if admitted to hospital	50% after deductible	15% after deductible	15% after deductible
Emergency Room		\$200 waived if admitted to hospital	\$250 waived if admitted to hospital	\$250 waived if admitted to hospital	15% after deductible	15% after deductible
Ambulance		\$0	15% after deductible	15% after deductible	15% after deductible	15% after deductible
Durable Medical Equipment/Medical Supplies No annual limit		\$0	15% after deductible per item per month	50% after deductible	15% after deductible	50% after deductible
Physical Therapy - Limited to 60 In- & Out-of-Network visits/days per year combined with therapies below		\$30	\$40	50% after deductible	15% after deductible	50% after deductible
Pulmonary Rehab, Speech, Occupational and Cognitive Therapy - Limited to 60 In- & Out-of-Network visits/days per year combined with Physical Therapy		\$45	\$55	50% after deductible	15% after deductible	50% after deductible
Cardiac Rehab - Limited to 36 combined In- & Out-of-Network visits/days per year		\$45	\$55	50% after deductible	15% after deductible	50% after deductible
Bariatric Surgery 1 year waiting period from initial employment		\$1,000 copay after deductible; in addition to Inpatient Hospital Facility Services	\$1,000 copay after deductible; in addition to Inpatient Hospital Facility Services	Covered In-Network only	15% after deductible	Covered In-Network only

For more detail, review the plan summaries on the Benefits Home Page at www.maricopa.gov/benefits. In the event of a discrepancy between the information in this chart and the official plan documents and contracts, the official plan document and contracts govern.

1. County contribution to the HSA is prorated based on benefit eligibility start date and calculated according to the pay periods remaining in the plan year.

2. You pay lower copays when you use a provider with the Cigna Care Designation (CCD). You pay lower copays when you use a Primary Care Physician or Specialist with the UnitedHealthcare Premium Tier 1 Designation.

3. You pay higher copays when you use a provider without the CCD or UHC Tier 1 Designation. Not all specialties are included. When the provider is not included in the CCD or UHC Tier 1, the higher Non-CCD or Non-UHC Tier 1 copay applies.

4. Does not apply to inpatient facility services. Subject to applicable place of service coinsurance and plan deductible.

5. UnitedHealthcare HDHP and PPO Co-Insurance is 25% if in a hospital-based facility for outpatient services; 15% Co-Insurance applies to freestanding office or facility.