## Cigna Open Access Plus (OAP) Plan Cost Estimator

(Estimate number of annual visits for you and your covered dependents)

### A) PCP Visits
\[ \text{Number} \times \$15 \]  
Total: $

### B) Specialist Visits
\[ \text{Number} \times \$30 \]  
Total: $

### C) Emergency Room Visits
\[ \text{Number} \times \$100 \]  
Total: $

### D) Urgent Care Visits
\[ \text{Number} \times \$50 \]  
Total: $

### E) Physical Therapy Visits
\[ \text{Number} \times \$30 \]  
Total: $

### F) Mental Health Visits
\[ \text{Number} \times \$30 \]  
Total: $

### G) Chiropractic Visits
\[ \text{Number} \times \$30 \]  
Total: $

### H) Inpatient Facility Procedures
\[ \text{Number} \times \$200 \]  
Total: $

(Your 10% co-insurance will be reflected on Line N below)

### I) Outpatient Facility Procedures
\[ \text{Number} \times \$100 \]  
Total: $

(Your 10% co-insurance will be reflected on Line O below)

### J) Preventive Care Visits
\[ \text{Number} \times \$0 \]  
Total: $

**ADD LINES A-J FOR TOTAL CO-PAYS PAID DURING PLAN YEAR** (A4)

For the charges below, the first $200 per individual will go towards your deductible, and you will pay 10% of the estimated charge until the individual out-of-pocket maximum of $1000 is reached. Family deductible is $400; Family out-of-pocket maximum is $2,000.

### K) Lab Work (not billed as office visit)
\[ \text{Number} \times \$24^* \]  
Total: $

### L) X-Ray (not billed as office visit)
\[ \text{Number} \times \$59^* \]  
Total: $

### M) MRI/PET/CAT Scan
\[ \text{Number} \times \$475^* \]  
Total: $

### N) Inpatient Facility Procedures (use # in H above)
\[ \text{Number} \times \$9500^* \]  
Total: $

### O) Outpatient Facility Procedures (use # in I above)
\[ \text{Number} \times \$4000^* \]  
Total: $

### P) Ultrasound
\[ \text{Number} \times \$119^* \]  
Total: $

**ADD LINES K-P FOR ADDITIONAL COSTS INCURRED** (A5)

### DEDUCTIBLE

For single coverage, enter $200 on lines Q and A2. For two-party or family coverage, enter $400 on lines Q and A2.

**MULTIPLY BY 0.10 (10%)**

\[ \text{(A1)} \times 0.10 \]  
\[ \text{(A2)} \text{ADD (DEDUCTIBLE)} \]  
\[ \text{(A7)} \text{TOTAL $} \]

For single coverage, enter whichever is less: (A7) or your remaining out-of-pocket maximum of $800 OR For two-party or family coverage, enter whichever is less: (A7) or your remaining out-of-pocket maximum of $1,600.

\[ \text{$} \text{(A3)} \text{If you carried down a number from (A5), the text to the left does not apply.} \]

**ADD LINES A3 AND A4 FOR TOTAL OUT-OF-POCKET COSTS** (A6)

### PROPOSED MONTHLY RATES¹

(choose one)

<table>
<thead>
<tr>
<th>Coverage</th>
<th>Monthly Rate</th>
<th>Number of Months</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Employee Only</td>
<td>$15.00</td>
<td>12</td>
<td>$180.00</td>
</tr>
<tr>
<td>Employee + Child</td>
<td>$81.97</td>
<td>12</td>
<td>$983.64</td>
</tr>
<tr>
<td>Employee + Spouse</td>
<td>$195.13</td>
<td>12</td>
<td>$2,341.56</td>
</tr>
<tr>
<td>Family</td>
<td>$292.70</td>
<td>12</td>
<td>$3,512.40</td>
</tr>
</tbody>
</table>

**ADD LINE (W), (X), (Y), OR (Z) to LINE (A6) FOR TOTAL PLAN COSTS**

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*Costs are based on average Cigna contracted rates, and not physician charges. Your actual charges may be higher or lower depending on the health care professional or facility and geographic location.

¹Rates are proposed and subject to School Board approval
## Cigna Point Of Service (POS) Plan Cost Estimator

(Estimate number of annual visits for you and your covered dependents)

| A) PCP Visits | ___ x $15 | Total: $ ___ |
| B) Specialist Visits | ___ x $30 | Total: $ ___ |
| C) Emergency Room Visits | ___ x $100 | Total: $ ___ |
| D) Urgent Care Visits | ___ x $25 | Total: $ ___ |
| E) Physical Therapy Visits | ___ x $30 | Total: $ ___ |
| F) Mental Health Visits | ___ x $30 | Total: $ ___ |
| G) Chiropractic Visits | ___ x $30 | Total: $ ___ |
| H) Inpatient Facility Procedures | ___ x $0 | Total: $ ___ |
| I) Outpatient Facility Procedures | ___ x $0 | Total: $ ___ |
| J) Preventive Care Visits | ___ x $0 | Total: $ 0 |

**ADD LINES A-J FOR TOTAL CO-PAYS PAID DURING PLAN YEAR** (A4)

*The charges below are covered at 100%.*

| K) Lab Work (not billed as office visit) | ___ x $0 | Total: $ ___ |
| L) X-Ray (not billed as office visit) | ___ x $0 | Total: $ ___ |
| M) MRI/PET/CAT Scan | ___ x $0 | Total: $ ___ |
| N) Inpatient Facility Procedures | ___ x $0 | Total: $ ___ |
| O) Outpatient Facility Procedures | ___ x $0 | Total: $ ___ |
| P) Ultrasound | ___ x $0 | Total: $ ___ |

**ADD LINES K-P FOR ADDITIONAL COSTS INCURRED** (A5)

**DEDUCTIBLE** (Q) **SUBTRACT** N/A **(DEDUCTIBLE)** FROM (A5)

**MULTIPLY BY 0.10 (10%)**

| (A1) | x 1 | N/A |
| (A2) | ADD | N/A | (DEDUCTIBLE) |
| (A3) | TOTAL | N/A |

**ADD LINES A4 AND A5 FOR TOTAL OUT-OF-POCKET COSTS** (A6)

**PROPOSED MONTHLY RATES¹**

*(choose one)*

| Employee Only | $107.07 x 12 | (W) $1,284.84 |
| Employee + Child | $212.69 x 12 | (X) $2,552.28 |
| Employee + Spouse | $379.27 x 12 | (Y) $4,551.24 |
| Family | $522.89 x 12 | (Z) $6,274.68 |

**ADD LINE (W), (X), (Y), OR (Z) TO LINE (A6) FOR TOTAL PLAN COSTS**

*Costs are based on average Cigna contracted rates, and not physician charges.*

*Your actual charges may be higher or lower depending on the health care professional or facility and geographic location.*

*¹ Rates are proposed and subject to School Board approval*