Volusia County Government

Health Plan Schedule of Benefits and Payments

Network – Current to 2017 Cigna

Service	2016			2017
	In Network (VHN & FMHN)	**Expanded Network** (Multi-Plan)		**In Network** (Cigna National)
Calendar Year Deductible	$250/$750 Major Radiology Only	$500/$1,500		**$0/$0**
Out-of-Pocket Expense (Includes Co-pay and Co-insurance)	$5,000/$10,000	$5,000/$10,000		$5,000/$10,000
Annual Physical Exam	$0	$0		$0
Well Woman Services	$0	$0		$0
Well Child Services	$0	$0		$0
Colonoscopy Screening	$0	$0		$0
Primary Care Physician Office Visit	$25.00	Deductible + 20%		**$20.00**
Specialist Physician Visit	$40.00	Deductible + 20%		$40.00
Obstetrical Care Including Delivery	$105.00	Deductible + 20%		$105.00
Hospital-In Patient	$250.00 per day, 3 day max.	Deductible + 20%		**$250.00 per day, 4 day max.**
Hospital-Out Patient Surgery	$250.00	Deductible + 20%		$250.00
Outpatient Surgery – Ambulatory Surgical Center	$40.00 + $40.00 Physician Co-pay	Deductible + 20%		**$125.00**
Physician Office Surgery	$40.00 + $40.00 Physician Co-pay	Deductible + 20%		$80 Co-pay
Skilled Nursing Facility Per Admission	$55.00	Deductible + 20%		$55.00
Emergency Room Visit *waived if admitted	$65.00	$65.00		**$150.00**
Urgent Care	$50.00	20%		**$45.00**
Telemedicine Visit	N/A	N/A		**$0**
Immunizations/inoculations (not preventive)	$30.00	Deductible + 20%		$30.00

Service	2016			2017
	In Network **(VHN & FMHN)**	**Expanded Network** **(Multi-Plan)**		**In Network** **(Cigna National)**
MRI/CAT Scan Hospital Out Patient	Deductible + 10%	Deductible + 20%		**$250.00**
MRI/CAT Scan Freestanding Facility	Deductible + 10%	Deductible + 20%		**$125.00**
X-Rays - Diagnostic	$25.00	Deductible + 20%		$25.00
Lab Test	$25.00	Deductible + 20%		$25.00
Chiropractic	$25.00	Deductible + 20%		**$30.00**
Sleep Study	$25.00	Deductible + 20%		**$100.00**
Outpatient Therapies – Per Visit	$25.00	Deductible + 20%		**$30.00**
Ambulance	$65.00	Deductible + 20%		$65.00
Durable Medical Equipment	$25.00	Deductible + 20%		**$20.00 per occurrence**
Medical Supplies	$15.00	Deductible + 20%		**$20.00**
Breast Prostheses	$10.00	Deductible + 20%		**$105.00**
Prosthetic Devices-Per Device	$105.00	Deductible + 20%		$105.00
Behavioral Health- Inpatient Services	$250.00 per day, 3 day max.	Deductible + 20%		**$250.00 per day, 4 day max.**
Behavioral Health- Outpatient Physician's office	$25.00	Deductible + 20%		**$20.00**
Behavioral Health – All other services	$25.00	Deductible + 20%		**$0**
Surgical Removal of Impacted Wisdom Teeth	$35.00 + $35.00	$35.00 + $35.00 subject to U&C		Covered Under Dental Plan
RX-Tier 1(Retail)	$20.00	$20.00		$20.00
RX-Tier 2(Retail)	$35.00	$35.00		$35.00
RX-Tier 3(Retail)	$55.00	$55.00		$55.00
RX-Tier 1 (Mail)	$40.00	$40.00		$40.00
RX-Tier 2 (Mail)	$70.00	$70.00		$70.00
RX-Tier 3 (Mail)	$110.00	$110.00		$110.00

Out of Network Deductible and Co-Insurance Remains the Same ($2,000/$4,000 and 60% Plan/40% Member)