

**The George Washington University
Benefit Comparison Chart-Medical Insurance Plans
Effective January 1, 2009**

Plan Provisions	CareFirst BCBS PPO		CIGNA HMO		CIGNA POS	
	In-Network	Out-of-Network	In-Network	Out-of-Network	In-Network	Out-of-Network
Basic Plan Design	<p>The Preferred Provider option offers a wide selection of providers within your community. This option requires that you pay a deductible after which you are reimbursed 80% of in-network plan allowance (70% for out-of-network) for most medical expenses. Participating providers must be used to receive the highest level of reimbursement. However, you do not need a Primary Care Physician or referrals to specialists. If you do not use a provider within the network, then you will receive a lower level of reimbursement.</p> <p>Please note that pre-approval is required for all hospitalizations, hospice, surgery, and certain other services including diagnostic tests. If you are uncertain of whether pre-approval is required, please check with the carrier before obtaining services.</p>		<p>The CIGNA HMO provides you with health coverage that requires a copay for most eligible medical services. However, in order to receive coverage you must use participating providers unless you have a serious emergency. The HMO requires that your health care be provided either by your Primary Care Physician or by his/her referral to another provider in the network.</p> <p>Please note that pre-approval is required for all hospitalizations, hospice, surgery, and certain other services including diagnostic tests. If you are uncertain of whether pre-approval is required, please check with the carrier before obtaining services.</p>		<p>The CIGNA POS plan is similar to the PPO Plan in that it allows both in-network and out of network benefits. In order to receive the highest level of benefits you must receive your care from your Primary Care Physician or from another participating provider with a referral from your PCP. If you do not use your PCP or you see a specialist without a referral, you are still eligible for reimbursement under the out-of-network portion of the plan</p> <p>Please note that pre-approval is required for all hospitalizations, hospice, surgery, and certain other services including diagnostic tests. If you are uncertain of whether pre-approval is required, please check with the carrier before obtaining services.</p>	
Eligible Dependents	<p>Spouse or same sex Domestic Partner Unmarried dependent children to age 19 or 26 if full-time students; disabled children.. Child or children includes your: unmarried natural or adopted children; stepchildren who reside with you; your same sex Domestic Partner's children who reside with you; and children for whom you are legal guardian</p>		<p>Spouse or same sex Domestic Partner Unmarried dependent children to age 19 or 26 if full-time students; handicapped children of any age. Child or children includes your: unmarried natural or adopted children; stepchildren who reside with you; your same sex DP's children who reside with you; and children for whom you are legal guardian</p>		<p>Spouse or same sex Domestic Partner Unmarried dependent children to age 19 or 26 if full-time students; handicapped children of any age. Child or children includes your: unmarried natural or adopted children; stepchildren who reside with you; your same sex DP's children who reside with you; and children for whom you are legal guardian</p>	
Deductible (exclusive of separate Rx deductible)	\$750 per person Maximum of 2 deductibles per family.	\$750 per person Maximum of 2 deductibles per family.	No deductible	N/A	\$300 per person Maximum of 2 deductibles per family	\$750 per person Maximum of 2 deductibles per family

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Co-Insurance	After deductible: 80% of Allowed Benefit up to the out-of-pocket maximum of \$3,000 then 100% of the remaining balance of the allowed benefit for the calendar year. In and out-of-network expenses combined.	After deductible: 70% of Allowed Benefit up to the out-of-pocket maximum of \$3,000 then 100% of the remaining balance of the allowed benefit for the calendar year. In and out-of-network expenses combined.	Plan pays 100% after copay unless otherwise noted.	Plan pays 0%	100% for all benefits other than, Inpatient Hospital Facility, Outpatient Hospital Facility, Skilled Nursing Facility, Rehabilitation Hospital, Sub-Acute Facilities, Inpatient Hospice, Inpatient Hospital Doctor's Visits/Consultations, Inpatient Professional Charges, Hospice Bereavement Counseling, Ambulance, Global Maternity Fee and Inpatient MH/SA benefits. For those services listed above, after deductible: 90% of eligible charges up to the out-of-pocket maximum of, \$2,500 individual / \$5,000 family, then 100% for the balance for the calendar year	After deductible: 70% of eligible charges up to the out-of-pocket maximum of, \$5,000 individual / \$10,000 family, then 100% for the balance for the calendar year .
In-patient Hospitalization	After annual deductible and a \$200 per admission deductible, (the \$200.00 deductible does not apply to the out of pocket maximum): 80% of Allowed Benefit. 365 days/confinement	After annual deductible and a \$200 per admission deductible, (the \$200.00 deductible does not apply to the out of pocket maximum): 70% of Allowed Benefit. 365 days/confinement	100% of eligible charges after a \$200 per admission copay.	Plan pays 0%	After deductible: 90% after \$150 per day copay; maximum of 5 days per admission	After deductible: 70% of eligible charges. Pre-certification required.

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Other in-hospital charges	After deductible, 80% of Allowed Benefit	After deductible 70% of Allowed Benefit	100% of eligible charges after a \$200 per admission copay.	Plan pays 0%	After deductible: 90% of eligible charges.	After deductible: 70% of eligible charges.
Surgery	After deductible, 80% of Allowed Benefit	After deductible 70% of Allowed Benefit	100% of eligible charges after \$200 copay.	Plan pays 0%	After deductible: 90% of eligible charges.	After deductible: 70% of eligible charges.
In-hospital physician	After deductible, 80% of Allowed Benefit	After deductible 70% of Allowed Benefit	100% of eligible charges after a \$200 per admission copay.	Plan pays 0%	After deductible: 90% of eligible charges.	After deductible: 70% of eligible charges.
Outpatient X-ray and Lab	After deductible, 80% of Allowed Benefit	After deductible 70% of Allowed Benefit	100% of eligible charges after a \$100 per admission copay.	Plan Pays 0%	After deductible: 90% of eligible charges after a \$100 per admission copay.	After deductible: 70% of eligible charges.
Approved ER	After deductible, 80% of Allowed Benefit	After deductible 70% of Allowed Benefit	\$100 copay, waived if admitted. \$50 copay, waived if admitted for Urgent Care	Plan pays 0% unless there is a life threatening emergency.	\$100 copay, waived if admitted. \$50 co-pay, waived if admitted for Urgent Care.	\$100 copay, waived if admitted. \$50 co-pay, waived if admitted for Urgent Care.
Ambulance	After deductible, 80% of Allowed Benefit	After deductible 70% of Allowed Benefit	100% of eligible charges in an approved medical emergency. No copay.	0% unless there is a life threatening emergency.	90% of eligible charges in a medical emergency.	90% of eligible charges in a medical emergency.
GYN visits	After deductible, 80% of Allowed Benefit	After deductible 70% of Allowed Benefit	\$15 or \$25 copay per office.	0%	\$20 or \$30 co-pay per visit.	After deductible: 70% of eligible charges.
Maternity Care	Maternity (office visit): \$25 copay per visit Maternity Care (professional care ex. prenatal care, delivery, post natal care): After deductible, 80% of Allowed Benefit	After deductible 70% of Allowed Benefit	\$15 or \$25 copay for initial visit. Subsequent visits and delivery, after \$200 copay, 100% of eligible charges.	0%	\$20 or \$30 copay for initial visit. Subsequent visits and delivery, after deductible: 90% after \$150 per day copay; maximum of 5 days per admission.	After deductible: 70% of eligible charges
Well child care	100% of Allowed Benefit	70% of Allowed Benefit	\$15 or \$25 copay per office visit.	0%	\$20 or \$30 copay per office visit.	After deductible: 70% of eligible charges

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Preventive mammography	100% of Allowed Benefit for one preventative mammogram per calendar year for age 40 and over	100% of Allowed Benefit for one preventative mammogram per calendar year for age 40 and over	100% of eligible charges for one preventative mammogram per calendar year. \$15 or \$25 copay per office visit for associated wellness exam..	0%	100% of eligible charges for one preventative mammogram per calendar year . \$20 or \$30 copay per office visit for associated wellness exam.	70% of eligible charges for one preventative mammogram per calendar year.
Pap test	100% of Allowed Benefit	100% of Allowed Benefit	100% of eligible charges. \$15 or \$25 copay per office visit for associated wellness exam	0%	100% of eligible charges. \$20 or \$30 copay per office visit for associated wellness exam.	After deductible: 70% of eligible charges.
Prostate Exam	100% of Allowed Benefit	100% of Allowed Benefit	100% of eligible charges. \$15 or \$25 copay per office visit for associated wellness exam	0%	100% of eligible charges. \$20 or \$30 copay per office visit for associated wellness exam.	After deductible: 70% of eligible charges.
Routine office visit and lab	\$25 copay per office visit. After deductible, 80% of Allowed Benefit for lab	After deductible 70% of Allowed Benefit	\$15 or \$25 copay for office visit. 100% of eligible charges for lab	0%	\$20 or \$30 co-pay for office visit. 100% of eligible charges for lab.	After deductible: 70% of eligible charges.
Office visit with diagnosis	\$25 copay per office visit	After deductible 70% of Allowed Benefit	\$15 co-pay for office visit. \$25 co-pay for specialty office visit.	0%	\$20 or \$30 co-pay for office visit. 100% of eligible charges for lab.	After deductible: 70% of eligible charges.
Chiropractic visits	\$25 copay per office visit	After deductible 70% of Allowed Benefit	\$25 copay per office visit. Maximum of 60 visits per calendar year.	0%	\$30 copay per office visit. limit 60 visits per calendar year	After deductible: 70% of eligible charges. Limit 60 visits per calendar year
Home Health Care	After deductible, 80% of Allowed Benefit	After deductible 70% of Allowed Benefit	100% of eligible charges. 16 hour maximum per day. Must be pre-approved.	0%	100% of eligible charges. 16 hour maximum per day.	After deductible, 70% of eligible charges. 16 hour maximum per day.
Hospice	After deductible, 80% of Allowed Benefit. Maximum lifetime benefit is 180 days.	After deductible 70% of Allowed Benefit. Maximum lifetime benefit is 180 days.	100% of eligible charges.	0%	After deductible: 90% of eligible charges.	After deductible: 70% of eligible charges.

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Mental Health (MH) / Substance Abuse (SA) In-patient	After annual deductible and a \$200 per admission deductible, which does not apply to the out of pocket maximum: 80% of Allowed Benefit. Must be pre-authorized.	MH: After annual deductible and a \$200 per admission deductible, which does not apply to the out of pocket maximum, 70% of Allowed Benefit (maximum 30 days per calendar year. Must be pre authorized. SA: After annual deductible and a \$200 per admission deductible, which does not apply to the out of pocket maximum: 70% of Allowed Benefit to a maximum of \$250 per day (maximum 30 days or \$5,000 per calendar year. Must be pre-authorized.	After a \$200 per admission copay, 100% of eligible charges. Unlimited days. Must be pre-authorized.	0%	90% after \$150 per day copay; maximum of 5 days per admission. After deductible: unlimited days. Must be pre-authorized.	After deductible: 50% of eligible expenses. Unlimited days. Must be pre-authorized
Mental Health (MH) / Substance Abuse (SA) Out-patient	\$25 copay per office visit	After annual deductible 70% of Allowed Benefit.	\$25 copay per visit. Must be pre-authorized. Unlimited days	0%	\$30 copay for specialty office visit. Unlimited days Must be pre-authorized.	After deductible: 70% of eligible charges. Unlimited days.
Vision	Some discounted services	N/A	Some discounted services	N/A	Some discounted services	N/A
Lifetime Maximum	Unlimited	Unlimited	Unlimited		Unlimited	Unlimited

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Prescription Drug Coverage

Prescription drug coverage is provided by Caremark , regardless of your medical plan option. In order to receive reimbursement, you must use a Caremark participating pharmacy and show your ID card. If you have had a prescription filled prior to receiving your card or had an emergency situation, claim forms are available in the Employee Benefits Department or online at gwu.edu/~hrs/forms.

If you have waived medical coverage through GW , then you are not eligible for prescription coverage.

Plan Provision	Retail	Mail Order
Deductible	\$100 per person per calendar year (combined retail and mail order). Generics do not apply.	\$100 per person per calendar year (combined retail and mail order). Generics do not apply.
Maximum supply per order	30 days	90 days
Generic Drug Co-pay	\$5	\$10
Preferred Brand Co-pay	\$20	\$40
Non-preferred Brand Co-pay	\$30	\$60
Vacation Exception	Additional 30-day supply one time per year	N/A

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