Medical—Field Employee

Plan Name	Gold PPO Plan	Silver PPO Plan	Consumer Value HDHP/HSA
	You Pay	*You Pay*	*You Pay*
Preventative Care	Covered in full	Covered in full	Covered in full
Doctor's Office Visits	Copay only	Copay only	Copay begins *after* deductible is met
Prescription Drug Coverage—Retail	$20 / $60 / $120	$20 / $60 / $120	$20 / $60 / $120 *after* deductible is met
Virtual Care *(online medical visit)*	Covered in full	Covered in full	$49 copay *after* deductible is met
Urgent Care	Copay only	Copay only	$50 copay *after* deductible is met
Emergency Room Care	$250 copay, **then** deductible	$250 copay, **then** deductible	$250 copay *after* deductible is met
Hospitalization	0% after deductible	0% after deductible	0% *after* deductible
Annual Deductible*	$3,000	$6,000	$3,500 single** $7,000 family**
Out of Pocket*	$6,850	$6,850	$4,500**
Annual Out-of-Pocket Limit	$6,850	$6,850	$9,000
Flagger Force HSA Contribution	N/A	N/A	$250 [1]

*Benefits illustrated above are for in-network services using Capital Blue Cross providers. Services incurred out-of-network are covered at a lower benefit schedule and are subject to balance billing above the Cigna allowed amount.

**Aggregate: All eligible family members contribute towards the family limit before the plan begins to pay.

[1] Employee must elect to contribute at least $100 to their Health Savings Account (HSA) per year to receive Flagger Force HSA contribution.

Field Employee Contributions

Coverage Tier	Your GOLD PPO PLAN Contribution Per Pay	Your SILVER PPO PLAN Contribution Per Pay	Your CONSUMER VALUE HDHP/HSA PLAN Contribution Per Pay*
Employee Only	$36.24	$30.77	$28.19
Employee + Spouse	$157.81	$137.88	$126.35
Employee + Child	$118.58	$102.91	$94.30
Employee + Children	$158.22	$138.87	$127.26
Employee + Family	$198.35	$149.87	$137.34

*Consumer Value HDHP Contribution amount does not include individual HSA contributions.

Dental—Field Employee

Plan Name	Base PPO Plan	Buy-Up PPO Plan
	You Pay	*You Pay*
Preventative	Covered in full	Covered in full
Basic	20% after deductible	20% after deductible
Major	Not covered	70% after deductible
Orthodontia	Not covered	70% after deductible
Deductible*	$50/person $150/family	$50/person $150/family
Annual Maximum Benefit*	$1,500/person	$1,500/person

*PPO benefits illustrated above are for in-network services using Guardian preferred providers. Services incurred out-of-network are covered at lower coinsurance levels and are subject to balance billing above the Guardian allowed amount.

Field Employee Contributions

Coverage Tier	Your Base Dental Contribution Per Pay	Your Buy-Up Dental Contribution Per Pay
Employee Only	$1.47	$3.23
Employee + Spouse	$2.94	$6.47
Employee + Child	$2.47	$5.44
Employee + Children	$2.47	$5.44
Employee + Family	$3.94	$8.66

*Consumer Value HDHP Contribution amount does not include individual HSA contributions

Vision—Field Employee

Plan Name	12/10 Plus Plan
	You Pay
Eye Exam*	Every 12 months: $10 copay
Lenses*	Every 12 months: 100% covered
Frames*	Every 12 months: $100 allowance
Contact Lenses*	Every 12 months: $100 allowance

*Benefits illustrated above are for in-network services using Capital Blue Cross providers. Services incurred out-of-network are reimbursed directly to the member at lower, specified rates.

Field Employee Contributions

Coverage Tier	Your Vision Contribution Per Pay
Employee Only	$0.21
Employee + Spouse	$0.61
Employee + Child	$0.61
Employee + Children	$0.61
Employee + Family	$0.61

*Consumer Value HDHP Contribution amount does not include individual HSA contributions