

# Medical—Office Employee

Plan Name	Gold PPO Plan	Silver PPO Plan	Consumer Value HDHP/HSA
	<i>You Pay</i>	<i>You Pay</i>	<i>You Pay</i>
Preventative Care	Covered in full	Covered in full	Covered in full
Doctor's Office Visits	Copay only	Copay only	Copays begin <i>after</i> deductible is met
Prescription Drug Coverage—Retail	\$20 / \$60 / \$120	\$20 / \$60 / \$120	\$20 / \$60 / \$120 <i>after</i> deductible is met
Virtual Care ( <i>online medical visit</i> )	Covered in full	Covered in full	\$49 copay <i>after</i> deductible is met
Urgent Care	Copay only	Copay only	\$50 copay <i>after</i> deductible is met
Emergency Room Care	\$250 copay, then deductible	\$250 copay, then deductible	\$250 copay <i>after</i> deductible is met
Hospitalization	0% after deductible	0% after deductible	0% <i>after</i> 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 Annual Contribution	N/A	N/A	\$250 <sup>1</sup>

\*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.

<sup>1</sup> Employee must elect to contribute at least \$100 to their Health Savings Account (HSA) per year to receive Flagger Force HSA contribution.

## Office 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	\$43.50	\$37.13	\$34.02
Employee + Spouse	\$97.61	\$84.46	\$77.40
Employee + Child	\$73.36	\$62.83	\$57.58
Employee + Children	\$98.65	\$84.46	\$77.41
Employee + Family	\$122.68	\$106.09	\$97.21

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

# Dental—Office Employee

Plan Name	Base PPO Plan	Buy-Up PPO Plan
	<i>You Pay</i>	<i>You Pay</i>
Preventative	Covered in full	Covered in full
Basic	20% after deductible	20% after deductible
Major	Not covered	70% after deductible
Orthodontia	Not covered	50%, \$1,500 lifetime max per person
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.

## Office 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-Office Employee

Plan Name	12/10 Plus Plan
	<i>You Pay</i>
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.

## Office 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