

# Premier PPO™ - Platinum 1.1

PPO plan | Cigna PPO network

Monthly premiums and member cost sharing at a glance

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| DEDUCTIBLE     |                | OUT-OF-POCKET MAXIMUM |                |
|----------------|----------------|-----------------------|----------------|
| INDIVIDUAL     |                | INDIVIDUAL            |                |
| <b>\$1,250</b> | <b>\$2,500</b> | <b>\$1,250</b>        | <b>\$3,750</b> |
| IN NETWORK     | OUT OF NETWORK | IN NETWORK            | OUT OF NETWORK |
| FAMILY         |                | FAMILY                |                |
| <b>\$2,500</b> | <b>\$5,000</b> | <b>\$2,500</b>        | <b>\$7,500</b> |
| IN NETWORK     | OUT OF NETWORK | IN NETWORK            | OUT OF NETWORK |

## Monthly premiums

Standard plan rates before any employer contribution

| EMPLOYEE ONLY   | EMPLOYEE + SPOUSE | EMPLOYEE + CHILDREN | EMPLOYEE + FAMILY |
|-----------------|-------------------|---------------------|-------------------|
| <b>\$799.53</b> | <b>\$1,384.11</b> | <b>\$1,319.15</b>   | <b>\$2,851.85</b> |

## What you pay for covered care

Unless noted, amounts below are after the applicable deductible

| OFFICE AND URGENT CARE                     |                  | FACILITY AND OTHER CARE                  |                 | PRESCRIPTION DRUGS                 |                     |
|--------------------------------------------|------------------|------------------------------------------|-----------------|------------------------------------|---------------------|
| <b>Preventive care</b>                     | <b>\$0</b>       | <b>Diagnostic tests</b>                  | <b>0%</b>       | <b>Generic</b>                     | <b>\$0</b>          |
| In network; deductible waived              |                  | Office-visit labs included in copay      |                 | Retail and mail; deductible waived |                     |
| <b>Primary care</b>                        | <b>\$25</b>      | <b>Advanced imaging</b>                  | <b>0%</b>       | <b>Preferred brand</b>             | <b>\$35 / \$105</b> |
| Copay; deductible waived                   |                  | CT, PET and MRI                          |                 | Retail / mail; deductible waived   |                     |
| <b>Specialist</b>                          | <b>\$45</b>      | <b>Outpatient surgery</b>                | <b>0%</b>       | <b>Non-preferred brand</b>         | <b>\$75 / \$225</b> |
| Copay; deductible waived                   |                  | Facility and physician services          |                 | Retail / mail; deductible waived   |                     |
| <b>Urgent care</b>                         | <b>\$45</b>      | <b>Hospital care</b>                     | <b>0%</b>       | <b>Specialty</b>                   | <b>\$200</b>        |
| Copay; deductible waived                   |                  | Facility and physician services          |                 | PBM rules apply; deductible waived |                     |
| <b>Emergency care</b>                      | <b>\$300</b>     | <b>Maternity care</b>                    | <b>\$0 / 0%</b> | <b>Pediatric eye exam</b>          | <b>\$0</b>          |
| ER copay; deductible waived; transport \$0 |                  | Office visits / delivery services        |                 | In network; one exam per year      |                     |
| <b>Mental health</b>                       | <b>\$25 / 0%</b> | <b>Recovery services</b>                 | <b>0%</b>       | <b>Chiropractic care</b>           | <b>Covered</b>      |
| Office copay (ded. waived) / other care    |                  | Home health, rehab, SNF, DME and hospice |                 | Up to 25 visits per plan year      |                     |