

# Premier PPO™ - Silver 3.2

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>\$3,000</b> | <b>\$6,000</b>  | <b>\$6,000</b>        | <b>\$12,000</b> |
| IN NETWORK     | OUT OF NETWORK  | IN NETWORK            | OUT OF NETWORK  |
| FAMILY         |                 | FAMILY                |                 |
| <b>\$6,000</b> | <b>\$12,000</b> | <b>\$12,000</b>       | <b>\$24,000</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>\$708.04</b> | <b>\$1,210.28</b> | <b>\$1,154.47</b>   | <b>\$2,305.55</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><br>In network; deductible waived                | <b>Diagnostic tests</b> <b>20%</b><br>Office-visit labs included in copay       | <b>Generic</b> <b>\$0</b><br>Retail and mail; deductible waived                    |
| <b>Primary care</b> <b>\$35</b><br>Copay; deductible waived                       | <b>Advanced imaging</b> <b>20%</b><br>CT, PET and MRI                           | <b>Preferred brand</b> <b>\$35 / \$105</b><br>Retail / mail; deductible waived     |
| <b>Specialist</b> <b>\$55</b><br>Copay; deductible waived                         | <b>Outpatient surgery</b> <b>20%</b><br>Facility and physician services         | <b>Non-preferred brand</b> <b>\$75 / \$225</b><br>Retail / mail; deductible waived |
| <b>Urgent care</b> <b>\$55</b><br>Copay; deductible waived                        | <b>Hospital care</b> <b>20%</b><br>Facility and physician services              | <b>Specialty</b> <b>\$200</b><br>PBM rules apply; deductible waived                |
| <b>Emergency care</b> <b>\$500</b><br>ER copay; deductible waived; transport \$0  | <b>Maternity care</b> <b>\$0 / 20%</b><br>Office visits / delivery services     | <b>Pediatric eye exam</b> <b>\$0</b><br>In network; one exam per year              |
| <b>Mental health</b> <b>\$35 / 20%</b><br>Office copay (ded. waived) / other care | <b>Recovery services</b> <b>20%</b><br>Home health, rehab, SNF, DME and hospice | <b>Chiropractic care</b> <b>Covered</b><br>Up to 25 visits per plan year           |