Summary of In-Network Medical Coverage

	Cigna Traditional PPO In-Network (**embedded deductible – see pg 8)	Cigna Core HRA (Health Reimbursement Account) Plan In-Network (**embedded deductible – see pg 8)
Individual Deductible	$950	$2,500
Family Deductible	$1,900	$5,000
Coinsurance (the amount paid by the Plan)	80% after Deductible	80% after Deductible
Individual Maximum Out-of-Pocket	$3,500	$5,000
Family Maximum Out-of-Pocket	$7,000	$10,000
Primary Care Physician Office Visits	$25 Co-Pay (No Deductible)	$25 Co-Pay (No Deductible)
Specialist Physician Office Visits	$50 Co-Pay (No Deductible)	$50 Co-Pay (No Deductible)
Preventative Care Pediatric (Well Baby Care and Immunizations)	100% (No Co-Pay or Deductible)	100% (No Deductible)
Preventative Care Adult (Routine Physical Exams, Immunizations, and Routine Gynecological Exam, including a PAP test)	100% (No Co-Pay or Deductible)	100% (No Co-Pay or Deductible)
MDLive/Cigna Telehealth for Urgent Care, Primary Care, and Specialist Visits (e.g. dermatology)	100% (No Co-Pay or Deductible)	100% (No Co-Pay or Deductible)
MDLive/Cigna Telehealth for Mental/Behavioral Health	100% (No Co-Pay or Deductible)	100% (No Co-Pay or Deductible)
Emergency Room Service (Co-Pay waived if admitted)	80% after $250 Co-Pay (Deductible does not apply)	80% after $250 Co-Pay (Deductible does not apply)
Hospital Expenses (Inpatient)	80% after Deductible	80% after Deductible
Hospital Expenses (Outpatient)	80% after Deductible	80% after Deductible
Medical/Surgical Expenses (Except Office Visits)	80% after Deductible	80% after Deductible
Maternity (Facility and Professional Services)	80% after Deductible	80% after Deductible
Infertility Counseling, Testing, and Treatment through PROGYNY	80% after Deductible	80% after Deductible
Assisted Fertilization Procedures	80% after Deductible All fertility management counseling, testing, treatment and procedures are to be accessed with PROGYNY	80% after Deductible All fertility management counseling, testing, treatment and procedures are to be accessed with PROGYNY
Spinal Manipulations (Chiropractic Care)	$50 Co-Pay (No Deductible) (Limited to 50 days per Benefit Period)	$50 Co-Pay (No Deductible) (Limited to 50 days per Benefit Period)
Diagnostic Services (All Laboratory, X-Ray, and Diagnostic Tests)	80% after Deductible	80% after Deductible
Physical, Speech, and Occupational Therapy	$50 Co-Pay (No Deductible) (Limited to 120 days per Therapy)	$50 Co-Pay (No Deductible) (Limited to 120 days per Therapy)
Allergy Extracts and Injections	80% after Deductible	80% after Deductible
Mental Health (Inpatient)	80% after Deductible	80% after Deductible
Mental Health (Outpatient)	$25 Co-Pay (No Deductible)	$25 Co-Pay (No Deductible)
Substance Abuse (Inpatient)	80% after Deductible	80% after Deductible
Substance Abuse (Outpatient)	$25 Co-Pay (No Deductible)	$25 Co-Pay (No Deductible)
Express Scripts Prescription Drug Non-Specialty Retail 30-day Supply (included with your medical plan)	$10 – Generic $40 – Formulary $75 – Non-Formulary	$10 – Generic $40 – Formulary $75 – Non-Formulary
Express Scripts Prescription Drug Non-Specialty Mail Order, 90-day Supply	$20 – Generic $80 – Formulary $150 – Non-Formulary	$20 – Generic $80 – Formulary $150 – Non-Formulary
Specialty Retail Rx (30-day Supply) Specialty Mail Order Rx (30-day Supply)	10% up to $100 maximum – Generic 20% up to $250 maximum – Formulary 10% – Non-Formulary	10% up to $100 maximum – Generic 20% up to $250 maximum – Formulary 10% – Non-Formulary
FSA Eligible (see pages 39 – 41 for more information)	Yes, you can contribute up to $3,400 into an FSA each plan year	Yes, you can contribute up to $3,400 in an FSA each plan year
HSA or HRA Eligible (see pages 39 – 41 for more information)	No (You are not eligible for an HSA or HRA)	Yes – HRA only (DSG will contribute $500 for teammate only, $1,000 for all coverage tiers with dependents into your HRA each year you are enrolled. Continuous enrollment allows for rollover of funds to a maximum balance of $2,500/teammate only or $5,000/coverage tiers with dependents.)

COST PER PAY	YOU PAY	PLAN PAYS	YOU PAY	PLAN PAYS
Teammate	$97.00	$223.22	$51.00	$248.66
Teammate + Spouse	$225.00	$517.05	$97.00	$596.07
Teammate + Child(ren)	$169.00	$372.83	$82.00	$424.49
Family	$334.00	$579.30	$143.00	$707.01

Below is a comparison of all medical plan offering's plan designs in regards to "In-Network" benefits. **NOTE:** If you choose to get service from an out-of-network provider, the benefit levels will be significantly less or not covered at all. The deductibles and out-of-pocket maximums are also substantially higher for out-of-network services as well.

	Cigna Buy-up HSA (Health Savings Account) Plan In-Network (*non-embedded deductible – see pg 8)		Cigna Base HSA (Health Savings Account) Plan In-Network (**embedded deductible – see pg 8)	
Individual Deductible	$1,700		$3,500	
Family Deductible	$3,400		$7,000	
Coinsurance (the amount paid by the Plan)	80% after Deductible		80% after Deductible	
Individual Maximum Out-of-Pocket	$4,000		$7,000	
Family Maximum Out-of-Pocket	$8,000		$14,000	
Primary Care Physician Office Visits	$25 Co-Pay after Deductible		$25 Co-Pay after Deductible	
Specialist Physician Office Visits	$50 Co-Pay after Deductible		$50 Co-Pay after Deductible	
Preventative Care Pediatric (Well Baby Care and Immunizations)	100% (No Deductible)		100% (No Deductible)	
Preventative Care Adult (Routine Physical Exams, Immunizations, and Routine Gynecological Exam, including a PAP test)	100% (No Deductible)		100% (No Deductible)	
MDLive/Cigna Telehealth for Urgent Care, Primary Care, and Specialist Visits (e.g. dermatology)	100% after Deductible		100% after Deductible	
MDLive/Cigna Telehealth for Mental/Behavioral Health	100% after Deductible		100% after Deductible	
Emergency Room Service (Co-Pay waived if admitted)	80% after Deductible		80% after Deductible	
Hospital Expenses (Inpatient)	80% after Deductible		80% after Deductible	
Hospital Expenses (Outpatient)	80% after Deductible		80% after Deductible	
Medical/Surgical Expenses (Except Office Visits)	80% after Deductible		80% after Deductible	
Maternity (Facility and Professional Services)	80% after Deductible		80% after Deductible	
Infertility Counseling, Testing, and Treatment through PROGYNY	80% after Deductible		80% after Deductible	
Assisted Fertilization Procedures	80% after Deductible All fertility management counseling, testing, treatment and procedures are to be accessed with PROGYNY		80% after Deductible All fertility management counseling, testing, treatment and procedures are to be accessed with PROGYNY	
Spinal Manipulations (Chiropractic Care)	80% after Deductible (Limited to 50 days per Benefit Period)		80% after Deductible (Limited to 50 days per Benefit Period)	
Diagnostic Services (All Laboratory, X-Ray, and Diagnostic Tests)	80% after Deductible		80% after Deductible	
Physical, Speech, and Occupational Therapy	80% after Deductible (Limited to 120 days per Therapy)		80% after Deductible (Limited to 120 days per Therapy)	
Allergy Extracts and Injections	80% after Deductible		80% after Deductible	
Mental Health (Inpatient)	80% after Deductible		80% after Deductible	
Mental Health (Outpatient)	$25 Co-Pay after Deductible		$25 Co-Pay after Deductible	
Substance Abuse (Inpatient)	80% after Deductible		80% after Deductible	
Substance Abuse (Outpatient)	$25 Co-Pay after Deductible		$25 Co-Pay after Deductible	
Express Scripts Prescription Drug Non-Specialty Retail 30-day Supply (included with your medical plan)	Co-Pay structure AFTER deductible has been met. Then, Express Scripts Prescription Drug Non-Specialty Retail 30-day Supply (included with your medical plan) $10 – Generic $40 – Formulary $75 – Non-Formulary		Co-Pay structure AFTER deductible has been met. Then, Express Scripts Prescription Drug Non-Specialty Retail 30-day Supply (included with your medical plan) $10 – Generic $40 – Formulary $75 – Non-Formulary	
Express Scripts Prescription Drug Non-Specialty Mail Order, 90-day Supply	Co-Pay structure AFTER deductible has been met $20 – Generic $80 – Formulary $150 – Non-Formulary		Co-Pay structure AFTER deductible has been met $20 – Generic $80 – Formulary $150 – Non-Formulary	
Specialty Retail Rx (30-day Supply) Specialty Mail Order Rx (30-day Supply)	AFTER deductible has been met	10% up to $100 max – Generic 20% up to $250 max – Formulary 10% – Non-Formulary	AFTER deductible has been met	10% up to $100 max – Generic 20% up to $250 max – Formulary 10% – Non-Formulary
FSA Eligible (see pages 39 – 41 for more information)	No, you are not eligible to contribute to an FSA		No, you are not eligible to contribute to an FSA	
HSA or HRA Eligible (see pages 39 – 41 for more information)	Yes – HSA only (You can contribute up to $4,400 for teammate only and up to $8,750 for tiers of coverage including dependents. DSG will contribute $500 for teammate only and $1,000 for tiers of coverage with dependents.)		Yes – HSA only (You can contribute up to $4,400 for teammate only and up to $8,750 for tiers of coverage including dependents. DSG will contribute $250 for teammate only and $500 for tiers of coverage with dependents.)	
COST PER PAY	**YOU PAY**	**PLAN PAYS**	**YOU PAY**	**PLAN PAYS**
Teammate	$67.00	$237.88	$26.00	$241.78
Teammate + Spouse	$174.00	$532.11	$77.00	$543.43
Teammate + Child(ren)	$138.00	$377.54	$51.00	$401.01
Family	$190.00	$674.06	$102.00	$657.56

Summary of Out-of-Network Medical Coverage

	Cigna Traditional PPO Out-of-Network (**embedded deductible – see pg 8)	Cigna Core HRA (Health Reimbursement Account) Plan Out-of-Network (**embedded deductible – see pg 8)
Individual Deductible	$1,900	$5,000
Family Deductible	$3,800	$10,000
Coinsurance	60% after Deductible	60% after Deductible
Individual Maximum Out-of-Pocket	$7,000	$10,000
Family Maximum Out-of-Pocket	$14,000	$20,000
Primary Care Physician Office Visits	60% after Deductible	60% after Deductible
Specialist Physician Office Visits	60% after Deductible	60% after Deductible
Preventative Care Pediatric (Well Baby Care and Immunizations)	60% after Deductible (Routine Physical Exams not covered)	Routine Physical Exams: not covered Immunizations: 60% after Deductible
Preventative Care Adult (Routine Physical Exams, Immunizations, and Routine Gynecological Exam, including a PAP test)	60% after Deductible (Routine Physical Exams not covered)	60% after Deductible (Routine Physical Exams: not covered)
Telemedicine	Not Covered	Not Covered
Emergency Room Service (Co-Pay waived if admitted)	80% after $250 Co-Pay (Deductible does not apply)	80% after $250 Co-Pay (Deductible does not apply)
Hospital Expenses (Inpatient)	60% after Deductible	60% after Deductible
Hospital Expenses (Outpatient)	60% after Deductible	60% after Deductible
Medical/Surgical Expenses (Except Office Visits)	60% after Deductible	60% after Deductible
Maternity (Facility and Professional Services)	60% after Deductible	60% after Deductible
Infertility Counseling, Testing, and Treatment through PROGYNY	Not Covered	Not Covered
Assisted Fertilization Procedures	Not Covered All In-Network services are through PROGYNY	Not Covered All In-Network services are through PROGYNY
Spinal Manipulations (Chiropractic Care)	60% after Deductible (Limited to 50 days per Benefit Period)	60% after Deductible (Limited to 50 days per Benefit Period)
Diagnostic Services (All Laboratory, X-Ray, and Diagnostic Tests)	60% after Deductible	60% after Deductible
Physical, Speech, and Occupational Therapy	60% after Deductible (Limited to 120 days per Therapy)	60% after Deductible (Limited to 120 days per Therapy)
Allergy Extracts and Injections	60% after Deductible	60% after Deductible
Mental Health (Inpatient)	60% after Deductible	60% after Deductible
Mental Health (Outpatient)	60% after Deductible	60% after Deductible
Substance Abuse (Inpatient)	60% after Deductible	60% after Deductible
Substance Abuse (Outpatient)	60% after Deductible	60% after Deductible
Express Scripts Prescription Drug Program (included with your medical plan)	Not Covered	Not Covered
Express Scripts Prescription Drug Mandatory Mail Order	Not Covered	Not Covered
FSA Eligible (see pages 39 – 41 for more information)	Yes, you can contribute up to $3,400 into an FSA each plan year	Yes, you can contribute up to $3,400 in an FSA each plan year
HSA or HRA Eligible (see pages 39 – 41 for more information)	No (You are not eligible for an HSA or HRA)	Yes – HRA only (DSG will contribute $500 for teammate only, $1,000 for all coverage tiers with dependents into your HRA each year you are enrolled. Continuous enrollment allows for rollover of funds to a maximum balance of $2,500/teammate only or $5,000/coverage tiers with dependents.)

COST PER PAY	YOU PAY	PLAN PAYS	YOU PAY	PLAN PAYS
Teammate	$97.00	$223.22	$51.00	$248.66
Teammate + Spouse	$225.00	$517.05	$97.00	$596.07
Teammate + Child(ren)	$169.00	$372.83	$82.00	$424.49
Family	$334.00	$579.30	$143.00	$707.01

Below is a comparison of all medical plan offering's plan designs in regards to "Out-of-Network" benefits. **NOTE:** If you choose to get service from an out-of-network provider, the benefit levels will be significantly less or not covered at all. The deductibles and out-of-pocket maximums are also substantially higher for out-of-network services as well. For more details on in-network services, please refer to pages 12 – 13.

	Cigna Buy-up HSA (Health Savings Account) Plan Out-of-Network (**non-embedded deductible – see pg 8)	Cigna Base HSA (Health Savings Account) Plan Out-of-Network (**embedded deductible – see pg 8)
Individual Deductible	$3,400	$7,000
Family Deductible	$6,800	$14,000
Coinsurance	60% after Deductible	60% after Deductible
Individual Maximum Out-of-Pocket	$8,000	$14,000
Family Maximum Out-of-Pocket	$16,000	$28,000
Primary Care Physician Office Visits	60% after Deductible	60% after Deductible
Specialist Physician Office Visits	60% after Deductible	60% after Deductible
Preventative Care Pediatric (Well Baby Care and Immunizations)	Routine Physical Exams: not covered Immunizations: 60% (Deductible does not apply)	Routine Physical Exams: not covered Immunizations: 60% (Deductible does not apply)
Preventative Care Adult (Routine Physical Exams, Immunizations, and Routine Gynecological Exam, including a PAP test)	Routine Physical Exams: not covered Immunizations: 0% after Deductible Routine Gynecological Exam, including a PAP test: 60% (Deductible does not apply)	Routine Physical Exams: not covered Immunizations: 0% after Deductible Routine Gynecological Exam, including a PAP test: 60% (Deductible does not apply)
Telemedicine	Not Covered	Not Covered
Emergency Room Service (Co-Pay waived if admitted)	80% after Deductible	80% after Deductible
Hospital Expenses (Inpatient)	60% after Deductible	60% after Deductible
Hospital Expenses (Outpatient)	60% after Deductible	60% after Deductible
Medical/Surgical Expenses (Except Office Visits)	60% after Deductible	60% after Deductible
Maternity (Facility and Professional Services)	60% after Deductible	60% after Deductible
Infertility Counseling, Testing, and Treatment through PROGYNY	Not Covered	Not Covered
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Physical, Speech, and Occupational Therapy	60% after Deductible (Limited to 120 days per Therapy)	60% after Deductible (Limited to 120 days per Therapy)
Allergy Extracts and Injections	60% after Deductible	60% after Deductible
Mental Health (Inpatient)	60% after Deductible	60% after Deductible
Mental Health (Outpatient)	60% after Deductible	60% after Deductible
Substance Abuse (Inpatient)	60% after Deductible	60% after Deductible
Substance Abuse (Outpatient)	60% after Deductible	60% after Deductible
Express Scripts Prescription Drug Program (included with your medical plan)	Not Covered	Not Covered
Express Scripts Prescription Drug Mandatory Mail Order	Not Covered	Not Covered
FSA Eligible (see pages 39 – 41 for more information)	No, you are not eligible to contribute to an FSA	No, you are not eligible to contribute to an FSA
HSA or HRA Eligible (see pages 39 – 41 for more information)	Yes – HSA only (You can contribute up to $4,400 for teammate only and up to $8,750 for tiers of coverage including dependents. DSG will contribute $500 for teammate only and $1,000 for tiers of coverage with dependents.)	Yes – HSA only (You can contribute up to $4,400 for teammate only and up to $8,750 for tiers of coverage including dependents. DSG will contribute $250 for teammate only and $500 for tiers of coverage with dependents.)

COST PER PAY	YOU PAY	PLAN PAYS	YOU PAY	PLAN PAYS
Teammate	$67.00	$237.88	$26.00	$241.78
Teammate + Spouse	$174.00	$532.11	$77.00	$543.43
Teammate + Child(ren)	$138.00	$377.54	$51.00	$401.01
Family	$190.00	$674.06	$102.00	$657.56