

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	\$2,000	\$3,500
Family Deductible	\$4,000	\$7,000
Coinsurance (the amount paid by the Plan)	80% after Deductible	80% after Deductible
Individual Maximum Out-of-Pocket	\$4,500	\$6,000
Family Maximum Out-of-Pocket	\$9,000	\$12,000
Garner Reimbursement	\$2,000 individual / \$4,000 family	\$2,000 individual / \$4,000 family
Primary Care Physician Office Visits	\$25 Co-Pay (No Deductible)	\$35 Co-Pay (No Deductible)
Specialist Physician Office Visits	\$50 Co-Pay (No Deductible)	\$70 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 \$300 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)
Evernorth Express Scripts Prescription Drug Non-Specialty Retail 30-day Supply (included with your medical plan)	\$10 – Generic 30% (\$40 – \$170) 40% (\$65 – \$250)	\$10 – Generic 30% (\$40 – \$170) 40% (\$65 – \$250)
Evernorth Express Scripts Prescription Drug Non-Specialty Mail Order, 90-day Supply	3x 30-day supply	3x 30-day supply
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 and/or LPFSA Eligible (see pages 43 – 45 for more information)	Yes, specific to the Health Care FSA	Yes, specific to the Health Care FSA
HSA or HRA Eligible (see pages 43 – 45 for more information)	No (You are not eligible for an HSA or HRA)	Yes — HRA only (DSG will contribute \$250 for teammate only, \$500 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.)

Please see separate rate sheet for details on premium costs per pay.

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	\$1,750		\$3,500	
Family Deductible	\$3,500		\$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	
Garner Reimbursement	\$0 individual / \$0 family		\$0 individual / \$0 family	
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	
Evernorth Express Scripts Prescription Drug Non-Specialty Retail 30-day Supply (included with your medical plan)	Co-Pay structure AFTER deductible has been met. Then, Evernorth Express Scripts Prescription Drug Non-Specialty Retail 30-day Supply (included with your medical plan) \$10 – Generic 30% (\$40 – \$170) 40% (\$65 – \$250)		Co-Pay structure AFTER deductible has been met. Then, Evernorth Express Scripts Prescription Drug Non- Specialty Retail 30-day Supply (included with your medical plan) \$10 – Generic 30% (\$40 – \$170) 40% (\$65 – \$250)	
Evernorth Express Scripts Prescription Drug Non-Specialty Mail Order, 90-day Supply	Co-Pay structure AFTER deductible has been met 3x 30-day supply		Co-Pay structure AFTER deductible has been met 3x 30-day supply	
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 and/or LPFSA Eligible (see pages 43 – 45 for more information)	Yes, specific to the Limited Purpose FSA		Yes, specific to the Limited Purpose FSA	
HSA or HRA Eligible (see pages 43 – 45 for more information)	Yes — HSA only (You can contribute up to \$4,500 for teammate only and up to \$9,000 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 \$4,500 for teammate only and up to \$9,000 for tiers of coverage including dependents.)	

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	\$4,000	\$7,000
Family Deductible	\$8,000	\$14,000
Coinsurance	60% after Deductible	60% after Deductible
Individual Maximum Out-of-Pocket	\$9,000	\$12,000
Family Maximum Out-of-Pocket	\$18,000	\$24,000
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 \$300 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
Evernorth Express Scripts Prescription Drug Program (included with your medical plan)	Not Covered	Not Covered
Evernorth Express Scripts Prescription Drug Mail Order	Not Covered	Not Covered
FSA and/or LPFSA Eligible (see pages 43 – 45 for more information)	Yes, specific to the Health Care FSA	Yes, specific to the Health Care FSA
HSA or HRA Eligible (see pages 43 – 45 for more information)	No (You are not eligible for an HSA or HRA)	Yes — HRA only (DSG will contribute \$250 for teammate only, \$500 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.)

Please see separate rate sheet for details on premium costs per pay.

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 14 – 15](#).

	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	\$3,500	\$7,000
Family Deductible	\$7,000	\$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
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
Evernorth Express Scripts Prescription Drug Program (included with your medical plan)	Not Covered	Not Covered
Evernorth Express Scripts Prescription Drug Mail Order	Not Covered	Not Covered
FSA and/or LPFSA Eligible (see pages 43 – 45 for more information)	Yes, specific to the Limited Purpose FSA	Yes, specific to the Limited Purpose FSA
HSA or HRA Eligible (see pages 43 – 45 for more information)	Yes — HSA only (You can contribute up to \$4,500 for teammate only and up to \$9,000 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 \$4,500 for teammate only and up to \$9,000 for tiers of coverage including dependents.)