2020 EMPLOYEE BI-WEEKLY RATES

HEALTH INSURANCE

	Open Access Plus (OAP) Plan/ HMO with Cigna Healthcare	PPO Base Plan administered by United Healthcare	PPO Premier Plan administered by United Healthcare
Employee only	$32.44	$50.71	$80.52
Employee and Spouse	$66.91	$123.63	$186.77
Employee and Child(ren)	$59.92	$114.90	$174.36
Employee and Family	$119.42	$173.31	$261.82

GAP (GAP CAN ONLY BE USED WITH HMO PLAN)

	Basic GAP Plan through American Public Life with HMO Plan		Advanced GAP Plan through American Public Life with HMO Plan	
	Ages 18-54	Ages 55+	Ages 18-54	Ages 55+
Employee only	$8.79	$16.74	$27.39	$41.08
Employee and Spouse	$18.96	$33.52	$49.30	$67.10
Employee and Child(ren)	$21.38	$29.46	$53.41	$73.94
Employee and Family	$34.32	$48.89	$75.32	$99.97

DENTAL AND VISION

	Dental DHMO Base Plan with Cigna Healthcare	Dental DHMO Premier Plan with Cigna Healthcare	Dental PPO Plan with Cigna Healthcare	Vision with Cigna Healthcare
Employee only	$6.46	$9.02	$19.33	$3.02
Employee and Spouse	$11.37	$16.99	$36.40	$6.03
Employee and Child(ren)	$11.27	$17.06	$36.55	$6.09
Employee and Family	$16.68	$26.70	$57.23	$9.72

2020 MEDICAL PLAN SUMMARIES

	CIGNA	UNITED HEALTHCARE	
	OPEN ACCESS PLUS Option OAP/ HMO	BASE Option PPO	PREMIER Option PPO
	In-Network	In-Network	In-Network
CALENDAR YEAR DED. (CYD):			
Individual:	$6,000	$1,500 In / $3,000 Out-of-Network	$750 In / $1,250 Out-of-Network
Family:	$12,000	$4,500 In / $9,000 Out-of-Network	$1,500 In / $3,750 Out-of-Network
COINSURANCE (COINS)	30%	20% in-network / 40% out of network	10% in-network / 30% out of network
PRIMARY PHYSICIAN VISIT (PCP)	$10 co-pay	$25 co-pay	$25 co-pay
SPECIALIST VISIT	$60 co-pay	$50 co-pay	$50 co-pay
PCP REFERRAL REQUIRED	NO	NO	NO
VIRTUAL VISITS (E-VISITS)	$10 co-pay	$5 co-pay	$5 co-pay
IN-PATIENT HOSPITAL SERVICES	30% AFTER CYD	20% AFTER CYD	10% AFTER CYD
OUT-PATIENT SURGERY			
Hospital :	30% AFTER CYD	20% AFTER CYD	10% AFTER CYD
Freestanding Facility:	$350 co-pay	20% AFTER CYD	10% AFTER CYD
MAJOR DIAGNOSTIC/COMPLEX IMAGING	$75 co-pay	20% AFTER CYD	10% AFTER CYD
EMERGENCY ROOM	$350 co-pay	$250 co-pay	$250 co-pay
URGENT CARE	$50 co-pay	$50 co-pay	$50 co-pay
PRESCRIPTION DRUG (RX): 30 DAYS			
Preferred Tier 1:	$0 / $10 co-pay	$10 co-pay	$10 co-pay
Preferred Tier 2:	$50 co-pay	$30 co-pay	$30 co-pay
Preferred Tier 3:	$75 co-pay	$50 co-pay	$50 co-pay
Preferred Tier 4:	20%	20%	20%
RX DRUG DEDUCTIBLE	NONE	$25	$25
OUT-OF-POCKET:	Includes CYD, Coins, & Copays	Includes CYD, Coins, & Copays	Includes CYD, Coins, & Copays
Individual:	$7,900	$5,000 In / $10,000 Out-of-Network	$4,000 In / $8,000 Out-of-Network
Family:	$15,800	$15,000 In / $30,000 Out-of-Network	$12,000 In / $24,000 Out-of-Network
LIFETIME MAXIMUM	Unlimited	Unlimited	Unlimited

2020 GAP PLAN OPTIONS

American Public Life

	Basic GAP Plan		Advanced GAP Plan
In Hospital Policy:	**Plan 1**		**Plan 2**
Max In-Hospital Benefits	$7,900 per person per CY* Max $15,800 per family per CY*		$7,900 per person per CY* Max $15,800 per family per CY*
In-Hospital Ambulance Benefits	Up to $7,900 per ground transport Up to $7,900 per air transport Limited to one trip per CY confined as an inpatient*		Up to $7900 per ground transport Up to $7,900 per air transport Limited to one trip per CY confined as an inpatient*
Outpatient Policy:			
Max Outpatient Benefits	$250 per covered person per CY*		$7900 per covered person per CY*
Outpatient Ambulance Benefit	Up to $250 per ground trip Up to $250 per air transport Limited to one trip per CY* residing less than 18 hrs*		Up to $7,900 per ground trip Up to $7,900 per air transport Limited to one trip per CY* residing less than 18 hrs*
Optional Benefit Riders:			
Physician or Specialty Outpatient Treatment	Physician - $25 per visit Specialist - $50 per visit *For treatment in hospital outpatient facility or physician's office*		Physician - $25 per visit Specialist - $50 per visit *For treatment in hospital outpatient facility or physician's office*

2020 DENTAL PLAN OPTIONS

SERVICES	Cigna DHMO Base Plan P7X00 In-Network Only	Cigna DHMO Premier Plan A2I09 In-Network Only	Dental PPO Plan In-Network	Dental PPO Plan Out-of-Network
Provider Network	Access Plus National Network	Access Plus National Network	PPO	
PROVIDER NETWORK				
CALENDAR YEAR DEDUCTIBLE (CYD)				
Individual:	N/A	N/A	$50	
Family:	N/A	N/A	$150	
Applied to Preventive	N/A	N/A	Yes	
Annual Maximum	Unlimited	Unlimited	$1,200	
Out-of-Network Reimbursement	N/A	N/A	MAC	
Reimbursement Schedule:				
Preventive	Copay Schedule	Copay Schedule	100%	
Basic Services	Copay Schedule	Copay Schedule	80%	
Major Services	Copay Schedule	Copay Schedule	50%	
Oral Evaluations	D0120 - $0	D0120 - $0	Preventive	
Intraoral Series, X-rays	D0210 - $0	D0210 - $0	Preventive	
Prophylaxis (Cleanings)	D1110 - $0	D1110 - $0	Preventive	
Fluoride Treatment	D1208 - $0	D1208 - $0	Preventive	
Sealants	D1351 - $12 per tooth	D1351 - $0	Preventive	
Restorations (*Amalgam / Composite*)	D2140 - $0 / D2330 - $0	D2140 - $0 / D2330 - $0	Basic	
Simple Extractions	D7140 - $6	D7140 - $0	Basic	
Periodontics Scaling/Planning	D4910 - $40	D4910 - $30	Major	
Endodontics (Root Canal)	D3310 - $100	D3310 - $50	Major	
Complex Extractions	D7241 - $135	D7241 - $70	Major	
Crowns	D2740 - $285	D2740 - $225	Major	
Dentures	D5110 - $225	D5110 - $275	Major	
Bridges	D5211 - $225	D5211 - $275	Major	
Orthodontia:				
Orthodontics	(Adult & Child) $2,592 Max	(Adult & Child) $1,992 Max	(Children) 50% to $1,000 Max	

2020 VISION PLAN OPTION
CIGNA

SERVICES	In-Network
Provider Network	
FREQUENCY SCHEDULE:	**12/12/24/12**
Comprehensive Exam	Once every 12 months
Eyeglass Lenses	Once every 12 months
Eyeglass Frames	Once every 24 months
Contact Lenses (in lieu of glasses)	Once every 12 months
PLAN FEATURES:	
Exam	$10 copay
Materials	$10 copay (contact lenses N/A)
Standard Contact Lens Fit	$160 allowance also applies
Premium Contact Lens Fit	$160 allowance also applies
EYEGLASS LENSES OPTIONS:	
Single Vision Lenses	Covered 100% after copay
Bifocal Lenses	Covered 100% after copay
Trifocal Lenses	Covered 100% after copay
Lenticular Lenses	Covered 100% after copay
Standard Progressive Lenses	Covered 100% after copay + 20% discount
Premium Progressive Lenses	Covered 100% after copay + 20% discount
CONTACT LENSES OPTIONS:	
Elective	$160 allowance applies to all contact lens materials and fittings/evaluations
All Other Elective Contact Lenses	
Necessary Contact Lenses	Covered 100%
Frame Retail Allowance	Up to $120 allowance, then 20% discount
ADDITIONAL SERVICES:	
Laser Vision Discount	Discounts may be available