| Medical | In-network | Out-of-network |
|---|---|---|
| **Lifetime maximum medical benefits** | **Unlimited** | **Unlimited** |
| **You pay...** | | |
| Annual deductible | $300/person;<br>$900/family | $800/person;<br>$2,050/family |
| Annual medical out-of-pocket maximum | $2,500/person<br>$7,500/family | $5,000/person |
| **Wellness** | | |
| Preventive care/immunizations | $0 | 40% after deductible |
| **Office/routine care** | | |
| MNPS Employee & Family Healthcare Center visits | $0 | |
| Primary care visits/convenient care clinics | $30 | 40% after deductible |
| Mental health/substance abuse office visit | $0 | 40% after deductible |
| Specialist visits | $40 | 40% after deductible |
| Lab and x-ray in physician's office | $0 | 40% after deductible |
| Urgent care facility | $30 | $30 |
| Chiropractic (up to 24 visits/year) | $40 | Not covered |
| Physical, occupational and speech therapy | 10% after deductible | 40% after deductible |
| Durable medical equipment | 10% after deductible | 40% after deductible |
| **Maternity/fertility** | | |
| **Prenatal care** | You pay $30 copay<br>for initial visit | 40% after deductible |
| **Delivery** | 10% after deductible | 40% after deductible |
| **Fertility** | Call 1-855-507-6311 | Not covered |
| **Hospital care/outpatient facility** | | |
| Inpatient hospitalization | 10% after deductible | 40% after deductible |
| Outpatient surgery | 10% after deductible | 40% after deductible |
| Outpatient/diagnostic facility | 10% after deductible | 40% after deductible |
| Emergency (copay waived if admitted) | $150, then 10% after deductible | |
| Ambulance | 10% after deductible | |
| Skilled nursing facility | 10% after deductible | 40% after deductible |
| Home health care | 10% after deductible | 40% after deductible |
| **Mental health and substance abuse** | | |
| Inpatient treatment | $0 | 40% after deductible |
| Outpatient therapy (individual and group) | $0 | 40% after deductible |

| Prescription | In-network | Out-of-network |
|---|---|---|
| **Annual pharmacy out-of-pocket maximum** | $1,500/person<br>$3,000/family | |
| **You pay...** | | |
| **Certain preventive drugs** | | |
| Generic and brand | $0 | $0 |
| **Network retail (30-day supply)** | | |
| Generic | $5 | $5 |
| Preferred brand | $25 | $25 |
| Non-preferred brand | $80 | $80 |
| **Network retail (90-day supply)** | | |
| Generic | $10 | Not covered |
| Preferred brand | $50 | Not covered |
| Non-preferred brand | $160 | Not covered |
| **Mail order (90-day supply)** | **Cigna Home Delivery** | **Other pharmacies** |
| Generic | $10 | Not covered |
| Preferred brand | $50 | Not covered |
| Non-preferred brand | $160 | Not covered |

| Dental | In-network (Cigna Total DPPO Network dentists) | Out-of-network[1] (Non-participating dentists) |
|---|---|---|
| **Annual deductible** (does not apply to preventive/diagnostic services) | $50/person $150/family | $50/person $150/family |
| **Plan pays…** | | |
| **Preventive/diagnostic[2]** Exams/cleanings/standard x-rays up to 2x/year, fluoride treatments, sealants, pace maintainers (frequency limits apply) | 100% no deductible | 100% no deductible |
| **Basic restorative** (fillings, bridge repair, denture repair, extractions, oral surgery, root canals, periodontics) | 80% after deductible | 80% after deductible |
| **Major restorative** (inlays/onlays, crowns/crown repair, bridges, dentures/denture adjustment/reline, implants) | 50% after deductible | 50% after deductible |
| **Orthodontia** (children and adults) | 50% no deductible | 50% no deductible |
| **Annual benefit maximum** (not including preventive/diagnostic care or orthodontia) | $1,000/person | $1,000/person |
| **Lifetime orthodontia maximum** | $1,000/person | $1,000/person |

[1] Cigna Total DPPO Network dentists have agreed to a lower contracted fee for services; if you use an out-of-network provider, you'll be responsible for charges exceeding the Maximum Allowable Charge (MAC).

[2] Costs for preventive/diagnostic services do not count toward your annual benefit maximum.

| Vision | In-network (EyeMed provider) | Out-of-network (Non-EyeMed provider) |
|---|---|---|
| **Annual deductible** | $0 | $0 |
| **Eye exams** (every 12 months) | You pay $10 copay | Plan pays up to $45 |
| **Frames** (every 24 months) | You pay $0 copay<br>(up to $120 retail, then 20% off) | Plan pays up to $50 |
| **Lenses** (every 12 months) | | |
| Single vision | You pay $10 copay | Plan pays up to $40 |
| Bifocals | You pay $10 copay | Plan pays up to $55 |
| Trifocals | You pay $10 copay | Plan pays up to $70 |
| Standard progressive | You pay $10 copay | Plan pays up to $55 |
| **Contact lenses** (materials only) | | |
| Conventional | Plan pays up to $120<br>(15% off balance over $120) | Plan pays up to $120 |
| Disposable | Play pays up to $120 | Plan pays up to $120 |
| Medically necessary | Plan pays 100% | Plan pays up to $210 |
| Additional pairs | Once above benefits used, receive 40% off eyeglasses and 15% off conventional contacts | N/A |

| Medical/Dental/ Vision/Hearing | Total annual cost | Your annual share | Your share (10 months) | Your share (12 months) |
|---|---|---|---|---|
| **Employee only** | $11,578.18 | $2,894.55 | $144.73 | $111.33 |
| **Employee + Spouse** | $23,156.10 | $5,789.03 | $289.45 | $222.65 |
| **Employee + child(ren)** | $16,458.46 | $4,114.61 | $205.73 | $158.25 |
| **Family** | $27,802.56 | $6,950.64 | $347.53 | $267.33 |

| Life and AD&D Rates | Your share (10 months) | Your share (12 months) |
|---|---|---|
| **Employee only** | $0.00 | $0.00 |
| **Employee + Spouse** | $3.00 | $2.31 |
| **Employee + child(ren)** | $0.60 | $0.46 |
| **Family** | $3.60 | $2.77 |