



# PPO \$35/\$50 \$4,000 30%

For groups effective 10/1/24 - 12/1/24

Medical	In-network	Out-of-network
<b>Annual Deductible</b> (individual/family)	\$4,000 / \$8,000	\$8,000 / \$16,000
<b>Coinsurance</b>	30%	50% after deductible
<b>Annual Maximum Out-of-Pocket</b> (individual/family)	\$7,900 / \$15,800	\$15,800 / \$31,600
<b>Preventive Care</b>	\$0 copay	Not Covered
<b>Primary Care Services</b>	\$35 copay	50% after deductible
<b>Virtual Preventive<sup>1</sup> &amp; Primary Care Services via Recuro Network</b>	\$0 copay	Not Covered
<b>Specialist Services</b>	\$50 copay	50% after deductible
<b>Hospital Inpatient<sup>2</sup></b>	30% after deductible	50% after deductible
<b>Urgent Care</b>	\$75 copay	\$75 copay
<b>Virtual Urgent Care via Recuro Network<sup>3</sup></b>	\$0 copay (deductible waived)	\$0 copay (deductible waived)
<b>Emergency Room Services</b>	30% after deductible	30% after in-network deductible
<b>Ambulance Service</b>	30% after deductible	30% after in-network deductible
<b>Outpatient Surgery: Office Setting</b>	30% after deductible	50% after deductible
<b>Outpatient Surgery: Independent Facility<sup>2</sup></b>	30% after deductible	50% after deductible
<b>Outpatient Surgery: Hospital Setting<sup>2</sup></b>	30% after deductible	50% after deductible
<b>Advanced Imaging: Preferred Network<sup>4</sup></b>	\$0 copay	50% after deductible
<b>Advanced Imaging: All Other Locations</b>	30% after deductible	50% after deductible
<b>Non-Advanced Imaging</b> (General X-Ray)	\$40 copay	50% after deductible
<b>Lab</b>	\$10 copay	50% after deductible
<b>Speech, Occupational &amp; Physical Therapy<sup>2</sup></b> (up to 40 visits per year, combined for in- and out-of-network, includes services combined for speech, physical, and occupational therapy)	\$50 copay/visit (deductible waived)	50% after deductible
<b>Routine Vision Exam</b> (one exam per contract year)	\$50 copay	Not covered
Prescription Drug (Retail)	In-network	Out-of-network
<b>Prescription Drug Deductible</b>	N/A	Integrated with medical deductible
<b>Tier 1 - Generic</b>	\$10 copay	50% after deductible
<b>Tier 2 - Preferred Brand &amp; High Cost Generic</b>	\$40 copay	50% after deductible
<b>Tier 3 - Non-Preferred Brand</b>	30% up to \$500/script	50% after deductible
<b>Tier 4 - Specialty</b>	30% up to \$750/script	50% after deductible

This summary section contains highlights only. Full benefit information, including plan benefit exclusions and limitations can be found in the plan documents. All plans operate on a contract-year basis. Referrals are not required for any plan. MAC A - Mandatory Generic: Generic substitution is required when available. If a member chooses a brand-name drug when a generic equivalent is available, the member will pay the copay plus the cost difference between the brand-name and generic drug.

<sup>1</sup>Virtual Preventive Care eligible to adults aged 18+ years old.

<sup>2</sup>Cigna precertification required.

<sup>3</sup>Members must contact Concierge Services for assistance with network facilities.

<sup>4</sup>Members must contact NaVcare Member Services for available network facilities and to coordinate services.