IBEW MEDICAL PLAN COMPARISON

**Plan Year January 1, 2025 – December 31, 2025**

|  |  |  |  |
| --- | --- | --- | --- |
|  | Premium | **Preferred** | **Economy** |
|  | In-Network | Out-of-Network | In-Network | Out-of-Network | In-Network | Out-of-Network |
| Annual DeductibleIndividualFamily | $0$0 | $500$1,000 | $500$1,000 | $700$1,400 | $700$1,400 | $1,300$2,600 |
| Employee Co-Insurance(% you pay, remaining paid by insurance company) | 0% | Deductible, then 20% | Deductible, then 20% | Deductible, then 30% | Deductible, then 30% | Deductible, then 40% |
| Annual Out-of-Pocket Max IndividualFamily(*Includes deductible)* | $0$0 | $2,300$4,600 | $2,300$4,600 | $3,300$6,600 | $3,300$6,600 | $5,400$10,800 |
| Office Visit Primary CareSpecialist Visit | $30$40 | Deductible, 20/80Deductible, 20/80 | $20$30 | Deductible, 30/70Deductible, 30/70 | Deductible, 30/70Deductible, 30/70 | Deductible, 40/60Deductible, 40/60 |
| Preventative ExamsChild & Adult(Annual &/or Wellness Exams) | $30 Primary$40 Specialist | Deductible, 20/80 | $20 Primary$30 Specialist | Deductible, 30/70 | Deductible, 30/70 | Deductible, 40/60 |
| Surgery / HospitalIn-Patient 1Out-Patient 2 | $0$0 | Deductible, 20/80Deductible, 20/80 | Deductible, 20/80$0 | Deductible, 20/80Deductible, 20/80 | Deductible, 30/70$0 | Deductible, 20/80$0 |
| Emergency Room (co-pay waived if admitted from ER) | $150 co-pay per visitThen plan pays 100% | $150 co-pay per visitThen plan pays 100% | $150 co-pay per visit,Deductible, 20/80 | $150 co-pay per visit,Deductible, 20/80 | $150 co-pay per visit,Deductible, 30/70 | $150 co-pay per visit,Deductible, 30/70 |
| Urgent Care | $40 per visit, No deductible applies | $40 per visit, No deductible applies | $30 per visit,No deductible applies | $30 per visit,No deductible applies | Deductible, 30/70 | Deductible, 30/70 |
| Prescription Drugs3 (Retail or Mail Order)30 Day GenericName Brand90 Day GenericName Brand | Max. $8$30Max. $20$75 | Not CoveredNot Covered Not CoveredNot Covered | Max. $8$30Max. $20$75 | Not CoveredNot Covered Not CoveredNot Covered | Max. $8$30Max. $20$75 | Not CoveredNot Covered Not CoveredNot Covered |
| Weekly PremiumsEmployee OnlyEE + Family | $78.17$185.77 | $31.19$80.16 | $7.98$27.96 |

This summary was prepared to show the member’s copay, member’s portion of the co-insurance and deductibles. This is for illustrative purposes only and does not cover all the terms and conditions of the plan. In the event of any discrepancies, the Plan document will prevail. See SPD for clarification.

### 1 A Pre-Certification must be obtained prior to all Inpatient admissions, except in the case of an emergency admission. In the event of an emergency inpatient admission, the provider must notify Cigna Healthcare, Inc. within 48 hours of confinement. Failure to obtain required pre-certification could result in a benefit payment reduction or denial.

### 2 A Pre-Certification must be obtained prior to selected outpatient procedures and diagnostic testing. Failure to obtain required pre-certification could result in a benefit payment reduction or denial.

3 Prescription Coverage is Administered by Express Scripts.