BI·STATE DEVELOPMENT

ATU 788 MEDICAL PLAN COMPARISON

Plan Year January 1, 2027 – December 31, 2027

	Premium		Preferred		Economy	
	In-Network	Out-of-Network	In-Network	Out-of-Network	In-Network	Out-of-Network
Annual Deductible Individual Family	$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 Individual Family *(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 Care Specialist Visit	$30 $40	Deductible, 20/80 Deductible, 20/80	$20 $30	Deductible, 30/70 Deductible, 30/70	Deductible, 30/70 Deductible, 30/70	Deductible, 40/60 Deductible, 40/60
Preventative Exams Child & 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 / Hospital In-Patient [1] Out-Patient [2]	$0 $0	Deductible, 20/80 Deductible, 20/80	Deductible, 20/80 $0	Deductible, 30/70 Deductible, 30/70	Deductible, 30/70 $0	Deductible, 40/60 Deductible, 40/60
Emergency Room (co-pay waived if admitted from ER)	$150 co-pay per visit Then plan pays 100%	$150 co-pay per visit Then 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 Drugs[3] **(Retail or Mail Order)** 30 Day Generic Name Brand 90 Day Generic Name Brand	 Max. $20 $25 Max. $40 $50	 Not Covered Not Covered Not Covered Not Covered	 Max. $20 $25 Max. $40 $50	 Not Covered Not Covered Not Covered Not Covered	 Max. $20 $25 Max. $40 $50	 Not Covered Not Covered Not Covered Not Covered
Weekly Premiums Employee Only Employee + Spouse Employee + Child(ren) Family (EE + Sp + Ch)	 $92.21 $179.79 $165.03 $252.65		 $38.33 $74.74 $68.61 $105.02		 $11.70 $22.83 $20.94 $32.09	

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.