ARLINGTON VIRGINIA

FY2025 Pre-Medicare Retiree Medical Plan Comparison

Effective July 1, 2024 - June 30, 2025

	Kaiser	Cigna Copay	Cigna Coinsurance	Cigna Choice + HSA	
				In-Network	Out-of-Network
Plan Type	Copay	Copay	Coinsurance	Coinsurance	
Network	In-network coverage only at Kaiser facilities	In-network coverage only in the Cigna OAP network	In-network coverage only in the Cigna OAP network	In- and out-of-network coverage	
Annual Deductible[1]	$0	$0	$0	$1,600 Individual $3,200 Family	$3,200 Individual $6,400 Family
Out-of-Pocket Maximum (OOPM)[2]	$2,250 Individual $4,500 Family	$6,600 Individual $13,200 Family	$3,500 Individual $7,000 Family	$5,000 Individual $10,000 Family	$10,000 Individual $20,000 Family
Preventive Care Routine well-person and child exams; immunizations; some preventive tests	No Charge	No Charge	No Charge	No Charge	30% coinsurance after deductible
PCP Office Visit	$20 copay	$30 copay	10% coinsurance	10% coinsurance after deductible	30% coinsurance after deductible
Specialist Office Visit	$40 copay	$60 copay	10% coinsurance	10% coinsurance after deductible	30% coinsurance after deductible
Physical Therapy	$40 copay	$45 copay	10% coinsurance	10% coinsurance after deductible	30% coinsurance after deductible
Inpatient Hospital	$200/admission	$500/admission	10% coinsurance	10% coinsurance after deductible	30% coinsurance after deductible
Outpatient Surgery/ Procedures	$100/visit	$250/visit	10% coinsurance	10% coinsurance after deductible	30% coinsurance after deductible
Specialty Imaging (MRI, CT Scan)	$75/test	$100/visit	10% coinsurance	10% coinsurance after deductible	30% coinsurance after deductible
Urgent Care	$50/visit	$75/visit	10% coinsurance	10% coinsurance after deductible	10% coinsurance after deductible
Emergency Room	$200/visit	$200/visit	10% coinsurance	10% Coinsurance after deductible	10% Coinsurance after deductible

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Mental Health, Behavioral Health, and Substance Abuse Services Outpatient services	$20/individual visit; $10/group visit	$30/copay	10% coinsurance	10% coinsurance after deductible	30% coinsurance after deductible
Inpatient services	$200/admission	$500/admission	10% coinsurance	10% coinsurance after deductible	30% coinsurance after deductible
Maternity Services	$200 global maternity fee	$500 global maternity fee	10% coinsurance	10% coinsurance after deductible	30% coinsurance after deductible
Prescription Drugs 30 Day Retail Supply (generic/preferred/non-preferred)	$15 / $30/ $55 at KP $20 / $45 / $60	$10 / $40 / $80	Tier 1: Up to $10 Tier 2: 25% up to $50 Tier 3: 40% up to $90	Tier 1: Up to $10 after deductible Tier 2: 25% up to $50 after deductible Tier 3: 40% up to $90 after deductible	In-network coverage only
Prescription Drugs 90 Day Supply from Mail Order or 90 Now Pharmacy	$30 / $60 / $110	$20 / $80 / $160 *Certain generics are $0*	Tier 1: Up to $20 Tier2: 25% up to $100 max Tier 3: 40% up to $180 max *Certain generics are $0*	Tier 1: Up to $20 after deductible Tier2: 25% up to $100 after deductible Tier 3: 40% up to $180 after deductible *Certain generics are $0*	In-network coverage only
Vision	Vision coverage included with medical plan	Vision coverage included with medical plan	Vision coverage included with medical plan	Vision coverage included with medical plan	

NOTE: Complete benefit summaries are available on AC Commons by going to: **www.arlingtonva.us/retirement**

[1] Annual Deductible – the amount you must pay this amount out-of-pocket before the plan will cover services and prescriptions. The annual deductible resets every year on January 1 regardless of when you enroll in the plan.

[2] Out-of-Pocket Maximum (OOPM) – the Plan will pay 100% for covered services after a member reaches this limit. Biweekly premiums do not count toward reaching the annual OOPM. The OOPM is tracked on a Calendar Year basis and resets every January 1.