TEX TRINITY ELECTRIC

2025 Benefits Package

Medical

Deductibles and Copays

Annual Medical Maximum Benefit		Unlimited per individual
	In-Network	Out-Of-Network
Deductible (Calendar Year)		
Individual	$2,000	$2,000
Combined In- and Out-of-Network	$2,000	
Family	$4,000	$4,000
Combined In- and Out-of-Network	$4,000	

All benefits are after deductibles and applicable copays unless noted otherwise. **Emergency Room copays are in addition to the calendar year deductible and coinsurance percentage.**

Out-Of-Pocket Limit (Calendar Year)		
Individual	$4,000	$4,000
Combined In- and Out-of-Network	$4,000	
Family	$8,000	$8,000
Combined In- and Out-of-Network	$8,000	

The out-of-pocket limit is met by accumulated medical copays (except for the Emergency Room Penalty Copay), prescription drug copays, medical deductible, and medical coinsurance.

For calendar year 2025, the Maximum Out-Of-Pocket is $9,200 per individual/$18,400 per family.

Physician - Non-Preventive Benefits		
(1) Office Visit*	100%	50%
Deductible (Calendar Year)	None	$2,000
Per Visit Copay-Primary Care Physician	$25	N/A
Per Visit Copay-Specialist	$50	N/A
Per Visit Copay-Urgent Care Center	$50	N/A
Per Visit Benefit Limit**	$500	N/A
* This Benefit does not apply to MRIs, Cardiac Related testing, Mental Health, and Alcohol/Substance abuse.		
** Remainder of charges per visit subject to deductible and coinsurance.		
(2) Other physician services	80%	50%

Other Covered Services

Mental Health, Alcohol and Substance Abuse*		
Inpatient Treatment		
Hospital	70%	50%
Physician	70%	50%
Outpatient Treatment	70%	50%
Benefit Limits		
Lifetime (Inpatient)	30 days	15 days
Combined In- and Out-of-Network	30 days	
Calendar Year (Outpatient)	40 visits	20 visits
Combined In- and Out-of-Network	40 visits	
(Outpatient charges do not apply to Out-of-Pocket Limits)		

* Groups that have an average of more than 50 employees on business days during the preceding calendar year must provide M&N (D&A) on the same basis as any other condition IF THEY PROVIDE ANY COVERAGE for M&N (D&A) AT ALL.

Chiropractic Care	**100%**	**50%**
Per Visit Copay	$50	N/A
Deductible (Calendar Year)	None	$2,000
Calendar Year Benefit Limit	26 visits	26 visits

Physical Therapy	**100%**	**50%**
Per Visit Copay	$50	N/A
Deductible (Calendar Year)	None	$2,000
Calendar Year Benefit Limit	26 visits	26 visits

Children		
Coverage To Age	26	26

Network: Cigna PPO
Provider Lookup:

Rates

	Employee Only	Employee Spouse	Employee Child(ren)	Employee Family
Weekly Rate	$ 49.50	$ 174.81	$ 157.04	$ 270.35

Hospital and Pharmaceutical

	In-Network	Out-Of-Network
Hospital		
(1) Inpatient	80%	50%
Deductible (Calendar Year)	$2,000	$2,000
(2) Outpatient	80%	50%
Deductible (Calendar Year)	$2,000	$2,000
(3) Emergency Room (Non-emergency use)	80%	50%
Emergency Room Penalty Copay Per Visit*		None
Deductible (Calendar Year)	$2,000	$2,000
* Remainder of charges per visit subject to deductible and coinsurance.		

Outpatient Diagnostic X-Ray and Lab - Non-Preventive Benefits		
(1) When performed in a Physician's office on the same day for which an office visit copay was applied for that physician*	100%	N/A
(2) When performed on an outpatient basis other than as described in (1) above**	80%	50%
Deductible (Calendar Year)	$2,000	$2,000
* This Benefit does not apply to MRIs, Cardiac Related testing, Mental Health, and Alcohol/Substance abuse.		

Outpatient Prescription Copay Card	**100%**	**100%**
Copay per prescription		
Generic Drugs	$10	$10
Preferred Brand	$30	$30
Non-Preferred Brand	$50	$50
Specialty Drugs	$150	$150
Oral Contraceptives	Included	Included
Mail Order Maintenance Drugs Program	90 day supply	90 day supply
Copay per mail order prescription		
Generic Drugs	$20	$20
Preferred Brand	$60	$60
Non-Preferred Brand	$100	$100
Specialty Drugs	$300	$300

Persons Residing Outside of Network Service Area	**N/A**	**80%**
Preventive Care	N/A	In-Network Benefit

Preventive Care	**100%**	**50%**
Deductible (Calendar Year)	None	$2,000

Preventive benefits are equal to the minimum amount required by Federal Health Care Reform Legislation.