2024 Medical Trust Health Plan	Cigna CDHP 15/HSA		Cigna CDHP 20/HSA		Cigna OAP PPO 80		Cigna OAP PPO 90 (MSP Only)	
	Network	Out-of-Network	Network	Out-of-Network	Network	Out-of-Network	Network	Out-of-Network
Annual Deductible (CDHPs have a combined medical & Rx deductible)	$1,600 per person $3,200 per family (deductible is non-embedded)	$3,200 per person $6,400 per family (deductible is non-embedded)	$3,200 per person $5,450 per family	$3,200 per person $6,000 per family	$1,000 per person $2,000 per family	$2,000 per person $4,000 per family	$500 per person $1,000 per family	$1,000 per person $2,000 per family
Annual Out-of-Pocket Limit	$2,400 per person $4,800 per family (out-of-pocket limit is non-embedded)	$4,800 per person $9,600 per family (out-of-pocket limit is non-embedded)	$4,200 per person $8,450 per family	$7,000 per person $13,000 per family	$3,500 per person $7,000 per family	$7,000 per person $14,000 per family	$2,500 per person $5,000 per family	$5,000 per person $10,000 per family
Preventive Care								
Preventive Services & Well-Child Care	$0 copay	40% coinsurance plus any balance billing	$0 copay	45% coinsurance plus any balance billing	$0 copay	50% coinsurance plus any balance billing	$0 copay	50% coinsurance plus any balance billing
Physician Services								
Office Visit	15% coinsurance	40% coinsurance plus any balance billing	20% coinsurance	45% coinsurance plus any balance billing	$30 copay	50% coinsurance plus any balance billing	$30 copay	50% coinsurance plus any balance billing
Diagnostic Services (outpatient) (non-routine)	15% coinsurance	40% coinsurance plus any balance billing	20% coinsurance	45% coinsurance plus any balance billing	20% coinsurance	50% coinsurance plus any balance billing	10% coinsurance	50% coinsurance plus any balance billing
Specialist Care	15% coinsurance	40% coinsurance plus any balance billing	20% coinsurance	45% coinsurance plus any balance billing	$45 copay	50% coinsurance	$45 copay	50% coinsurance
Hospital Services								
Inpatient Services (including inpatient maternity services)	15% coinsurance	40% coinsurance plus any balance billing	20% coinsurance	45% coinsurance plus any balance billing	20% coinsurance	50% coinsurance plus any balance billing	10% coinsurance	50% coinsurance plus any balance billing
Outpatient Surgery	15% coinsurance	40% coinsurance plus any balance billing	20% coinsurance	45% coinsurance plus any balance billing	20% coinsurance	50% coinsurance plus any balance billing	10% coinsurance	50% coinsurance plus any balance billing
Emergency Room Care	15% coinsurance	Covered at in-network benefit level	20% coinsurance	Covered at in-network benefit level	$250 copay	Covered at in-network benefit level	$250 copay	Covered at in-network benefit level
Ambulance Services	15% coinsurance	Covered at in-network benefit level for emergency transport	20% coinsurance	Covered at in-network benefit level for emergency transport	20% coinsurance	Covered at in-network benefit level for emergency transport	10% coinsurance	Covered at in-network benefit level for emergency transport

Behavioral Health								
Outpatient Services	15% coinsurance	40% coinsurance plus any balance billing	20% coinsurance	45% coinsurance plus any balance billing	$30 copay	30% coinsurance plus any balance billing	$30 copay	30% coinsurance plus any balance billing
Inpatient Services	15% coinsurance	40% coinsurance plus any balance billing	20% coinsurance	45% coinsurance plus any balance billing	20% coinsurance	50% coinsurance plus any balance billing	10% coinsurance	50% coinsurance plus any balance billing
Other Medical Services								
Durable Medical Equipment	15% coinsurance	40% coinsurance plus any balance billing	20% coinsurance	45% coinsurance plus any balance billing	20% coinsurance	50% coinsurance plus any balance billing	10% coinsurance	50% coinsurance plus any balance billing
Home Health Care (210 visits per calendar year, combined network and out-of- network)	15% coinsurance	40% coinsurance plus any balance billing	20% coinsurance	45% coinsurance plus any balance billing	20% coinsurance	50% coinsurance plus any balance billing	10% coinsurance	50% coinsurance plus any balance billing
Outpatient Therapy (e.g., Physical Therapy/ Occupational Therapy/ Speech Therapy) (60 visits per calendar year per each type of therapy, combined network and out-of-network)	15% coinsurance (includes speech, physical, and occupational)	40% coinsurance plus any balance billing (includes speech, physical, and occupational)	20% coinsurance (includes speech, physical, and occupational)	45% coinsurance plus any balance billing (includes speech, physical, and occupational)	$30 copay PCP/$45 copay specialist (includes speech, physical, and occupational)	50% coinsurance plus any balance billing (includes speech, physical, and occupational)	$30 copay PCP/$45 copay specialist (includes speech, physical, and occupational)	50% coinsurance plus any balance billing (includes speech, physical, and occupational)
Skilled Nursing / Acute Rehabilitation Facility (60 days per calendar year, combined network and out-of- network)	15% coinsurance	40% coinsurance plus any balance billing	20% coinsurance	45% coinsurance plus any balance billing	20% coinsurance	50% coinsurance plus any balance billing	10% coinsurance	50% coinsurance plus any balance billing
Urgent Care Services	15% coinsurance	15% coinsurance plus any balance billing	20% coinsurance	20% coinsurance plus any balance billing	$50 copay	$50 copay plus any balance billing	$50 copay	$50 copay plus any balance billing

Prescription Drug Benefits

	Express Scripts						
	Standard		Premium		CDHP-15/HSA	CDHP-20/HSA	CDHP-
	Retail	Home Delivery	Retail	Home Delivery	Retail and Home Delivery	Retail and Home	Retail and Home
Annual Prescription Deductible (in-network)	None	None	None	None	$1,600 per person $3,200 per family (combined with medical deductible) (non-embedded deductible)	$3,200 per person $5,450 per family (combined with medical deductible)	$3,500 per person $7,000 per family (combined with medical deductible)
Tier 1: Generic	Up to a $10 copay	Up to a $25 copay	Up to a $5 copay	Up to a $12 copay	You pay 15% after deductible	You pay 15% after deductible	You pay 15% after deductible
Tier 2: Preferred Brand Name	Up to a $40 copay	Up to a $100 copay	Up to a $30 copay	Up to a $75 copay	You pay 25% after deductible	You pay 25% after deductible	You pay 25% after deductible
Tier 3: Non-Preferred Brand Name	Up to a $80 copay	Up to a $200 copay	Up to a $60 copay	Up to a $150 copay	You pay 50% after deductible	You pay 50% after deductible	You pay 50% after deductible
Tier 4: Specialty Rx	40%; up to $100 min / $200 max	40%; up to $250 min / $500 max	Up to a $90 copay	Up to a $225 copay	You pay 50% after deductible	You pay 50% after deductible	You pay 50% after deductible
Dispensing Limits Per Copayment	Up to a 30-day supply	Up to a 90-day supply	Up to a 30-day supply	Up to a 90-day supply	Up to a 30-day supply (retail) or 90-day supply (mail order)	Up to a 30-day supply (retail) or 90-day supply (mail order)	Up to a 30-day supply (retail) or

Vision Benefits

	EyeMed	
	Network	**Out-of-Network**
Eye Examinations	$0 copay	Plan pays up to $30 for ophthalmologists or optometrists
Lenses (eligible once every calendar year)	$10 copay	Plan pays up to: $32 for single vision $46 for bifocal $57 for trifocal
Lens Options		
Standard progressive (add-on to bifocal)	Up to $75 copay	Plan pays up to $46
UV Coating	Up to $15 copay	You are responsible for the cost of any lens options that you elect from out-of-network providers,
Tint (solid and gradient)	Up to $15 copay	
Standard Scratch Resistance	Up to $15 copay	
Standard Polycarbonate	$0 copay	
Standard Anti-Reflective Coating	Up to $45 copay	
Disposable	20% off retail price	
Frames (eligible once every calendar year)	$200 allowance, 20% off balance over $200	Plan pays up to $47
Contact Lenses (eligible once every calendar year)		
Conventional	$200 allowance, 15% off balance over $200	Plan pays up to $100
Disposable	$200 allowance, then you pay balance over $200	Plan pays up to $100

	Dental Benefits								
	Delta Dental								
	Premium PPO Plan			Comprehensive PPO Plan			Basic PPO Plan		
	PPO Network	*Premier Network*	*Out-of-Network*	*PPO Network*	*Premier Network*	*Out-of-Network*	*PPO Network*	*Premier Network*	*Out-of-Network*
Annual Deductible	$0 per person / $0 per family	$0 per person / $0 per family	$50 per person / $150 per family	$0 per person / $0 per family	$0 per person / $0 per family	$100 per person / $300 per family	$0 per person / $0 per family	$0 per person / $0 per family	$0 per person / $0 per family
Annual Benefit Maximum (Plan maximums cross-accumulate between the PPO Network, Premier	$3,000	$2,500	$2,000	$2,500	$2,000	$1,500	$2,000	$1,500	$1,000
Diagnostic and Preventive Services (e.g., exams, cleanings, x-rays, sealants and space maintainers)	You pay $0 (not subject to annual deductible)		You pay $0 (not subject to annual deductible) plus any balance billing	You pay $0 (not subject to annual deductible)		You pay $0 (not subject to annual deductible) plus any balance billing	You pay $0 (not subject to annual deductible)		You pay $0 (not subject to annual deductible) plus any balance billing
Basic Services (Includes fillings, simple extractions, root canals, oral surgery, and denture reline/repair/rebase)	You pay 15% coinsurance	You pay 15% coinsurance	You pay 25% coinsurance plus any balance billing	You pay 15% coinsurance	You pay 15% coinsurance	You pay 25% coinsurance plus any balance billing	You pay 20% coinsurance	You pay 20% coinsurance	You pay 30% coinsurance plus any balance billing
Major Services (Includes crowns, bridges, and dentures)	You pay 15% coinsurance	You pay 15% coinsurance	You pay 25% coinsurance plus any balance billing	You pay 50% coinsurance	You pay 50% coinsurance	You pay 60% coinsurance plus any balance billing	You pay 60% coinsurance	You pay 60% coinsurance	You pay 99% coinsurance plus any balance billing
Orthodontic Services	You pay 50% coinsurance up to individual lifetime benefit limit of $2,000	You pay 50% coinsurance up to individual lifetime benefit limit of $2,000	You pay 60% coinsurance up to individual lifetime benefit limit of $1,500 after $50 lifetime deductible plus any balance billing	You pay 50% coinsurance up to individual lifetime benefit limit of $1,500	You pay 50% coinsurance up to individual lifetime benefit limit of $1,500	You pay 60% coinsurance up to individual lifetime benefit limit of $1,000 after $100 lifetime deductible plus any balance	Not covered. You pay 100%.	Not covered. You pay 100%.	Not covered. You pay 100%.

EPISCOPAL CHURCH MEDICAL TRUST

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