

2025 Medical Trust Health Plan	Cigna CDHP 15/HSA		Cigna OAP PPO 80 (Standard or MSP)		Cigna CDHP 20/HSA		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)	\$1,650 per person \$3,300 per family (deductible is non-embedded)	\$3,300 per person \$6,600 per family (deductible is non-embedded)	\$1,000 per person \$2,000 per family	\$2,000 per person \$4,000 per family	\$3,300 per person \$6,600 per family	\$3,300 per person \$6,600 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)	\$3,500 per person \$7,000 per family	\$7,000 per person \$14,000 per family	\$4,200 per person \$8,450 per family	\$7,000 per person \$13,000 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	\$0 copay	50% coinsurance	\$0 copay	45% coinsurance	\$0 copay	50% coinsurance
Physician Services								
Office Visit	15% coinsurance	40% coinsurance	\$30 copay	50% coinsurance	20% coinsurance	45% coinsurance	\$30 copay	50% coinsurance
Diagnostic Services (outpatient)	15% coinsurance	40% coinsurance	20% coinsurance	50% coinsurance	20% coinsurance	45% coinsurance	10% coinsurance	50% coinsurance
Specialist Care	15% coinsurance	40% coinsurance	\$45 copay	50% coinsurance	20% coinsurance	45% coinsurance	\$45 copay	50% coinsurance
Hospital Services								
Inpatient Services (including inpatient maternity services)	15% coinsurance	40% coinsurance	20% coinsurance	50% coinsurance	20% coinsurance	45% coinsurance	10% coinsurance	50% coinsurance
Outpatient Surgery	15% coinsurance	40% coinsurance	20% coinsurance	50% coinsurance	20% coinsurance	45% coinsurance	10% coinsurance	50% coinsurance
Emergency Room Care	15% coinsurance	15% coinsurance	\$250 copay	\$250 copay	20% coinsurance	20% coinsurance	\$250 copay	\$250 copay
Ambulance Services	15% coinsurance	15% coinsurance	20% coinsurance	20% coinsurance	20% coinsurance	20% coinsurance	10% coinsurance	10% coinsurance
Behavioral Health								
Outpatient Services	15% coinsurance	40% coinsurance	\$30 copay	30% coinsurance	20% coinsurance	45% coinsurance	\$30 copay	30% coinsurance
Inpatient Services	15% coinsurance	40% coinsurance	20% coinsurance	50% coinsurance	20% coinsurance	45% coinsurance	10% coinsurance	50% coinsurance
Other Medical Services								
Durable Medical Equipment	15% coinsurance	40% coinsurance	20% coinsurance	50% coinsurance	20% coinsurance	45% coinsurance	10% coinsurance	50% coinsurance
Home Health Care (210 visits per calendar year, combined network and out-of-network)	15% coinsurance	40% coinsurance	20% coinsurance	50% coinsurance	20% coinsurance	45% coinsurance	10% coinsurance	50% coinsurance
Outpatient 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 (includes speech, physical, and occupational)	\$30 copay PCP/\$45 copay specialist (includes speech, physical, and occupational)	50% coinsurance (includes speech, physical, and occupational)	20% coinsurance (includes speech, physical, and occupational)	45% coinsurance (includes speech, physical, and occupational)	\$30 copay PCP/\$45 copay specialist (includes speech, physical, and occupational)	50% coinsurance (includes speech, physical, and occupational)

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Skilled Nursing / Acute Rehabilitation Facility (60 days per calendar year, combined network and out-of-network)	15% coinsurance	40% coinsurance	20% coinsurance	50% coinsurance	20% coinsurance	45% coinsurance	10% coinsurance	50% coinsurance
Urgent Care Services	15% coinsurance	15% coinsurance	\$50 copay	\$50 copay	20% coinsurance	20% coinsurance	\$50 copay	\$50 copay
	Pharmacy Benefits Administered by Express Scripts		Pharmacy Benefits Administered by Express Scripts		Pharmacy Benefits Administered by Express Scripts		Pharmacy Benefits Administered by Express Scripts	
Prescription Drug Benefits	Retail	Home Delivery	Retail	Home Delivery	Retail	Home Delivery	Retail	Home Delivery
Annual Prescription Deductible (in-network)	\$1,650 per person \$3,300 per family (combined with medical deductible) (non-embedded deductible)	\$1,650 per person \$3,300 per family (combined with medical deductible) (non-embedded deductible)	None	None	\$3,300 per person \$6,600 per family (combined with medical deductible)	\$3,300 per person \$6,600 per family (combined with medical deductible)	None	None
Tier 1: Generic	You pay 15% after deductible	You pay 15% after deductible	Up to a \$10 copay	Up to a \$10 copay	You pay 15% after deductible	You pay 15% after deductible	Up to a \$10 copay	Up to a \$10 copay
Tier 2: Preferred Brand Name	You pay 25% after deductible	You pay 25% after deductible	25%; up to \$40 min / \$80 max	25%; up to \$40 min / \$80 max	You pay 25% after deductible	You pay 25% after deductible	25%; up to \$40 min / \$80 max	25%; up to \$40 min / \$80 max
Tier 3: Non-Preferred Brand Name	You pay 50% after deductible	You pay 50% after deductible	40%; up to \$80 min / \$160 max	40%; up to \$80 min / \$160 max	You pay 50% after deductible	You pay 50% after deductible	40%; up to \$80 min / \$160 max	40%; up to \$80 min / \$160 max
Tier 4: Specialty Rx	You pay 50% after deductible	You pay 50% after deductible	40%; up to \$100 min / \$200 max	40%; up to \$100 min / \$200 max	You pay 50% after deductible	You pay 50% after deductible	40%; up to \$100 min / \$200 max	40%; up to \$100 min / \$200 max
Dispensing Limits Per Copayment	Up to a 30-day supply (retail) or 90-day supply	Up to a 30-day supply (retail) or 90-day supply	Up to a 30-day supply	Up to a 30-day supply	Up to a 30-day supply (retail) or 90-day supply	Up to a 30-day supply (retail) or 90-day supply	Up to a 30-day supply	Up to a 30-day supply

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	Vision Benefits Administered by EyeMed		Vision Benefits Administered by EyeMed		Vision Benefits Administered by EyeMed		Vision Benefits Administered by EyeMed	
Vision Benefits	Network	Out-of-Network	Network	Out-of-Network	Network	Out-of-Network	Network	Out-of-Network
Eye Examinations	\$0 copay	Plan pays up to \$30 for ophthalmologists or optometrists	\$0 copay	Plan pays up to \$30 for ophthalmologists or optometrists	\$0 copay	Plan pays up to \$30 for ophthalmologists or optometrists	\$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	\$10 copay	Plan pays up to: \$32 for single vision \$46 for bifocal \$57 for trifocal	\$10 copay	Plan pays up to: \$32 for single vision \$46 for bifocal \$57 for trifocal	\$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	Up to \$75 copay	Plan pays up to \$46	Up to \$75 copay	Plan pays up to \$46	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,	Up to \$15 copay	You are responsible for the cost of any lens options that you elect from out-of-network providers,	Up to \$15 copay	You are responsible for the cost of any lens options that you elect from out-of-network providers,	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		Up to \$15 copay		Up to \$15 copay		Up to \$15 copay	
Standard Scratch Resistance	Up to \$15 copay		Up to \$15 copay		Up to \$15 copay		Up to \$15 copay	
Standard Polycarbonate	\$0 copay		\$0 copay		\$0 copay		\$0 copay	
Standard Anti-Reflective Coating	Up to \$45 copay		Up to \$45 copay		Up to \$45 copay		Up to \$45 copay	
Disposable	20% off retail price		20% off retail price		20% off retail price		20% off retail price	
Frames (eligible once every calendar year)								
	\$200 allowance, 20% off balance over \$200	Plan pays up to \$47	\$200 allowance, 20% off balance over \$200	Plan pays up to \$47	\$200 allowance, 20% off balance over \$200	Plan pays up to \$47	\$200 allowance, 20% off balance over \$200	Plan pays up to \$47
Contact Lenses (eligible once every								
Conventional	\$200 allowance, 15% off balance over \$200	Plan pays up to \$100	\$200 allowance, 15% off balance over \$200	Plan pays up to \$100	\$200 allowance, 15% off balance over \$200	Plan pays up to \$100	\$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	\$200 allowance, then you pay balance over \$200	Plan pays up to \$100	\$200 allowance, then you pay balance over \$200	Plan pays up to \$100	\$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	Out-
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	\$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, fluoride sealants)	You pay \$0 (not subject to annual deductible)			You pay \$0 (not subject to annual deductible)			You pay \$0 (not subject to annual deductible)		
Basic Services (Includes fillings, simple extractions, root canals, oral)	You pay 15% coinsurance	You pay 15% coinsurance	You pay 25% coinsurance	You pay 15% coinsurance	You pay 15% coinsurance	You pay 25% coinsurance	You pay 20% coinsurance	You pay 20% coinsurance	You pay 30% coinsurance
Major Services (Includes crowns)	You pay 15% coinsurance	You pay 15% coinsurance	You pay 25% coinsurance	You pay 50% coinsurance	You pay 50% coinsurance	You pay 60% coinsurance	You pay 60% coinsurance	You pay 60% coinsurance	You pay 99% coinsurance
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	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	Not covered. You pay 100%.	Not covered. You pay 100%.	Not covered. You pay 100%.



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