



2024 Medical Trust Health Plan	Anthem BCBS BlueCard PPO 100		Anthem BCBS BlueCard PPO 90		Anthem BCBS BlueCard PPO 80		Anthem BCBS BlueCard PPO 70		Anthem BCBS CDHP 15/HSA	
	Network	Out-of-Network	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)	\$0 per person \$0 per family	\$500 per person \$1,000 per family	\$500 per person \$1,000 per family	\$1,000 per person \$2,000 per family	\$1,000 per person \$2,000 per family		\$3,500 per person \$7,000 per family	\$7,000 per person \$14,000 per family	\$1,600 per person \$3,200 per family (deductible is non-embedded)	\$3,200 per person \$6,400 per family (deductible is non-embedded)
Annual Out-of-Pocket Limit	\$2,000 per person \$4,000 per family	\$4,000 per person \$8,000 per family	\$2,500 per person \$5,000 per family	\$5,000 per person \$10,000 per family	\$3,500 per person \$7,000 per family	\$7,000 per person \$14,000 per family	\$5,000 per person \$10,000 per family	\$10,000 per person \$20,000 per family	\$2,400 per person \$4,800 per family (out-of-pocket)	\$4,800 per person \$9,600 per family (out-of-pocket limit is non-embedded)
<b>Preventive Care</b>										
Preventive Services & Well-Child Care	\$0 copay	50% coinsurance plus any balance billing	\$0 copay	50% coinsurance plus any balance billing	\$0 copay	50% coinsurance plus any balance billing	\$0 copay	50% coinsurance plus any balance billing	\$0 copay	40% coinsurance plus any balance billing
<b>Physician Services</b>										
Office Visit	\$30 copay	50% coinsurance plus any balance billing	\$30 copay	50% coinsurance plus any balance billing	\$30 copay	50% coinsurance plus any balance billing	\$30 copay	50% coinsurance plus any balance billing	15% coinsurance	40% coinsurance plus any balance billing
Diagnostic Services (outpatient) (non-routine)	\$0 copay	50% coinsurance plus any balance billing	10% coinsurance	50% coinsurance plus any balance billing	20% coinsurance	50% coinsurance plus any balance billing	30% coinsurance	50% coinsurance plus any balance billing	15% coinsurance	40% coinsurance plus any balance billing
Specialist Care	\$45 copay	50% coinsurance plus any balance billing	\$45 copay	50% coinsurance plus any balance billing	\$45 copay	50% coinsurance plus any balance billing	\$45 copay	50% coinsurance plus any balance billing	15% coinsurance	40% coinsurance plus any balance billing
<b>Hospital Services</b>										
Inpatient Services (including inpatient maternity services)	\$250 copay	50% coinsurance plus any balance billing	10% coinsurance	50% coinsurance plus any balance billing	20% coinsurance	50% coinsurance plus any balance billing	30% coinsurance	50% coinsurance plus any balance billing	15% coinsurance	40% coinsurance plus any balance billing
Outpatient Surgery	\$200 copay	50% coinsurance plus any balance billing	10% coinsurance	50% coinsurance plus any balance billing	20% coinsurance	50% coinsurance plus any balance billing	30% coinsurance	50% coinsurance plus any balance billing	15% coinsurance	40% coinsurance plus any balance billing
Emergency Room Care	\$250 copay	Covered at in-network benefit level	\$250 copay	Covered at in-network benefit level	\$250 copay	Covered at in-network benefit level	\$250 copay	Covered at in-network benefit level	15% coinsurance	Covered at in-network benefit level
Ambulance Services	\$0 copay	Covered at in-network benefit level for emergency transport	10% coinsurance	Covered at in-network benefit level for emergency transport	20% coinsurance	Covered at in-network benefit level for emergency transport	30% coinsurance	Covered at in-network benefit level for emergency transport	15% coinsurance	Covered at in-network benefit level for emergency transport
<b>Behavioral Health</b>										
Outpatient Services	\$0 copay	30% coinsurance plus any balance billing	\$30 copay	30% coinsurance plus any balance billing	\$30 copay	30% coinsurance plus any balance billing	\$30 copay	30% coinsurance plus any balance billing	15% coinsurance	40% coinsurance plus any balance billing
Inpatient Services	\$250 copay	50% coinsurance plus any balance billing	10% coinsurance	50% coinsurance plus any balance billing	20% coinsurance	50% coinsurance plus any balance billing	30% coinsurance	50% coinsurance plus any balance billing	15% coinsurance	40% coinsurance plus any balance billing
<b>Other Medical Services</b>										
Durable Medical Equipment	\$0 copay	50% coinsurance plus any balance billing	10% coinsurance	50% coinsurance plus any balance billing	20% coinsurance	50% coinsurance plus any balance billing	30% coinsurance	50% coinsurance plus any balance billing	15% coinsurance	40% coinsurance plus any balance billing
Home Health Care (210 visits per calendar year, combined network and out-of-network)	\$0 copay	50% coinsurance plus any balance billing	10% coinsurance	50% coinsurance plus any balance billing	20% coinsurance	50% coinsurance plus any balance billing	30% coinsurance	50% coinsurance plus any balance billing	15% coinsurance	40% 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)	\$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)	\$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)	15% coinsurance (includes speech, physical, and occupational)	40% 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)	\$0 copay	50% coinsurance plus any balance billing	10% coinsurance	50% coinsurance plus any balance billing	20% coinsurance	50% coinsurance plus any balance billing	30% coinsurance	50% coinsurance plus any balance billing	15% coinsurance	40% coinsurance plus any balance billing
Urgent Care Services	\$50 copay	\$50 copay plus any balance billing	\$50 copay	\$50 copay plus any balance billing	\$50 copay	\$50 copay plus any balance billing	\$50 copay	\$50 copay plus any balance billing	15% coinsurance	15% coinsurance plus any balance billing



2024 Medical Trust Health Plan	Cigna OAP PPO 100		Cigna OAP PPO 90		Cigna OAP PPO 80		Cigna OAP PPO 70		Cigna CDHP 15/HSA	
	Network	Out-of-Network	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)	\$0 per person \$0 per family	\$500 per person \$1,000 per family	\$500 per person \$1,000 per family	\$1,000 per person \$2,000 per family	\$1,000 per person \$2,000 per family	\$2,000 per person \$4,000 per family	\$3,500 per person \$7,000 per family	\$7,000 per person \$14,000 per family	\$1,600 per person \$3,200 per family (deductible is non-embedded)	\$3,200 per person \$6,400 per family (deductible is non-embedded)
Annual Out-of-Pocket Limit	\$2,000 per person \$4,000 per family	\$4,000 per person \$8,000 per family	\$2,500 per person \$5,000 per family	\$5,000 per person \$10,000 per family	\$3,500 per person \$7,000 per family	\$7,000 per person \$14,000 per family	\$5,000 per person \$10,000 per family	\$10,000 per person \$20,000 per family	\$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)
<b>Preventive Care</b>										
Preventive Services & Well-Child Care	\$0 copay	50% coinsurance plus any balance billing	\$0 copay	50% coinsurance plus any balance billing	\$0 copay	50% coinsurance plus any balance billing	\$0 copay	50% coinsurance plus any balance billing	\$0 copay	40% coinsurance plus any balance billing
<b>Physician Services</b>										
Office Visit	\$30 copay	50% coinsurance plus any balance billing	\$30 copay	50% coinsurance plus any balance billing	\$30 copay	50% coinsurance plus any balance billing	\$30 copay	50% coinsurance plus any balance billing	15% coinsurance	40% coinsurance plus any balance billing
Diagnostic Services (outpatient) (non-routine)	\$0 copay	50% coinsurance plus any balance billing	10% coinsurance	50% coinsurance plus any balance billing	20% coinsurance	50% coinsurance plus any balance billing	30% coinsurance	50% coinsurance plus any balance billing	15% coinsurance	40% coinsurance plus any balance billing
Specialist Care	\$45 copay	50% coinsurance plus any balance billing	\$45 copay	50% coinsurance	\$45 copay	50% coinsurance	\$45 copay	50% coinsurance	15% coinsurance	40% coinsurance plus any balance billing
<b>Hospital Services</b>										
Inpatient Services (including inpatient maternity services)	\$250 copay	50% coinsurance plus any balance billing	10% coinsurance	50% coinsurance plus any balance billing	20% coinsurance	50% coinsurance plus any balance billing	30% coinsurance	50% coinsurance plus any balance billing	15% coinsurance	40% coinsurance plus any balance billing
Outpatient Surgery	\$200 copay	50% coinsurance plus any balance billing	10% coinsurance	50% coinsurance plus any balance billing	20% coinsurance	50% coinsurance plus any balance billing	30% coinsurance	50% coinsurance plus any balance billing	15% coinsurance	40% coinsurance plus any balance billing
Emergency Room Care	\$250 copay	Covered at in-network benefit level	\$250 copay	Covered at in-network benefit level	\$250 copay	Covered at in-network benefit level	\$250 copay	Covered at in-network benefit level	15% coinsurance	Covered at in-network benefit level
Ambulance Services	\$0 copay	Covered at in-network benefit level for emergency transport	10% coinsurance	Covered at in-network benefit level for emergency transport	20% coinsurance	Covered at in-network benefit level for emergency transport	30% coinsurance	Covered at in-network benefit level for emergency transport	15% coinsurance	Covered at in-network benefit level for emergency transport
<b>Behavioral Health</b>										
Outpatient Services	\$0 copay	30% coinsurance plus any balance billing	\$30 copay	30% coinsurance plus any balance billing	\$30 copay	30% coinsurance plus any balance billing	\$30 copay	30% coinsurance plus any balance billing	15% coinsurance	40% coinsurance plus any balance billing
Inpatient Services	\$250 copay	50% coinsurance plus any balance billing	10% coinsurance	50% coinsurance plus any balance billing	20% coinsurance	50% coinsurance plus any balance billing	30% coinsurance	50% coinsurance plus any balance billing	15% coinsurance	40% coinsurance plus any balance billing
<b>Other Medical Services</b>										
Durable Medical Equipment	\$0 copay	50% coinsurance plus any balance billing	10% coinsurance	50% coinsurance plus any balance billing	20% coinsurance	50% coinsurance plus any balance billing	30% coinsurance	50% coinsurance plus any balance billing	15% coinsurance	40% coinsurance plus any balance billing
Home Health Care (210 visits per calendar year, combined network and out-of-network)	\$0 copay	50% coinsurance plus any balance billing	10% coinsurance	50% coinsurance plus any balance billing	20% coinsurance	50% coinsurance plus any balance billing	30% coinsurance	50% coinsurance plus any balance billing	15% coinsurance	40% 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)	\$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)	\$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)	15% coinsurance (includes speech, physical, and occupational)	40% 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)	\$0 copay	50% coinsurance plus any balance billing	10% coinsurance	50% coinsurance plus any balance billing	20% coinsurance	50% coinsurance plus any balance billing	30% coinsurance	50% coinsurance plus any balance billing	15% coinsurance	40% coinsurance plus any balance billing
Urgent Care Services	\$50 copay	\$50 copay plus any balance billing	\$50 copay	\$50 copay plus any balance billing	\$50 copay	\$50 copay plus any balance billing	\$50 copay	\$50 copay plus any balance billing	15% coinsurance	15% coinsurance plus any balance billing



2024 Medical Trust Health Plan	Kaiser EPO High		Kaiser EPO 80		Kaiser CDHP 20/HSA	
	Network	Out-of-Network	Network	Out-of-Network	Network	Out-of-Network
Annual Deductible (CDHPs have a combined medical & Rx deductible)	\$0 per person \$0 per family	Not Applicable	\$500 per person \$1,000 per family	Not Applicable	\$3,200 per person \$5,450 per family	Not Applicable
Annual Out-of-Pocket Limit	\$1,750 per person \$3,500 per family	Not Applicable	\$3,500 per person \$7,000 per family	Not Applicable	\$4,200 per person \$8,450 per family	Not Applicable
<b>Preventive Care</b>						
Preventive Services & Well-Child Care	\$0 copay	Not Applicable	\$0 copay	Not Applicable	\$0 copay	Not Applicable
<b>Physician Services</b>						
Office Visit	\$25 copay	Not Applicable	\$25 copay	Not Applicable	20% coinsurance	Not Applicable
Diagnostic Services (outpatient) (non-routine)	\$50 copay	Not Applicable	20% coinsurance	Not Applicable	20% coinsurance	Not Applicable
Specialist Care	\$25 copay	Not Applicable	\$35 copay	Not Applicable	20% coinsurance	Not Applicable
<b>Hospital Services</b>						
Inpatient Services (including inpatient maternity services)	\$100 per day copay to maximum of \$600	Not Applicable	20% coinsurance	Not Applicable	20% coinsurance	Not Applicable
Outpatient Surgery	\$100 copay	Not Applicable	20% coinsurance	Not Applicable	20% coinsurance	Not Applicable
Emergency Room Care	\$100 copay	Covered at in-network benefit level	20% coinsurance	Covered at in-network benefit level	20% coinsurance	Covered at in-network benefit level
Ambulance Services	\$0 copay	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
<b>Behavioral Health</b>						
Outpatient Services	\$25 copay per visit for individual visit	Not Applicable	\$25 copay per visit for individual	Not Applicable	20% coinsurance	Not Applicable
Inpatient Services	\$100 per day copay to maximum of \$600	Not Applicable	20% coinsurance	Not Applicable	20% coinsurance	Not Applicable
<b>Other Medical Services</b>						
Durable Medical Equipment	\$0 copay	Not Applicable	20% coinsurance	Not Applicable	20% coinsurance	Not Applicable
Home Health Care (210 visits per calendar year, combined network and out-of-network)	\$0 copay	Not Applicable	\$0 copay	Not Applicable	\$0 copay	Not Applicable
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)	\$25 copay (includes speech, physical, and occupational)	Not Applicable	\$25 copay (includes speech, physical, and occupational)	Not Applicable	20% coinsurance (includes speech, physical, and occupational)	Not Applicable
Skilled Nursing / Acute Rehabilitation Facility (60 days per calendar year, combined network and out-of-network)	\$0 copay	Not Applicable	20% coinsurance	Not Applicable	20% coinsurance	Not Applicable
Urgent Care Services	\$50 copay	Not Applicable	\$50 copay	Not Applicable	20% coinsurance	Not Applicable