2024 Medical Plan

Comparisons & Descriptions

EPISCOPAL CHURCH MEDICAL TRUST

2024 Medical Trust Health Plan 0497 - Diocese of Michigan	Anthem BCBS BlueCard PPO 100		Anthem BCBS BlueCard PPO 90		Anthem BCBS BlueCard PPO 80	
	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
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
Preventive Care						
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
Physician Services						
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
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
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
Hospital Services						
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
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
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
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
Behavioral Health						
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
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
Other Medical Services						
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
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

2024 Medical Trust Health Plan 0497 - Diocese of Michigan	Anthem BCBS BlueCard PPO 100		Anthem BCBS BlueCard PPO 90		Anthem BCBS BlueCard PPO 80	
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)
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
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

EPISCOPAL CHURCH MEDICAL TRUST

2024 Medical Trust Health Plan 0497 - Diocese of Michigan	Anthem BCBS BlueCard PPO 100		Anthem BCBS BlueCard PPO 90		Anthem BCBS BlueCard PPO 80	
	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**
Annual Prescription Deductible (In-network)	None	None	None	None	None	None
Tier 1: Generic	Up to a $10 copay	Up to a $25 copay	Up to a $10 copay	Up to a $25 copay	Up to a $10 copay	Up to a $25 copay
Tier 2: Preferred Brand Name	25%; up to $40 min / $80 max	25%; up to $100 min / $200 max	25%; up to $40 min / $80 max	25%; up to $100 min / $200 max	25%; up to $40 min / $80 max	25%; up to $100 min / $200 max
Tier 3: Non-Preferred Brand Name	40%; up to $80 min / $160 max	40%; up to $200 min / $400 max	40%; up to $80 min / $160 max	40%; up to $200 min / $400 max	40%; up to $80 min / $160 max	40%; up to $200 min / $400 max
Tier 4: Specialty Rx	40%; up to $100 min / $200 max	40%; up to $250 min / $500 max	40%; up to $100 min / $200 max	40%; up to $250 min / $500 max	40%; up to $100 min / $200 max	40%; up to $250 min / $500 max
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	Up to a 90-day supply

EPISCOPAL CHURCH MEDICAL TRUST

2024 Medical Trust Health Plan 0497 - Diocese of Michigan	Anthem BCBS BlueCard PPO 100		Anthem BCBS BlueCard PPO 90		Anthem BCBS BlueCard PPO 80	
	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**
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
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
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
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,
Tint (solid and gradient)	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	
Standard Polycarbonate	$0 copay		$0 copay		$0 copay	
Standard Anti-Reflective Coating	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	
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
Contact Lenses (eligible once every calendar year)						
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
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

EPISCOPAL CHURCH MEDICAL TRUST

2024 Medical Trust Health Plan 0497 - Diocese of Michigan	Anthem BCBS CDHP 15/HSA		Anthem BCBS CDHP 20/HSA	
	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
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
Preventive Care				
Preventive Services & Well-Child Care	$0 copay	40% coinsurance plus any balance billing	$0 copay	45% 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
Diagnostic Services (outpatient) (non-routine)	15% coinsurance	40% coinsurance plus any balance billing	20% coinsurance	45% coinsurance plus any balance billing
Specialist Care	15% coinsurance	40% coinsurance plus any balance billing	20% coinsurance	45% coinsurance plus any balance billing
Hospital Services				
Inpatient Services (including inpatient maternity services)	15% coinsurance	40% coinsurance plus any balance billing	20% coinsurance	45% coinsurance plus any balance billing
Outpatient Surgery	15% coinsurance	40% coinsurance plus any balance billing	20% coinsurance	45% coinsurance plus any balance billing
Emergency Room Care	15% coinsurance	Covered at in-network benefit level	20% coinsurance	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
Behavioral Health				
Outpatient Services	15% coinsurance	40% coinsurance plus any balance billing	20% coinsurance	45% coinsurance plus any balance billing
Inpatient Services	15% coinsurance	40% coinsurance plus any balance billing	20% coinsurance	45% 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
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

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2024 Medical Trust Health Plan 0497 - Diocese of Michigan	Anthem BCBS CDHP 15/HSA		Anthem BCBS CDHP 20/HSA	
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)
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
Urgent Care Services	15% coinsurance	15% coinsurance plus any balance billing	20% coinsurance	20% coinsurance plus any balance billing

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	Pharmacy Benefits Administered by Express Scripts		Pharmacy Benefits Administered by Express Scripts	
Prescription Drug Benefits	**Retail**	**Home Delivery**	**Retail**	**Home Delivery**
Annual Prescription Deductible (In-network)	$1,600 per person $3,200 per family (combined with medical deductible) (non-embedded deductible)	$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)	$3,200 per person $5,450 per family (combined with medical deductible)
Tier 1: Generic	You pay 15% after deductible	You pay 15% after deductible	You pay 15% after deductible	You pay 15% after deductible
Tier 2: Preferred Brand Name	You pay 25% after deductible	You pay 25% after deductible	You pay 25% after deductible	You pay 25% after deductible
Tier 3: Non-Preferred Brand Name	You pay 50% after deductible	You pay 50% after deductible	You pay 50% after deductible	You pay 50% after deductible
Tier 4: Specialty Rx	You pay 50% after deductible	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 (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 90-day supply (mail order)	Up to a 30-day supply (retail) or 90-day supply (mail order)

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Standard progressive (add-on to bifocal)	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,
Tint (solid and gradient)	Up to $15 copay		Up to $15 copay	
Standard Scratch Resistance	Up to $15 copay		Up to $15 copay	
Standard Polycarbonate	$0 copay		$0 copay	
Standard Anti-Reflective Coating	Up to $45 copay		Up to $45 copay	
Disposable	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
Contact Lenses (eligible once every calendar year)				
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
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

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