

2024 Medical Trust Health Plan 0053 - Diocese of Arkansas	Anthem BCBS BlueCard PPO 90		Anthem BCBS BlueCard PPO 80		Anthem BCBS CDHP 20/HSA	
	Network	Out-of-Network	Network	Out-of-Network	Network	Out-of-Network
Annual Deductible (CDHPs have a combined medical & Rx deductible)	\$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	\$3,200 per person \$5,450 per family	\$3,200 per person \$6,000 per family
Annual Out-of-Pocket Limit	\$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	\$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	50% coinsurance plus any balance billing	\$0 copay	50% coinsurance plus any balance billing	\$0 copay	45% 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	20% coinsurance	45% coinsurance plus any balance billing
Diagnostic Services (outpatient) (non-routine)	10% coinsurance	50% coinsurance plus any balance billing	20% coinsurance	50% coinsurance plus any balance billing	20% coinsurance	45% coinsurance plus any balance billing
Specialist Care	\$45 copay	50% coinsurance plus any balance billing	\$45 copay	50% coinsurance plus any balance billing	20% coinsurance	45% coinsurance plus any balance billing
Hospital Services						
Inpatient Services (including inpatient maternity services)	10% coinsurance	50% coinsurance plus any balance billing	20% coinsurance	50% coinsurance plus any balance billing	20% coinsurance	45% coinsurance plus any balance billing
Outpatient Surgery	10% coinsurance	50% coinsurance plus any balance billing	20% coinsurance	50% coinsurance plus any balance billing	20% coinsurance	45% coinsurance plus any balance billing
Emergency Room Care	\$250 copay	Covered at in-network benefit level	\$250 copay	Covered at in-network benefit level	20% coinsurance	Covered at in-network benefit level
Ambulance Services	10% 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
Behavioral Health						
Outpatient Services	\$30 copay	30% coinsurance plus any balance billing	\$30 copay	30% coinsurance plus any balance billing	20% coinsurance	45% coinsurance plus any balance billing
Inpatient Services	10% coinsurance	50% coinsurance plus any balance billing	20% coinsurance	50% coinsurance plus any balance billing	20% coinsurance	45% coinsurance plus any balance billing
Other Medical Services						
Durable Medical Equipment	10% coinsurance	50% coinsurance plus any balance billing	20% coinsurance	50% 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)	10% coinsurance	50% coinsurance plus any balance billing	20% coinsurance	50% coinsurance plus any balance billing	20% coinsurance	45% coinsurance plus any balance billing

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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)	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)	10% coinsurance	50% coinsurance plus any balance billing	20% coinsurance	50% coinsurance plus any balance billing	20% coinsurance	45% coinsurance plus any balance billing
Urgent Care Services	\$50 copay	\$50 copay plus any balance billing	\$50 copay	\$50 copay 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		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	\$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	Up to a \$10 copay	Up to a \$25 copay	Up to a \$10 copay	Up to a \$25 copay	You pay 15% after deductible	You pay 15% after deductible
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	You pay 25% after deductible	You pay 25% after deductible
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	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	40%; up to \$100 min / \$200 max	40%; up to \$250 min / \$500 max	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)

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	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

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