2025 Medical Trust Health Plan	Anthem BCBS CDHP 20/HSA		Anthem BCBS CDHP 40/HSA	
	Network	Out-of-Network	Network	Out-of-Network
Annual Deductible (CDHPs have a combined medical & Rx deductible)	$3,300 per person $6,600 per family	$3,300 per person $6,600 per family	$3,500 per person $7,000 per family	$7,000 per person $14,000 per family
Annual Out-of-Pocket Limit	$4,200 per person $8,450 per family	$7,000 per person $13,000 per family	$6,000 per person $12,000 per family	$10,000 per person $20,000 per family
Preventive Care				
Preventive Services & Well-Child	$0 copay	45% coinsurance	$0 copay	60% coinsurance
Physician Services				
Office Visit	20% coinsurance	45% coinsurance	40% coinsurance	60% coinsurance
Diagnostic Services (outpatient)	20% coinsurance	45% coinsurance	40% coinsurance	60% coinsurance
Specialist Care	20% coinsurance	45% coinsurance	40% coinsurance	60% coinsurance
Hospital Services				
Inpatient Services (including inpatient	20% coinsurance	45% coinsurance	40% coinsurance	60% coinsurance
Outpatient Surgery	20% coinsurance	45% coinsurance	40% coinsurance	60% coinsurance
Emergency Room Care	20% coinsurance	20% coinsurance	40% coinsurance	40% coinsurance
Ambulance Services	20% coinsurance	20% coinsurance	40% coinsurance	40% coinsurance
Behavioral Health				
Outpatient Services	20% coinsurance	45% coinsurance	40% coinsurance	60% coinsurance
Inpatient Services	20% coinsurance	45% coinsurance	40% coinsurance	60% coinsurance
Other Medical Services				
Durable Medical Equipment	20% coinsurance	45% coinsurance	40% coinsurance	60% coinsurance
Home Health Care	20% coinsurance	45% coinsurance	40% coinsurance	60% coinsurance
Outpatient Therapy (60 visits per calendar year per each type of therapy, combined network and out-of-network)	20% coinsurance (includes speech, physical, and occupational)	45% coinsurance (includes speech, physical, and occupational)	40% coinsurance (includes speech, physical, and occupational)	60% coinsurance (includes speech, physical, and occupational)
Skilled Nursing / Acute Rehabilitation Facility	20% coinsurance	45% coinsurance	40% coinsurance	60% coinsurance
Urgent Care Services	20% coinsurance	20% coinsurance	40% coinsurance	40% coinsurance

2025 Medical Trust Health Plan	Cigna CDHP 20/HSA		Cigna CDHP 40/HSA	
	Network	Out-of-Network	Network	Out-of-Network
Annual Deductible (CDHPs have a combined medical & Rx deductible)	$3,300 per person	$3,300 per person	$3,500 per person	$7,000 per person
Annual Out-of-Pocket Limit	$4,200 per person	$7,000 per person	$6,000 per person	$10,000 per person
Preventive Care				
Preventive Services & Well-Child	$0 copay	45% coinsurance	$0 copay	60% coinsurance
Physician Services				
Office Visit	20% coinsurance	45% coinsurance	40% coinsurance	60% coinsurance
Diagnostic Services (outpatient)	20% coinsurance	45% coinsurance	40% coinsurance	60% coinsurance
Specialist Care	20% coinsurance	45% coinsurance	40% coinsurance	60% coinsurance
Hospital Services				
Inpatient Services (including inpatient	20% coinsurance	45% coinsurance	40% coinsurance	60% coinsurance
Outpatient Surgery	20% coinsurance	45% coinsurance	40% coinsurance	60% coinsurance
Emergency Room Care	20% coinsurance	20% coinsurance	40% coinsurance	40% coinsurance
Ambulance Services	20% coinsurance	20% coinsurance	40% coinsurance	40% coinsurance
Behavioral Health				
Outpatient Services	20% coinsurance	45% coinsurance	40% coinsurance	60% coinsurance
Inpatient Services	20% coinsurance	45% coinsurance	40% coinsurance	60% coinsurance
Other Medical Services				
Durable Medical Equipment	20% coinsurance	45% coinsurance	40% coinsurance	60% coinsurance
Home Health Care	20% coinsurance	45% coinsurance	40% coinsurance	60% coinsurance
Outpatient Therapy (60 visits per calendar year per each type of therapy, combined network and out-of-network)	20% coinsurance (includes speech, physical, and occupational)	45% coinsurance (includes speech, physical, and occupational)	40% coinsurance (includes speech, physical, and occupational)	60% coinsurance (includes speech, physical, and occupational)
Skilled Nursing / Acute Rehabilitation Facility	20% coinsurance	45% coinsurance	40% coinsurance	60% coinsurance
Urgent Care Services	20% coinsurance	20% coinsurance	40% coinsurance	40% coinsurance

2025 Medical Trust Health Plan	Anthem BCBS BlueCard PPO 90		Anthem BCBS BlueCard PPO 80		Anthem BCBS BlueCard PPO 70	
	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	$3,500 per person $7,000 per family	$7,000 per person $14,000 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	$5,000 per person $10,000 per family	$10,000 per person $20,000 per family
Preventive Care						
Preventive Services & Well-Child	$0 copay	50% coinsurance	$0 copay	50% coinsurance	$0 copay	50% coinsurance
Physician Services						
Office Visit	$30 copay	50% coinsurance	$30 copay	50% coinsurance	$30 copay	50% coinsurance
Diagnostic Services (outpatient)	10% coinsurance	50% coinsurance	20% coinsurance	50% coinsurance	30% coinsurance	50% coinsurance
Specialist Care	$45 copay	50% coinsurance	$45 copay	50% coinsurance	$45 copay	50% coinsurance
Hospital Services						
Inpatient Services (including inpatient	10% coinsurance	50% coinsurance	20% coinsurance	50% coinsurance	30% coinsurance	50% coinsurance
Outpatient Surgery	10% coinsurance	50% coinsurance	20% coinsurance	50% coinsurance	30% coinsurance	50% coinsurance
Emergency Room Care	$250 copay	$250 copay	$250 copay	$250 copay	$250 copay	$250 copay
Ambulance Services	10% coinsurance	10% coinsurance	20% coinsurance	20% coinsurance	30% coinsurance	30% coinsurance
Behavioral Health						
Outpatient Services	$30 copay	30% coinsurance	$30 copay	30% coinsurance	$30 copay	30% coinsurance
Inpatient Services	10% coinsurance	50% coinsurance	20% coinsurance	50% coinsurance	30% coinsurance	50% coinsurance
Other Medical Services						
Durable Medical Equipment	10% coinsurance	50% coinsurance	20% coinsurance	50% coinsurance	30% coinsurance	50% coinsurance
Home Health Care	10% coinsurance	50% coinsurance	20% coinsurance	50% coinsurance	30% coinsurance	50% coinsurance
Outpatient 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 (includes speech, physical, and occupational)	$30 copay PCP/$45 copay specialist (includes speech, physical, and occupational)	50% coinsurance (includes speech, physical, and occupational)	$30 copay PCP/$45 copay specialist (includes speech, physical, and occupational)	50% coinsurance (includes speech, physical, and occupational)
Skilled Nursing / Acute Rehabilitation Facility	10% coinsurance	50% coinsurance	20% coinsurance	50% coinsurance	30% coinsurance	50% coinsurance
Urgent Care Services	$50 copay	$50 copay	$50 copay	$50 copay	$50 copay	$50 copay

2025 Medical Trust Health Plan	Cigna OAP PPO 90		Cigna OAP PPO 80		Cigna OAP PPO 70	
	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	$3,500 per person $7,000 per family	$7,000 per person $14,000 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	$5,000 per person $10,000 per family	$10,000 per person $20,000 per family
Preventive Care						
Preventive Services & Well-Child	$0 copay	50% coinsurance	$0 copay	50% coinsurance	$0 copay	50% coinsurance
Physician Services						
Office Visit	$30 copay	50% coinsurance	$30 copay	50% coinsurance	$30 copay	50% coinsurance
Diagnostic Services (outpatient)	10% coinsurance	50% coinsurance	20% coinsurance	50% coinsurance	30% coinsurance	50% coinsurance
Specialist Care	$45 copay	50% coinsurance	$45 copay	50% coinsurance	$45 copay	50% coinsurance
Hospital Services						
Inpatient Services (including inpatient	10% coinsurance	50% coinsurance	20% coinsurance	50% coinsurance	30% coinsurance	50% coinsurance
Outpatient Surgery	10% coinsurance	50% coinsurance	20% coinsurance	50% coinsurance	30% coinsurance	50% coinsurance
Emergency Room Care	$250 copay	$250 copay	$250 copay	$250 copay	$250 copay	$250 copay
Ambulance Services	10% coinsurance	10% coinsurance	20% coinsurance	20% coinsurance	30% coinsurance	30% coinsurance
Behavioral Health						
Outpatient Services	$30 copay	30% coinsurance	$30 copay	30% coinsurance	$30 copay	30% coinsurance
Inpatient Services	10% coinsurance	50% coinsurance	20% coinsurance	50% coinsurance	30% coinsurance	50% coinsurance
Other Medical Services						
Durable Medical Equipment	10% coinsurance	50% coinsurance	20% coinsurance	50% coinsurance	30% coinsurance	50% coinsurance
Home Health Care	10% coinsurance	50% coinsurance	20% coinsurance	50% coinsurance	30% coinsurance	50% coinsurance
Outpatient 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 (includes speech, physical, and occupational)	$30 copay PCP/$45 copay specialist (includes speech, physical, and	50% coinsurance (includes speech, physical, and occupational)	$30 copay PCP/$45 copay specialist (includes speech, physical, and occupational)	50% coinsurance (includes speech, physical, and occupational)
Skilled Nursing / Acute Rehabilitation Facility	10% coinsurance	50% coinsurance	20% coinsurance	50% coinsurance	30% coinsurance	50% coinsurance
Urgent Care Services	$50 copay	$50 copay	$50 copay	$50 copay	$50 copay	$50 copay

EPISCOPAL CHURCH MEDICAL TRUST

	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 (Maximum cross applies across networks)	$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)			You pay $0 (not subject to annual deductible)		
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	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, bridges, and dentures)	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%.

EPISCOPAL CHURCH MEDICAL TRUST

2025 Prescription Drug Benefits

	Express Scripts					
	Standard		Premium		CDHP-20/HSA	CDHP-40/HSA
	Retail	Home Delivery	Retail	Home Delivery	Retail and Home Delivery	Retail and Home Delivery
Annual Prescription Deductible (in-network)	None	None	None	None	$3,300 per person $6,600 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 $25 copay	Up to a $5 copay	Up to a $12 copay	You pay 15% after deductible	You pay 15% after deductible
Tier 2: Preferred Brand Name	Up to a $40 copay	Up to $100 copay	Up to a $30 copay	Up to a $75 copay	You pay 25% after deductible	You pay 25% after deductible
Tier 3: Non-Preferred Brand Name	Up to a $80 copay	Up to $200 copay	Up to a $60 copay	Up to a $150 copay	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
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)

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

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The Plans are church plans within the meaning of section 3(33) of the Employee Retirement Income Security Act of 1974, as amended, and section 414(e) of the Internal Revenue Code. Not all Plans are available in all areas of the United States or outside the United States, and not all Plans are available on both a self-funded and fully insured basis. Additionally, the Plan may be exempt from federal and state laws that may otherwise apply to health insurance arrangements. The Plans do not cover all healthcare expenses, so members should read the official Plan documents carefully to determine which benefits