

2025 Medical Trust Health Plan	Anthem BCBS BlueCard PPO 90		Anthem BCBS BlueCard PPO 80	
	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
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
Preventive Care				
Preventive Services & Well-Child Care	\$0 copay	50% coinsurance	\$0 copay	50% coinsurance
Physician Services				
Office Visit	\$30 copay	50% coinsurance	\$30 copay	50% coinsurance
Diagnostic Services (outpatient)	10% coinsurance	50% coinsurance	20% coinsurance	50% coinsurance
Specialist Care	\$45 copay	50% coinsurance	\$45 copay	50% coinsurance
Hospital Services				
Inpatient Services (including inpatient maternity services)	10% coinsurance	50% coinsurance	20% coinsurance	50% coinsurance
Outpatient Surgery	10% coinsurance	50% coinsurance	20% coinsurance	50% coinsurance
Emergency Room Care	\$250 copay	\$250 copay	\$250 copay	\$250 copay
Ambulance Services	10% coinsurance	10% coinsurance	20% coinsurance	20% coinsurance
Behavioral Health				
Outpatient Services	\$30 copay	30% coinsurance	\$30 copay	30% coinsurance
Inpatient Services	10% coinsurance	50% coinsurance	20% coinsurance	50% coinsurance
Other Medical Services				
Durable Medical Equipment	10% coinsurance	50% coinsurance	20% coinsurance	50% coinsurance
Home Health Care (210 visits per calendar year, combined network and out-of-network)	10% coinsurance	50% coinsurance	20% 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)
2025 Medical Trust Health Plan				
	Anthem BCBS BlueCard PPO 90		Anthem BCBS BlueCard PPO 80	
Skilled Nursing / Acute Rehabilitation Facility (60 days per calendar year, combined network and out-of-network)	10% coinsurance	50% coinsurance	20% coinsurance	50% coinsurance
Urgent Care Services	\$50 copay	\$50 copay	\$50 copay	\$50 copay
2025 Medical Trust Health Plan				
	Anthem BCBS BlueCard PPO 90		Anthem BCBS BlueCard PPO 80	
	Pharmacy Benefits Administered by Express Scripts		Pharmacy Benefits Administered by Express Scripts	
	Retail	Home Delivery	Retail	Home Delivery
Prescription Drug Benefits				
Annual Prescription Deductible (in-network)	None	None	None	None
Tier 1: Generic	Up to a \$10 copay	Up to a \$10 copay	Up to a \$10 copay	Up to a \$10 copay
Tier 2: Preferred Brand Name	25%; up to \$40 min / \$80 max	25%; up to \$40 min / \$80 max	25%; up to \$40 min / \$80 max	25%; up to \$40 min / \$80 max
Tier 3: Non-Preferred Brand Name	40%; up to \$80 min / \$160 max	40%; up to \$80 min / \$160 max	40%; up to \$80 min / \$160 max	40%; up to \$80 min / \$160 max
Tier 4: Specialty Rx	40%; up to \$100 min / \$200 max	40%; up to \$100 min / \$200 max	40%; up to \$100 min / \$200 max	40%; up to \$100 min / \$200 max
Dispensing Limits Per Copayment	Up to a 30-day supply	Up to a 30-day supply	Up to a 30-day supply	Up to a 30-day supply
2025 Medical Trust Health Plan				
	Anthem BCBS BlueCard PPO 90		Anthem BCBS BlueCard PPO 80	
	Vision Benefits Administered by EyeMed		Vision Benefits Administered by EyeMed	
	Network	Out-of-Network	Network	Out-of-Network
Vision Benefits				
Eye Examinations	\$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
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
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

2025 Medical Trust Health Plan	Anthem BCBS CDHP 15/HSA		Anthem BCBS CDHP 20/HSA		Anthem BCBS CDHP 40/HSA		
	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)	\$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	\$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	\$6,000 per person \$12,000 per family	\$10,000 per person \$20,000 per family	
Preventive Care							
Preventive Services & Well-Child Care	\$0 copay	40% coinsurance	\$0 copay	45% coinsurance	\$0 copay	60% coinsurance	
Physician Services							
Office Visit	15% coinsurance	40% coinsurance	20% coinsurance	45% coinsurance	40% coinsurance	60% coinsurance	
Diagnostic Services (outpatient)	15% coinsurance	40% coinsurance	20% coinsurance	45% coinsurance	40% coinsurance	60% coinsurance	
Specialist Care	15% coinsurance	40% coinsurance	20% coinsurance	45% coinsurance	40% coinsurance	60% coinsurance	
Hospital Services							
Inpatient Services (including inpatient maternity services)	15% coinsurance	40% coinsurance	20% coinsurance	45% coinsurance	40% coinsurance	60% coinsurance	
Outpatient Surgery	15% coinsurance	40% coinsurance	20% coinsurance	45% coinsurance	40% coinsurance	60% coinsurance	
Emergency Room Care	15% coinsurance	15% coinsurance	20% coinsurance	20% coinsurance	40% coinsurance	40% coinsurance	
Ambulance Services	15% coinsurance	15% coinsurance	20% coinsurance	20% coinsurance	40% coinsurance	40% coinsurance	
Behavioral Health							
Outpatient Services	15% coinsurance	40% coinsurance	20% coinsurance	45% coinsurance	40% coinsurance	60% coinsurance	
Inpatient Services	15% coinsurance	40% coinsurance	20% coinsurance	45% coinsurance	40% coinsurance	60% coinsurance	
Other Medical Services							
Durable Medical Equipment	15% coinsurance	40% coinsurance	20% coinsurance	45% coinsurance	40% coinsurance	60% coinsurance	
Home Health Care (210 visits per calendar year, combined network and out-of-network)	15% coinsurance	40% coinsurance	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)	15% coinsurance (includes speech, physical, and occupational)	40% coinsurance (includes speech, physical, and occupational)	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)	
2025 Medical Trust Health Plan							
		Anthem BCBS CDHP 15/HSA		Anthem BCBS CDHP 20/HSA		Anthem BCBS CDHP 40/HSA	
Skilled Nursing / Acute Rehabilitation Facility (60 days per calendar year, combined network and out-of-network)	15% coinsurance	40% coinsurance	20% coinsurance	45% coinsurance	40% coinsurance	60% coinsurance	
Urgent Care Services	15% coinsurance	15% coinsurance	20% coinsurance	20% coinsurance	40% coinsurance	40% coinsurance	
2025 Medical Trust Health Plan							
		Anthem BCBS CDHP 15/HSA		Anthem BCBS CDHP 20/HSA		Anthem BCBS CDHP 40/HSA	
		Pharmacy Benefits Administered by Express Scripts		Pharmacy Benefits Administered by Express Scripts		Pharmacy Benefits Administered by Express Scripts	
		Retail	Home Delivery	Retail	Home Delivery	Retail	Home Delivery
Prescription Drug Benefits							
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)	\$3,300 per person \$6,600 per family (combined with medical deductible)	\$3,300 per person \$6,600 per family (combined with medical deductible)	\$3,500 per person \$7,000 per family (combined with medical deductible)	\$3,500 per person \$7,000 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	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	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	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	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	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 (retail) or 90-day supply	Up to a 30-day supply (retail) or 90-day supply	Up to a 30-day supply (retail) or 90-day supply	
2025 Medical Trust Health Plan							
		Anthem BCBS CDHP 15/HSA		Anthem BCBS CDHP 20/HSA		Anthem BCBS CDHP 40/HSA	
		Vision Benefits Administered by EyeMed		Vision Benefits Administered by EyeMed		Vision Benefits Administered by EyeMed	
		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)							
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	

	2025 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%.

2025 Prescription Drug Benefits

	Express Scripts						CDHP-20/HSA Retail and Home Delivery	CDHP-40/HSA Retail and Home Delivery
	Standard		Premium		CDHP-15/HSA Retail and Home Delivery			
	Retail	Home Delivery	Retail	Home Delivery				
Annual Prescription Deductible (in-network)	None	None	None	None	\$1,650 per person \$3,300 per family (combined with medical deductible) (non-embedded deductible)	\$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 a \$25 copay	Up to a \$5 copay	Up to a \$12 copay	You pay 15% after deductible	You pay 15% after deductible	You pay 15% after deductible	
Tier 2: Preferred Brand Name	Up to a \$40 copay	Up to a \$100 copay	Up to a \$30 copay	Up to a \$75 copay	You pay 25% after deductible	You pay 25% after deductible	You pay 25% after deductible	
Tier 3: Non-Preferred Brand Name	Up to a \$80 copay	Up to a \$200 copay	Up to a \$60 copay	Up to a \$150 copay	You pay 50% after deductible	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	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)	Up to a 30-day supply (retail) or 90-day supply (mail order)	

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Church Pension Group Services Corporation ("CPGSC"), doing business as The Episcopal Church Medical Trust, maintains a series of health and welfare plans (the "Plans") for eligible employees (and their eligible dependents) of The Episcopal Church (the "Church"). The Medical Trust serves only eligible Episcopal employers. The Plans that are self-funded are funded by the Episcopal Church Clergy and Employees' Benefit Trust, a voluntary employees' trust.

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