EPISCOPAL CHURCH MEDICAL TRUST

2025 Medical Trust Health Plan 1008 - Diocese of Washington	Anthem BCBS BlueCard PPO 100		Anthem BCBS BlueCard PPO 80		Anthem BCBS CDHP 15/HSA		Kaiser EPO High		Kaiser EPO 80	
	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	$1,000 per person $2,000 per family	$2,000 per person $4,000 per family	$1,650 per person $3,300 per family (deductible is non-embedded)	$3,300 per person $6,600 per family (deductible is non-embedded)	$0 per person $0 per family	Not Applicable	$500 per person $1,000 per family	Not Applicable
Annual Out-of-Pocket Limit	$2,000 per person $4,000 per family	$4,000 per person $8,000 per family	$3,500 per person $7,000 per family	$7,000 per person $14,000 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)	$1,750 per person $3,500 per family	Not Applicable	$3,500 per person $7,000 per family	Not Applicable
Preventive Care										
Preventive Services & Well-Child Care	$0 copay	50% coinsurance	$0 copay	50% coinsurance	$0 copay	40% coinsurance	$0 copay	Not Applicable	$0 copay	Not Applicable
Physician Services										
Office Visit	$30 copay	50% coinsurance	$30 copay	50% coinsurance	15% coinsurance	40% coinsurance	$25 copay	Not Applicable	$25 copay	Not Applicable
Hospital Services										
Inpatient Services (including inpatient maternity services)	$250 copay	50% coinsurance	20% coinsurance	50% coinsurance	15% coinsurance	40% coinsurance	$100 per day copay to maximum of $600	Not Applicable	20% coinsurance	Not Applicable
Outpatient Surgery	$200 copay	50% coinsurance	20% coinsurance	50% coinsurance	15% coinsurance	40% coinsurance	$100 copay	Not Applicable	20% coinsurance	Not Applicable
Emergency Room Care	$250 copay	$250 copay	$250 copay	$250 copay	15% coinsurance	15% coinsurance	$100 copay	Not Applicable	20% coinsurance	Not Applicable
Ambulance Services	$0 copay	$0 copay	20% coinsurance	20% coinsurance	15% coinsurance	15% coinsurance	$0 copay	Not Applicable	20% coinsurance	Not Applicable
Behavioral Health										
Outpatient Services	$0 copay	30% coinsurance	$30 copay	30% coinsurance	15% coinsurance	40% coinsurance	$25 copay per visit for	Not Applicable	$25 copay per visit for	Not Applicable
Inpatient Services	$250 copay	50% coinsurance	20% coinsurance	50% coinsurance	15% coinsurance	40% coinsurance	$100 per day copay to	Not Applicable	20% coinsurance	Not Applicable
Other Medical Services										
Durable Medical Equipment	$0 copay	50% coinsurance	20% coinsurance	50% coinsurance	15% coinsurance	40% coinsurance	$0 copay	Not Applicable	20% coinsurance	Not Applicable
Home Health Care (210 visits per calendar year, combined network and out-of-network)	$0 copay	50% coinsurance	20% coinsurance	50% coinsurance	15% coinsurance	40% coinsurance	$0 copay	Not Applicable	$0 copay	Not Applicable
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)	15% coinsurance (includes speech, physical, and occupational)	40% coinsurance (includes speech, physical, and occupational)	$25 copay (includes speech, physical, and occupational)	Not Applicable	$25 copay (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	50% coinsurance	20% coinsurance	50% coinsurance	15% coinsurance	40% coinsurance	$0 copay	Not Applicable	20% coinsurance	Not Applicable
Urgent Care Services	$50 copay	$50 copay	$50 copay	$50 copay	15% coinsurance	15% coinsurance	$50 copay	Not Applicable	$50 copay	Not Applicable

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	Pharmacy Benefits Administered by Express Scripts		Pharmacy Benefits Administered by Express Scripts		Pharmacy Benefits Administered by Express Scripts		Pharmacy Benefits Administered by Kaiser		Pharmacy Benefits Administered by Kaiser	
Prescription Drug Benefits	**Retail**	**Home Delivery**	**Retail**	**Home Delivery**	**Retail**	**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)	$1,650 per person $3,300 per family (combined with medical deductible) (non-embedded deductible)	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	You pay 15% after deductible	You pay 15% after deductible	Up to a $5 copay	Up to a $5 copay	Up to a $5 copay	Up to a $5 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	You pay 25% after deductible	You pay 25% after deductible	Up to a $30 copay	Up to a $30 copay	Up to a $30 copay	Up to a $30 copay
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	You pay 50% after deductible	You pay 50% after deductible	Up to a $70 copay	Up to a $70 copay	Up to a $70 copay	Up to a $70 copay
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	You pay 50% after deductible	You pay 50% after deductible	Up to a $90 copay	Up to a $90 copay	Up to a $90 copay	Up to a $90 copay
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	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	Up to a 30-day supply	Up to a 30-day supply	Up to a 30-day supply

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	Vision Benefits Administered by EyeMed		Vision Benefits Administered by EyeMed		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**	**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	$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	$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	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,	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		Up to $15 copay		Up to $15 copay	
Standard Scratch Resistance	Up to $15 copay		Up to $15 copay		Up to $15 copay		Up to $15 copay		Up to $15 copay	
Standard Polycarbonate	$0 copay		$0 copay		$0 copay		$0 copay		$0 copay	
Standard Anti-Reflective Coating	Up to $45 copay		Up to $45 copay		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		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	$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	$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	$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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1008 - Diocese of Washington	Delta Dental					
	Premium PPO Plan			Comprehensive PPO Plan		
	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
Annual Benefit Maximum (Maxmium cross applies across networks)	$3,000	$2,500	$2,000	$2,500	$2,000	$1,500
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)		
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
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
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

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