EPISCOPAL CHURCH MEDICAL TRUST

2026 Medical Trust Health Plan 0604 - Diocese of New York	Anthem BCBS BlueCard PPO 100		Anthem BCBS BlueCard PPO 80		Anthem BCBS CDHP 20/HSA		Cigna OAP PPO 100		Cigna OAP PPO 80		Cigna CDHP 20/HSA	
	Network	Out-of-Network	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	$3,400 per person $6,800 per family	$3,400 per person $6,800 per family	$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	$3,400 per person $6,800 per family	$3,400 per person $6,800 per family
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	$4,200 per person $8,450 per family	$7,000 per person $13,000 per family	$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	$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	$0 copay	50% coinsurance	$0 copay	45% coinsurance	$0 copay	50% coinsurance	$0 copay	50% coinsurance	$0 copay	45% coinsurance
Physician Services												
Office Visit	$30 copay	50% coinsurance	$30 copay	50% coinsurance	20% coinsurance	45% coinsurance	$30 copay	50% coinsurance	$30 copay	50% coinsurance	20% coinsurance	45% coinsurance
Diagnostic Services (outpatient)	$0 copay	50% coinsurance	20% coinsurance	50% coinsurance (Deductible does not apply)	20% coinsurance	45% coinsurance	$0 copay	50% coinsurance	20% coinsurance	50% coinsurance (Deductible does not apply)	20% coinsurance	45% coinsurance
Specialist Care	$45 copay	50% coinsurance	$45 copay	50% coinsurance	20% coinsurance	45% coinsurance	$45 copay	50% coinsurance	$45 copay	50% coinsurance	20% coinsurance	45% coinsurance
Hospital Services												
Inpatient Services (including inpatient maternity services)	$250 copay	50% coinsurance	20% coinsurance	50% coinsurance	20% coinsurance	45% coinsurance	$250 copay	50% coinsurance	20% coinsurance	50% coinsurance	20% coinsurance	45% coinsurance
Outpatient Surgery	$200 copay	50% coinsurance	20% coinsurance	50% coinsurance	20% coinsurance	45% coinsurance	$200 copay	50% coinsurance	20% coinsurance	50% coinsurance	20% coinsurance	45% coinsurance
Emergency Room Care	$250 copay	$250 copay	$250 copay	$250 copay	20% coinsurance	20% coinsurance	$250 copay	$250 copay	$250 copay	$250 copay	20% coinsurance	20% coinsurance
Ambulance Services	$0 copay	$0 copay	20% coinsurance	20% coinsurance	20% coinsurance	20% coinsurance	$0 copay	$0 copay	20% coinsurance	20% coinsurance	20% coinsurance	20% coinsurance
Behavioral Health												
Outpatient Services	$0 copay	30% coinsurance	$30 copay	30% coinsurance	20% coinsurance	45% coinsurance	$0 copay	30% coinsurance	$30 copay	30% coinsurance	20% coinsurance	45% coinsurance
Inpatient Services	$250 copay	50% coinsurance	20% coinsurance	50% coinsurance	20% coinsurance	45% coinsurance	$250 copay	50% coinsurance	20% coinsurance	50% coinsurance	20% coinsurance	45% coinsurance
Other Medical Services												
Durable Medical Equipment	$0 copay	50% coinsurance	20% coinsurance	50% coinsurance	20% coinsurance	45% coinsurance	$0 copay	50% coinsurance	20% coinsurance	50% coinsurance	20% coinsurance	45% coinsurance
Home Health Care (210 visits per calendar year, combined network and out-of-network)	$0 copay	50% coinsurance	20% coinsurance	50% coinsurance	20% coinsurance	45% coinsurance	$0 copay	50% coinsurance	20% coinsurance	50% coinsurance	20% coinsurance	45% 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)	20% coinsurance (includes speech, physical, and occupational)	45% 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)	20% coinsurance (includes speech, physical, and occupational)	45% coinsurance (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	20% coinsurance	50% coinsurance	20% coinsurance	45% coinsurance	$0 copay	50% coinsurance	20% coinsurance	50% coinsurance	20% coinsurance	45% coinsurance
Urgent Care Services	$50 copay	$50 copay	$50 copay	$50 copay	20% coinsurance	45% coinsurance	$50 copay	$50 copay	$50 copay	$50 copay	20% coinsurance	45% coinsurance

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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 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	Retail	Home Delivery	Retail	Home Delivery	Retail	Home Delivery
Annual Prescription Deductible (in-network)	None	None	None	None	$3,300 per person $6,600 per family (combined with medical deductible)	$3,300 per person $6,600 per family (combined with medical deductible)	None	None	None	None	$3,300 per person $6,600 per family (combined with medical deductible)	$3,300 per person $6,600 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	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	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	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	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)	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 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	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	$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	$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	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,	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		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		Up to $15 copay	
Standard Polycarbonate	$0 copay		$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		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		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	$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 $133	$200 allowance, 15% off balance over $200	Plan pays up to $133	$200 allowance, 15% off balance over $200	Plan pays up to $133	$200 allowance, 15% off balance over $200	Plan pays up to $133	$200 allowance, 15% off balance over $200	Plan pays up to $133	$200 allowance, 15% off balance over $200	Plan pays up to $133
Disposable	$200 allowance, then you pay balance over $200	Plan pays up to $133	$200 allowance, then you pay balance over $200	Plan pays up to $133	$200 allowance, then you pay balance over $200	Plan pays up to $133	$200 allowance, then you pay balance over $200	Plan pays up to $133	$200 allowance, then you pay balance over $200	Plan pays up to $133	$200 allowance, then you pay balance over $200	Plan pays up to $133

EPISCOPAL CHURCH MEDICAL TRUST

0604 - Diocese of New York	Delta Dental								
	Basic PPO Plan			Comprehensive PPO Plan			Premium 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	$0 per person / $0 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	$50 per person / $150 per family
Annual Benefit Maximum (Maxmium cross applies across networks)	$2,000	$1,500	$1,000	$2,500	$2,000	$1,500	$3,000	$2,500	$2,000
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 20% coinsurance	You pay 20% coinsurance	You pay 30% coinsurance	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 60% coinsurance	You pay 60% coinsurance	You pay 99% coinsurance	You pay 50% coinsurance	You pay 50% coinsurance	You pay 60% coinsurance	You pay 15% coinsurance	You pay 15% coinsurance	You pay 25% coinsurance
Orthodontic Services	Not covered. You pay 100%.	Not covered. You pay 100%.	Not covered. You pay 100%.	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	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

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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' beneficiary association within the meaning of section 501(c)(9) of the Internal Revenue Code.

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 are covered, as well as any applicable exclusions, limitations, and procedures.