

2026 Medical Trust Health Plan		Anthem BCBS BlueCard PPO 90		Anthem BCBS BlueCard PPO 80		Anthem BCBS BlueCard PPO 70		Anthem BCBS CDHP 15/HSA		Anthem BCBS CDHP 20/HSA		Anthem BCBS CDHP 40/HSA	
0638 - Diocese of North Carolina													
	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)	\$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	\$1,700 per person \$3,400 per family (deductible is non- embedded)	\$3,400 per person \$6,800 per family (deductible is non- embedded)	\$3,400 per person \$6,800 per family	\$3,400 per person \$6,800 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	\$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	50% coinsurance	\$0 copay	50% coinsurance	\$0 copay	50% coinsurance	\$0 copay	40% coinsurance	\$0 copay	45% coinsurance	\$0 copay	60% coinsurance	
Physician Services Office Visit	\$30 copay	50% coinsurance	\$30 copay	50% coinsurance	\$30 copay	50% coinsurance	15% coinsurance	40% coinsurance	20% coinsurance	45% coinsurance	40% coinsurance	60% coinsurance	
Diagnostic Services (outpatient)	10% coinsurance	50% coinsurance (Deductible does not apply)	20% coinsurance	50% coinsurance (Deductible does not apply)	30% coinsurance	50% coinsurance (Deductible does not apply)	15% coinsurance	40% coinsurance	20% coinsurance	45% coinsurance	40% coinsurance	60% coinsurance	
Specialist Care	\$45 copay	50% coinsurance	\$45 copay	50% coinsurance	\$45 copay	50% coinsurance	15% coinsurance	40% coinsurance	20% coinsurance	45% coinsurance	40% coinsurance	60% coinsurance	
Hospital Services	100/	F00/	000/	500/	000/	F00/ i	450/	400/	000/	450/	400/	000/	
Inpatient Services (including inpatient maternity services)	10% coinsurance	50% coinsurance	20% coinsurance	50% coinsurance	30% coinsurance	50% coinsurance	15% coinsurance	40% coinsurance	20% coinsurance	45% coinsurance	40% coinsurance	60% coinsurance	
Outpatient Surgery	10% coinsurance	50% coinsurance	20% coinsurance	50% coinsurance	30% coinsurance	50% coinsurance	15% coinsurance	40% coinsurance	20% coinsurance	45% coinsurance	40% coinsurance	60% coinsurance	
Emergency Room Care	\$250 copay	\$250 copay	\$250 copay	\$250 copay	\$250 copay	\$250 copay	15% coinsurance	15% coinsurance	20% coinsurance	20% coinsurance	40% coinsurance	40% coinsurance	
Ambulance Services	10% coinsurance	10% coinsurance	20% coinsurance	20% coinsurance	30% coinsurance	30% coinsurance	15% coinsurance	15% coinsurance	20% coinsurance	20% coinsurance	40% coinsurance	40% coinsurance	
Behavioral Health	***		***		*								
Outpatient Services Inpatient Services	\$30 copay 10% coinsurance	30% coinsurance 50% coinsurance	\$30 copay 20% coinsurance	30% coinsurance 50% coinsurance	\$30 copay 30% coinsurance	30% coinsurance 50% coinsurance	15% coinsurance	40% coinsurance 40% coinsurance	20% coinsurance 20% coinsurance	45% coinsurance 45% coinsurance	40% coinsurance 40% coinsurance	60% coinsurance	
Other Medical Services	1070 CONTIGURATION	0070 0011130101100	2070 001130101100	0070 CONTOURANCE	0070 CON ISCHARICE	0070 COINSUITATIOC	1070 GOILISGI GILOC	40 /0 CON ISCHARIOC	2070 00111001101100	4070 COILIBRITATION	4070 CON ISCHARICE	0070 COILIBUIUI	
Durable Medical Equipment	10% coinsurance	50% coinsurance	20% coinsurance	50% coinsurance	30% coinsurance	50% coinsurance	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)	10% coinsurance	50% coinsurance	20% coinsurance	50% coinsurance	30% coinsurance	50% coinsurance	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	\$30 copay PCP/\$45 copay specialist (includes speech,	50% coinsurance (includes speech, physical, and	\$30 copay PCP/\$45 copay specialist (includes speech,	50% coinsurance (includes speech, physical, and	\$30 copay PCP/\$45 copay specialist (includes speech,	50% coinsurance (includes speech, physical, and	15% coinsurance (includes speech, physical, and	40% coinsurance (includes speech, physical, and	20% coinsurance (includes speech, physical, and	45% coinsurance (includes speech, physical, and	40% coinsurance (includes speech, physical, and	60% coinsurance (includes speech, physical, and	
and out-of-network)	physical, and occupational)	occupational)	physical, and occupational)	occupational)	physical, and occupational)	occupational)	occupational)	occupational)	occupational)	occupational)	occupational)	occupational)	
Skilled Nursing / Acute Rehabilitation Facility (60 days per calendar year, combined network and out-of-network)	10% coinsurance	50% coinsurance	20% coinsurance	50% coinsurance	30% coinsurance	50% coinsurance	15% coinsurance	40% coinsurance	20% coinsurance	45% coinsurance	40% coinsurance	60% coinsurance	
Urgent Care Services	\$50 copay	\$50 copay	\$50 copay	\$50 copay	\$50 copay	\$50 copay	15% coinsurance	40% coinsurance	20% coinsurance	45% coinsurance	40% coinsurance	60% coinsurance	



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	1	dministered by Express	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 Expres 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	None	None	\$1,700 per person \$3,400 per family (combined with medical deductible) (non-embedded deductible)	\$1,700 per person	\$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	Up to a \$10 copay	Up to a \$25 copay	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	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			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	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	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	40%; up to \$80 min / \$160 max	40%; up to \$200 min / \$400 max	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	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	40%; up to \$100 min / \$200 max	40%; up to \$250 min / \$500 max	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	Up to a 90-day supply	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)	(retail) or	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)	Up to a 30-day supply (retail) or 90-day supply (mail order)



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0638 - Diocese of North Carolina												
	Vision Benefits Adm	Vision Benefits Administered by EyeMed		ninistered by EyeMed	Vision Benefits Administered by EyeMed							
Vision Benefits	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	r \$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	1
Standard Scratch Resistance	Up to \$15 copay		Up to \$15 copay		Up to \$15 copay	1	Up to \$15 copay		Up to \$15 copay	1	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											
<u> </u>	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 c	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



				Delta Dental						
0638 - Diocese of North Carolina		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	,000 \$2,50	00 \$2,0	\$1,500	\$3,00	\$2,50	0 \$2,000	
Diagnostic and Preventive Services (e.g., exams, cleanings, x-rays, sealants and space maintainers)		You pay \$0 (not subject to annual c	leductible)		You pay \$0 (not subject to annual de	eductible)		You pay \$0 (not subject to annual de	ductible)	
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	

Vision Be	enefits				
	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 Opt	ions				
Standard progressive (add-on to bifocal)	Up to \$75 copay	Plan pays up to \$46			
UV Coating	Up to \$15 copay				
Tint (solid and gradient)	Up to \$15 copay	You are responsible for the cost of			
Standard Scratch Resistance	Up to \$15 copay	any lens options that you elect from			
Standard Polycarbonate	\$0 copay	out-of-network providers,			
Standard Anti-Reflective Coating	Up to \$45 copay	Juli-or-network providers,			
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 ond		•			
Conventional	\$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			

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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.