

2026 Medical Trust Health Plan  0638 - Diocese of North Carolina	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	
	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												
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	\$30 copay	30% coinsurance	\$30 copay	30% coinsurance	\$30 copay	30% coinsurance	15% coinsurance	40% coinsurance	20% coinsurance	45% coinsurance	40% coinsurance	60% coinsurance
Inpatient 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
Other Medical Services												
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 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)	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)
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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0638 - Diocese of North Carolina	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

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 \$133
Disposable	\$200 allowance, then you pay balance over \$200	Plan pays up to \$133

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