2025 Medical Trust Health Plan 0581 - Diocese of New Jersey	Anthem BCBS BlueCard or Cigna OAP PPO 100		Anthem BCBS BlueCard or Cigna OAP PPO 90. (BASE PLAN - also recommend church provide $500/individual or $1,000/family to cover increase in Annual Out of Pocket Maximum)		Anthem BCBS BlueCard or Cigna OAP PPO 80		Anthem BCBS Cigna CDHP 20/HSA (ACCEPTABLE ALTERNATIVE TO BASE PLAN when Annual Out of Pocket Maximum is contributed to HSA)	
	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	$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	$3,300 per person $6,600 per family	$3,300 per person $6,600 per family
Annual Out-of-Pocket Limit	$2,000 per person $4,000 per family	$4,000 per person $8,000 per family	$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	$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	50% coinsurance	$0 copay	45% coinsurance
Physician Services								
Office Visit	$30 copay	50% coinsurance	$30 copay	50% coinsurance	$30 copay	50% coinsurance	20% coinsurance	45% coinsurance
Hospital Services								
Inpatient Services (including inpatient maternity services)	$250 copay	50% coinsurance	10% coinsurance	50% coinsurance	20% coinsurance	50% coinsurance	20% coinsurance	45% coinsurance
Outpatient Surgery	$200 copay	50% coinsurance	10% coinsurance	50% coinsurance	20% coinsurance	50% coinsurance	20% coinsurance	45% coinsurance
Emergency Room Care	$250 copay	$250 copay	$250 copay	$250 copay	$250 copay	$250 copay	20% coinsurance	20% coinsurance
Ambulance Services	$0 copay	$0 copay	10% coinsurance	10% coinsurance	20% coinsurance	20% coinsurance	20% coinsurance	20% coinsurance
Behavioral Health								
Outpatient Services	$0 copay	30% coinsurance	$30 copay	30% coinsurance	$30 copay	30% coinsurance	20% coinsurance	45% coinsurance
Inpatient Services	$250 copay	50% coinsurance	10% coinsurance	50% coinsurance	20% coinsurance	50% coinsurance	20% coinsurance	45% coinsurance
Other Medical Services								
Durable Medical Equipment	$0 copay	50% coinsurance	10% coinsurance	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	10% coinsurance	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)	$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	10% coinsurance	50% coinsurance	20% coinsurance	50% coinsurance	20% coinsurance	45% coinsurance
Urgent Care Services	$50 copay	$50 copay	$50 copay	$50 copay	$50 copay	$50 copay	20% coinsurance	20% coinsurance

2025 Medical Trust Health Plan 0581 - Diocese of New Jersey	Anthem BCBS BlueCard or Cigna OAP PPO 100		Anthem BCBS BlueCard or Cigna OAP PPO 90		Anthem BCBS BlueCard or Cigna OAP PPO 80		Anthem BCBS Cigna CDHP 20/HSA	
	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
Annual Prescription Deductible (in-network)	None	None	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 $10 copay	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
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	25%; up to $40 min / $80 max	25%; up to $40 min / $80 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 $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	40%; up to $80 min / $160 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 $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	40%; up to $100 min / $200 max	You pay 50% after deductible	You pay 50% after deductible
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	Up to a 30-day supply	Up to a 30-day supply (retail) or	Up to a 30-day supply (retail) or

2025 Medical Trust Health Plan 0581 - Diocese of New Jersey	Anthem BCBS BlueCard or Cigna OAP PPO 100		Anthem BCBS BlueCard or Cigna OAP PPO 90		Anthem BCBS BlueCard or Cigna OAP PPO 80		Anthem BCBS Cigna CDHP 20/HSA	
	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**
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
Lenses (eligible once every calendar year)	$10 copay	Plan pays up to: $32 for single vision $46 for bifocal	$10 copay	Plan pays up to: $32 for single vision $46 for bifocal	$10 copay	Plan pays up to: $32 for single vision $46 for bifocal	$10 copay	Plan pays up to: $32 for single vision $46 for bifocal
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
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,
Tint (solid and gradient)	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	
Standard Polycarbonate	$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	
Disposable	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
Contact Lenses (eligible once every calendar year)								
Conventional	$200 allowance, 15% off balance	Plan pays up to $100	$200 allowance, 15% off balance	Plan pays up to $100	$200 allowance, 15% off balance	Plan pays up to $100	$200 allowance, 15% off balance	Plan pays up to $100
Disposable	$200 allowance, then you pay balance over	Plan pays up to $100	$200 allowance, then you pay balance over	Plan pays up to $100	$200 allowance, then you pay balance over	Plan pays up to $100	$200 allowance, then you pay balance over	Plan pays up to $100

EPISCOPAL CHURCH MEDICAL TRUST	Delta Dental		
	Basic PPO Plan (STANDARD PLAN)		
	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
Annual Benefit Maximum (Maxmium cross applies across networks)	$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)		
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
Major Services (Includes crowns, bridges, and dentures)	You pay 60% coinsurance	You pay 60% coinsurance	You pay 99% coinsurance
Orthodontic Services	Not covered. You pay 100%.	Not covered. You pay 100%.	Not covered. You pay 100%.
	Comprehensive PPO Plan		
	PPO Network	*Premier Network*	*Out-of-Network*
Annual Deductible	$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)	$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)		
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
Major Services (Includes crowns, bridges, and dentures)	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 $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
	Premium PPO Plan		
	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
Annual Benefit Maximum (Maxmium cross applies across networks)	$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)		
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
Major Services (Includes crowns, bridges, and dentures)	You pay 15% coinsurance	You pay 15% coinsurance	You pay 25% 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