

**DIOCESE OF BETHLEHEM PLAN YEAR 2025**

Plan	Anthem BCBS BlueCard PPO 100		Anthem BCBS BlueCard PPO 90		Anthem BCBS CDHP 15/HSA		Anthem BCBS 20/HSA CDHP	
	Network	Out-of-Network	Network	Out-of-Network	Network	Out-of-Network	Network	Out-of-Network
Annual Medical 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	\$1,650 per person \$3,300 per family (deductible is non-embedded)	\$3,300 per person \$6,600 per family (deductible is non-embedded)	\$3,300 per person \$6,600 per family (deductible is non-embedded)	\$3,300 per person \$6,600 per family (deductible is non-embedded)
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	\$2,400 per person \$4,800 per family (out-of-pocket is non-embedded)	\$4,800 per person \$9,600 per family (out-of-pocket is non-embedded)	\$4,200 per person \$8,450 per family (out-of-pocket is non-embedded)	\$7,000 per person \$13,000 per family (out-of-pocket is non-embedded)
<b>Preventive Care</b>								
Preventive Services & Well-Child Care	\$0 copay	50% coinsurance	\$0 copay	50% coinsurance	\$0 copay	40% coinsurance	\$0 copay	45% coinsurance
<b>Physician Services</b>								
Office Visit	\$30 copay	50% coinsurance	\$30 copay	50% coinsurance	15% coinsurance	40% coinsurance	20% coinsurance	45% coinsurance
Diagnostic Services (outpatient)	\$0 copay	50% coinsurance	10% coinsurance	50% coinsurance	15% coinsurance	40% coinsurance	20% coinsurance	45% coinsurance
Specialist Care	\$45 copay	50% coinsurance	\$45 copay	50% coinsurance	15% coinsurance	40% coinsurance	20% coinsurance	45% coinsurance
<b>Hospital Services</b>								
Inpatient Services (including inpatient maternity services)	\$250 copay	50% coinsurance	10% coinsurance	50% coinsurance	15% coinsurance	40% coinsurance	20% coinsurance	45% coinsurance
Outpatient Surgery	\$200 copay	50% coinsurance	10% coinsurance	50% coinsurance	15% coinsurance	40% coinsurance	20% coinsurance	45% coinsurance
Emergency Room Care	\$250 copay	\$250 copay	\$250 copay	\$250 copay	15% coinsurance	15% coinsurance	20% coinsurance	20% coinsurance
Ambulance Services	\$0 copay	\$0 copay	10% coinsurance	10% coinsurance	15% coinsurance	15% coinsurance	20% coinsurance	20% coinsurance
<b>Behavioral Health</b>								
Outpatient Services	\$0 copay	30% coinsurance	\$30 copay	30% coinsurance	15% coinsurance	40% coinsurance	20% coinsurance	45% coinsurance
Inpatient Services	\$250 copay	50% coinsurance	10% coinsurance	50% coinsurance	15% coinsurance	40% coinsurance	20% coinsurance	45% coinsurance
<b>Other Medical Services</b>								
Durable Medical Equipment	\$0 copay	50% coinsurance	10% coinsurance	50% coinsurance	15% coinsurance	40% coinsurance	20% coinsurance	45% coinsurance
Home Health Care (210 visits per calendar year, combined network & out-of-network)	\$0 copay	50% coinsurance	10% coinsurance	50% coinsurance	15% coinsurance	40% coinsurance	20% coinsurance	45% coinsurance
Outpatient Therapy (60 visits per calendar year per each type of therapy, combined network & 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)	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 & out-of-network)	\$0 copay	50% coinsurance	10% coinsurance	50% coinsurance	15% coinsurance	40% coinsurance	20% coinsurance	45% coinsurance
Urgent Care Services	\$50 copay	\$50 copay	\$50 copay	\$50 copay	15% coinsurance	15% coinsurance	20% coinsurance	20% coinsurance

**DIOCESE OF BETHLEHEM PLAN YEAR 2025, continued**

<b>Prescription Drug Benefits</b>						
	<b>Pharmacy Benefits Administered by Express Scripts</b>					
	<b>Anthem BCBS PPO 100</b>		<b>Anthem BCBS PPO 90</b>		<b>CDHP-15/HSA</b>	<b>CDHP-20/HSA</b>
	<b>Retail</b>	<b>Home Delivery</b>	<b>Retail</b>	<b>Home Delivery</b>	<b>Retail and Home Delivery</b>	<b>Retail and Home Delivery</b>
<b>Annual Prescription Deductible (in-network)</b>	None	None	None	None	\$1,650 per person \$3,300 per family (combined with medical deductible) (non-embedded deductible)	\$3,300 per person \$6,600 per family (combined with medical deductible) (non-embedded deductible)
<b>Tier 1: Generic</b>	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
<b>Tier 2: Preferred Brand Name</b>	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
<b>Tier 3: Non-Preferred Brand Name</b>	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
<b>Tier 4: Specialty Rx</b>	40%; up to a \$100 min / \$200 max	40%; up to a \$100 min / \$200 max	40%; up to a \$100 min / \$200 max	40%; up to a \$100 min / \$200 max	You pay 50% after deductible	You pay 50% after deductible
<b>Dispensing Limits Per Copayment</b>	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 (mail order)	Up to a 30-day supply (retail) or 90-day supply (mail order)

<b>Vision Benefits - (Tied to all above plans)</b>		
This benefit is tied into the medical benefit and is not available independently.	<b>EyeMed</b>	
	<b>Network</b>	<b>Out-of-Network</b>
<b>Eye Examinations</b>	\$0 copay	Plan pays up to \$30 for ophthalmologists or optometrists
<b>Lenses (eligible once every calendar year)</b>	\$10 copay	Plan pays up to: \$32 for single vision \$46 for bifocal \$57 for trifocal
<b>Lens Options</b>		
<b>Standard Progressive (add-on to bifocal)</b>	Up to \$75 copay	Plan pays up to \$46
<b>UV Coating</b>	up to \$15 copay	You are responsible for the cost of any lens options that you elect from out-of-network providers.
<b>Tint (solid and Gradient)</b>	up to \$15 copay	
<b>Standard Scratch Resistance</b>	up to \$15 copay	
<b>Standard Polycarbonate</b>	\$0 copay	
<b>Standard Anti-Reflective Coating</b>	up to \$45 copay	
<b>Disposable</b>	20% off retail price	
<b>Frames (eligible once every calendar year)</b>	\$200 allowance, 20% off balance over \$200	Plan pays up to \$47
<b>Contact Lenses (eligible once every calendar year)</b>		
<b>Conventional</b>	\$200 allowance, 15% off balance over \$200	Plan pays up to \$100
<b>Disposable</b>	\$200 allowance, then you pay balance over \$200	Plan pays up to \$100

**DIOCESE OF BETHLEHEM PLAN YEAR 2025, continued**

	<b>Dental Benefits</b>		
	<b>Delta Dental Premium PPO Plan</b>		
	<b>PPO Network</b>	<b>Premier Network</b>	<b>Out-of-Network</b>
<b>Annual Deductible</b>	\$0 per person / \$0 per family	\$0 per person \$0 per family	\$50 per person / \$150 per family
<b>Annual Benefit Maximum (Plan maximums cross-accumulate between the PPO Network, Premier Network, and out-of-network dentist)</b>	\$3,000	\$2,500	\$2,000
<b>Diagnostic and Preventative Services (e.g., exams, cleanings, x-rays, sealants, and space maintainers)</b>	You pay \$0 (not subject to annual deductible)		You pay \$0 (not subject to annual deductible) plus any balance billing
<b>Basic Services (Includes fillings, simple extractions, root canals, oral surgery, and denture relines/repair/rebase)</b>	You pay 15% coinsurance	You pay 15% coinsurance	You pay 25% coinsurance
<b>Major Services (Includes crowns, bridges, and dentures)</b>	You pay 15% coinsurance	You pay 15% coinsurance	You pay 25% coinsurance
<b>Orthodontic Services</b>	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 plus any balance billing

This material is provided for informational purposes only and should not be viewed as investment, tax, or other advice. It does not constitute a contract or an offer for any products or services. In the event of a conflict between this material and the official plan documents or insurance policies, any official plan documents or insurance policies will govern. The Church Pension Fund (“CPF”) and its affiliates (collectively, “CPG”) retain the right to amend, terminate, or modify the terms of any benefit plan and/or insurance policy described in this material at any time, for any reason, and, unless otherwise required by applicable law, without notice.

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.