EPISCOPAL CHURCH MEDICAL TRUST

2025 Medical Trust Health Plan 0722 - Diocese of Olympia	Anthem BCBS BlueCard PPO 100		Kaiser EPO High		Anthem BCBS BlueCard PPO 90		Kaiser EPO 80	
	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	$0 per person $0 per family	Not Applicable	$500 per person $1,000 per family	$1,000 per person $2,000 per family	$500 per person $1,000 per family	Not Applicable
Annual Out-of-Pocket Limit	$2,000 per person $4,000 per family	$4,000 per person $8,000 per family	$1,750 per person $3,500 per family	Not Applicable	$2,500 per person $5,000 per family	$5,000 per person $10,000 per family	$3,500 per person $7,000 per family	Not Applicable
Preventive Care								
Preventive Services & Well-Child Care	$0 copay	50% coinsurance	$0 copay	Not Applicable	$0 copay	50% coinsurance	$0 copay	Not Applicable
Physician Services								
Office Visit	$30 copay	50% coinsurance	$25 copay	Not Applicable	$30 copay	50% coinsurance	$25 copay	Not Applicable
Diagnostic Services (outpatient)	$0 copay	50% coinsurance	$50 copay	Not Applicable	10% coinsurance	50% coinsurance	20% coinsurance	Not Applicable
Specialist Care	$45 copay	50% coinsurance	$25 copay	Not Applicable	$45 copay	50% coinsurance	$35 copay	Not Applicable
Hospital Services								
Inpatient Services (including inpatient maternity services)	$250 copay	50% coinsurance	$100 per day copay to maximum of $600	Not Applicable	10% coinsurance	50% coinsurance	20% coinsurance	Not Applicable
Outpatient Surgery	$200 copay	50% coinsurance	$100 copay	Not Applicable	10% coinsurance	50% coinsurance	20% coinsurance	Not Applicable
Emergency Room Care	$250 copay	$250 copay	$100 copay	Not Applicable	$250 copay	$250 copay	20% coinsurance	Not Applicable
Ambulance Services	$0 copay	$0 copay	$0 copay	Not Applicable	10% coinsurance	10% coinsurance	20% coinsurance	Not Applicable
Behavioral Health								
Outpatient Services	$0 copay	30% coinsurance	$25 copay per visit for individual visit	Not Applicable	$30 copay	30% coinsurance	$25 copay per visit for individual visit	Not Applicable
Inpatient Services	$250 copay	50% coinsurance	$100 per day copay to maximum of $600	Not Applicable	10% coinsurance	50% coinsurance	20% coinsurance	Not Applicable
Other Medical Services								
Durable Medical Equipment	$0 copay	50% coinsurance	$0 copay	Not Applicable	10% coinsurance	50% coinsurance	20% coinsurance	Not Applicable
Home Health Care (210 visits per calendar year, combined network and out-of-network)	$0 copay	50% coinsurance	$0 copay	Not Applicable	10% coinsurance	50% coinsurance	$0 copay	Not Applicable
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)	$25 copay (includes speech, physical, and occupational)	Not Applicable	$30 copay PCP/$45 copay specialist (includes speech, physical, and occupational)	50% coinsurance (includes speech, physical, and occupational)	$25 copay (includes speech, physical, and occupational)	Not Applicable
Skilled Nursing / Acute Rehabilitation Facility (60 days per calendar year, combined network and out-of-network)	$0 copay	50% coinsurance	$0 copay	Not Applicable	10% coinsurance	50% coinsurance	20% coinsurance	Not Applicable
Urgent Care Services	$50 copay	$50 copay	$50 copay	Not Applicable	$50 copay	$50 copay	$50 copay	Not Applicable

EPISCOPAL CHURCH MEDICAL TRUST

2025 Medical Trust Health Plan 0722 - Diocese of Olympia	Anthem BCBS BlueCard PPO 100		Kaiser EPO High		Anthem BCBS BlueCard PPO 90		Kaiser EPO 80	
	Pharmacy Benefits Administered by Express Scripts		Pharmacy Benefits Administered by Kaiser		Pharmacy Benefits Administered by Express Scripts		Pharmacy Benefits Administered by Kaiser	
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	None	None
Tier 1: Generic	Up to a $10 copay	Up to a $10 copay	Up to a $5 copay	Up to a $5 copay	Up to a $10 copay	Up to a $10 copay	Up to a $5 copay	Up to a $5 copay
Tier 2: Preferred Brand Name	25%; up to $40 min / $80 max	25%; up to $40 min / $80 max	Up to a $30 copay	Up to a $30 copay	25%; up to $40 min / $80 max	25%; up to $40 min / $80 max	Up to a $30 copay	Up to a $30 copay
Tier 3: Non-Preferred Brand Name	40%; up to $80 min / $160 max	40%; up to $80 min / $160 max	Up to a $70 copay	Up to a $70 copay	40%; up to $80 min / $160 max	40%; up to $80 min / $160 max	Up to a $70 copay	Up to a $70 copay
Tier 4: Specialty Rx	40%; up to $100 min / $200 max	40%; up to $100 min / $200 max	Up to a $90 copay	Up to a $90 copay	40%; up to $100 min / $200 max	40%; up to $100 min / $200 max	Up to a $90 copay	Up to a $90 copay
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	Up to a 30-day supply

EPISCOPAL CHURCH MEDICAL TRUST

2025 Medical Trust Health Plan 0722 - Diocese of Olympia	Anthem BCBS BlueCard PPO 100		Kaiser EPO High		Anthem BCBS BlueCard PPO 90		Kaiser EPO 80	
	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 $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
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 over $200	Plan pays up to $100	$200 allowance, 15% off balance over $200	Plan pays up to $100	$200 allowance, 15% off balance over $200	Plan pays up to $100	$200 allowance, 15% off balance over $200	Plan pays up to $100
Disposable	$200 allowance, then you pay balance over $200	Plan pays up to $100	$200 allowance, then you pay balance over $200	Plan pays up to $100	$200 allowance, then you pay balance over $200	Plan pays up to $100	$200 allowance, then you pay balance over $200	Plan pays up to $100

EPISCOPAL CHURCH MEDICAL TRUST

2025 Medical Trust Health Plan 0722 - Diocese of Olympia	Anthem BCBS BlueCard PPO 80		Anthem BCBS CDHP 20/HSA		Kaiser CDHP 20/HSA	
	Network	Out-of-Network	Network	Out-of-Network	Network	Out-of-Network
Annual Deductible (CDHPs have a combined medical & Rx deductible)	$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	$3,300 per person $6,600 per family	Not Applicable
Annual Out-of-Pocket Limit	$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	$4,200 per person $8,450 per family	Not Applicable
Preventive Care						
Preventive Services & Well-Child Care	$0 copay	50% coinsurance	$0 copay	45% coinsurance	$0 copay	Not Applicable
Physician Services						
Office Visit	$30 copay	50% coinsurance	20% coinsurance	45% coinsurance	20% coinsurance	Not Applicable
Diagnostic Services (outpatient)	20% coinsurance	50% coinsurance	20% coinsurance	45% coinsurance	20% coinsurance	Not Applicable
Specialist Care	$45 copay	50% coinsurance	20% coinsurance	45% coinsurance	20% coinsurance	Not Applicable
Hospital Services						
Inpatient Services (including inpatient maternity services)	20% coinsurance	50% coinsurance	20% coinsurance	45% coinsurance	20% coinsurance	Not Applicable
Outpatient Surgery	20% coinsurance	50% coinsurance	20% coinsurance	45% coinsurance	20% coinsurance	Not Applicable
Emergency Room Care	$250 copay	$250 copay	20% coinsurance	20% coinsurance	20% coinsurance	Not Applicable
Ambulance Services	20% coinsurance	20% coinsurance	20% coinsurance	20% coinsurance	20% coinsurance	Not Applicable
Behavioral Health						
Outpatient Services	$30 copay	30% coinsurance	20% coinsurance	45% coinsurance	20% coinsurance	Not Applicable
Inpatient Services	20% coinsurance	50% coinsurance	20% coinsurance	45% coinsurance	20% coinsurance	Not Applicable
Other Medical Services						
Durable Medical Equipment	20% coinsurance	50% coinsurance	20% coinsurance	45% coinsurance	20% coinsurance	Not Applicable
Home Health Care (210 visits per calendar year, combined network and out-of-network)	20% coinsurance	50% coinsurance	20% coinsurance	45% coinsurance	$0 copay	Not Applicable
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)	20% coinsurance (includes speech, physical, and occupational)	45% coinsurance (includes speech, physical, and occupational)	20% coinsurance (includes speech, physical, and occupational)	Not Applicable
Skilled Nursing / Acute Rehabilitation Facility (60 days per calendar year, combined network and out-of-network)	20% coinsurance	50% coinsurance	20% coinsurance	45% coinsurance	20% coinsurance	Not Applicable
Urgent Care Services	$50 copay	$50 copay	20% coinsurance	20% coinsurance	20% coinsurance	Not Applicable

EPISCOPAL CHURCH MEDICAL TRUST

2025 Medical Trust Health Plan 0722 - Diocese of Olympia	Anthem BCBS BlueCard PPO 80		Anthem BCBS CDHP 20/HSA		Kaiser CDHP 20/HSA	
	Pharmacy Benefits Administered by Express Scripts		Pharmacy Benefits Administered by Express Scripts		Pharmacy Benefits Administered by Kaiser	
Prescription Drug Benefits	Retail	Home Delivery	Retail	Home Delivery	Retail	Home Delivery
Annual Prescription Deductible (in-network)	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)	$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	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 $40 min / $80 max	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 $80 min / $160 max	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 $100 min / $200 max	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 30-day supply	Up to a 30-day supply (retail) or 90-day supply	Up to a 30-day supply (retail) or 90-day supply	Up to a 30-day supply (retail) or 90-day supply	Up to a 30-day supply (retail) or 90-day supply

EPISCOPAL CHURCH MEDICAL TRUST

2025 Medical Trust Health Plan 0722 - Diocese of Olympia	Anthem BCBS BlueCard PPO 80		Anthem BCBS CDHP 20/HSA		Kaiser CDHP 20/HSA	
	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
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
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
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
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,
Tint (solid and gradient)	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	
Standard Polycarbonate	$0 copay		$0 copay		$0 copay	
Standard Anti-Reflective Coating	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	
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
Contact Lenses (eligible once every cal						
Conventional	$200 allowance, 15% off balance over $200	Plan pays up to $100	$200 allowance, 15% off balance over $200	Plan pays up to $100	$200 allowance, 15% off balance over $200	Plan pays up to $100
Disposable	$200 allowance, then you pay balance over $200	Plan pays up to $100	$200 allowance, then you pay balance over $200	Plan pays up to $100	$200 allowance, then you pay balance over $200	Plan pays up to $100

EPISCOPAL CHURCH MEDICAL TRUST

0722 - Diocese of Olympia	Dental Benefits								
	Delta Dental								
	Premium PPO Plan			Comprehensive PPO Plan			Basic 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	$50 per person / $150 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	$0 per person / $0 per family
Annual Benefit Maximum (Maxmium cross applies across networks)	$3,000	$2,500	$2,000	$2,500	$2,000	$1,500	$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)			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 15% coinsurance	You pay 15% coinsurance	You pay 25% coinsurance	You pay 15% coinsurance	You pay 15% coinsurance	You pay 25% coinsurance	You pay 20% coinsurance	You pay 20% coinsurance	You pay 30% coinsurance
Major Services (Includes crowns, bridges, and dentures)	You pay 15% coinsurance	You pay 15% coinsurance	You pay 25% coinsurance	You pay 50% coinsurance	You pay 50% coinsurance	You pay 60% coinsurance	You pay 60% coinsurance	You pay 60% coinsurance	You pay 99% 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	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	Not covered. You pay 100%.	Not covered. You pay 100%.	Not covered. You pay 100%.

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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

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