

2025 Medical Trust Health Plan 0015 - Diocese of Alabama	Anthem BCBS BlueCard PPO 80		Anthem BCBS BlueCard PPO 70		Anthem BCBS 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	\$3,500 per person \$7,000 per family	\$7,000 per person \$14,000 per family	\$3,300 per person \$6,600 per family	\$3,300 per person \$6,600 per family
Annual Out-of-Pocket Limit	\$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	\$4,200 per person \$8,450 per family	\$7,000 per person \$13,000 per family
<b>Preventive Care</b>						
Preventive Services & Well-Child Care	\$0 copay	50% coinsurance	\$0 copay	50% coinsurance	\$0 copay	45% coinsurance
<b>Physician Services</b>						
Office Visit	\$30 copay	50% coinsurance	\$30 copay	50% coinsurance	20% coinsurance	45% coinsurance
Diagnostic Services (outpatient)	20% coinsurance	50% coinsurance	30% coinsurance	50% coinsurance	20% coinsurance	45% coinsurance
Specialist Care	\$45 copay	50% coinsurance	\$45 copay	50% coinsurance	20% coinsurance	45% coinsurance
<b>Hospital Services</b>						
Inpatient Services (including inpatient maternity services)	20% coinsurance	50% coinsurance	30% coinsurance	50% coinsurance	20% coinsurance	45% coinsurance
Outpatient Surgery	20% coinsurance	50% coinsurance	30% coinsurance	50% coinsurance	20% coinsurance	45% coinsurance
Emergency Room Care	\$250 copay	\$250 copay	\$250 copay	\$250 copay	20% coinsurance	20% coinsurance
Ambulance Services	20% coinsurance	20% coinsurance	30% coinsurance	30% coinsurance	20% coinsurance	20% coinsurance
<b>Behavioral Health</b>						
Outpatient Services	\$30 copay	30% coinsurance	\$30 copay	30% coinsurance	20% coinsurance	45% coinsurance
Inpatient Services	20% coinsurance	50% coinsurance	30% coinsurance	50% coinsurance	20% coinsurance	45% coinsurance
<b>Other Medical Services</b>						
Durable Medical Equipment	20% coinsurance	50% coinsurance	30% coinsurance	50% coinsurance	20% coinsurance	45% coinsurance
Home Health Care (210 visits per calendar year, combined network and out-of-network)	20% coinsurance	50% coinsurance	30% 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)	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)	20% coinsurance	50% coinsurance	30% coinsurance	50% coinsurance	20% coinsurance	45% coinsurance
Urgent Care Services	\$50 copay	\$50 copay	\$50 copay	\$50 copay	20% coinsurance	20% coinsurance
	<b>Pharmacy Benefits Administered by Express Scripts</b>		<b>Pharmacy Benefits Administered by Express Scripts</b>		<b>Pharmacy Benefits Administered by Express Scripts</b>	
<b>Prescription Drug Benefits</b>	<b>Retail</b>	<b>Home Delivery</b>	<b>Retail</b>	<b>Home Delivery</b>	<b>Retail</b>	<b>Home Delivery</b>
<b>Annual Prescription Deductible (in-network)</b>	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)
<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 \$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
<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)

Vision Benefits	Vision Benefits Administered by EyeMed		Vision Benefits Administered by EyeMed		Vision Benefits Administered by EyeMed	
	Network	Out-of-Network	Network	Out-of-Network	Network	Out-of-Network
<b>Eye Examinations</b>	\$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
<b>Lenses (eligible once every calendar year)</b>	\$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
<b>Lens Options</b>						
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	
<b>Frames (eligible once every calendar year)</b>	\$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
<b>Contact Lenses (eligible once every calendar year)</b>						
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

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