Dio of Central Gulf Coast

Plan	Anthem BCBS PPO 90/70		Anthem BCBS PPO 80/60		Anthem BCBS PPO 75/50		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 Medical Deductible	$250 per person $500 per family	$500 per person $1,000 per family	$500 per person $1,000 per family	$1,000 per person $2,000 per family	$900 per person $1,800 per family	$1,800 per person $3,600 per family	$1,400 per person $2,800 per family (deductible includes medical & prescriptions) (deductible is non-embedded)	$2,800 per person $5,600 per family (deductible includes medical & prescriptions) (deductible is non-embedded)	$2,700 per person $5,450 per family (deductible includes medical & prescriptions)	$3,000 per person $6,000 per family (deductible includes medical & prescriptions)	$3,500 per person $7,000 per family (deductible includes medical & prescriptions)	$7,000 per person $14,000 per family (deductible includes medical & prescriptions)
Annual Out-of-Pocket Maximum	$1,750 per person $3,500 per family	$4,500 per person $9,000 per family	$2,500 per person $5,000 per family	$6,500 per person $13,000 per family	$4,100 per person $8,200 per family	$8,200 per person $16,400 per family	$2,400 per person $4,800 per family	$4,800 per person $9,600 per family	$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	30% coinsurance	$0 copay	40% coinsurance	$0 copay (both PCP and specialist)	50% coinsurance	$0 copay	40% coinsurance	$0 copay	45% coinsurance	$0 copay	60% coinsurance
Physician Services												
Office Visit	$25 copay	30% coinsurance	$25 copay	40% coinsurance	$35 copay	50% coinsurance	15% coinsurance	40% coinsurance	20% coinsurance	45% coinsurance	40% coinsurance	60% coinsurance
Diagnostic Services	20% coinsurance	20% coinsurance	20% coinsurance	20% coinsurance	25% coinsurance	25% coinsurance	15% coinsurance	15% coinsurance	20% coinsurance	20% coinsurance	40% coinsurance	40% coinsurance
Specialist Care	$25 copay	30% coinsurance	$25 copay	40% 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)	Copay of $100 per day not to exceed $600, then 10% coinsurance	30% coinsurance	Copay of $100 per day not to exceed $600, then 20% coinsurance	40% coinsurance	Copay of $100 per day not to exceed $600, then 25% coinsurance	50% coinsurance	15% coinsurance	40% coinsurance	20% coinsurance	45% coinsurance	40% coinsurance	60% coinsurance
Outpatient Surgery	10% coinsurance	30% coinsurance	20% coinsurance	40% coinsurance	25% coinsurance	50% coinsurance	15% coinsurance	40% coinsurance	20% coinsurance	45% coinsurance	40% coinsurance	60% coinsurance
Emergency Room Care	$100 copay	$100 copay	$100 copay	$100 copay	$100 copay	$100 copay	15% coinsurance	15% coinsurance	20% coinsurance	20% coinsurance	40% coinsurance	40% coinsurance
Ambulance Services	10% coinsurance	10% coinsurance	20% coinsurance	20% coinsurance	25% coinsurance	25% coinsurance	15% coinsurance	40% coinsurance	20% coinsurance	45% coinsurance	40% coinsurance	60% coinsurance

Dio of Central Gulf Coast

Plan	Anthem BCBS PPO 90/70		Anthem BCBS PPO 80/60		Anthem BCBS PPO 75/50		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**
Mental Health/Substance Abuse												
Outpatient Services	$20 copay Services are provided through Cigna Behavioral Health, not through Anthem	30% coinsurance Services are provided through Cigna Behavioral Health, not through Anthem	$20 copay Services are provided through Cigna Behavioral Health, not through Anthem	30% coinsurance Services are provided through Cigna Behavioral Health, not through Anthem	$20 copay Services are provided through Cigna Behavioral Health not, through Anthem	30% coinsurance Services are provided through Cigna Behavioral Health, not through Anthem	15% coinsurance	40% coinsurance	20% coinsurance	45% coinsurance	40% coinsurance	60% coinsurance
Inpatient Services	Covered at 100% after $100 per day copay/$600 maximum Services are provided through Cigna Behavioral Health, not through Anthem	30% coinsurance Services are provided through Cigna Behavioral Health, not through Anthem	Covered at 100% after $100 per day copay/$600 maximum Services are provided through Cigna Behavioral Health, not through Anthem	30% coinsurance Services are provided through Cigna Behavioral Health, not through Anthem	Covered at 100% after $100 per day copay/$600 maximum Services are provided through Cigna Behavioral Health, not through Anthem	30% coinsurance Services are provided through Cigna Behavioral Health, not through Anthem	15% coinsurance	40% coinsurance	20% coinsurance	45% coinsurance	40% coinsurance	60% coinsurance
Other Medical Services												
Durable Medical Equipment	10% coinsurance	10% coinsurance	20% coinsurance	20% coinsurance	25% coinsurance	25% coinsurance	15% coinsurance	15% coinsurance	20% coinsurance	20% coinsurance	40% coinsurance	40% coinsurance
Home Health Care	10% coinsurance	30% coinsurance	20% coinsurance	40% coinsurance	25% coinsurance	50% coinsurance	15% coinsurance	40% coinsurance	20% coinsurance	45% coinsurance	40% coinsurance	60% coinsurance
Outpatient Therapy	$25 copay (includes hearing/speech, physical, and occupational) (60 visits per year per each type of therapy)	30% coinsurance (includes hearing/ speech, physical, and occupational) (60 visits per year per each type of therapy)	$25 copay (includes hearing/ speech, physical, and occupational) (60 visits per year per each type of therapy)	40% coinsurance (includes hearing/speech, physical, and occupational) (60 visits per year per each type of therapy)	$35 copay (PCP) $45 copay (specialist) (includes hearing/ speech, physical, and occupational) (60 visits per year per each type of therapy)	50% coinsurance (includes hearing/speech, physical, and occupational) (60 visits per year per each type of therapy)	15% coinsurance (includes hearing/speech, physical, and occupational) (60 visits per year per each type of therapy)	40% coinsurance (includes hearing/speech, physical, and occupational) (60 visits per year per each type of therapy)	20% coinsurance (includes hearing/speech, physical, and occupational) (60 visits per year per each type of therapy)	45% coinsurance (includes hearing/speech, physical, and occupational) (60 visits per year per each type of therapy)	40% coinsurance (includes hearing/speech, physical, and occupational) (60 visits per year per each type of therapy)	60% coinsurance (includes hearing/speech, physical, and occupational) (60 visits per year per each type of therapy)
Skilled Nursing / Acute Rehabilitation Facility	10% coinsurance	30% coinsurance	20% coinsurance	40% coinsurance	25% coinsurance	50% coinsurance	15% coinsurance	40% coinsurance	20% coinsurance	45% coinsurance	40% coinsurance	60% coinsurance
Urgent Care Services	10% coinsurance	30% coinsurance	20% coinsurance	40% coinsurance	25% coinsurance	50% coinsurance	15% coinsurance	40% coinsurance	20% coinsurance	45% coinsurance	40% coinsurance	60% coinsurance

EPISCOPAL CHURCH MEDICAL TRUST

Dental Benefits			
	Cigna Dental		
	Dental & Orthodontia PPO Plan	Basic Dental PPO Plan	Preventive Dental PPO Plan
Annual DPPO & Out-of-Network Deductible	$25 per person $75 per family	$50 per person $150 per family	None
Preventive & Diagnostic Services (e.g., oral exams, cleanings, x-rays, emergency care to relieve pain)	$0 (not subject to annual deductible)	$0 (not subject to annual deductible)	$0 (includes sealants to age 14 in addition to all other preventive and emergency care)
Basic Restorative Care	15% coinsurance Includes fillings, root canal therapy, periodontal scaling and root planing, denture adjustments and repairs, extractions	15% coinsurance Includes fillings, root canal therapy, periodontal scaling and root planing, denture adjustments and repairs, extractions	20% coinsurance Includes only fillings, denture adjustments and repairs, root canal therapy
Major Restorative Services	15% coinsurance Includes crowns, dentures, oral surgery, osseous surgery, dental implants, night guards, anesthetics, and bridges	50% coinsurance Includes crowns, dentures, oral surgery, osseous surgery, dental implants, night guards, anestheetics, and bridges	99% coinsurance Includes crowns, dentures, oral surgery, osseous surgery, and bridges
Orthodontia	50% ($1,500 individual lifetime limit)	Not covered	99% coinsurance
Annual Benefit Maximum	$2,000	$2,000	$1,500

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EPISCOPAL CHURCH MEDICAL TRUST

Prescription Drug Benefits

	Express Scripts						
	Standard		Premium		CDHP-15/HSA	CDHP-20/HSA	CDHP-40/HSA
	Retail	Home Delivery	Retail	Home Delivery	Retail and Home Delivery	Retail and Home Delivery	Retail and Home Delivery
Annual Prescription Deductible (in-network)	$50 per person	None	$50 per person	None	$1,400 per person $2,800 per family (combined with medical deductible) (non-embedded deductible)	$2,700 per person $5,450 per family (combined with medical deductible)	$3,500 per person $7,000 per family (combined with medical deductible)
Annual Prescription Out-of-Pocket limit (includes deductible)	In-Network $2,500 Individual/$5,000 Family Out-of-Network $2,500 Individual/$5,000 Family		In-Network $2,500 Individual/$5,000 Family Out-of-Network $2,500 Individual/$5,000 Family		$2,400 Individual / $4,800 family (in-network) $4,800 Individual / $9,600 family out-of-network (combined with medical out-of-pocket limit)	$4,200 Individual/ $8,450 Family (in-network) $7,000 Individual/$13,000 Family (out-of-network) (combined with medical out-of-pocket limit)	$6,000 Individual / $12,000 family (in-network) $10,000 Individual / $20,000 family (out-of-network) (combined with medical out-of-pocket limit)
Tier 1: Generic	Up to a $10 copay	Up to a $25 copay	Up to a $5 copay	Up to a $12 copay	15% after deductible	15% after deductible	15% after deductible
Tier 2: Preferred Brand Name	Up to a $35 copay	Up to a $90 copay	Up to a $25 copay	Up to a $70 copay	25% after deductible	25% after deductible	25% after deductible
Tier 3: Non-Preferred Brand Name	Up to a $60 copay	Up to a $150 copay	Up to a $45 copay	Up to a $110 copay	50% after deductible	50% after deductible	50% after deductible
Dispensing Limits Per Copayment	Up to a 30-day supply	Up to a 90-day supply	Up to a 30-day supply	Up to a 90-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)	Up to a 30-day supply (retail) or 90-day supply (mail order)

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EPISCOPAL CHURCH MEDICAL TRUST

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	Play 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)	$130 allowance, 20% off balance over $130	Plan pays up to $47
Contact Lenses (eligible once every calendar year)		
Conventional	$130 allowance, 15% off balance over $130	Plan pays up to $100
Disposable	$130 allowance, then balance over $130	Plan pays up to $100

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