Diocesan Medical, Dental, Group Life Insurance

2027 Options (change to CDHP15 and PPO 70)

Effective January 1, 2027- December 31, 2027

Medical Insurance Plan (Choose 1) / Dental Insurance Plan (Choose 1)					Employer Cost (90%)				Employee Cost Share (10%)
PLAN NAMES	Monthly Rate	Annual Rate	100% HSA Contribution	Total Cost	EO	EC	ES	EF	
Medical Insurance Plan (Choose 1)									
Anthem Blue Cross CDHP-15 with HSA									
Employee Only (EO)	$1,090	$13,080	$2,200	$15,280	$13,752				$1,528
Employee Child(ren) (EC)	$1,962	$23,544	$4,400	$27,944		$25,150			$2,794
Employee Spouse (ES)	$2,180	$26,160	$4,400	$30,560			$27,504		$3,056
- OR - Employee Family (EF)	$3,270	$39,240	$4,400	$43,640				$39,276	$4,364
Employer puts 100% of HSA contribution in Employee's Account Minimum of 50% paid in January, remainder over remaining 11 months									
OR - Medical Insurance Plan									
Anthem Blue Cross BlueCard PPO 70									
Employee Only (EO)	$984	$11,808		$11,808	$10,627				$1,181
Employee Child(ren) (EC)	$1,771	$21,252		$21,252		$19,127			$2,125
Employee Spouse (ES)	$1,968	$23,616		$23,616			$21,254		$2,362
- OR - Employee Family (EF)	$2,952	$35,424		$35,424				$31,882	$3,542
Dental Plans (Choose 1)									
Plan A - Delta Dental Premium									
Employee Only (EO)	$68	$816		$816	$734				$82
Employee Child(ren) (EC)	$122	$1,464		$1,464		$1,318			$146
Employee Spouse (ES)	$136	$1,632		$1,632			$1,469		$163
- OR - Employee Family (EF)	$204	$2,448		$2,448				$2,203	$245
Plan B - Delta Dental Comprehensive									
Employee Only (EO)	$52	$624		$624	$562				$62
Employee Child(ren) (EC)	$94	$1,128		$1,128		$1,015			$113
Employee Spouse (ES)	$104	$1,248		$1,248			$1,123		$125
- OR - Employee Family (EF)	$156	$1,872		$1,872				$1,685	$187
Plan C - Delta Dental Basic									
Employee Only (EO)	$30	$360		$360	$324				$36
Employee Child(ren) (EC)	$54	$648		$648		$583			$65
Employee Spouse (ES)	$60	$720		$720			$648		$72
- OR - Employee Family (EF)	$90	$1,080		$1,080				$972	$108
Group Term Life Insurance (Required)									
Clergy Active - $50,000	$21	$252		$252					$0
Lay Active - $25,000	$11	$126		$126					$0

Notes

All Medical Plans include Express Scripts Health Rx, EAP, Quantum Health Advocate and Eye Med Vision Plan

NOTE: Due to the better CDHP plan, the Health Savings Account (HSA) amount for Employee Only Coverage decreased from $3,400 to $2,200.
Employee +Child(ren), +Spouse, +Family decreased from $6,800 to $4,400.

Diocesan Insurance Package

Medical Trust
2027 Medical Plans

	Anthem BCBS 2027 BlueCard PPO 70		Anthem BCBS 2027 CDHP 15/HSA	
	Network	**Out-of-Network**	**Network**	**Out-of-Network**
Annual Deductible (CDHPs have a combined medical & Rx deductible)	$3,500 per person $7,000 per family	$7,000 per person $14,000 per family	$2,200 per person $4,400 per family	$4,400 per person $8,800 per family
Annual Out-of-Pocket Limit	$6,500 per person $13,000 per family	$13,000 per person $26,000 per family	$3,900 per person $7,800 per family	$7,800 per person $15,000 per family
Preventive Care Preventive Services				
Preventive Services & Well-Child Care	$0 copay	50% coinsurance plus any balance billing	$0 copay	40% coinsurance
Physician Services				
Office Visit	$35 copay	50% coinsurance	15% coinsurance	40% coinsurance
Diagnostic Services (outpatient)	30% coinsurance (Deductible does not apply)	50% coinsurance	15% coinsurance	15% coinsurance
Specialist Care	$50 copay	50% coinsurance	15% coinsurance	40% coinsurance
Hospital Services Inpatient Services				
Inpatient Services (including inpatient maternity services)	30% coinsurance	50% coinsurance	15% coinsurance	40% coinsurance
Outpatient Surgery	30% coinsurance	50% coinsurance	15% coinsurance	40% coinsurance
Emergency Room Care	$250 copay	$250 copay	15% coinsurance	15% coinsurance
Ambulance Services	30% coinsurance	30% coinsurance	15% coinsurance	15% coinsurance
Behavioral Health				
Outpatient Services	$35 copay	30% coinsurance	15% coinsurance	40% coinsurance
Inpatient Services	30% coinsurance	50% coinsurance	15% coinsurance	40% coinsurance
Other Medical Services				
Durable Medical Equipment	30% coinsurance	50% coinsurance	15% coinsurance	40% coinsurance
Home Health Care (210 visits per calendar year, combined network and out-of- network)	30% coinsurance	50% coinsurance	15% coinsurance	40% coinsurance
Outpatient Therapy (60 visits per calendar year per each type of therapy, combined network and out-of-network)	$35 copay PCP/$50 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)
Skilled Nursing / Acute Rehabilitation Facility (60 days per calendar year, combined network and out-of- network)	30% coinsurance	50% coinsurance plus any balance billing	15% coinsurance	40% coinsurance
Urgent Care Services	$60 copay	$60 copay	15% coinsurance	40% coinsurance
Total Cost of Insurance *Employer Pays 90% / Employee Pays 10%*	Employee Only $11,808 Employee + Child $21,252 Employee + Spouse $23,616 Employee + Family $35,424		Employee Only $15,280 Employee + Child $27,944 Employee + Spouse $30,560 Employee + Family $43,640	

HSA Amounts

(ONLY with CDHP Plan)

2027

Coverage Type	**HSA Amounts** *(½ deposited in January and remaining over next 11 months)*	**IRA Limits***	**Additional Allowed** *(deducted from employee as pre-tax amount)*
Employee Only	$2,200	$4,500	$2,300
Employee +Child(ren)	$4,400	$9,000	$4,600
Employee +Spouse	$4,400	$9,000	$4,600
Employee +Family	$4,400	$9,000	$4,600

*over age 55 can contribute an additional $1,000

GLP-1 COVERAGE CHANGES
NEW WEIGHT MANAGEMENT

To act as a steward of plan resources on behalf of all participants, the Medical Trust will continue coverage of GLP-1s for the treatment of type 2 diabetes, but not for weight reduction.

To support members' wellness goals, next year Medical Trust will make Digbi Health's services available at no cost to members.

digbi health

Manage **Weight, Type 2 Diabetes, Heart health** and **Digestive issues**.

https://go.digbihealth.ai/cpg

What You Get in the Program



1 At-home test kits

Gut microbiome and genetic kits shipped to your door.



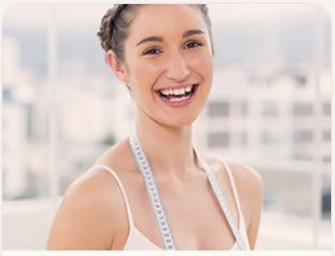
2 Continuous Glucose Monitor

See how food and lifestyle affect your blood sugar in real time.



3 Food and lifestyle guidance

Personalized meal and habit plans built around your biology.



4 Dedicated health coaching

1:1 support from a coach who knows your goals and history.

2027 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**
Deductible	$0 person / $0 Per Family		$50 per person / $150 Per Family	$0 person / $0 Per Family		$100 per person / $300 per Family	$0 person / $0 Per Family		
Annual Benefit Maximum	$3,000	$2,500	$2,000	$2,500	$2,000	$1,500	$2,000	$1,500	$1,000
Preventive and Diagnostic Services (exams, cleanings, x-rays, sealants, 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 (fillings, simple extractions, root canals, oral surgery, denture reline/repair/rebase	You pay 15% coinsurance		You pay 25% coinsurance	You pay 15% coinsurance		You pay 25% coinsurance	You pay 20% coinsurance		You pay 30% coinsurance plus any balance billing
Major Services (crowns, bridges, dentures)	You pay 15% coinsurance		You pay 25% coinsurance	You pay 50% coinsurance		You pay 60% coinsurance	You pay 60% coinsurance		You pay 99% coinsurance plus any balance billing
Orthodontic Services	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 60% coinsurance up to individual lifetime benefit limit of $1,000 after $100 lifetime deductible	Not covered. You pay 100%.		

Prescription Drug Benefits

Express Scripts

	Standard with PPO Plan		CDHP-15/HSA
	Retail	**Home Delivery**	**Retail and Home Delivery**
Annual Prescription Deductible (in-network)	None	None	$2,200 per person $4,400 per family
Tier 1: Generic	Up to a $10 copay	Up to a $25 copay	You pay 15% after deductible
Tier 2: Preferred Brand Name	25%; Up to a $40 min / $120 max	25%; Up to a $100 min / $300 max	You pay 25% after deductible
Tier 3: Non-Preferred Brand Name	40%; Up to a $80 min / $160 max	40%; Up to a $200 min / $400 max	You pay 50% after deductible
Tier 4: Specialty Rx	50%; up to $250 min / $500 max	50%; up to $250 min / $500 max	You pay 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 (retail) or 90-day supply (mail order)

Vision Benefits

EyeMed

	Network	Out-of-Network
Eye Examinations	$0 copay	$30 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	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,
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)	$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 $133
Disposable	$200 allowance, then you pay balance over $200	Plan pays up to $133