EPISCOPAL CHURCH MEDICAL TRUST

Plan	Anthem BCBS BlueCard PPO 90		Anthem BCBS BlueCard PPO 80		Anthem BCBS BlueCard PPO 70		Anthem BCBS CDHP 15/HSA		Anthem BCBS CDHP 20/HSA		Kaiser EPO 80
	Network	Out-of-Network	Network	Out-of-Network	Network	Out-of-Network	Network	Out-of-Network	Network	Out-of-Network	Network Only
Annual Deductible (CDHPs have a combined medical & Rx deductible)	$500 per person $1,000 per family	$1,000 per person $2,000 per family	$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	$1,400 per person $2,800 per family (deductible is non-embedded)	$2,800 per person $5,600 per family (deductible is non-embedded)	$2,800 per person $5,450 per family	$3,000 per person $6,000 per family	$500 per person $1,000 per family
Annual Out-of-Pocket Limit	$2,500 per person $5,000 per family	$5,000 per person $10,000 per family	$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	$2,400 per person $4,800 per family (out-of-pocket limit is non-embedded)	$4,800 per person $9,600 per family (out-of-pocket limit is non-embedded)	$4,200 per person $8,450 per family	$7,000 per person $13,000 per family	$3,500 per person $7,000 per family
Preventive Care											
Preventive Services & Well-Child Care	$0 copay	50% coinsurance	$0 copay	50% coinsurance	$0 copay	50% coinsurance	$0 copay	40% coinsurance	$0 copay	45% coinsurance	$0 copay
Physician Services											
Office Visit	$30 copay	50% coinsurance	$30 copay	50% coinsurance	$30 copay	50% coinsurance	15% coinsurance	40% coinsurance	20% coinsurance	45% coinsurance	$25 copay
Diagnostic Services (outpatient)	10% coinsurance	50% coinsurance	20% coinsurance	50% coinsurance	30% coinsurance	50% coinsurance	15% coinsurance	40% coinsurance	20% coinsurance	45% coinsurance	20% coinsurance
Specialist Care	$45 copay	50% coinsurance	$45 copay	50% coinsurance	$45 copay	50% coinsurance	15% coinsurance	40% coinsurance	20% coinsurance	45% coinsurance	$35 copay
Hospital Services											
Inpatient Services (including inpatient maternity services)	10% coinsurance	50% coinsurance	20% coinsurance	50% coinsurance	30% coinsurance	50% coinsurance	15% coinsurance	40% coinsurance	20% coinsurance	45% coinsurance	20% coinsurance
Outpatient Surgery	10% coinsurance	50% coinsurance	20% coinsurance	50% coinsurance	30% coinsurance	50% coinsurance	15% coinsurance	40% coinsurance	20% coinsurance	45% coinsurance	20% coinsurance
Emergency Room Care	$250 copay	$250 copay	$250 copay	$250 copay	$250 copay	$250 copay	15% coinsurance	15% coinsurance	20% coinsurance	20% coinsurance	20% coinsurance
Ambulance Services	10% coinsurance	10% coinsurance	20% coinsurance	20% coinsurance	30% coinsurance	30% coinsurance	15% coinsurance	15% coinsurance	20% coinsurance	20% coinsurance	20% coinsurance
Behavioral Health											
Outpatient Services	$30 copay	30% coinsurance	$30 copay	30% coinsurance	$30 copay	30% coinsurance	15% coinsurance	40% coinsurance	20% coinsurance	45% coinsurance	$25 copay per visit for individual visit
Inpatient Services	10% coinsurance	50% coinsurance	20% coinsurance	50% coinsurance	30% coinsurance	50% coinsurance	15% coinsurance	40% coinsurance	20% coinsurance	45% coinsurance	20% coinsurance
Other Medical Services											
Durable Medical Equipment	10% coinsurance	50% coinsurance	20% coinsurance	50% coinsurance	30% coinsurance	50% coinsurance	15% coinsurance	40% coinsurance	20% coinsurance	45% coinsurance	20% coinsurance
Home Health Care (210 visits per calendar year, combined network and out-of-network)	10% coinsurance	50% coinsurance	20% coinsurance	50% coinsurance	30% coinsurance	50% coinsurance	15% coinsurance	40% coinsurance	20% coinsurance	45% coinsurance	$0 copay
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)	$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)	$25 copay (includes speech, physical, and occupational)
Skilled Nursing / Acute Rehabilitation Facility (60 days per calendar year, combined network and out-of-network)	10% coinsurance	50% coinsurance	20% coinsurance	50% coinsurance	30% coinsurance	50% coinsurance	15% coinsurance	40% coinsurance	20% coinsurance	45% coinsurance	20% coinsurance
Urgent Care Services	$50 copay	$50 copay	$50 copay	$50 copay	$50 copay	$50 copay	15% coinsurance	15% coinsurance	20% coinsurance	20% coinsurance	$50 copay

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Prescription Drug Benefits

	Express Scripts				Kaiser	
	Premium		CDHP-15/HSA	CDHP-20/HSA	EPO 80	
	Retail	Home Delivery	Retail and Home Delivery	Retail and Home Delivery	Retail	Home Delivery
Annual Prescription Deductible (in-network)	None	None	$1,400 per person $2,800 per family (combined with medical deductible) (non-embedded deductible)	$2,800 per person $5,450 per family (combined with medical deductible)	None	None
Tier 1: Generic	Up to a $5 copay	Up to a $12 copay	d	You pay 15% after deductible	Up to a $10 copay	Up to a $10 copay for a 30-day supply or $20 for up to a 90-day supply
Tier 2: Preferred Brand Name	Up to a $30 copay	Up to a $75 copay	You pay 25% after deductible	You pay 25% after deductible	Up to a $30 copay	Up to a $30 copay for a 30-day supply or $60 for up to a 90-day supply
Tier 3: Non-Preferred Brand Name	Up to a $60 copay	Up to a $150 copay	You pay 50% after deductible	You pay 50% after deductible	Not Applicable	Not Applicable
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)	Up to a 30-day supply (retail) or 90-day supply (mail order)	Up to a 30-day supply	Up to a 90-day supply

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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)	$150 allowance, 20% off balance over $150	Plan pays up to $47
Contact Lenses (eligible once every calendar year)		
Conventional	$150 allowance, 15% off balance over $150	Plan pays up to $100
Disposable	$150 allowance, then you pay balance over $150	Plan pays up to $100

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DENTAL BENEFITS						
	CIGNA DENTAL					
	Preventive Dental PPO Plan		Basic Dental PPO Plan		Dental & Orthodontia PPO Plan	
	DPPO Advantage	*DPPO and Out-of-Network*	*DPPO Advantage*	*DPPO and Out-of-Network*	*DPPO Advantage*	*DPPO and Out-of-Network*
Deductible	$0 per person / $0 per family	$0 per person / $0 per family	$0 per person / $0 per family	$50 per person / $150 per family	$0 per person / $0 per family	$25 per person / $75 per family
Annual Benefit Limit	$1,500		$2,000		$2,000	
(e.g., oral exams, cleanings, x-rays, emergency care to relieve pain)	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 Restorative Services (Includes fillings, root canal therapy, and denture adjustments and repairs)	You pay 20% coinsurance		You pay 15% coinsurance	You pay 15% coinsurance after deductible	You pay 15% coinsurance	You pay 15% coinsurance after deductible
Major Restorative Services (Includes crowns, dentures, oral surgery, osseous surgery, and bridges)	You pay 99% coinsurance		You pay 50% coinsurance	You pay 50% coinsurance after deductible	You pay 15% coinsurance	You pay 15% coinsurance after deductible
Orthodontia Services	You pay 99% coinsurance		Not covered. You pay 100%.		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 after deductible

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The Plans described in this document (collectively, the Plans) are sponsored and administered by the Church Pension Group Services Corporation (CPGSC), also known as The Episcopal Church Medical Trust (the Medical Trust). The Plans that are self-funded are funded by The Episcopal Church Clergy and Employees' Benefit Trust (ECCEBT), which is a voluntary employees' beneficiary association within the meaning of section 501(c)(9) of the Internal Revenue Code.

This document contains only a partial, general description of the Plans. It is provided for informational purposes only and should not be viewed as a contract, an offer of coverage, a confirmation of eligibility, or investment, tax, medical or other advice. In the event of a conflict between this document and the official Plan documents (summary of benefits and coverage, Plan Document Handbook), the official Plan documents will govern. The Church Pension Fund and CPGSC (collectively, CPG), retain the right to amend, terminate or modify the terms of the Plans, as well as any post-retirement health subsidy, at any time, for any reason and, unless required by law, without notice.

The Plans are church plans within the meaning of section 3(33) of the Employee Retirement Income Security Act and section 414(e) of the Internal Revenue Code. Not all Plans are available in all areas of the United States, and not all Plans are available on both a self-funded and fully insured basis. The Plans do not cover all healthcare expenses, and Plan participants should read the official Plan documents carefully to determine which benefits are covered, as well as any applicable exclusions, limitations and procedures.

All benefits under the Plans are subject to applicable laws, regulations and policies.

Except for the Preventive Dental PPO Plan, all such benefits are subject to coordination of benefits. The Plans are subrogated to all of the rights of a Plan participant against any party liable for such participant's illness or injury, to the extent of the reasonable value of the benefits provided to such participant under the Plans. The Plans may assert this right independently of a Plan participant, and such participant is obligated to cooperate with the Medical Trust in order to protect the Plans' subrogation rights.

CPG does not provide any healthcare services and therefore cannot guarantee any results or outcomes. Healthcare providers and vendors are independent contractors in private practice and are neither employees nor agents of CPG. The availability of any particular provider cannot be guaranteed, and provider network composition is subject to change.