EPISCOPAL CHURCH MEDICAL TRUST

Plan	Anthem BCBS BlueCard PPO 90		Anthem BCBS BlueCard PPO 80		Anthem BCBS CDHP 20/HSA	
	Network	Out-of-Network	Network	Out-of-Network	Network	Out-of-Network
Annual Medical 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	$2,800 per person $5,450 per family	$3,000 per person $6,000 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	$4,200 per person $8,450 per family	$7,000 per person $13,000 per family
Preventive Care						
Preventive Services & Well-Child Care	$0 copay	50% coinsurance	$0 copay	50% coinsurance	$0 copay	45% coinsurance
Physician Services						
Office Visit	$30 copay	50% coinsurance	$30 copay	50% coinsurance	20% coinsurance	45% coinsurance
Diagnostic Services (outpatient)	10% coinsurance	50% coinsurance	20% coinsurance	50% coinsurance	20% coinsurance	45% coinsurance
Specialist Care	$45 copay	50% coinsurance	$45 copay	50% coinsurance	20% coinsurance	45% coinsurance
Hospital Services						
Inpatient Services (including inpatient maternity services)	10% coinsurance	50% coinsurance	20% coinsurance	50% coinsurance	20% coinsurance	45% coinsurance
Outpatient Surgery	10% coinsurance	50% coinsurance	20% coinsurance	50% coinsurance	20% coinsurance	45% coinsurance
Emergency Room Care	$250 copay	$250 copay	$250 copay	$250 copay	20% coinsurance	20% coinsurance
Ambulance Services	10% coinsurance	10% coinsurance	20% coinsurance	20% coinsurance	20% coinsurance	20% coinsurance
Mental Health/Substance Abuse						
Outpatient Services	$30 copay	30% coinsurance	$30 copay	30% coinsurance	20% coinsurance	45% coinsurance
Inpatient Services	10% coinsurance	50% coinsurance	20% coinsurance	50% coinsurance	20% coinsurance	45% coinsurance
Other Medical Services						
Durable Medical Equipment	10% coinsurance	50% coinsurance	20% coinsurance	50% coinsurance	20% coinsurance	45% coinsurance
Home Health Care	10% coinsurance	50% coinsurance	20% coinsurance	50% coinsurance	20% coinsurance	45% coinsurance
Outpatient Therapy	$30 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)	$30 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)	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)
Skilled Nursing / Acute Rehabilitation Facility	10% coinsurance	50% coinsurance	20% coinsurance	50% coinsurance	20% coinsurance	45% coinsurance
Urgent Care Services	$50 copay	$50 copay	$50 copay	$50 copay	20% coinsurance	20% coinsurance

EPISCOPAL CHURCH MEDICAL TRUST

Prescription Drug Benefits

	Express Scripts		
	Standard		CDHP-20/HSA
	Retail	Home Delivery	Retail and Home Delivery
Annual Prescription Deductible (in-network)	None	None	$2,800 per person $5,450 per family (combined with medical deductible)
Tier 1: Generic	Up to a $10 copay	Up to a $25 copay	You pay 15% after deductible
Tier 2: Preferred Brand Name	Up to a $40 copay	Up to a $100 copay	You pay 25% after deductible
Tier 3: Non-Preferred Brand Name	Up to a $80 copay	Up to a $200 copay	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)

This chart is a general description and is provided for informational purposes only. It should not be viewed as an offer of coverage. In the event of a conflict between this chart and the official Plan documents, the official Plan documents will govern.

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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		
	Dental & Orthodontia PPO Plan	Basic Dental PPO Plan	Preventive Dental PPO Plan
Annual DPPO & Out-of-Network Deductible (No deductible for DPPO Advantage providers)	$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)	You pay $0 (not subject to annual deductible)	You pay $0 (not subject to annual deductible)	You pay $0 (includes sealants to age 14 in addition to all other preventive and emergency care)
Basic Restorative Care	You pay 15% Includes fillings, root canal therapy, periodontal scaling and root planing, denture adjustments and repairs, extractions	You pay 15% Includes fillings, root canal therapy, periodontal scaling and root planing, denture adjustments and repairs, extractions	You pay 20% Includes only fillings, denture adjustments and repairs, root canal therapy
Major Restorative Services	You pay 15% Includes crowns, dentures, oral surgery, osseous surgery, dental implants, night guards, anesthetics, and bridges	You pay 50% Includes crowns, dentures, oral surgery, osseous surgery, dental implants, night guards, anestheetics, and bridges	You pay 99% Includes crowns, dentures, oral surgery, osseous surgery, and bridges
Orthodontia	You pay 50% ($1,500 individual lifetime limit)	Not covered	You pay 99%
Annual Benefit Maximum	$2,000	$2,000	$1,500

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.