EPISCOPAL CHURCH MEDICAL TRUST

2024 Medical Trust Health Plan	Anthem BCBS BlueCard PPO 100 NOT OFFERED IN EDSD		Anthem BCBS BlueCard PPO 90		Anthem BCBS BlueCard PPO 80 NOT OFFERED IN EDSD		Anthem BCBS BlueCard PPO 70 NOT OFFERED IN EDSD	
	Network	**Out-of-Network**	**Network**	**Out-of-Network**	**Network**	**Out-of-Network**	**Network**	**Out-of-Network**
Annual Deductible (CDHPs have a combined medical & Rx deductible)	$0 per person $0 per family	$500 per person $1,000 per family	$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
Annual Out-of-Pocket Limit	$2,000 per person $4,000 per family	$4,000 per person $8,000 per family	$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
Preventive Care								
Preventive Services & Well-Child Care	$0 copay	50% coinsurance plus any balance billing	$0 copay	50% coinsurance plus any balance billing	$0 copay	50% coinsurance plus any balance billing	$0 copay	50% coinsurance plus any balance billing
Physician Services								
Office Visit	$30 copay	50% coinsurance plus any balance billing	$30 copay	50% coinsurance plus any balance billing	$30 copay	50% coinsurance plus any balance billing	$30 copay	50% coinsurance plus any balance billing
Diagnostic Services (outpatient) (non-routine)	$0 copay	50% coinsurance plus any balance billing	10% coinsurance	50% coinsurance plus any balance billing	20% coinsurance	50% coinsurance plus any balance billing	30% coinsurance	50% coinsurance plus any balance billing
Specialist Care	$45 copay	50% coinsurance plus any balance billing	$45 copay	50% coinsurance plus any balance billing	$45 copay	50% coinsurance plus any balance billing	$45 copay	50% coinsurance plus any balance billing
Hospital Services								
Inpatient Services (including inpatient maternity services)	$250 copay	50% coinsurance plus any balance billing	10% coinsurance	50% coinsurance plus any balance billing	20% coinsurance	50% coinsurance plus any balance billing	30% coinsurance	50% coinsurance plus any balance billing
Outpatient Surgery	$200 copay	50% coinsurance plus any balance billing	10% coinsurance	50% coinsurance plus any balance billing	20% coinsurance	50% coinsurance plus any balance billing	30% coinsurance	50% coinsurance plus any balance billing
Emergency Room Care	$250 copay	Covered at in-network benefit level	$250 copay	Covered at in-network benefit level	$250 copay	Covered at in-network benefit level	$250 copay	Covered at in-network benefit level
Ambulance Services	$0 copay	Covered at in-network benefit level for emergency transport	10% coinsurance	Covered at in-network benefit level for emergency transport	20% coinsurance	Covered at in-network benefit level for emergency transport	30% coinsurance	Covered at in-network benefit level for emergency transport
Behavioral Health								
Outpatient Services	$0 copay	30% coinsurance plus any balance billing	$30 copay	30% coinsurance plus any balance billing	$30 copay	30% coinsurance plus any balance billing	$30 copay	30% coinsurance plus any balance billing
Inpatient Services	$250 copay	50% coinsurance plus any balance billing	10% coinsurance	50% coinsurance plus any balance billing	20% coinsurance	50% coinsurance plus any balance billing	30% coinsurance	50% coinsurance plus any balance billing
Other Medical Services								
Durable Medical Equipment	$0 copay	50% coinsurance plus any balance billing	10% coinsurance	50% coinsurance plus any balance billing	20% coinsurance	50% coinsurance plus any balance billing	30% coinsurance	50% coinsurance plus any balance billing
Home Health Care (210 visits per calendar year, combined network and out-of-network)	$0 copay	50% coinsurance plus any balance billing	10% coinsurance	50% coinsurance plus any balance billing	20% coinsurance	50% coinsurance plus any balance billing	30% coinsurance	50% coinsurance plus any balance billing
Outpatient Therapy (e.g., Physical Therapy/ Occupational Therapy/ Speech 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 plus any balance billing (includes speech, physical, and occupational)	$30 copay PCP/$45 copay specialist (includes speech, physical, and occupational)	50% coinsurance plus any balance billing (includes speech, physical, and occupational)	$30 copay PCP/$45 copay specialist (includes speech, physical, and occupational)	50% coinsurance plus any balance billing (includes speech, physical, and occupational)	$30 copay PCP/$45 copay specialist (includes speech, physical, and occupational)	50% coinsurance plus any balance billing (includes speech, physical, and occupational)
Skilled Nursing / Acute Rehabilitation Facility (60 days per calendar year, combined network and out-of-network)	$0 copay	50% coinsurance plus any balance billing	10% coinsurance	50% coinsurance plus any balance billing	20% coinsurance	50% coinsurance plus any balance billing	30% coinsurance	50% coinsurance plus any balance billing
Urgent Care Services	$50 copay	$50 copay plus any balance billing	$50 copay	$50 copay plus any balance billing	$50 copay	$50 copay plus any balance billing	$50 copay	$50 copay plus any balance billing

EPISCOPAL CHURCH MEDICAL TRUST

2024 Medical Trust Health Plan	Anthem BCBS CDHP 15/HSA		Anthem BCBS CDHP 20/HSA		Anthem BCBS CDHP 40/HSA NOT OFFERED IN EDSD	
	Network	**Out-of-Network**	**Network**	**Out-of-Network**	**Network**	**Out-of-Network**
Annual Deductible (CDHPs have a combined medical & Rx deductible)	$1,600 per person $3,200 per family (deductible is non-embedded)	$3,200 per person $6,400 per family (deductible is non-embedded)	$3,200 per person $5,450 per family	$3,200 per person $6,000 per family	$3,500 per person $7,000 per family	$7,000 per person $14,000 per family
Annual Out-of-Pocket Limit	$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	$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	40% coinsurance plus any balance billing	$0 copay	45% coinsurance plus any balance billing	$0 copay	60% coinsurance plus any balance billing
Physician Services						
Office Visit	15% coinsurance	40% coinsurance plus any balance billing	20% coinsurance	45% coinsurance plus any balance billing	40% coinsurance	60% coinsurance plus any balance billing
Diagnostic Services (outpatient) (non-routine)	15% coinsurance	40% coinsurance plus any balance billing	20% coinsurance	45% coinsurance plus any balance billing	40% coinsurance	60% coinsurance
Specialist Care	15% coinsurance	40% coinsurance plus any balance billing	20% coinsurance	45% coinsurance plus any balance billing	40% coinsurance	60% coinsurance plus any balance billing
Hospital Services						
Inpatient Services (including inpatient maternity services)	15% coinsurance	40% coinsurance plus any balance billing	20% coinsurance	45% coinsurance plus any balance billing	40% coinsurance	60% coinsurance plus any balance billing
Outpatient Surgery	15% coinsurance	40% coinsurance plus any balance billing	20% coinsurance	45% coinsurance plus any balance billing	40% coinsurance	60% coinsurance plus any balance billing
Emergency Room Care	15% coinsurance	Covered at in-network benefit level	20% coinsurance	Covered at in-network benefit level	40% coinsurance	Covered at in-network benefit level
Ambulance Services	15% coinsurance	Covered at in-network benefit level for emergency transport	20% coinsurance	Covered at in-network benefit level for emergency transport	40% coinsurance	Covered at in-network benefit level for emergency transport
Behavioral Health						
Outpatient Services	15% coinsurance	40% coinsurance plus any balance billing	20% coinsurance	45% coinsurance plus any balance billing	40% coinsurance	60% coinsurance plus any balance billing
Inpatient Services	15% coinsurance	40% coinsurance plus any balance billing	20% coinsurance	45% coinsurance plus any balance billing	40% coinsurance	60% coinsurance plus any balance billing
Other Medical Services						
Durable Medical Equipment	15% coinsurance	40% coinsurance plus any balance billing	20% coinsurance	45% coinsurance plus any balance billing	40% coinsurance	60% coinsurance plus any balance billing
Home Health Care (210 visits per calendar year, combined network and out-of-network)	15% coinsurance	40% coinsurance plus any balance billing	20% coinsurance	45% coinsurance plus any balance billing	40% coinsurance	60% coinsurance plus any balance billing
Outpatient Therapy (e.g., Physical Therapy/ Occupational Therapy/ Speech Therapy) (60 visits per calendar year per each type of therapy, combined network and out-of-network)	15% coinsurance (includes speech, physical, and occupational)	40% coinsurance plus any balance billing (includes speech, physical, and occupational)	20% coinsurance (includes speech, physical, and occupational)	45% coinsurance plus any balance billing (includes speech, physical, and occupational)	40% coinsurance (includes speech, physical, and occupational)	60% coinsurance plus any balance billing (includes speech, physical, and occupational)
Skilled Nursing / Acute Rehabilitation Facility (60 days per calendar year, combined network and out-of-network)	15% coinsurance	40% coinsurance plus any balance billing	20% coinsurance	45% coinsurance plus any balance billing	40% coinsurance	60% coinsurance plus any balance billing
Urgent Care Services	15% coinsurance	15% coinsurance plus any balance billing	20% coinsurance	20% coinsurance plus any balance billing	40% coinsurance	40% coinsurance plus any balance billing

EPISCOPAL CHURCH MEDICAL TRUST

2024 Medical Trust Health Plan	Kaiser EPO High		Kaiser EPO 80		Kaiser CDHP 20/HSA NOT OFFERED IN EDSD	
	Network	Out-of-Network	Network	Out-of-Network	Network	Out-of-Network
Annual Deductible (CDHPs have a combined medical & Rx deductible)	$0 per person $0 per family	Not Applicable	$500 per person $1,000 per family	Not Applicable	$3,200 per person $5,450 per family	Not Applicable
Annual Out-of-Pocket Limit	$1,750 per person $3,500 per family	Not Applicable	$3,500 per person $7,000 per family	Not Applicable	$4,200 per person $8,450 per family	Not Applicable
Preventive Care						
Preventive Services & Well-Child Care	$0 copay	Not Applicable	$0 copay	Not Applicable	$0 copay	Not Applicable
Physician Services						
Office Visit	$25 copay	Not Applicable	$25 copay	Not Applicable	20% coinsurance	Not Applicable
Diagnostic Services (outpatient) (non-routine)	$50 copay	Not Applicable	20% coinsurance	Not Applicable	20% coinsurance	Not Applicable
Specialist Care	$25 copay	Not Applicable	$35 copay	Not Applicable	20% coinsurance	Not Applicable
Hospital Services						
Inpatient Services (including inpatient maternity services)	$100 per day copay to maximum of $600	Not Applicable	20% coinsurance	Not Applicable	20% coinsurance	Not Applicable
Outpatient Surgery	$100 copay	Not Applicable	20% coinsurance	Not Applicable	20% coinsurance	Not Applicable
Emergency Room Care	$100 copay	Covered at in-network benefit level	20% coinsurance	Covered at in-network benefit level	20% coinsurance	Covered at in-network benefit level
Ambulance Services	$0 copay	Covered at in-network benefit level for emergency transport	20% coinsurance	Covered at in-network benefit level for emergency transport	20% coinsurance	Covered at in-network benefit level for emergency transport
Behavioral Health						
Outpatient Services	$25 copay per visit for individual visit	Not Applicable	$25 copay per visit for individual visit	Not Applicable	20% coinsurance	Not Applicable
Inpatient Services	$100 per day copay to maximum of $600	Not Applicable	20% coinsurance	Not Applicable	20% coinsurance	Not Applicable
Other Medical Services						
Durable Medical Equipment	$0 copay	Not Applicable	20% coinsurance	Not Applicable	20% coinsurance	Not Applicable
Home Health Care (210 visits per calendar year, combined network and out-of-network)	$0 copay	Not Applicable	$0 copay	Not Applicable	$0 copay	Not Applicable
Outpatient Therapy (e.g., Physical Therapy/ Occupational Therapy/ Speech Therapy) (60 visits per calendar year per each type of therapy, combined network and out-of-network)	$25 copay (includes speech, physical, and occupational)	Not Applicable	$25 copay (includes speech, physical, and occupational)	Not Applicable	20% coinsurance (includes speech, physical, and occupational)	Not Applicable
Skilled Nursing / Acute Rehabilitation Facility (60 days per calendar year, combined network and out-of-network)	$0 copay	Not Applicable	20% coinsurance	Not Applicable	20% coinsurance	Not Applicable
Urgent Care Services	$50 copay	Not Applicable	$50 copay	Not Applicable	20% coinsurance	Not Applicable

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)	None	None	None	None	$1,600 per person $3,200 per family (combined with medical deductible) (non-embedded deductible)	$3,200 per person $5,450 per family (combined with medical deductible)	$3,500 per person $7,000 per family (combined with medical deductible)
Tier 1: Generic	Up to a $10 copay	Up to a $25 copay	Up to a $5 copay	Up to a $12 copay	You pay 15% after deductible	You pay 15% after deductible	You pay 15% after deductible
Tier 2: Preferred Brand Name	Up to a $40 copay	Up to a $100 copay	Up to a $30 copay	Up to a $75 copay	You pay 25% after deductible	You pay 25% after deductible	You pay 25% after deductible
Tier 3: Non-Preferred Brand Name	Up to a $80 copay	Up to a $200 copay	Up to a $60 copay	Up to a $150 copay	You pay 50% after deductible	You pay 50% after deductible	You pay 50% after deductible
Tier 4: Specialty Rx	40%; up to $100 min / $200 max	40%; up to $250 min / $500 max	Up to a $90 copay	Up to a $225 copay	You pay 50% after deductible	You pay 50% after deductible	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	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)

Prescription Drug Benefits

	Kaiser Health Plans		
	EPO High and EPO 80		CDHP-20/HSA
	Retail	Home Delivery	Retail and Home Delivery
Annual Prescription Deductible (in-network)	None	None	$3,200 per person $5,450 per family (combined with medical deductible)
Tier 1: Generic	Up to a $10 copay	Up to a $10 copay for a 30-day supply or $20 for up to a 90-day supply*	You pay 15% after deductible
Tier 2: Preferred Brand Name	Up to a $25 copay	Up to a $25 copay for a 30-day supply or $50 for up to a 90-day supply*	You pay 25% after deductible
Tier 3: Non-Preferred Brand Name	Not Applicable	Not Applicable	You pay 50% after deductible
Tier 4: Specialty Rx	Up to a $90 copay	Up to a $90 copay for a 30-day supply	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)

* California residents may receive up to a 100-day supply when using home delivery.

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	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 over $200	Plan pays up to $100
Disposable	$200 allowance, then you pay balance over $200	Plan pays up to $100

EPISCOPAL CHURCH MEDICAL TRUST

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*
Annual Deductible	$0 per person / $0 per family	$0 per person / $0 per family	$50 per person / $150 per family	$0 per person / $0 per family	$0 per person / $0 per family	$100 per person / $300 per family	$0 per person / $0 per family	$0 per person / $0 per family	$0 per person / $0 per family
Annual Benefit Maximum (Plan maximums cross-accumulate between the PPO Network, Premier Network, and out-of-network dentists)	$3,000	$2,500	$2,000	$2,500	$2,000	$1,500	$2,000	$1,500	$1,000
Diagnostic and Preventive Services (e.g., exams, cleanings, x-rays, sealants and space maintainers)	You pay $0 (not subject to annual deductible)		You pay $0 (not subject to annual deductible) plus any balance billing	You pay $0 (not subject to annual deductible)		You pay $0 (not subject to annual deductible) plus any balance billing	You pay $0 (not subject to annual deductible)		You pay $0 (not subject to annual deductible) plus any balance billing
Basic Services (Includes fillings, simple extractions, root canals, oral surgery, and denture reline/repair/rebase)	You pay 15% coinsurance	You pay 15% coinsurance	You pay 25% coinsurance plus any balance billing	You pay 15% coinsurance	You pay 15% coinsurance	You pay 25% coinsurance plus any balance billing	You pay 20% coinsurance	You pay 20% coinsurance	You pay 30% coinsurance plus any balance billing
Major Services (Includes crowns, bridges, and dentures)	You pay 15% coinsurance	You pay 15% coinsurance	You pay 25% coinsurance plus any balance billing	You pay 50% coinsurance	You pay 50% coinsurance	You pay 60% coinsurance plus any balance billing	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 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 plus any balance billing	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	You pay 60% coinsurance up to individual lifetime benefit limit of $1,000 after $100 lifetime deductible plus any balance billing	Not covered. You pay 100%.	Not covered. You pay 100%.	Not covered. You pay 100%.

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Church Pension Group Services Corporation ("CPGSC"), doing business as The Episcopal Church Medical Trust, maintains a series of health and welfare plans (the "Plans") for eligible employees (and their eligible dependents) of The Episcopal Church (the "Church"). The Medical Trust serves only eligible Episcopal employers. The Plans that are self-funded are funded by the Episcopal Church Clergy and Employees' Benefit Trust, a voluntary employees' beneficiary association within the meaning of section 501(c)(9) of the Internal Revenue Code.

The Plans are church plans within the meaning of section 3(33) of the Employee Retirement Income Security Act of 1974, as amended, and section 414(e) of the Internal Revenue Code. Not all Plans are available in all areas of the United States or outside the United States, and not all Plans are available on both a self-funded and fully insured basis. Additionally, the Plan may be exempt from federal and state laws that may otherwise apply to health insurance arrangements. The Plans do not cover all healthcare expenses, so members should read the official Plan documents carefully to determine which benefits are covered, as well as any applicable exclusions, limitations, and procedures.