

2023 Medical Trust Health Plan	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
Annual Deductible (CDHPs have a combined medical & Rx deductible)	\$1,500 per person \$3,000 per family (deductible is non- embedded)	\$3,000 per person \$6,000 per family (deductible is non- embedded)	\$2,800 per person \$5,450 per family	\$3,000 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	\$0 copay	45% coinsurance	\$0 copay	60% coinsurance
Physician Services						
Office Visit	15% coinsurance	40% coinsurance	20% coinsurance	45% coinsurance	40% coinsurance	60% coinsurance
Diagnostic Services (outpatient)	15% coinsurance	40% coinsurance	20% coinsurance	45% coinsurance	40% coinsurance	60% coinsurance
Specialist Care	15% coinsurance	40% coinsurance	20% coinsurance	45% coinsurance	40% coinsurance	60% coinsurance
Hospital Services						
Inpatient Services (including inpatient maternity services)	15% coinsurance	40% coinsurance	20% coinsurance	45% coinsurance	40% coinsurance	60% coinsurance
Outpatient Surgery	15% coinsurance	40% coinsurance	20% coinsurance	45% coinsurance	40% coinsurance	60% coinsurance
Emergency Room Care	15% coinsurance	15% coinsurance	20% coinsurance	20% coinsurance	40% coinsurance	40% coinsurance
Ambulance Services	15% coinsurance	15% coinsurance	20% coinsurance	20% coinsurance	40% coinsurance	40% coinsurance
Behavioral Health						
Outpatient Services	15% coinsurance	40% coinsurance	20% coinsurance	45% coinsurance	40% coinsurance	60% coinsurance
Inpatient Services	15% coinsurance	40% coinsurance	20% coinsurance	45% coinsurance	40% coinsurance	60% coinsurance
Other Medical Services						
Durable Medical Equipment	15% coinsurance	40% coinsurance	20% coinsurance	45% coinsurance	40% coinsurance	60% coinsurance
Home Health Care (210 visits per calendar year, combined network and out-of- network)	15% coinsurance	40% coinsurance	20% coinsurance	45% coinsurance	40% coinsurance	60% coinsurance
Outpatient 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 (includes speech, physical, and occupational)	20% coinsurance (includes speech, physical, and occupational)	45% coinsurance (includes speech, physical, and occupational)	40% coinsurance (includes speech, physical, and occupational)	60% coinsurance (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	20% coinsurance	45% coinsurance	40% coinsurance	60% coinsurance
Urgent Care Services	15% coinsurance	15% coinsurance	20% coinsurance	20% coinsurance	40% coinsurance	40% coinsurance

2023 Medical Trust Health Plan	Cigna CDHP 15/HSA		Cigna CDHP 20/HSA		Cigna CDHP 40/HSA	
	Network	Out-of-Network	Network	Out-of-Network	Network	Out-of-Network
Annual Deductible (CDHPs have a combined medical & Rx deductible)	\$1,500 per person \$3,000 per family (deductible is non-embedded)	\$3,000 per person \$6,000 per family (deductible is non-embedded)	\$2,800 per person \$5,450 per family	\$3,000 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	\$0 copay	45% coinsurance	\$0 copay	60% coinsurance
Physician Services						
Office Visit	15% coinsurance	40% coinsurance	20% coinsurance	45% coinsurance	40% coinsurance	60% coinsurance
Diagnostic Services (outpatient)	15% coinsurance	40% coinsurance	20% coinsurance	45% coinsurance	40% coinsurance	60% coinsurance
Specialist Care	15% coinsurance	40% coinsurance	20% coinsurance	45% coinsurance	40% coinsurance	60% coinsurance
Hospital Services						
Inpatient Services (including inpatient maternity services)	15% coinsurance	40% coinsurance	20% coinsurance	45% coinsurance	40% coinsurance	60% coinsurance
Outpatient Surgery	15% coinsurance	40% coinsurance	20% coinsurance	45% coinsurance	40% coinsurance	60% coinsurance
Emergency Room Care	15% coinsurance	15% coinsurance	20% coinsurance	20% coinsurance	40% coinsurance	40% coinsurance
Ambulance Services	15% coinsurance	15% coinsurance	20% coinsurance	20% coinsurance	40% coinsurance	40% coinsurance
Behavioral Health						
Outpatient Services	15% coinsurance	40% coinsurance	20% coinsurance	45% coinsurance	40% coinsurance	60% coinsurance
Inpatient Services	15% coinsurance	40% coinsurance	20% coinsurance	45% coinsurance	40% coinsurance	60% coinsurance
Other Medical Services						
Durable Medical Equipment	15% coinsurance	40% coinsurance	20% coinsurance	45% coinsurance	40% coinsurance	60% coinsurance
Home Health Care (210 visits per calendar year, combined network and out-of-network)	15% coinsurance	40% coinsurance	20% coinsurance	45% coinsurance	40% coinsurance	60% coinsurance
Outpatient 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 (includes speech, physical, and occupational)	20% coinsurance (includes speech, physical, and occupational)	45% coinsurance (includes speech, physical, and occupational)	40% coinsurance (includes speech, physical, and occupational)	60% coinsurance (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	20% coinsurance	45% coinsurance	40% coinsurance	60% coinsurance
Urgent Care Services	15% coinsurance	15% coinsurance	20% coinsurance	20% coinsurance	40% coinsurance	40% coinsurance

2023 Medical Trust Health Plan	Kaiser EPO High	Kaiser EPO 80	Kaiser CDHP 20/HSA
	Network Only	Network Only	Network Only
Annual Deductible (CDHPs have a combined medical & Rx deductible)	\$0 per person \$0 per family	\$500 per person \$1,000 per family	\$2,800 per person \$5,450 per family
Annual Out-of-Pocket Limit	\$1,750 per person \$3,500 per family	\$3,500 per person \$7,000 per family	\$4,200 per person \$8,450 per family
Preventive Care			
Preventive Services & Well-Child Care	\$0 copay	\$0 copay	\$0 copay
Physician Services			
Office Visit	\$25 copay	\$25 copay	20% coinsurance
Diagnostic Services (outpatient)	\$50 copay	20% coinsurance	20% coinsurance
Specialist Care	\$25 copay	\$35 copay	20% coinsurance
Hospital Services			
Inpatient Services (including inpatient maternity services)	\$100 per day copay to maximum of \$600	20% coinsurance	20% coinsurance
Outpatient Surgery	\$100 copay	20% coinsurance	20% coinsurance
Emergency Room Care	\$100 copay	20% coinsurance	20% coinsurance
Ambulance Services	\$0 copay	20% coinsurance	20% coinsurance
Behavioral Health			
Outpatient Services	\$25 copay per visit for individual visit	\$25 copay per visit for individual visit	20% coinsurance
Inpatient Services	\$100 per day copay to maximum of \$600	20% coinsurance	20% coinsurance
Other Medical Services			
Durable Medical Equipment	\$0 copay	20% coinsurance	20% coinsurance
Home Health Care (210 visits per calendar year, combined network and out-of-network)	\$0 copay	\$0 copay	\$0 copay
Outpatient Therapy (60 visits per calendar year per each type of therapy, combined network and out-of-network)	\$25 copay (includes speech, physical, and occupational)	\$25 copay (includes speech, physical, and occupational)	20% coinsurance (includes speech, physical, and occupational)
Skilled Nursing / Acute Rehabilitation Facility (60 days per calendar year, combined network and out-of-network)	\$0 copay	20% coinsurance	20% coinsurance
Urgent Care Services	\$50 copay	\$50 copay	20% coinsurance

2023 Prescription Drug Benefits

	Express Scripts			
	Standard		Premium	
	Retail	Home Delivery	Retail	Home Delivery
Annual Prescription Deductible (in-network)	None	None	None	None
Tier 1: Generic	Up to a \$10 copay	Up to a \$25 copay	Up to a \$5 copay	Up to a \$12 copay
Tier 2: Preferred Brand Name	25%; up to \$40 min / \$80 max	25%; up to \$100 min / \$200 max	Up to a \$35 copay	Up to a \$87 copay
Tier 3: Non-Preferred Brand Name	40%; up to \$80 min / \$160 max	40%; up to \$200 min / \$400 max	Up to a \$70 copay	Up to a \$175 copay
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
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

2023 Prescription Drug Benefits

	Express Scripts		
	CDHP-15/HSA	CDHP-20/HSA	CDHP-40/HSA
	Retail and Home Delivery	Retail and Home Delivery	Retail and Home Delivery
Annual Prescription Deductible (in-network)	\$1,500 per person \$3,000 per family (combined with medical deductible) (non-embedded deductible)	\$2,800 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	You pay 15% after deductible	You pay 15% after deductible	You pay 15% after deductible
Tier 2: Preferred Brand Name	You pay 25% after deductible	You pay 25% after deductible	You pay 25% after deductible
Tier 3: Non-Preferred Brand Name	You pay 50% after deductible	You pay 50% after deductible	You pay 50% after deductible
Tier 4: Specialty Rx	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 (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)

2023 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	\$2,800 per person \$5,450 per family (combined with medical deductible)
Tier 1: Generic	Up to a \$5 copay	Up to a \$5 copay for a 30-day supply or \$10 for up to a 90-day supply	You pay 15% after deductible
Tier 2: Preferred Brand Name	Up to a \$30 copay	Up to a \$30 copay for a 30-day supply or \$60 for up to a 90-day supply	You pay 25% after deductible
Tier 3: Non-Preferred Brand Name	Up to a \$70 copay	Up to a \$70 copay for a 30-day supply or \$140 for up to a 90-day supply	You pay 50% after deductible
Tier 4: Specialty Rx	Up to a \$90 copay	Up to a \$90 copay for a 30-day supply or \$180 for up to a 90-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)

2023 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

2023 Dental Benefits

Cigna Dental						
	Preventive Dental PPO Plan		Basic Dental PPO Plan		Dental & Orthodontia PPO Plan	
	<i>DPPPO Advantage</i>	<i>DPPPO and Out-of-Network</i>	<i>DPPPO Advantage</i>	<i>DPPPO and Out-of-Network</i>	<i>DPPPO Advantage</i>	<i>DPPPO and Out-of-Network</i>
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	
Preventive and Diagnostic Services <i>(e.g., oral exams, cleanings, x-rays, emergency care to relieve pain)</i>	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 <i>(Includes fillings, root canal therapy, oral surgery, osseous surgery, and denture adjustments and repairs)</i>	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 <i>(Includes crowns, dentures, and bridges)</i>	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	Not covered. You pay 100%.		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

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' benefit 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.

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.

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 the rights of a Plan participant against any party liability for such participant's illness or injury, to the extent of the reasonable value of the benefits provided to such a participant under the Plans. The Plans may assert this right independently of a Plan participant, and This material is not a substitute for professional medical advice or treatment. CPG does not provide any healthcare services and, therefore, cannot guarantee any results or outcomes. Always seek the advice of a healthcare professional with any questions about your personal healthcare, including diet and