EPISCOPAL CHURCH MEDICAL TRUST

Plan	Empire BCBS PPO 80/60		Empire BCBS PPO 75/50		Empire BCBS HDHP/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	$900 per person $1,800 per family	$1,800 per person $3,600 per family	$2,700 per person $5,450 per family (deductible includes medical & prescriptions)	$3,000 per person $6,000 per family (deductible includes medical & prescriptions)
Annual Out-of-Pocket Maximum (includes deductible)	$2,500 per person $5,000 per family	$6,500 per person $13,000 per family	$4,100 per person $8,200 per family	$8,200 per person $16,400 per family	$4,200 per person $8,450 per family	$7,000 per person $13,000 per family
Preventive Care						
Routine and Preventive Services, Well-Child Care	$0 copay	You pay 40%	$0 copay (both PCP and specialist)	You pay 50%	$0 copay	You pay 45%
Physician Services						
Office Visit	$25 copay	You pay 40%	$35 copay	You pay 50%	You pay 20%	You pay 45%
Diagnostic Services	You pay 20%	You pay 20%	You pay 25%	You pay 25%	You pay 20%	You pay 20%
Specialist Care	$25 copay	You pay 40%	$45 copay	You pay 50%	You pay 20%	You pay 45%
Hospital Services						
Inpatient Services (including inpatient maternity services)	Copay of $100 per day not to exceed $600 per admission, then you pay 20%	You pay 40%	Copay of $100 per day not to exceed $600, then you pay 25%	You pay 50%	You pay 20%	You pay 45%
Outpatient Surgery	You pay 20%	You pay 40%	You pay 25%	You pay 50%	You pay 20%	You pay 45%
Emergency Room Care (copay waived if admitted within 24 hours)	$100 copay	$100 copay	$100 copay	$100 copay	You pay 20%	You pay 20%
Ambulance Services	You pay 20%	You pay 20%	You pay 25%	You pay 25%	You pay 20%	You pay 45%
Maternity Services						
Prenatal Care (copay applies only to visit to confirm pregnancy)	$25 copay	You pay 40%	$35 copay/ $45 specialist	You pay 50%	You pay 20%	You pay 45%

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.

EPISCOPAL CHURCH MEDICAL TRUST

Plan	Empire BCBS PPO 80/60		Empire BCBS PPO 75/50		Empire BCBS HDHP/HSA	
	Network	Out-of-Network	Network	Out-of-Network	Network	Out-of-Network
Mental Health/Substance Abuse						
Outpatient Services	$20 copay Services are provided through Cigna Behavioral Health, not through Empire	You pay 30% Services are provided through Cigna Behavioral Health, not through Empire	$20 copay Services are provided through Cigna Behavioral Health not through Empire	You pay 30% Services are provided through Cigna Behavioral Health, not through Empire	You pay 20%	You pay 45%
Inpatient Services	Covered at 100% after $100 per day copay/$600 maximum Services are provided through Cigna Behavioral Health, not through Empire	You pay 30% Services are provided through Cigna Behavioral Health, not through Empire	Covered at 100% after $100 per day copay/$600 maximum Services are provided through Cigna Behavioral Health, not through Empire	You pay 30% Services are provided through Cigna Behavioral Health, not through Empire	You pay 20%	You pay 45%
Other Medical Services						
Durable Medical Equipment (DME)	You pay 20%	You pay 20%	You pay 25%	You pay 25%	You pay 20%	You pay 20%
Home Health Care (210 visits per year, combined in- and out-of-network)	You pay 20%	You pay 40%	You pay 25%	You pay 50%	You pay 20%	You pay 45%
Outpatient Therapy (limits are combined in- and out-of-network)	$25 copay (includes hearing/ speech, physical, and occupational) (60 visits per year per each type of therapy)	You pay 40% (includes hearing/speech, physical, and occupational) (60 visits per year per each type of therapy)	$35 copay (PCP) $45 copay (specialist) (includes hearing/ speech, physical, and occupational) (60 visits per year per each type of therapy)	You pay 50% (includes hearing/speech, physical, and occupational) (60 visits per year per each type of therapy)	You pay 20% (includes hearing/speech, physical, and occupational) (60 visits per year per each type of therapy)	You pay 45% (includes hearing/speech, physical, and occupational) (60 visits per year per each type of therapy)
Skilled Nursing Facility (60 days per year)	You pay 20%	You pay 40%	You pay 25%	You pay 50%	You pay 20%	You pay 45%
Urgent Care Services	You pay 20%	You pay 40%	You pay 25%	You pay 50%	You pay 20%	You pay 45%

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.

Prescription Drug Benefits			
	Express Scripts		
	Premium		HDHP/HSA
	Retail	Mail Order	Retail & Mail Order
Annual Prescription Deductible	$50 per person	None	$2,700 per person $5,450 per family (combined with medical deductible)
Tier 1: Generic	Up to a $5 copay	Up to a $12 copay	You pay 15% after deductible
Tier 2: Preferred Brand Name	Up to a $25 copay	Up to a $70 copay	You pay 25% after deductible
Tier 3: Non-Preferred Brand Name	Up to a $45 copay	Up to a $110 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.

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)	$130 allowance, 20% off balance over $130	Plan pays up to $47
Contact Lenses (eligible once every calendar year)		
Conventional	$130 allowance, 15% off balance over $130	Plan pays up to $100
Disposable	$130 allowance, then you pay balance over $130	Plan pays up to $100

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.

Dental Benefits			
	Cigna Dental		
	Dental & Orthodontia PPO Plan	Basic Dental PPO Plan	Preventive Dental PPO Plan
Annual Out-of-Network Deductible	$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, and anesthetics	You pay 15% Includes fillings, root canal therapy, periodontal scaling and root planing, denture adjustments and repairs, extractions, and anesthetics	You pay 20% Includes only fillings, denture adjustments and repairs
Major Restorative Services	You pay 15% Includes crowns, dentures, oral surgery, osseous surgery, dental implants, night guards, and bridges	You pay 50% Includes crowns, dentures, oral surgery, osseous surgery, dental implants, night guards, and bridges	You pay 99% Includes crowns, dentures, oral surgery, osseous surgery, and bridges, root canal therapy
Orthodontia	You pay 50% ($1,500 individual lifetime maximum)	Not covered	You pay 99%
Annual Benefit Maximum	$2,000	$2,000	$1,500

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.

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, summary Plan description, booklet, booklet-certificate), 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, without notice and for any reason.

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 health care 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 health care services and therefore cannot guarantee any results or outcomes. Health care 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.