EPISCOPAL CHURCH MEDICAL TRUST

2024 Medical Trust Health Plan 0067 - Diocese of Atlanta	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**	**Out-of-Network**
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	$1,600 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	$500 per person $1,000 per family	Not Applicable
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	Not Applicable
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	40% coinsurance plus any balance billing	$0 copay	45% coinsurance plus any balance billing	$0 copay	Not Applicable
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	15% coinsurance	40% coinsurance plus any balance billing	20% coinsurance	45% coinsurance plus any balance billing	$25 copay	Not Applicable
Diagnostic Services (outpatient) (non-routine)	10% coinsurance	50% coinsurance plus any balance billing	20% coinsurance	50% coinsurance plus any balance billing	30% coinsurance	50% coinsurance plus any balance billing	15% coinsurance	40% coinsurance plus any balance billing	20% coinsurance	45% coinsurance plus any balance billing	20% coinsurance	Not Applicable
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	15% coinsurance	40% coinsurance plus any balance billing	20% coinsurance	45% coinsurance plus any balance billing	$35 copay	Not Applicable
Hospital Services												
Inpatient Services (including inpatient maternity services)	10% coinsurance	50% coinsurance plus any balance billing	20% coinsurance	50% coinsurance plus any balance billing	30% coinsurance	50% coinsurance plus any balance billing	15% coinsurance	40% coinsurance plus any balance billing	20% coinsurance	45% coinsurance plus any balance billing	20% coinsurance	Not Applicable
Outpatient Surgery	10% coinsurance	50% coinsurance plus any balance billing	20% coinsurance	50% coinsurance plus any balance billing	30% coinsurance	50% coinsurance plus any balance billing	15% coinsurance	40% coinsurance plus any balance billing	20% coinsurance	45% coinsurance plus any balance billing	20% coinsurance	Not Applicable
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	15% coinsurance	Covered at in-network benefit level	20% coinsurance	Covered at in-network benefit level	20% coinsurance	Covered at in-network benefit level
Ambulance Services	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	15% coinsurance	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	$30 copay	30% coinsurance plus any balance billing	$30 copay	30% coinsurance plus any balance billing	$30 copay	30% coinsurance plus any balance billing	15% coinsurance	40% coinsurance plus any balance billing	20% coinsurance	45% coinsurance plus any balance billing	$25 copay per visit for individual visit	Not Applicable
Inpatient Services	10% coinsurance	50% coinsurance plus any balance billing	20% coinsurance	50% coinsurance plus any balance billing	30% coinsurance	50% coinsurance plus any balance billing	15% coinsurance	40% coinsurance plus any balance billing	20% coinsurance	45% coinsurance plus any balance billing	20% coinsurance	Not Applicable
Other Medical Services												
Durable Medical Equipment	10% coinsurance	50% coinsurance plus any balance billing	20% coinsurance	50% coinsurance plus any balance billing	30% coinsurance	50% coinsurance plus any balance billing	15% coinsurance	40% coinsurance plus any balance billing	20% coinsurance	45% coinsurance plus any balance billing	20% coinsurance	Not Applicable
Home Health Care (210 visits per calendar year, combined network and out-of-network)	10% coinsurance	50% coinsurance plus any balance billing	20% coinsurance	50% coinsurance plus any balance billing	30% coinsurance	50% coinsurance plus any balance billing	15% coinsurance	40% coinsurance plus any balance billing	20% coinsurance	45% coinsurance plus any balance billing	$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)	$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)	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)	$25 copay (includes speech, physical, and occupational)	Not Applicable
Skilled Nursing / Acute Rehabilitation Facility (60 days per calendar year, combined network and out-of-network)	10% coinsurance	50% coinsurance plus any balance billing	20% coinsurance	50% coinsurance plus any balance billing	30% coinsurance	50% coinsurance plus any balance billing	15% coinsurance	40% coinsurance plus any balance billing	20% coinsurance	45% coinsurance plus any balance billing	20% coinsurance	Not Applicable
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	15% coinsurance	15% coinsurance plus any balance billing	20% coinsurance	20% coinsurance plus any balance billing	$50 copay	Not Applicable

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	Pharmacy Benefits Administered by Express Scripts		Pharmacy Benefits Administered by Express Scripts		Pharmacy Benefits Administered by Express Scripts		Pharmacy Benefits Administered by Express Scripts		Pharmacy Benefits Administered by Express Scripts		Pharmacy Benefits Administered by Kaiser	
Prescription Drug Benefits	**Retail**	**Home Delivery**	**Retail**	**Home Delivery**	**Retail**	**Home Delivery**	**Retail**	**Home Delivery**	**Retail**	**Home Delivery**	**Retail**	**Home Delivery**
Annual Prescription Deductible (in-network)	None	None	None	None	None	None	$1,600 per person $3,200 per family (combined with medical deductible) (non-embedded deductible)	$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)	$3,200 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	Up to a $5 copay	Up to a $12 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	You pay 15% after deductible	Up to a $5 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 $35 copay	Up to a $87 copay	Up to a $35 copay	Up to a $87 copay	Up to a $35 copay	Up to a $87 copay	You pay 25% after deductible	You pay 25% after deductible	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 $70 copay	Up to a $175 copay	Up to a $70 copay	Up to a $175 copay	Up to a $70 copay	Up to a $175 copay	You pay 50% after deductible	You pay 50% after deductible	You pay 50% after deductible	You pay 50% after deductible	Up to a $70 copay	Up to a $70 copay for a 30-day supply or $140 for up to a 90-day supply
Tier 4: Specialty Rx	Up to a $90 copay	Up to a $225 copay	Up to a $90 copay	Up to a $225 copay	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	You pay 50% after deductible	Up to a $90 copay	Up to a $90 copay for a 30-day supply
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	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)	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 Administered by EyeMed		Vision Benefits Administered by EyeMed		Vision Benefits Administered by EyeMed		Vision Benefits Administered by EyeMed		Vision Benefits Administered by EyeMed		.	
Vision Benefits	**Network**	**Out-of-Network**	**Network**	**Out-of-Network**	**Network**	**Out-of-Network**	**Network**	**Out-of-Network**	**Network**	**Out-of-Network**	**Network**	**Out-of-Network**
Eye Examinations	$0 copay	Plan pays up to $30 for ophthalmologists or optometrists	$0 copay	Plan pays up to $30 for ophthalmologists or optometrists	$0 copay	Plan pays up to $30 for ophthalmologists or optometrists	$0 copay	Plan pays up to $30 for ophthalmologists or optometrists	$0 copay	Plan pays up to $30 for ophthalmologists or optometrists	$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	$10 copay	Plan pays up to: $32 for single vision $46 for bifocal $57 for trifocal	$10 copay	Plan pays up to: $32 for single vision $46 for bifocal $57 for trifocal	$10 copay	Plan pays up to: $32 for single vision $46 for bifocal $57 for trifocal	$10 copay	Plan pays up to: $32 for single vision $46 for bifocal $57 for trifocal	$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	Up to $75 copay	Plan pays up to $46	Up to $75 copay	Plan pays up to $46	Up to $75 copay	Plan pays up to $46	Up to $75 copay	Plan pays up to $46	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,	Up to $15 copay	You are responsible for the cost of any lens options that you elect from out-of-network providers,	Up to $15 copay	You are responsible for the cost of any lens options that you elect from out-of-network providers,	Up to $15 copay	You are responsible for the cost of any lens options that you elect from out-of-network providers,	Up to $15 copay	You are responsible for the cost of any lens options that you elect from out-of-network providers,	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		Up to $15 copay		Up to $15 copay		Up to $15 copay		Up to $15 copay		Up to $15 copay	
Standard Scratch Resistance	Up to $15 copay		Up to $15 copay		Up to $15 copay		Up to $15 copay		Up to $15 copay		Up to $15 copay	
Standard Polycarbonate	$0 copay		$0 copay		$0 copay		$0 copay		$0 copay		$0 copay	
Standard Anti-Reflective Coating	Up to $45 copay		Up to $45 copay		Up to $45 copay		Up to $45 copay		Up to $45 copay		Up to $45 copay	
Disposable	20% off retail price		20% off retail price		20% off retail price		20% off retail price		20% off retail price		20% off retail price	
Frames (eligible once every calendar year)	$200 allowance, 20% off balance over $200	Plan pays up to $47	$200 allowance, 20% off balance over $200	Plan pays up to $47	$200 allowance, 20% off balance over $200	Plan pays up to $47	$200 allowance, 20% off balance over $200	Plan pays up to $47	$200 allowance, 20% off balance over $200	Plan pays up to $47	$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	$200 allowance, 15% off balance over $200	Plan pays up to $100	$200 allowance, 15% off balance over $200	Plan pays up to $100	$200 allowance, 15% off balance over $200	Plan pays up to $100	$200 allowance, 15% off balance over $200	Plan pays up to $100	$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	$200 allowance, then you pay balance over $200	Plan pays up to $100	$200 allowance, then you pay balance over $200	Plan pays up to $100	$200 allowance, then you pay balance over $200	Plan pays up to $100	$200 allowance, then you pay balance over $200	Plan pays up to $100	$200 allowance, then you pay balance over $200	Plan pays up to $100

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0067 - Diocese of Atlanta	Dental Benefits								
	Delta Dental								
	Basic PPO Plan			Comprehensive PPO Plan			Premium 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	$0 per person / $0 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	$50 per person / $150 per family
Annual Benefit Maximum *(Plan maximums cross-accumulate between the PPO Network, Premier Network, and out-of-network dentists)*	$2,000	$1,500	$1,000	$2,500	$2,000	$1,500	$3,000	$2,500	$2,000
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 20% coinsurance	You pay 20% coinsurance	You pay 30% coinsurance plus any balance billing	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
Major Services *(Includes crowns, bridges, and dentures)*	You pay 60% coinsurance	You pay 60% coinsurance	You pay 99% coinsurance plus any balance billing	You pay 50% coinsurance	You pay 50% coinsurance	You pay 60% coinsurance plus any balance billing	You pay 15% coinsurance	You pay 15% coinsurance	You pay 25% coinsurance plus any balance billing
Orthodontic Services	Not covered. You pay 100%.	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	You pay 60% coinsurance up to individual lifetime benefit limit of $1,000 after $100 lifetime deductible plus any balance billing	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

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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.