EPISCOPAL CHURCH MEDICAL TRUST

2027 Medical Trust Health Plan 0539 - Diocese of Missouri	Anthem BCBS BlueCard PPO 90		Anthem BCBS BlueCard PPO 80		Anthem BCBS BlueCard PPO 70		Cigna OAP PPO 90	
	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)	$1,000 per person $2,000 per family	$2,000 per person $4,000 per family	$1,500 per person $3,000 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	$1,000 per person $2,000 per family	$2,000 per person $4,000 per family
Annual Out-of-Pocket Limit	$4,000 per person $8,000 per family	$8,000 per person $16,000 per family	$5,000 per person $10,000 per family	$10,000 per person $20,000 per family	$6,500 per person $13,000 per family	$13,000 per person $26,000 per family	$4,000 per person $8,000 per family	$8,000 per person $16,000 per family
Preventive Care								
Preventive Services & Well-Child Care	$0 copay	50% coinsurance	$0 copay	50% coinsurance	$0 copay	50% coinsurance	$0 copay	50% coinsurance
Physician Services								
Office Visit	$35 copay	50% coinsurance	$35 copay	50% coinsurance	$35 copay	50% coinsurance	$35 copay	50% coinsurance
Diagnostic Services (outpatient)	10% coinsurance (Deductible does not apply)	50% coinsurance	20% coinsurance (Deductible does not apply)	50% coinsurance	30% coinsurance (Deductible does not apply)	50% coinsurance	10% coinsurance (Deductible does not apply)	50% coinsurance
Specialist Care	$50 copay	50% coinsurance	$50 copay	50% coinsurance	$50 copay	50% coinsurance	$50 copay	50% coinsurance
Hospital Services								
Inpatient Services (including inpatient maternity services)	10% coinsurance	50% coinsurance	20% coinsurance	50% coinsurance	30% coinsurance	50% coinsurance	10% coinsurance	50% coinsurance
Outpatient Surgery	10% coinsurance	50% coinsurance	20% coinsurance	50% coinsurance	30% coinsurance	50% coinsurance	10% coinsurance	50% coinsurance
Emergency Room Care	$250 copay	$250 copay	$250 copay	$250 copay	$250 copay	$250 copay	$250 copay	$250 copay
Ambulance Services	10% coinsurance	10% coinsurance	20% coinsurance	20% coinsurance	30% coinsurance	30% coinsurance	10% coinsurance	10% coinsurance
Behavioral Health								
Outpatient Services	$35 copay	30% coinsurance	$35 copay	30% coinsurance	$35 copay	30% coinsurance	$35 copay	30% coinsurance
Inpatient Services	10% coinsurance	50% coinsurance	20% coinsurance	50% coinsurance	30% coinsurance	50% coinsurance	10% coinsurance	50% coinsurance
Other Medical Services								
Durable Medical Equipment	10% coinsurance	50% coinsurance	20% coinsurance	50% coinsurance	30% coinsurance	50% coinsurance	10% coinsurance	50% coinsurance

EPISCOPAL CHURCH MEDICAL TRUST

2027 Medical Trust Health Plan 0539 - Diocese of Missouri	Anthem BCBS BlueCard PPO 90		Anthem BCBS BlueCard PPO 80		Anthem BCBS BlueCard PPO 70		Cigna OAP PPO 90	
Home Health Care (210 visits per calendar year, combined network and out-of-network)	10% coinsurance	50% coinsurance	20% coinsurance	50% coinsurance	30% coinsurance	50% coinsurance	10% coinsurance	50% coinsurance
Outpatient Therapy (60 visits per calendar year per each type of therapy, combined network and out-of-network)	$35 copay PCP/$50 copay specialist (includes speech, physical, and occupational)	50% coinsurance (includes speech, physical, and occupational)	$35 copay PCP/$50 copay specialist (includes speech, physical, and occupational)	50% coinsurance (includes speech, physical, and occupational)	$35 copay PCP/$50 copay specialist (includes speech, physical, and occupational)	50% coinsurance (includes speech, physical, and occupational)	$35 copay PCP/$50 copay specialist (includes speech, physical, and occupational)	50% coinsurance (includes speech, physical, and occupational)
Skilled Nursing / Acute Rehabilitation Facility (60 days per calendar year, combined network and out-of-network)	10% coinsurance	50% coinsurance	20% coinsurance	50% coinsurance	30% coinsurance	50% coinsurance	10% coinsurance	50% coinsurance
Urgent Care Services	$60 copay	$60 copay	$60 copay	$60 copay	$60 copay	$60 copay	$60 copay	$60 copay

EPISCOPAL CHURCH MEDICAL TRUST

2027 Medical Trust Health Plan 0539 - Diocese of Missouri	Anthem BCBS BlueCard PPO 90		Anthem BCBS BlueCard PPO 80		Anthem BCBS BlueCard PPO 70		Cigna OAP PPO 90	
	Pharmacy Benefits Administered by Express Scripts		Pharmacy Benefits Administered by Express Scripts		Pharmacy Benefits Administered by Express Scripts		Pharmacy Benefits Administered by Express Scripts	
Prescription Drug Benefits	Retail	Home Delivery	Retail	Home Delivery	Retail	Home Delivery	Retail	Home Delivery
Annual Prescription Deductible (in-network)	None	None	None	None	None	None	None	None
Tier 1: Generic	$10 copay	$25 copay	$10 copay	$25 copay	$10 copay	$25 copay	$10 copay	$25 copay
Tier 2: Preferred Brand Name	25%; $40 min / $120 max	25%; $100 min / $300 max	25%; $40 min / $120 max	25%; $100 min / $300 max	25%; $40 min / $120 max	25%; $100 min / $300 max	25%; $40 min / $120 max	25%; $100 min / $300 max
Tier 3: Non-Preferred Brand Name	40%; $80 min / $160 max	40%; $200 min / $400 max	40%; $80 min / $160 max	40%; $200 min / $400 max	40%; $80 min / $160 max	40%; $200 min / $400 max	40%; $80 min / $160 max	40%; $200 min / $400 max
Tier 4: Specialty Rx	50%; $250 min / $500 max	50%; $625 min / $1250 max	50%; $250 min / $500 max	50%; $625 min / $1250 max	50%; $250 min / $500 max	50%; $625 min / $1250 max	50%; $250 min / $500 max	50%; $625 min / $1250 max
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	Up to a 90-day supply

EPISCOPAL CHURCH MEDICAL TRUST

2027 Medical Trust Health Plan 0539 - Diocese of Missouri	Anthem BCBS BlueCard PPO 90		Anthem BCBS BlueCard PPO 80		Anthem BCBS BlueCard PPO 70		Cigna OAP PPO 90	
	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
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
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
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
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,
Tint (solid and gradient)	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	
Standard Polycarbonate	$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	
Disposable	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
Contact Lenses (eligible once every calendar year)								
Conventional	$200 allowance, 15% off balance over $200	Plan pays up to $133	$200 allowance, 15% off balance over $200	Plan pays up to $133	$200 allowance, 15% off balance over $200	Plan pays up to $133	$200 allowance, 15% off balance over $200	Plan pays up to $133
Disposable	$200 allowance, then you pay balance over $200	Plan pays up to $133	$200 allowance, then you pay balance over $200	Plan pays up to $133	$200 allowance, then you pay balance over $200	Plan pays up to $133	$200 allowance, then you pay balance over $200	Plan pays up to $133

EPISCOPAL CHURCH MEDICAL TRUST

2027 Medical Trust Health Plan 0539 - Diocese of Missouri	Cigna OAP PPO 80		Cigna OAP PPO 70	
	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	$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	$5,000 per person $10,000 per family	$10,000 per person $20,000 per family	$6,500 per person $13,000 per family	$13,000 per person $26,000 per family
Preventive Care				
Preventive Services & Well-Child Care	$0 copay	50% coinsurance	$0 copay	50% coinsurance
Physician Services				
Office Visit	$35 copay	50% coinsurance	$35 copay	50% coinsurance
Diagnostic Services (outpatient)	20% coinsurance (Deductible does not apply)	50% coinsurance	30% coinsurance (Deductible does not apply)	50% coinsurance
Specialist Care	$50 copay	50% coinsurance	$50 copay	50% coinsurance
Hospital Services				
Inpatient Services (including inpatient maternity services)	20% coinsurance	50% coinsurance	30% coinsurance	50% coinsurance
Outpatient Surgery	20% coinsurance	50% coinsurance	30% coinsurance	50% coinsurance
Emergency Room Care	$250 copay	$250 copay	$250 copay	$250 copay
Ambulance Services	20% coinsurance	20% coinsurance	30% coinsurance	30% coinsurance
Behavioral Health				
Outpatient Services	$35 copay	30% coinsurance	$35 copay	30% coinsurance
Inpatient Services	20% coinsurance	50% coinsurance	30% coinsurance	50% coinsurance
Other Medical Services				
Durable Medical Equipment	20% coinsurance	50% coinsurance	30% coinsurance	50% coinsurance

EPISCOPAL CHURCH MEDICAL TRUST

2027 Medical Trust Health Plan 0539 - Diocese of Missouri	Cigna OAP PPO 80		Cigna OAP PPO 70	
Home Health Care (210 visits per calendar year, combined network and out-of-network)	20% coinsurance	50% coinsurance	30% coinsurance	50% coinsurance
Outpatient Therapy (60 visits per calendar year per each type of therapy, combined network and out-of-network)	$35 copay PCP/$50 copay specialist (includes speech, physical, and occupational)	50% coinsurance (includes speech, physical, and occupational)	$35 copay PCP/$50 copay specialist (includes speech, physical, and occupational)	50% coinsurance (includes speech, physical, and occupational)
Skilled Nursing / Acute Rehabilitation Facility (60 days per calendar year, combined network and out-of-network)	20% coinsurance	50% coinsurance	30% coinsurance	50% coinsurance
Urgent Care Services	$60 copay	$60 copay	$60 copay	$60 copay

EPISCOPAL CHURCH MEDICAL TRUST

2027 Medical Trust Health Plan 0539 - Diocese of Missouri	Cigna OAP PPO 80		Cigna OAP PPO 70	
	Pharmacy Benefits Administered by Express Scripts		Pharmacy Benefits Administered by Express Scripts	
Prescription Drug Benefits	Retail	Home Delivery	Retail	Home Delivery
Annual Prescription Deductible (in-network)	None	None	None	None
Tier 1: Generic	$10 copay	$25 copay	$10 copay	$25 copay
Tier 2: Preferred Brand Name	25%; $40 min / $120 max	25%; $100 min / $300 max	25%; $40 min / $120 max	25%; $100 min / $300 max
Tier 3: Non-Preferred Brand Name	40%; $80 min / $160 max	40%; $200 min / $400 max	40%; $80 min / $160 max	40%; $200 min / $400 max
Tier 4: Specialty Rx	50%; $250 min / $500 max	50%; $625 min / $1250 max	50%; $250 min / $500 max	50%; $625 min / $1250 max
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

EPISCOPAL CHURCH MEDICAL TRUST

2027 Medical Trust Health Plan 0539 - Diocese of Missouri	Cigna OAP PPO 80		Cigna OAP PPO 70	
	Vision Benefits Administered by EyeMed		Vision Benefits Administered by EyeMed	
Vision Benefits	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
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
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
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,
Tint (solid and gradient)	Up to $15 copay		Up to $15 copay	
Standard Scratch Resistance	Up to $15 copay		Up to $15 copay	
Standard Polycarbonate	$0 copay		$0 copay	
Standard Anti-Reflective Coating	Up to $45 copay		Up to $45 copay	
Disposable	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
Contact Lenses (eligible once every c				
Conventional	$200 allowance, 15% off balance over $200	Plan pays up to $133	$200 allowance, 15% off balance over $200	Plan pays up to $133
Disposable	$200 allowance, then you pay balance over $200	Plan pays up to $133	$200 allowance, then you pay balance over $200	Plan pays up to $133

EPISCOPAL CHURCH MEDICAL TRUST

2027 Medical Trust Health Plan 0539 - Diocese of Missouri	Anthem BCBS CDHP 20/HSA		Anthem BCBS CDHP 15/HSA		Cigna CDHP 20/HSA		Cigna CDHP 15/HSA	
	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)	$3,600 per person $7,200 per family	$7,200 per person $14,400 per family	$2,200 per person $4,400 per family (deductible is non-embedded)	$4,400 per person $8,800 per family (deductible is non-embedded)	$3,600 per person $7,200 per family	$7,200 per person $14,400 per family	$2,200 per person $4,400 per family (deductible is non-embedded)	$4,400 per person $8,800 per family (deductible is non-embedded)
Annual Out-of-Pocket Limit	$5,000 per person $10,000 per family	$10,000 per person $20,000 per family	$3,900 per person $7,800 per family (out-of-pocket limit is non-embedded)	$7,800 per person $15,600 per family (out-of-pocket limit is non-embedded)	$5,000 per person $10,000 per family	$10,000 per person $20,000 per family	$3,900 per person $7,800 per family (out-of-pocket limit is non-embedded)	$7,800 per person $15,600 per family (out-of-pocket limit is non-embedded)
Preventive Care								
Preventive Services & Well-Child Care	$0 copay	45% coinsurance	$0 copay	40% coinsurance	$0 copay	45% coinsurance	$0 copay	40% coinsurance
Physician Services								
Office Visit	20% coinsurance	45% coinsurance	15% coinsurance	40% coinsurance	20% coinsurance	45% coinsurance	15% coinsurance	40% coinsurance
Diagnostic Services (outpatient)	20% coinsurance	20% coinsurance	15% coinsurance	15% coinsurance	20% coinsurance	45% coinsurance	15% coinsurance	40% coinsurance
Specialist Care	20% coinsurance	45% coinsurance	15% coinsurance	40% coinsurance	20% coinsurance	45% coinsurance	15% coinsurance	40% coinsurance
Hospital Services								
Inpatient Services (including inpatient maternity services)	20% coinsurance	45% coinsurance	15% coinsurance	40% coinsurance	20% coinsurance	45% coinsurance	15% coinsurance	40% coinsurance
Outpatient Surgery	20% coinsurance	45% coinsurance	15% coinsurance	40% coinsurance	20% coinsurance	45% coinsurance	15% coinsurance	40% coinsurance
Emergency Room Care	20% coinsurance	20% coinsurance	15% coinsurance	15% coinsurance	20% coinsurance	20% coinsurance	15% coinsurance	15% coinsurance
Ambulance Services	20% coinsurance	20% coinsurance	15% coinsurance	15% coinsurance	20% coinsurance	20% coinsurance	15% coinsurance	15% coinsurance
Behavioral Health								
Outpatient Services	20% coinsurance	45% coinsurance	15% coinsurance	40% coinsurance	20% coinsurance	45% coinsurance	15% coinsurance	40% coinsurance
Inpatient Services	20% coinsurance	45% coinsurance	15% coinsurance	40% coinsurance	20% coinsurance	45% coinsurance	15% coinsurance	40% coinsurance
Other Medical Services								
Durable Medical Equipment	20% coinsurance	45% coinsurance	15% coinsurance	40% coinsurance	20% coinsurance	45% coinsurance	15% coinsurance	40% coinsurance

EPISCOPAL CHURCH MEDICAL TRUST

2027 Medical Trust Health Plan 0539 - Diocese of Missouri	Anthem BCBS CDHP 20/HSA		Anthem BCBS CDHP 15/HSA		Cigna CDHP 20/HSA		Cigna CDHP 15/HSA	
Home Health Care (210 visits per calendar year, combined network and out-of-network)	20% coinsurance	45% coinsurance	15% coinsurance	40% coinsurance	20% coinsurance	45% coinsurance	15% coinsurance	40% coinsurance
Outpatient Therapy (60 visits per calendar year per each type of therapy, combined network and out-of-network)	20% coinsurance (includes speech, physical, and occupational)	45% coinsurance (includes speech, physical, and occupational)	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)	15% coinsurance (includes speech, physical, and occupational)	40% coinsurance (includes speech, physical, and occupational)
Skilled Nursing / Acute Rehabilitation Facility (60 days per calendar year, combined network and out-of-network)	20% coinsurance	45% coinsurance	15% coinsurance	40% coinsurance	20% coinsurance	45% coinsurance	15% coinsurance	40% coinsurance
Urgent Care Services	20% coinsurance	45% coinsurance	15% coinsurance	40% coinsurance	20% coinsurance	20% coinsurance	15% coinsurance	15% coinsurance

EPISCOPAL CHURCH MEDICAL TRUST

2027 Medical Trust Health Plan 0539 - Diocese of Missouri	Anthem BCBS CDHP 20/HSA		Anthem BCBS CDHP 15/HSA		Cigna CDHP 20/HSA		Cigna CDHP 15/HSA	
	Pharmacy Benefits Administered by Express Scripts		Pharmacy Benefits Administered by Express Scripts		Pharmacy Benefits Administered by Express Scripts		Pharmacy Benefits Administered by Express Scripts	
Prescription Drug Benefits	Retail	Home Delivery	Retail	Home Delivery	Retail	Home Delivery	Retail	Home Delivery
Annual Prescription Deductible (in-network)	$3,600 per person $7,200 per family (combined with medical deductible)	$3,600 per person $7,200 per family (combined with medical deductible)	$2,200 per person $4,400 per family (combined with medical deductible) (non-embedded deductible)	$2,200 per person $4,400 per family (combined with medical deductible) (non-embedded deductible)	$3,600 per person $7,200 per family (combined with medical deductible)	$3,600 per person $7,200 per family (combined with medical deductible)	$2,200 per person $4,400 per family (combined with medical deductible) (non-embedded deductible)	$2,200 per person $4,400 per family (combined with medical deductible) (non-embedded deductible)
Tier 1: Generic	You pay 15% after deductible	You pay 15% after deductible	You pay 15% after deductible	You pay 15% after deductible	You pay 15% after deductible	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	You pay 25% after deductible	You pay 25% after deductible	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	You pay 50% after deductible	You pay 50% after deductible	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	You pay 50% after deductible	You pay 50% after deductible	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)	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 (retail) or 90-day supply (mail order)

EPISCOPAL CHURCH MEDICAL TRUST

2027 Medical Trust Health Plan 0539 - Diocese of Missouri	Anthem BCBS CDHP 20/HSA		Anthem BCBS CDHP 15/HSA		Cigna CDHP 20/HSA		Cigna CDHP 15/HSA	
	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
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
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
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
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,
Tint (solid and gradient)	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	
Standard Polycarbonate	$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	
Disposable	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
Contact Lenses (eligible once every calendar year)								
Conventional	$200 allowance, 15% off balance over $200	Plan pays up to $133	$200 allowance, 15% off balance over $200	Plan pays up to $133	$200 allowance, 15% off balance over $200	Plan pays up to $133	$200 allowance, 15% off balance over $200	Plan pays up to $133
Disposable	$200 allowance, then you pay balance over $200	Plan pays up to $133	$200 allowance, then you pay balance over $200	Plan pays up to $133	$200 allowance, then you pay balance over $200	Plan pays up to $133	$200 allowance, then you pay balance over $200	Plan pays up to $133

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 $133
Disposable	$200 allowance, then you pay balance over $200	Plan pays up to $133

EPISCOPAL CHURCH MEDICAL TRUST

0539 - Diocese of Missouri	Delta Dental								
	Basic PPO Plan			Comprehensive PPO Plan			Premium PPO Plan		
Dental Benefits	*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 (Maxmium cross applies across networks)	$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)			You pay $0 (not subject to annual deductible)		
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	You pay 15% coinsurance	You pay 15% coinsurance	You pay 25% coinsurance	You pay 15% coinsurance	You pay 15% coinsurance	You pay 25% coinsurance
Major Services (Includes crowns, bridges, and dentures)	You pay 60% coinsurance	You pay 60% coinsurance	You pay 99% coinsurance	You pay 50% coinsurance	You pay 50% coinsurance	You pay 60% coinsurance	You pay 15% coinsurance	You pay 15% coinsurance	You pay 25% coinsurance
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	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

2027 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	$1,700 per person $3,400 per family (combined with medical deductible) (non-embedded deductible)	$3,400 per person $6,800 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)

This material is provided for informational purposes only and should not be viewed as investment, tax, or other advice. It does not constitute a contract or an offer for any products or services. In the event of a conflict between this material and the official plan documents or insurance policies, any official plan documents or insurance policies will govern. The Church Pension Fund ("CPF") and its affiliates (collectively, "CPG") retain the right to amend, terminate, or modify the terms of any benefit plan and/or insurance policy described in this material at any time, for any reason, and, unless otherwise required by applicable 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.