EPISCOPAL CHURCH
MEDICAL TRUST

2027 Medical Trust Health Plan 1013 - Diocese of West Missouri	Anthem BCBS BlueCard PPO 100		Anthem BCBS BlueCard PPO 90		Anthem BCBS BlueCard PPO 80	
	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	$1,500 per person $3,000 per family	$3,000 per person $6,000 per family
Annual Out-of-Pocket Limit	$3,500 per person $7,000 per family	$7,000 per person $14,000 per family	$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
Preventive Care						
Preventive Services & Well-Child Care	$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
Diagnostic Services (outpatient)	$0 copay	50% coinsurance	10% coinsurance (Deductible does not apply)	50% coinsurance	20% coinsurance (Deductible does not apply)	50% coinsurance
Specialist Care	$50 copay	50% coinsurance	$50 copay	50% coinsurance	$50 copay	50% coinsurance
Hospital Services						
Inpatient Services (including inpatient maternity services)	$250 copay	50% coinsurance	10% coinsurance	50% coinsurance	20% coinsurance	50% coinsurance
Outpatient Surgery	$200 copay	50% coinsurance	10% coinsurance	50% coinsurance	20% coinsurance	50% coinsurance
Emergency Room Care	$250 copay	$250 copay	$250 copay	$250 copay	$250 copay	$250 copay
Ambulance Services	0% Coinsurance	0% Coinsurance	10% coinsurance	10% coinsurance	20% coinsurance	20% coinsurance
Behavioral Health						
Outpatient Services	$35 copay	30% coinsurance	$35 copay	30% coinsurance	$35 copay	30% coinsurance
Inpatient Services	$250 copay	50% coinsurance	10% coinsurance	50% coinsurance	20% coinsurance	50% coinsurance
Other Medical Services						
Durable Medical Equipment	0% coinsurance	50% coinsurance	10% coinsurance	50% coinsurance	20% coinsurance	50% coinsurance
Home Health Care (210 visits per calendar year, combined network and out-of-network)	0% coinsurance	50% coinsurance	10% coinsurance	50% coinsurance	20% 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)

EPISCOPAL CHURCH
MEDICAL TRUST

2027 Medical Trust Health Plan 1013 - Diocese of West Missouri	Anthem BCBS BlueCard PPO 100		Anthem BCBS BlueCard PPO 90		Anthem BCBS BlueCard PPO 80	
Skilled Nursing / Acute Rehabilitation Facility (60 days per calendar year, combined network and out-of-network)	0% coinsurance	50% coinsurance	10% coinsurance	50% coinsurance	20% coinsurance	50% coinsurance
Urgent Care Services	$60 copay	$60 copay	$60 copay	$60 copay	$60 copay	$60 copay

EPISCOPAL CHURCH
MEDICAL TRUST

2027 Medical Trust Health Plan 1013 - Diocese of West Missouri	Anthem BCBS BlueCard PPO 100		Anthem BCBS BlueCard PPO 90		Anthem BCBS BlueCard PPO 80	
	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**
Annual Prescription Deductible (in-network)	None	None	None	None	None	None
Tier 1: Generic	$5 copay	$12 copay	$5 copay	$12 copay	$5 copay	$12 copay
Tier 2: Preferred Brand Name	$35 copay	$87 copay	$35 copay	$87 copay	$35 copay	$87 copay
Tier 3: Non-Preferred Brand Name	$70 copay	$175 copay	$70 copay	$175 copay	$70 copay	$175 copay
Tier 4: Specialty Rx	$90 copay	$90 copay for a 30-day supply	$90 copay	$90 copay for a 30-day supply	$90 copay	$90 copay for a 30-day supply
Dispensing Limits Per Copayment	Up to a 30-day supply	Up to a 90-day supply (except Specialty Rx)	Up to a 30-day supply	Up to a 90-day supply (except Specialty Rx)	Up to a 30-day supply	Up to a 90-day supply (except Specialty Rx)

EPISCOPAL CHURCH
MEDICAL TRUST

2027 Medical Trust Health Plan 1013 - Diocese of West Missouri	Anthem BCBS BlueCard PPO 100		Anthem BCBS BlueCard PPO 90		Anthem BCBS BlueCard PPO 80	
	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**
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
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
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
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,
Tint (solid and gradient)	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	
Standard Polycarbonate	$0 copay		$0 copay		$0 copay	
Standard Anti-Reflective Coating	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	
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
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
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

EPISCOPAL CHURCH
MEDICAL TRUST

2027 Medical Trust Health Plan 1013 - Diocese of West Missouri	Cigna OAP PPO 100		Cigna OAP PPO 90		Cigna OAP PPO 80	
	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	$1,500 per person $3,000 per family	$3,000 per person $6,000 per family
Annual Out-of-Pocket Limit	$3,500 per person $7,000 per family	$7,000 per person $14,000 per family	$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
Preventive Care						
Preventive Services & Well-Child Care	$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
Diagnostic Services (outpatient)	$0 copay	50% coinsurance	10% coinsurance (Deductible does not apply)	50% coinsurance	20% coinsurance (Deductible does not apply)	50% coinsurance
Specialist Care	$50 copay	50% coinsurance	$50 copay	50% coinsurance	$50 copay	50% coinsurance
Hospital Services						
Inpatient Services (including inpatient maternity services)	$250 copay	50% coinsurance	10% coinsurance	50% coinsurance	20% coinsurance	50% coinsurance
Outpatient Surgery	$200 copay	50% coinsurance	10% coinsurance	50% coinsurance	20% coinsurance	50% coinsurance
Emergency Room Care	$250 copay	$250 copay	$250 copay	$250 copay	$250 copay	$250 copay
Ambulance Services	0% Coinsurance	0% Coinsurance	10% coinsurance	10% coinsurance	20% coinsurance	20% coinsurance
Behavioral Health						
Outpatient Services	$35 copay	30% coinsurance	$35 copay	30% coinsurance	$35 copay	30% coinsurance
Inpatient Services	$250 copay	50% coinsurance	10% coinsurance	50% coinsurance	20% coinsurance	50% coinsurance
Other Medical Services						
Durable Medical Equipment	0% coinsurance	50% coinsurance	10% coinsurance	50% coinsurance	20% coinsurance	50% coinsurance
Home Health Care (210 visits per calendar year, combined network and out-of-network)	0% coinsurance	50% coinsurance	10% coinsurance	50% coinsurance	20% 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)

EPISCOPAL CHURCH
MEDICAL TRUST

2027 Medical Trust Health Plan 1013 - Diocese of West Missouri	Cigna OAP PPO 100		Cigna OAP PPO 90		Cigna OAP PPO 80	
Skilled Nursing / Acute Rehabilitation Facility (60 days per calendar year, combined network and out-of-network)	0% coinsurance	50% coinsurance	10% coinsurance	50% coinsurance	20% coinsurance	50% coinsurance
Urgent Care Services	$60 copay	$60 copay	$60 copay	$60 copay	$60 copay	$60 copay

EPISCOPAL CHURCH
MEDICAL TRUST

2027 Medical Trust Health Plan 1013 - Diocese of West Missouri	Cigna OAP PPO 100		Cigna OAP PPO 90		Cigna OAP PPO 80	
	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**
Annual Prescription Deductible (in-network)	None	None	None	None	None	None
Tier 1: Generic	$5 copay	$12 copay	$5 copay	$12 copay	$5 copay	$12 copay
Tier 2: Preferred Brand Name	$35 copay	$87 copay	$35 copay	$87 copay	$35 copay	$87 copay
Tier 3: Non-Preferred Brand Name	$70 copay	$175 copay	$70 copay	$175 copay	$70 copay	$175 copay
Tier 4: Specialty Rx	$90 copay	$90 copay for a 30-day supply	$90 copay	$90 copay for a 30-day supply	$90 copay	$90 copay for a 30-day supply
Dispensing Limits Per Copayment	Up to a 30-day supply	Up to a 90-day supply (except Specialty Rx)	Up to a 30-day supply	Up to a 90-day supply (except Specialty Rx)	Up to a 30-day supply	Up to a 90-day supply (except Specialty Rx)

EPISCOPAL CHURCH
MEDICAL TRUST

2027 Medical Trust Health Plan 1013 - Diocese of West Missouri	Cigna OAP PPO 100		Cigna OAP PPO 90		Cigna OAP PPO 80	
	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**
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
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
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
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,
Tint (solid and gradient)	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	
Standard Polycarbonate	$0 copay		$0 copay		$0 copay	
Standard Anti-Reflective Coating	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	
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
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
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

EPISCOPAL CHURCH
MEDICAL TRUST

2027 Medical Trust Health Plan 1013 - Diocese of West Missouri	Anthem BCBS CDHP 15/HSA		Anthem BCBS CDHP 20/HSA			
	Network	Out-of-Network	Network	Out-of-Network		
Annual Deductible (CDHPs have a combined medical & Rx deductible)	$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		
Annual Out-of-Pocket Limit	$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		
Preventive Care						
Preventive Services & Well-Child Care	$0 copay	40% coinsurance	$0 copay	45% coinsurance		
Physician Services						
Office Visit	15% coinsurance	40% coinsurance	20% coinsurance	45% coinsurance		
Diagnostic Services (outpatient)	15% coinsurance	15% coinsurance	20% coinsurance	20% coinsurance		
Specialist Care	15% coinsurance	40% coinsurance	20% coinsurance	45% coinsurance		
Hospital Services						
Inpatient Services (including inpatient maternity services)	15% coinsurance	40% coinsurance	20% coinsurance	45% coinsurance		
Outpatient Surgery	15% coinsurance	40% coinsurance	20% coinsurance	45% coinsurance		
Emergency Room Care	15% coinsurance	15% coinsurance	20% coinsurance	20% coinsurance		
Ambulance Services	15% coinsurance	15% coinsurance	20% coinsurance	20% coinsurance		
Behavioral Health						
Outpatient Services	15% coinsurance	40% coinsurance	20% coinsurance	45% coinsurance		
Inpatient Services	15% coinsurance	40% coinsurance	20% coinsurance	45% coinsurance		
Other Medical Services						
Durable Medical Equipment	15% coinsurance	40% coinsurance	20% coinsurance	45% coinsurance		
Home Health Care (210 visits per calendar year, combined network and out-of-network)	15% coinsurance	40% coinsurance	20% coinsurance	45% 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)		

EPISCOPAL CHURCH
MEDICAL TRUST

2027 Medical Trust Health Plan 1013 - Diocese of West Missouri	Anthem BCBS CDHP 15/HSA		Anthem BCBS CDHP 20/HSA			
Skilled Nursing / Acute Rehabilitation Facility (60 days per calendar year, combined network and out-of-network)	15% coinsurance	40% coinsurance	20% coinsurance	45% coinsurance		
Urgent Care Services	15% coinsurance	40% coinsurance	20% coinsurance	45% coinsurance		

EPISCOPAL CHURCH
MEDICAL TRUST

2027 Medical Trust Health Plan 1013 - Diocese of West Missouri	Anthem BCBS CDHP 15/HSA		Anthem BCBS CDHP 20/HSA			
	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)	$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)		
Tier 1: Generic	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		
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		
Tier 4: Specialty Rx	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)		

EPISCOPAL CHURCH
MEDICAL TRUST

2027 Medical Trust Health Plan 1013 - Diocese of West Missouri	Anthem BCBS CDHP 15/HSA		Anthem BCBS CDHP 20/HSA			
	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 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		
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 1013 - Diocese of West Missouri	Cigna CDHP 15/HSA		Cigna CDHP 20/HSA			
	Network	**Out-of-Network**	**Network**	**Out-of-Network**		
Annual Deductible (CDHPs have a combined medical & Rx deductible)	$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		
Annual Out-of-Pocket Limit	$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		
Preventive Care						
Preventive Services & Well-Child Care	$0 copay	40% coinsurance	$0 copay	45% coinsurance		
Physician Services						
Office Visit	15% coinsurance	40% coinsurance	20% coinsurance	45% coinsurance		
Diagnostic Services (outpatient)	15% coinsurance	40% coinsurance	20% coinsurance	45% coinsurance		
Specialist Care	15% coinsurance	40% coinsurance	20% coinsurance	45% coinsurance		
Hospital Services						
Inpatient Services (including inpatient maternity services)	15% coinsurance	40% coinsurance	20% coinsurance	45% coinsurance		
Outpatient Surgery	15% coinsurance	40% coinsurance	20% coinsurance	45% coinsurance		
Emergency Room Care	15% coinsurance	15% coinsurance	20% coinsurance	20% coinsurance		
Ambulance Services	15% coinsurance	15% coinsurance	20% coinsurance	20% coinsurance		
Behavioral Health						
Outpatient Services	15% coinsurance	40% coinsurance	20% coinsurance	45% coinsurance		
Inpatient Services	15% coinsurance	40% coinsurance	20% coinsurance	45% coinsurance		
Other Medical Services						
Durable Medical Equipment	15% coinsurance	40% coinsurance	20% coinsurance	45% coinsurance		
Home Health Care (210 visits per calendar year, combined network and out-of-network)	15% coinsurance	40% coinsurance	20% coinsurance	45% 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)		

EPISCOPAL CHURCH
MEDICAL TRUST

2027 Medical Trust Health Plan 1013 - Diocese of West Missouri	Cigna CDHP 15/HSA		Cigna CDHP 20/HSA			
Skilled Nursing / Acute Rehabilitation Facility (60 days per calendar year, combined network and out-of-network)	15% coinsurance	40% coinsurance	20% coinsurance	45% coinsurance		
Urgent Care Services	15% coinsurance	15% coinsurance	20% coinsurance	20% coinsurance		

EPISCOPAL CHURCH
MEDICAL TRUST

2027 Medical Trust Health Plan 1013 - Diocese of West Missouri	Cigna CDHP 15/HSA		Cigna CDHP 20/HSA			
	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)	$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)		
Tier 1: Generic	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		
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		
Tier 4: Specialty Rx	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)		

EPISCOPAL CHURCH
MEDICAL TRUST

2027 Medical Trust Health Plan 1013 - Diocese of West Missouri	Cigna CDHP 15/HSA		Cigna CDHP 20/HSA			
	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 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		
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		

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

1013 - Diocese of West Missouri	Delta Dental				
	Premium PPO Plan			Comprehensive PPO Pla	
Dental Benefits	*PPO Network*	*Premier Network*	*Out-of-Network*	*PPO Network*	*Premier 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
Annual Benefit Maximum (Maxmium cross applies across networks)	$3,000	$2,500	$2,000	$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 d	
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	You pay 15% coinsurance	You pay 15% coinsurance
Major Services (Includes crowns, bridges, and dentures)	You pay 15% coinsurance	You pay 15% coinsurance	You pay 25% coinsurance	You pay 50% coinsurance	You pay 50% coinsurance
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	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

EPISCOPAL CHURCH MEDICAL TRUST

1013 - Diocese of West Missouri				
	an	Basic PPO Plan		
Dental Benefits	*Out-of-Network*	*PPO Network*	*Premier Network*	*Out-of-Network*
Annual Deductible	$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 *(Maxmium cross applies across networks)*	$1,500	$2,000	$1,500	$1,000
Diagnostic and Preventive Services (e.g., exams, cleanings, x-rays, sealants and space maintainers)	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 25% coinsurance	You pay 20% coinsurance	You pay 20% coinsurance	You pay 30% coinsurance
Major Services (Includes crowns, bridges, and dentures)	You pay 60% coinsurance	You pay 60% coinsurance	You pay 60% coinsurance	You pay 99% coinsurance
Orthodontic Services	You pay 60% coinsurance up to individual lifetime benefit limit of $1,000 after $100 lifetime deductible	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.