

2024 Medical Trust Health Plan	Anthem BCBS BlueCard PPO 90		Cigna OAP PPO 90		Anthem BCBS BlueCard PPO 80		Cigna OAP PPO 80		Anthem BCBS CDHP 20/HSA		Cigna CDHP 20/HSA		Anthem BCBS CDHP 15/HSA		Cigna CDHP 15/HSA	
0619 - Diocese of Newark																
	Network	Out-of-Network	Network	Out-of-Network	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	\$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	\$1,000 per person \$2,000 per family	\$2,000 per person \$4,000 per family	\$3,200 per person \$5,450 per family	\$3,200 per person \$6,000 per family	\$3,200 per person \$5,450 per family	\$3,200 per person \$6,000 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)	\$1,600 per person \$3,200 per family (deductible is non- embedded)	\$3,200 per person \$6,400 per family (deductible is non- embedded)
Annual Out-of-Pocket Limit	\$2,500 per person \$5,000 per family	\$5,000 per person \$10,000 per family	\$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	\$3,500 per person \$7,000 per family	\$7,000 per person \$14,000 per family	\$4,200 per person \$8,450 per family	\$7,000 per person \$13,000 per family	\$4,200 per person \$8,450 per family	\$7,000 per person \$13,000 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)	\$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)
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	50% coinsurance plus any balance billing	\$0 copay	45% coinsurance plus any balance billing	\$0 copay	45% coinsurance plus any balance billing	\$0 copay	40% coinsurance plus any balance billing	\$0 copay	40% coinsurance plus any balance billing
Physician Services																
Office Visit	\$30 copay	50% coinsurance plus any balance billing		50% coinsurance plus any balance billing		50% coinsurance plus any balance billing		50% coinsurance plus any balance billing		45% coinsurance plus any balance billing		45% coinsurance plus any balance billing		40% coinsurance plus any balance billing		40% coinsurance plus any balance billing
Diagnostic Services (outpatient) (non-routine)	10% coinsurance	50% coinsurance plus any balance billing	10% coinsurance	50% coinsurance plus any balance billing	20% coinsurance	50% coinsurance plus any balance billing	20% coinsurance	50% coinsurance plus any balance billing	20% coinsurance	45% coinsurance plus any balance billing	20% coinsurance	45% coinsurance plus any balance billing	15% coinsurance	40% coinsurance plus any balance billing	15% coinsurance	40% coinsurance plus any balance billing
Specialist Care	\$45 copay	50% coinsurance plus any balance billing	\$45 copay	50% coinsurance	\$45 copay	50% coinsurance plus any balance billing	\$45 copay	50% coinsurance	20% coinsurance	45% coinsurance plus any balance billing	20% coinsurance	45% coinsurance plus any balance billing	15% coinsurance	40% coinsurance plus any balance billing	15% coinsurance	40% coinsurance plus any balance billing
Hospital Services																
Inpatient Services (including inpatient maternity services)	10% coinsurance	50% coinsurance plus any balance billing	10% coinsurance	50% coinsurance plus any balance billing	20% coinsurance	50% coinsurance plus any balance billing	20% coinsurance	50% coinsurance plus any balance billing	20% coinsurance	45% coinsurance plus any balance billing	20% coinsurance	45% coinsurance plus any balance billing	15% coinsurance	40% coinsurance plus any balance billing	15% coinsurance	40% coinsurance plus any balance billing
Outpatient Surgery	10% coinsurance	50% coinsurance plus any balance billing	10% coinsurance	50% coinsurance plus any balance billing	20% coinsurance	50% coinsurance plus any balance billing	20% coinsurance	50% coinsurance plus any balance billing	20% coinsurance	45% coinsurance plus any balance billing	20% coinsurance	45% coinsurance plus any balance billing	15% coinsurance	40% coinsurance plus any balance billing	15% coinsurance	40% coinsurance plus any balance billing
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	\$250 copay	Covered at in-network benefit level	20% coinsurance	Covered at in-network benefit level	20% coinsurance	Covered at in-network benefit level	15% coinsurance	Covered at in-network benefit level	15% coinsurance	Covered at in-network benefit level
Ambulance Services	10% coinsurance	Covered at in-network benefit level for emergency transport	10% 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	20% coinsurance	Covered at in-network benefit level for emergency transport	20% coinsurance	Covered at in-network benefit level for emergency transport	15% coinsurance	Covered at in-network benefit level for emergency transport	15% 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	\$30 copay	30% coinsurance plus any balance billing	20% coinsurance	45% coinsurance plus any balance billing	20% coinsurance	45% coinsurance plus any balance billing	15% coinsurance	40% coinsurance plus any balance billing	15% coinsurance	40% coinsurance plus any balance billing
Inpatient Services	10% coinsurance	50% coinsurance plus any balance billing	10% coinsurance	50% coinsurance plus any balance billing	20% coinsurance	50% coinsurance plus any balance billing	20% coinsurance	50% coinsurance plus any balance billing	20% coinsurance	45% coinsurance plus any balance billing	20% coinsurance	45% coinsurance plus any balance billing	15% coinsurance	40% coinsurance plus any balance billing	15% coinsurance	40% coinsurance plus any balance billing
Other Medical Services																
Durable Medical Equipment	10% coinsurance	50% coinsurance plus any balance billing	10% coinsurance	50% coinsurance plus any balance billing	20% coinsurance	50% coinsurance plus any balance billing	20% coinsurance	50% coinsurance plus any balance billing	20% coinsurance	45% coinsurance plus any balance billing	20% coinsurance	45% coinsurance plus any balance billing	15% coinsurance	40% coinsurance plus any balance billing	15% coinsurance	40% coinsurance plus any balance billing
Home Health Care (210 visits per calendar year, combined network and out-of-network)	10% coinsurance	50% coinsurance plus any balance billing	10% coinsurance	50% coinsurance plus any balance billing	20% coinsurance	50% coinsurance plus any balance billing	20% coinsurance	50% coinsurance plus any balance billing	20% coinsurance	45% coinsurance plus any balance billing	20% coinsurance	45% coinsurance plus any balance billing	15% coinsurance	40% coinsurance plus any balance billing	15% coinsurance	40% coinsurance plus any balance billing
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)	s \$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)	20% coinsurance (includes speech, physical, and occupational)	45% 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)	15% coinsurance (includes speech, physical, and occupational)	40% 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)
Skilled Nursing / Acute Rehabilitation Facility (60 days per calendar year, combined network and out-of-network)	10% coinsurance	50% coinsurance plus any balance billing	10% coinsurance	50% coinsurance plus any balance billing	20% coinsurance	50% coinsurance plus any balance billing	20% coinsurance	50% coinsurance plus any balance billing	20% coinsurance	45% coinsurance plus any balance billing	20% coinsurance	45% coinsurance plus any balance billing	15% coinsurance	40% coinsurance plus any balance billing	15% coinsurance	40% coinsurance plus any balance billing
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	\$50 copay	\$50 copay plus any balance billing	20% coinsurance	20% coinsurance plus any balance billing	20% coinsurance	20% coinsurance plus any balance billing	15% coinsurance	15% coinsurance plus any balance billing	15% coinsurance	15% coinsurance plus any balance billing



2024 Medical Trust Health Plan	Anthem BCBS BlueCard PPO 90				Anthem BCBS BlueCard PPO 80		Cigna OAP PPO 80		Anthem BCBS CDHP 20/HSA		Cigna CDHP 20/HSA		Anthem BCBS CDHP 15/HSA		Cigna CDHP 15/HSA	
0619 - Diocese of Newark																
	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 Express Scripts		Pharmacy Benefits Administered by Express Scripts		Pharmacy Benefits Administered b Express Scripts	
Prescription Drug Benefits	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	None	None	\$3,200 per person \$5,450 per family (combined with medical deductible)	\$1,600 per person \$3,200 per family (combined with medical deductible) (non-embedded deductible)						
Tier 1: Generic	Up to a \$10 copay	Up to a \$25 copay	Up to a \$10 copay	Up to a \$25 copay	Up to a \$10 copay	Up to a \$25 copay	Up to a \$10 copay	Up to a \$25 copay	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	25%; up to \$40 min / \$80 max	25%; up to \$100 min / \$200 max	25%; up to \$40 min / \$80 max	25%; up to \$100 min / \$200 max		25%; up to \$100 min / \$200 max	25%; up to \$40 min / \$80 max	25%; up to \$100 min / \$200 max	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	40%; up to \$80 min / \$160 max	40%; up to \$200 min / \$400 max	40%; up to \$80 min / \$160 max	40%; up to \$200 min / \$400 max		40%; up to \$200 min / \$400 max	40%; up to \$80 min / \$160 max	40%; up to \$200 min / \$400 max	You pay 50% after deductible	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	40%; up to \$100 min / \$200 max	40%; up to \$250 min / \$500 max		40%; up to \$250 min / \$500 max	40%; up to \$100 min / \$200 max	40%; up to \$250 min / \$500 max	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	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	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)



2024 Medical Trust Health Plan 0619 - Diocese of Newark	Anthem BCBS BlueCard PPO 90  Vision Benefits Administered by EyeMed				Anthem BCBS BlueCard PPO 80  I Vision Benefits Administered by EyeMed		Cigna OAP PPO 80  Vision Benefits Administered by EyeMed		Anthem BCBS CDHP 20/HSA  Vision Benefits Administered by EyeMed		Cigna CDHP 20/HSA		Anthem BCBS CDHP 15/HSA  Vision Benefits Administered by EyeMed		Cigna CDHP 15/HSA  d 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	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	\$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	\$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	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,	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	1	Up to \$15 copay	Ť	Up to \$15 copay		Up to \$15 copay		Up to \$15 copay		Up to \$15 copay	†
Standard Scratch Resistance	Up to \$15 copay	İ	Up to \$15 copay		Up to \$15 copay	1	Up to \$15 copay	Ť	Up to \$15 copay		Up to \$15 copay		Up to \$15 copay		Up to \$15 copay	†
Standard Polycarbonate	\$0 copay	İ	\$0 copay		\$0 copay		\$0 copay	İ	\$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	İ	Up to \$45 copay		Up to \$45 copay		Up to \$45 copay		Up to \$45 copay	†
Disposable	20% off retail price	Ť	20% off retail price		20% off retail price		20% off retail price	İ	20% off retail price		20% off retail price		20% off retail price		20% off retail price	†
	\$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	\$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 of																
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	\$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	\$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



	Dental Benefits												
0619 - Diocese of Newark	Delta Dental												
		Premium PPO Plan		С	omprehensive PPO P	lan	Basic PPO Plan						
	PPO Network	Premier Network	Out-of-Network	PPO Network	Premier Network	Out-of-Network	PPO Network	Premier Network	Out-of-Network				
			\$50 per person / \$150 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	\$0 per person / \$0 per family				
Annual Deductible	***	40.500	40.000	40.500	40.000	44.500	40.000	44.500	<b>A</b> 4 000				
Annual Benefit Maximum (Plan maximums cross-accumulate between the PPO Network, Premier Network, and out-of- network dentists)		\$2,500	\$2,000	\$2,500	\$2,000	\$1,500 You pay \$0 (not	\$2,000	\$1,500	\$1,000				
Diagnostic and Preventive Services (e.g., exams, cleanings, x-rays, sealants and space maintainers)	is, <i>x-rays</i> ,		You pay \$0 (not subject to annual deductible) plus any balance billing	You pay \$0 (not subje	ou pay \$0 (not subject to annual deductible)		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 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	You pay 20% coinsurance	You pay 20% coinsurance	You pay 30% coinsurance plus any balance billing				
Major Services (Includes crowns, bridges, and dentures)	You pay 15% coinsurance	You pay 15% coinsurance	You pay 25% coinsurance plus any balance billing	You pay 50% coinsurance	You pay 50% coinsurance	You pay 60% coinsurance plus any balance billing	You pay 60% coinsurance	You pay 60% coinsurance	You pay 99% coinsurance plus any balance billing				
Orthodontic Services	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	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	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.