

| 2027 Medical Trust Health Plan<br><br>1084 - Diocese of Western North Carolina                                      | Anthem BCBS<br>BlueCard PPO 80                                                        |                                                                  | Anthem BCBS<br>CDHP 15/HSA                                                     |                                                                                    | Anthem BCBS<br>CDHP 20/HSA                                       |                                                                  | Cigna OAP<br>PPO 80                                                                   |                                                                  | Cigna<br>CDHP 15/HSA                                                           |                                                                                    | Cigna<br>CDHP 20/HSA                                             |                                                                  |
|---------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------|------------------------------------------------------------------|--------------------------------------------------------------------------------|------------------------------------------------------------------------------------|------------------------------------------------------------------|------------------------------------------------------------------|---------------------------------------------------------------------------------------|------------------------------------------------------------------|--------------------------------------------------------------------------------|------------------------------------------------------------------------------------|------------------------------------------------------------------|------------------------------------------------------------------|
|                                                                                                                     | 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<br>(CDHPs have a combined medical & Rx deductible)                                                | \$1,500 per person<br>\$3,000 per family                                              | \$3,000 per person<br>\$6,000 per family                         | \$2,200 per person<br>\$4,400 per family<br>(deductible is non-embedded)       | \$4,400 per person<br>\$8,800 per family<br>(deductible is non-embedded)           | \$3,600 per person<br>\$7,200 per family                         | \$7,200 per person<br>\$14,400 per family                        | \$1,500 per person<br>\$3,000 per family                                              | \$3,000 per person<br>\$6,000 per family                         | \$2,200 per person<br>\$4,400 per family<br>(deductible is non-embedded)       | \$4,400 per person<br>\$8,800 per family<br>(deductible is non-embedded)           | \$3,600 per person<br>\$7,200 per family                         | \$7,200 per person<br>\$14,400 per family                        |
| Annual Out-of-Pocket Limit                                                                                          | \$5,000 per person<br>\$10,000 per family                                             | \$10,000 per person<br>\$20,000 per family                       | \$3,900 per person<br>\$7,800 per family (out-of-pocket limit is non-embedded) | \$7,800 per person<br>\$15,600 per family<br>(out-of-pocket limit is non-embedded) | \$5,000 per person<br>\$10,000 per family                        | \$10,000 per person<br>\$20,000 per family                       | \$5,000 per person<br>\$10,000 per family                                             | \$10,000 per person<br>\$20,000 per family                       | \$3,900 per person<br>\$7,800 per family (out-of-pocket limit is non-embedded) | \$7,800 per person<br>\$15,600 per family<br>(out-of-pocket limit is non-embedded) | \$5,000 per person<br>\$10,000 per family                        | \$10,000 per person<br>\$20,000 per family                       |
| Preventive Care                                                                                                     |                                                                                       |                                                                  |                                                                                |                                                                                    |                                                                  |                                                                  |                                                                                       |                                                                  |                                                                                |                                                                                    |                                                                  |                                                                  |
| Preventive Services & Well-Child Care                                                                               | \$0 copay                                                                             | 50% coinsurance                                                  | \$0 copay                                                                      | 40% coinsurance                                                                    | \$0 copay                                                        | 45% coinsurance                                                  | \$0 copay                                                                             | 50% coinsurance                                                  | \$0 copay                                                                      | 40% coinsurance                                                                    | \$0 copay                                                        | 45% coinsurance                                                  |
| Physician Services                                                                                                  |                                                                                       |                                                                  |                                                                                |                                                                                    |                                                                  |                                                                  |                                                                                       |                                                                  |                                                                                |                                                                                    |                                                                  |                                                                  |
| Office Visit                                                                                                        | \$35 copay                                                                            | 50% coinsurance                                                  | 15% coinsurance                                                                | 40% coinsurance                                                                    | 20% coinsurance                                                  | 45% coinsurance                                                  | \$35 copay                                                                            | 50% coinsurance                                                  | 15% coinsurance                                                                | 40% coinsurance                                                                    | 20% coinsurance                                                  | 45% coinsurance                                                  |
| Diagnostic Services (outpatient)                                                                                    | 20% coinsurance<br>(Deductible does not apply)                                        | 50% coinsurance                                                  | 15% coinsurance                                                                | 15% coinsurance                                                                    | 20% coinsurance                                                  | 20% coinsurance                                                  | 20% coinsurance<br>(Deductible does not apply)                                        | 50% coinsurance                                                  | 15% coinsurance                                                                | 40% coinsurance                                                                    | 20% coinsurance                                                  | 45% coinsurance                                                  |
| Specialist Care                                                                                                     | \$50 copay                                                                            | 50% coinsurance                                                  | 15% coinsurance                                                                | 40% coinsurance                                                                    | 20% coinsurance                                                  | 45% coinsurance                                                  | \$50 copay                                                                            | 50% coinsurance                                                  | 15% coinsurance                                                                | 40% coinsurance                                                                    | 20% coinsurance                                                  | 45% coinsurance                                                  |
| Hospital Services                                                                                                   |                                                                                       |                                                                  |                                                                                |                                                                                    |                                                                  |                                                                  |                                                                                       |                                                                  |                                                                                |                                                                                    |                                                                  |                                                                  |
| Inpatient Services (including inpatient maternity services)                                                         | 20% coinsurance                                                                       | 50% coinsurance                                                  | 15% coinsurance                                                                | 40% coinsurance                                                                    | 20% coinsurance                                                  | 45% coinsurance                                                  | 20% coinsurance                                                                       | 50% coinsurance                                                  | 15% coinsurance                                                                | 40% coinsurance                                                                    | 20% coinsurance                                                  | 45% coinsurance                                                  |
| Outpatient Surgery                                                                                                  | 20% coinsurance                                                                       | 50% coinsurance                                                  | 15% coinsurance                                                                | 40% coinsurance                                                                    | 20% coinsurance                                                  | 45% coinsurance                                                  | 20% coinsurance                                                                       | 50% coinsurance                                                  | 15% coinsurance                                                                | 40% coinsurance                                                                    | 20% coinsurance                                                  | 45% coinsurance                                                  |
| Emergency Room Care                                                                                                 | \$250 copay                                                                           | \$250 copay                                                      | 15% coinsurance                                                                | 15% coinsurance                                                                    | 20% coinsurance                                                  | 20% coinsurance                                                  | \$250 copay                                                                           | \$250 copay                                                      | 15% coinsurance                                                                | 15% coinsurance                                                                    | 20% coinsurance                                                  | 20% coinsurance                                                  |
| Ambulance Services                                                                                                  | 20% coinsurance                                                                       | 20% coinsurance                                                  | 15% coinsurance                                                                | 15% coinsurance                                                                    | 20% coinsurance                                                  | 20% coinsurance                                                  | 20% coinsurance                                                                       | 20% coinsurance                                                  | 15% coinsurance                                                                | 15% coinsurance                                                                    | 20% coinsurance                                                  | 20% coinsurance                                                  |
| Behavioral Health                                                                                                   |                                                                                       |                                                                  |                                                                                |                                                                                    |                                                                  |                                                                  |                                                                                       |                                                                  |                                                                                |                                                                                    |                                                                  |                                                                  |
| Outpatient Services                                                                                                 | \$35 copay                                                                            | 30% coinsurance                                                  | 15% coinsurance                                                                | 40% coinsurance                                                                    | 20% coinsurance                                                  | 45% coinsurance                                                  | \$35 copay                                                                            | 30% coinsurance                                                  | 15% coinsurance                                                                | 40% coinsurance                                                                    | 20% coinsurance                                                  | 45% coinsurance                                                  |
| Inpatient Services                                                                                                  | 20% coinsurance                                                                       | 50% coinsurance                                                  | 15% coinsurance                                                                | 40% coinsurance                                                                    | 20% coinsurance                                                  | 45% coinsurance                                                  | 20% coinsurance                                                                       | 50% coinsurance                                                  | 15% coinsurance                                                                | 40% coinsurance                                                                    | 20% coinsurance                                                  | 45% coinsurance                                                  |
| Other Medical Services                                                                                              |                                                                                       |                                                                  |                                                                                |                                                                                    |                                                                  |                                                                  |                                                                                       |                                                                  |                                                                                |                                                                                    |                                                                  |                                                                  |
| Durable Medical Equipment                                                                                           | 20% coinsurance                                                                       | 50% coinsurance                                                  | 15% coinsurance                                                                | 40% coinsurance                                                                    | 20% coinsurance                                                  | 45% coinsurance                                                  | 20% coinsurance                                                                       | 50% coinsurance                                                  | 15% coinsurance                                                                | 40% coinsurance                                                                    | 20% coinsurance                                                  | 45% coinsurance                                                  |
| Home Health Care<br>(210 visits per calendar year, combined network and out-of-network)                             | 20% coinsurance                                                                       | 50% coinsurance                                                  | 15% coinsurance                                                                | 40% coinsurance                                                                    | 20% coinsurance                                                  | 45% coinsurance                                                  | 20% coinsurance                                                                       | 50% coinsurance                                                  | 15% coinsurance                                                                | 40% coinsurance                                                                    | 20% coinsurance                                                  | 45% coinsurance                                                  |
| Outpatient Therapy<br>(60 visits per calendar year per each type of therapy, combined network and out-of-network)   | \$35 copay PCP/\$50 copay specialist<br>(includes speech, physical, and occupational) | 50% coinsurance<br>(includes speech, physical, and occupational) | 15% coinsurance<br>(includes speech, physical, and occupational)               | 40% coinsurance<br>(includes speech, physical, and occupational)                   | 20% coinsurance<br>(includes speech, physical, and occupational) | 45% coinsurance<br>(includes speech, physical, and occupational) | \$35 copay PCP/\$50 copay specialist<br>(includes speech, physical, and occupational) | 50% coinsurance<br>(includes speech, physical, and occupational) | 15% coinsurance<br>(includes speech, physical, and occupational)               | 40% coinsurance<br>(includes speech, physical, and occupational)                   | 20% coinsurance<br>(includes speech, physical, and occupational) | 45% coinsurance<br>(includes speech, physical, and occupational) |
| Skilled Nursing / Acute Rehabilitation Facility<br>(60 days per calendar year, combined network and out-of-network) | 20% coinsurance                                                                       | 50% coinsurance                                                  | 15% coinsurance                                                                | 40% coinsurance                                                                    | 20% coinsurance                                                  | 45% coinsurance                                                  | 20% coinsurance                                                                       | 50% coinsurance                                                  | 15% coinsurance                                                                | 40% coinsurance                                                                    | 20% coinsurance                                                  | 45% coinsurance                                                  |
| Urgent Care Services                                                                                                | \$60 copay                                                                            | \$60 copay                                                       | 15% coinsurance                                                                | 40% coinsurance                                                                    | 20% coinsurance                                                  | 45% coinsurance                                                  | \$60 copay                                                                            | \$60 copay                                                       | 15% coinsurance                                                                | 15% coinsurance                                                                    | 20% coinsurance                                                  | 20% coinsurance                                                  |

|                                                                                |                                                   |                                             |                                                                                                             |                                                                                                             |                                                                                |                                                                                |                                                   |                                             |                                                                                                             |                                                                                                             |                                                                                |                                                                                |
|--------------------------------------------------------------------------------|---------------------------------------------------|---------------------------------------------|-------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------|--------------------------------------------------------------------------------|---------------------------------------------------|---------------------------------------------|-------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------|--------------------------------------------------------------------------------|
| 2027 Medical Trust Health Plan<br><br>1084 - Diocese of Western North Carolina | Anthem BCBS<br>BlueCard PPO 80                    |                                             | Anthem BCBS<br>CDHP 15/HSA                                                                                  |                                                                                                             | Anthem BCBS<br>CDHP 20/HSA                                                     |                                                                                | Cigna OAP<br>PPO 80                               |                                             | Cigna<br>CDHP 15/HSA                                                                                        |                                                                                                             | Cigna<br>CDHP 20/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 |                                             | 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                               | Retail                                                                                                      | Home Delivery                                                                                               | Retail                                                                         | Home Delivery                                                                  |
| Annual Prescription Deductible (in-network)                                    | None                                              | None                                        | \$2,200 per person<br>\$4,400 per family<br>(combined with medical deductible)<br>(non-embedded deductible) | \$2,200 per person<br>\$4,400 per family<br>(combined with medical deductible)<br>(non-embedded deductible) | \$3,600 per person<br>\$7,200 per family<br>(combined with medical deductible) | \$3,600 per person<br>\$7,200 per family<br>(combined with medical deductible) | None                                              | None                                        | \$2,200 per person<br>\$4,400 per family<br>(combined with medical deductible)<br>(non-embedded deductible) | \$2,200 per person<br>\$4,400 per family<br>(combined with medical deductible)<br>(non-embedded deductible) | \$3,600 per person<br>\$7,200 per family<br>(combined with medical deductible) | \$3,600 per person<br>\$7,200 per family<br>(combined with medical deductible) |
| Tier 1: Generic                                                                | \$5 copay                                         | \$12 copay                                  | You pay 15% after deductible                                                                                | You pay 15% after deductible                                                                                | You pay 15% after deductible                                                   | You pay 15% after deductible                                                   | \$5 copay                                         | \$12 copay                                  | 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                                                   | \$35 copay                                        | \$87 copay                                  | You pay 25% after deductible                                                                                | You pay 25% after deductible                                                                                | You pay 25% after deductible                                                   | You pay 25% after deductible                                                   | \$35 copay                                        | \$87 copay                                  | 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                                               | \$70 copay                                        | \$175 copay                                 | You pay 50% after deductible                                                                                | You pay 50% after deductible                                                                                | You pay 50% after deductible                                                   | You pay 50% after deductible                                                   | \$70 copay                                        | \$175 copay                                 | You pay 50% after deductible                                                                                | You pay 50% after deductible                                                                                | You pay 50% after deductible                                                   | You pay 50% after deductible                                                   |
| Tier 4: Specialty Rx                                                           | \$90 copay                                        | \$90 copay for a 30-day supply              | You pay 50% after deductible                                                                                | You pay 50% after deductible                                                                                | You pay 50% after deductible                                                   | You pay 50% after deductible                                                   | \$90 copay                                        | \$90 copay for a 30-day supply              | 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 (except Specialty Rx) | 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 (except Specialty Rx) | 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)                   |

[illegible]

| 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:<br>\$32 for single vision<br>\$46 for bifocal<br>\$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                                                                              |

| 1084 - Diocese of Western North Carolina                                                                               | 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<br>(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<br>(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<br>(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<br>(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 |

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.