

2026 Medical Trust Health Plan		m BCBS d PPO 100		m BCBS rd PPO 90		m BCBS rd PPO 80		em BCBS ard PPO 70		aiser O High		aiser O 80		m BCBS 2 40/HSA		em BCBS P 20/HSA		em BCBS P 15/HSA		Kaiser P 20/HSA
0430 - Diocese of Los Angeles																				
	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	Network	Out-of-Network	Network	Out-of-Network
Annual Deductible (CDHPs have a combined medical & Rx deductible)	\$0 per person \$0 per family	\$500 per person \$1,000 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	\$3,500 per person \$7,000 per family	\$7,000 per person \$14,000 per family	\$0 per person \$0 per family	Not Applicable	\$500 per person \$1,000 per family	Not Applicable	\$3,500 per person \$7,000 per family	\$7,000 per person \$14,000 per family	\$3,400 per person \$6,800 per family	\$3,400 per person \$6,800 per family	\$1,700 per person \$3,400 per family (deductible is non- embedded)	\$3,400 per person \$6,800 per family (deductible is non- embedded)	\$3,400 per person \$6,800 per family	Not Applicable
Annual Out-of-Pocket Limit	\$2,000 per person \$4,000 per family	\$4,000 per person \$8,000 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	\$5,000 per person \$10,000 per family	\$10,000 per person \$20,000 per family	\$1,750 per person \$3,500 per family	Not Applicable	\$3,500 per person \$7,000 per family	Not Applicable	\$6,000 per person \$12,000 per family	\$10,000 per person \$20,000 per family	\$4,200 per person \$8,450 per family	\$7,000 per person \$13,000 per family		\$4,800 per person ut-\$9,600 per family (ou of-pocket limit is non- embedded)	\$4,200 per person ut-\$8,450 per family	Not Applicable
Preventive Care																				
Preventive Services & Well-Child Care	\$0 copay	50% coinsurance	\$0 copay	50% coinsurance	\$0 copay	50% coinsurance	\$0 copay	50% coinsurance	\$0 copay	Not Applicable	\$0 copay	Not Applicable	\$0 copay	60% coinsurance	\$0 copay	45% coinsurance	\$0 copay	40% coinsurance	\$0 copay	Not Applicable
Physician Services Office Visit	\$30 copay	50% coinsurance	\$30 copay	50% coinsurance	\$30 copay	50% coinsurance	\$30 copay	50% coinsurance	\$25 copay	Not Applicable	\$25 copay	Not Applicable	40% coinsurance	60% coinsurance	20% coinsurance	45% coinsurance	15% coinsurance	40% coinsurance	20% coinsurance	Not Applicable
Office visit	фоо сорау	0070 COI ISGI AI ICE	фоо сорау	3070 CONTINUE	фоо сорау	0070 COII ISUI AI ICE	фоо сорау	3070 CONTRAINCE	ф20 сорау	140t Applicable	ф20 сорау	140t Applicable	4070 COILISULALICS	0070 Collisulation	2070 COI ISUI AI ICE	4070 COINSUI AI ICE	1070 CON ISUI AN ICE	40 /0 COILISULALICE	2070 COI ISUI AI ICE	Not Applicable
Diagnostic Services (outpatient)	\$0 copay	50% coinsurance	10% coinsurance	50% coinsurance (Deductible does not apply)	20% coinsurance	50% coinsurance (Deductible does not apply)	30% coinsurance	50% coinsurance (Deductible does not apply)	\$50 copay	Not Applicable	20% coinsurance	Not Applicable	40% coinsurance	60% coinsurance	20% coinsurance	45% coinsurance	15% coinsurance	40% coinsurance	20% coinsurance	Not Applicable
Specialist Care	\$45 copay	50% coinsurance	\$45 copay	50% coinsurance	\$45 copay	50% coinsurance	\$45 copay	50% coinsurance	\$25 copay	Not Applicable	\$35 copay	Not Applicable	40% coinsurance	60% coinsurance	20% coinsurance	45% coinsurance	15% coinsurance	40% coinsurance	20% coinsurance	Not Applicable
Hospital Services	0050	E00/i	100/	E00/i	000/	F00/i	200/	F00/i	A100	Not Applicable	000/i	Nint Annalisatela	400/	000/!	000/	450/	450/	400/	000/i	Niek Australia
Inpatient Services (including inpatient maternity services)	\$250 copay	50% coinsurance	10% coinsurance	50% coinsurance	20% coinsurance	50% coinsurance	30% coinsurance	50% coinsurance	\$100 per day copay to maximum of \$600	INOT Applicable	20% coinsurance	Not Applicable	40% coinsurance	60% coinsurance	20% coinsurance	45% coinsurance	15% coinsurance	40% coinsurance	20% coinsurance	Not Applicable
Outpatient Surgery	\$200 copay	50% coinsurance	10% coinsurance	50% coinsurance	20% coinsurance	50% coinsurance	30% coinsurance	50% coinsurance	\$100 copay	Not Applicable	20% coinsurance	Not Applicable	40% coinsurance	60% coinsurance	20% coinsurance	45% coinsurance	15% coinsurance	40% coinsurance	20% coinsurance	Not Applicable
Emergency Room Care	\$250 copay	\$250 copay	\$250 copay	\$250 copay	\$250 copay	\$250 copay	\$250 copay	\$250 copay	\$100 copay	Not Applicable	20% coinsurance	Not Applicable	40% coinsurance	40% coinsurance	20% coinsurance	20% coinsurance	15% coinsurance	15% coinsurance	20% coinsurance	Not Applicable
Ambulance Services	\$0 copay	\$0 copay	10% coinsurance	10% coinsurance	20% coinsurance	20% coinsurance	30% coinsurance	30% coinsurance	\$0 copay	Not Applicable	20% coinsurance	Not Applicable	40% coinsurance	40% coinsurance	20% coinsurance	20% coinsurance	15% coinsurance	15% coinsurance	20% coinsurance	Not Applicable
Behavioral Health																				
Outpatient Services Inpatient Services	\$0 copay \$250 copay	30% coinsurance 50% coinsurance	\$30 copay 10% coinsurance	30% coinsurance 50% coinsurance	\$30 copay 20% coinsurance	30% coinsurance 50% coinsurance	\$30 copay 30% coinsurance	30% coinsurance 50% coinsurance	\$25 copay per visit for \$100 per day copay to		\$25 copay per visit for 20% coinsurance	Not Applicable Not Applicable	40% coinsurance 40% coinsurance	60% coinsurance 60% coinsurance	20% coinsurance 20% coinsurance	45% coinsurance 45% coinsurance	15% coinsurance 15% coinsurance	40% coinsurance 40% coinsurance	20% coinsurance 20% coinsurance	Not Applicable Not Applicable
Other Medical Services	ф200 сорау	3078 COITISCITATICE	1076 COITISULATICE	50% Collistratice	20% Collistratice	5076 Collisulatice	3076 COITISULALICE	3076 COILISULALICE	19100 per day copay to	Not Applicable	20% Collisulance	Not Applicable	4070 COILISCIALICE	00% Collisciance	20% coirisurance	40 /6 COII ISUI AI ICE	1376 COITISCITATICE	40 /6 COI ISUI AI ICE	20 / 6 COITISUI AITICE	Not Applicable
Durable Medical Equipment	\$0 copay	50% coinsurance	10% coinsurance	50% coinsurance	20% coinsurance	50% coinsurance	30% coinsurance	50% coinsurance	\$0 copay	Not Applicable	20% coinsurance	Not Applicable	40% coinsurance	60% coinsurance	20% coinsurance	45% coinsurance	15% coinsurance	40% coinsurance	20% coinsurance	Not Applicable
Home Health Care (210 visits per calendar year, combined network and out-of- network)	\$0 copay	50% coinsurance	10% coinsurance	50% coinsurance	20% coinsurance	50% coinsurance	30% coinsurance	50% coinsurance	0% coinsurance	Not Applicable	\$0 Copay	Not Applicable	40% coinsurance	60% coinsurance	20% coinsurance	45% coinsurance	15% coinsurance	40% coinsurance	0% coinsurance	Not Applicable
Outpatient Therapy	\$30 copay PCP/\$45	50% coinsurance	\$30 copay PCP/\$45	50% coinsurance	\$30 copay PCP/\$45	50% coinsurance	\$30 copay PCP/\$45		\$25 copay (includes	Not Applicable	\$25 copay (includes	Not Applicable	40% coinsurance	60% coinsurance	20% coinsurance	45% coinsurance	15% coinsurance	40% coinsurance	20% coinsurance	Not Applicable
(60 visits per calendar year per each	copay specialist	(includes speech,	copay specialist	(includes speech,	copay specialist	(includes speech,	copay specialist	(includes speech,	speech, physical, and	1	speech, physical, and		(includes speech,	(includes speech,	(includes speech,	(includes speech,	(includes speech,	(includes speech,	(includes speech,	
type of therapy, combined network and out-of-network)	(includes speech, physical, and	physical, and occupational)	(includes speech, physical, and	physical, and occupational)	(includes speech, physical, and	physical, and occupational)	(includes speech, physical, and	physical, and occupational)	occupational)	1	occupational)		physical, and occupational)	physical, and occupational)	physical, and occupational)	physical, and occupational)	physical, and occupational)	physical, and occupational)	physical, and occupational)	
and out of libeworky	occupational)	occupationally	occupational)	occupational	occupational)	occupational)	occupational)	occupational)					occupational	occupational	occupationally	occupational	Socupational	occupationaly	occupational)	
Skilled Nursing / Acute Rehabilitation Facility (60 days per calendar year, combined network and out-of-network)	\$0 copay	50% coinsurance	10% coinsurance	50% coinsurance	20% coinsurance	50% coinsurance	30% coinsurance	50% coinsurance	\$0 copay	Not Applicable	20% coinsurance	Not Applicable	40% coinsurance	60% coinsurance	20% coinsurance	45% coinsurance	15% coinsurance	40% coinsurance	20% coinsurance	Not Applicable
Urgent Care Services	\$50 copay	\$50 copay	\$50 copay	\$50 copay	\$50 copay	\$50 copay	\$50 copay	\$50 copay	\$50 copay	Not Applicable	\$50 copay	Not Applicable	40% coinsurance	60% coinsurance	20% coinsurance	45% coinsurance	15% coinsurance	40% coinsurance	20% coinsurance	Not Applicable



2026 Medical Trust Health Plan		em BCBS rd PPO 100		em BCBS ard PPO 90		m BCBS rd PPO 80		m BCBS rd PPO 70		aiser O High		Kaiser PO 80		em BCBS P 40/HSA		m BCBS 20/HSA		em BCBS P 15/HSA		Kaiser IP 20/HSA
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		Administered by Expres		Administered by Expres	s Pharmacy Benefits A	dministered by Express		dministered by Express	Pharmacy Benefits	Administered by Kaiser	Pharmacy Benefits	Administered by Kaiser		administered by Express		dministered by Express		Administered by Express	Pharmacy Benefits	s Administered by Kaiser
Prescription Drug Benefits	Retail	Home Delivery	Retail	Home Delivery	Retail	Home Delivery	Retail	Home Delivery	Retail	Home Delivery	Retail	Home Delivery	Retail	Home Delivery						
Annual Prescription Deductible (in-network)	None	None	None	None	None	\$3,500 per person \$7,000 per family (combined with	\$3,500 per person \$7,000 per family (combined with	\$3,300 per person \$6,600 per family (combined with	\$3,300 per person \$6,600 per family (combined with	\$1,700 per person \$3,400 per family (combined with	\$1,700 per person \$3,400 per family (combined with	\$3,300 per person \$6,600 per family (combined with	\$3,300 per person \$6,600 per family (combined with							
													medical deductible)	medical deductible)	medical deductible)	medical deductible)	medical deductible) (non-embedded deductible)	medical deductible) (non-embedded deductible)	medical deductible)	medical 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	Up to a \$5 copay	Up to a \$10 copay for a 30-day supply or \$20 for up to a 90-day supply	Up to a \$5 copay	Up to a \$10 copay for a 30-day supply or \$20 for up to a 90-day supply		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 \$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	Up to a \$30 copay	Up to a \$30 copay for a 30-day supply or \$60 for up to a 90-day supply		Up to a \$30 copay for a 30-day supply or \$60 for up to a 90-day supply		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 \$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	Up to a \$70 copay	Up to a \$70 copay for a 30-day supply or \$140 for up to a 90- day supply	Up to a \$70 copay	Up to a \$70 copay for a 30-day supply or \$140 for up to a 90- day supply	You pay 50% after deductible	You pay 50% after deductible	You pay 50% after deductible	You pay 50% after deductible	You pay 50% after deductible			
Tier 4: Specialty Rx	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 \$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	Up to a \$90 copay	Up to a \$90 copay for a 30-day supply	Up to a \$90 copay	Up to a \$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	You pay 50% after deductible			
Dispensing Limits Per Copayment	Up to a 30-day supply	y Up to a 90-day suppl	y Up to a 30-day suppl	y 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	y 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 suppl (retail) or 90-day supply (mail order)	y Up to a 30-day supply (retail) or 90-day supply (mail order)	Up to a 30-day suppi (retail) or 90-day supply (mail order)	ly Up to a 30-day supply (retail) or 90-day supply (mail order)



2026 Medical Trust Health Plan		m BCBS d PPO 100		m BCBS rd PPO 90		n BCBS d PPO 80		m BCBS d PPO 70		ilser High	K Ef	(aiser PO 80		m BCBS 40/HSA		m BCBS 20/HSA		m BCBS 15/HSA		aiser ' 20/HSA
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	Vision Benefits Adr	ministered by EyeMed	Vision Benefits Adr	ministered by EyeMed	Vision Benefits Adm	inistered by EyeMed	Vision Benefits Adm	inistered by EyeMed	Vision Benefits Adm	nistered by EyeMed	Vision Benefits Adn	ninistered by EyeMed	Vision Benefits Adr	ninistered by EyeMed	Vision Benefits Adn	ninistered by EyeMed	Vision Benefits Adn	ninistered by EyeMed	Vision Benefits Adm	ninistered 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	Network	Out-of-Network	Network	Out-of-Network
Eye Examinations	\$0 copay	Plan pays up to \$30 fo ophthalmologists or optometrists	r \$0 copay	Plan pays up to \$30 fo ophthalmologists or optometrists	r \$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 fo ophthalmologists or optometrists	or \$0 copay	Plan pays up to \$30 for ophthalmologists or optometrists	r \$0 copay	Plan pays up to \$30 for ophthalmologists or optometrists	\$0 copay	Plan pays up to \$30 for ophthalmologists or optometrists	r \$0 copay	Plan pays up to \$30 for ophthalmologists or optometrists	r \$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		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	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 fo 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,	r 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	†	Up to \$15 copay	†	Up to \$15 copay	†	Up to \$15 copay		Up to \$15 copay		Up to \$15 copay	1	Up to \$15 copay	1	Up to \$15 copay	1
Standard Scratch Resistance	Up to \$15 copay		Up to \$15 copay		Up to \$15 copay		Up to \$15 copay	1	Up to \$15 copay	1	Up to \$15 copay		Up to \$15 copay	1	Up to \$15 copay	1	Up to \$15 copay		Up to \$15 copay	1
	\$0 copay		\$0 copay		\$0 copay	1	\$0 copay]	\$0 copay]	\$0 copay		\$0 copay		\$0 copay		\$0 copay		\$0 copay	
Standard Anti-Reflective Coating	Up to \$45 copay		Up to \$45 copav		Up to \$45 copav		Up to \$45 copav		Up to \$45 copav		Up to \$45 copay		Up to \$45 copay		Up to \$45 copay		Up to \$45 copav		Up to \$45 copav	
Disposable	20% off retail price		20% off retail price		20% off retail price		20% off retail price		20% off retail price		20% off retail price		20% off retail price		20% off retail price		20% off retail price		20% off retail price	
Frames (eligible once every calendar year)	\$200 allowance, 20% off balance over \$200	Plan pays up to \$47	\$200 allowance, 20% off balance over \$200	Plan pays up to \$47	\$200 allowance, 20% off balance over \$200		\$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 c	nalendar vear)																			
CONTROL ECTIONS (CIIGIDIC OTICE EVEL) C		Plan pays up to \$133	\$200 allowance, 15%	Plan pays up to \$133	\$200 allowance, 15%	Plan pays up to \$133	\$200 allowance, 15%	Plan pays up to \$133	\$200 allowance, 15%	Plan pays up to \$133	\$200 allowance 15%	Plan pays up to \$133	\$200 allowance, 15%	Plan pays up to \$133	\$200 allowance, 15%	Plan pays up to \$133	\$200 allowance, 15%	Plan pays up to \$133	\$200 allowance, 15%	Plan pays up to \$133
Conventional	off balance over \$200	. a. pays up to \$100	off balance over \$200	. a. pays up to \$100	off balance over \$200		off balance over \$200	That pays up to \$100	off balance over \$200		off balance over \$200		off balance over \$200	. , , ,	off balance over \$200		off balance over \$200	1 x21 pays up to \$100	off balance over \$200	pays up to \$100
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		\$200 allowance, then you pay balance over \$200	Plan pays up to \$133	\$200 allowance, then you pay balance over \$200	Plan pays up to \$133	\$200 allowance, then you pay balance over \$200	Plan pays up to \$133	\$200 allowance, then you pay balance over \$200	Plan pays up to \$133	\$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



				Delta Dental								
0430 - Diocese of Los Angeles		Premium PPO Plan			Comprehensive PPO Plan		Basic PPO Plan					
	PPO Network	Premier Network	Out-of-Network	PPO Network	Premier Network	Out-of-Network	PPO Network	Premier Network	Out-of-Network			
Annual Deductible	\$0 per person / \$0 per family	\$0 per person / \$0 per family	\$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 Benefit Maximum (Maxmium cross applies across networks)	\$3,000	\$2,500	\$2,000	\$2,50	0 \$2,00	00 \$1,500	\$2,0	00 \$1,50	0 \$1,000			
Diagnostic and Preventive Services (e.g., exams, cleanings, x-rays, sealants and space maintainers,		You pay \$0 (not subject to annual deductib	le)		You pay \$0 (not subject to annual dec	ductible)		You pay \$0 (not subject to annual de	ductible)			
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	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 15% coinsurance	You pay 15% coinsurance	You pay 25% coinsurance	You pay 50% coinsurance	You pay 50% coinsurance	You pay 60% coinsurance	You pay 60% coinsurance	You pay 60% coinsurance	You pay 99% 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	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%.			

Vision Be	nefits	
	EyeM	1ed
	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 Opti	ons	·
Standard progressive (add-on to bifocal)	Up to \$75 copay	Plan pays up to \$46
UV Coating	Up to \$15 copay	
Tint (solid and gradient)	Up to \$15 copay	You are responsible for the cost of
Standard Scratch Resistance	Up to \$15 copay	any lens options that you elect from
Standard Polycarbonate	\$0 copay	out-of-network providers,
Standard Anti-Reflective Coating	Up to \$45 copay	out-or-network providers,
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 onc		•
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

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 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. Jimitations, and procedures