

| 2024 Medical Trust Health Plan  | Anthem BCBS BlueCard PPO 90  |  | Anthem BCBS BlueCard PPO 80  |  | Anthem BCBS BlueCard PPO 70  |  | Anthem BCBS<br>CDHP 15/HSA  |  |  | em BCBS<br>IP 20/HSA   | Anthem BCBS<br>CDHP 40/HSA   |   |
|---|--|--|--|--|--|--|---|--|--|--|--|---|
| 1107 - Diocese of Central Gulf Coast  |  |  |  |  |  |  |   |  |  |  |  |   |
|   | 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<br>medical & Rx deductible)   | \$500 per person<br>\$1,000 per family   | \$1,000 per person<br>\$2,000 per family   | \$1,000 per person<br>\$2,000 per family   | \$2,000 per person<br>\$4,000 per family   | \$3,500 per person<br>\$7,000 per family   | \$7,000 per person<br>\$14,000 per family  | \$1,600 per person<br>\$3,200 per family<br>(deductible is non-<br>embedded)          | \$3,200 per person<br>\$6,400 per family<br>(deductible is non-<br>embedded)                       | \$3,200 per person<br>\$5,450 per family                               | \$3,200 per person<br>\$6,000 per family   | \$3,500 per person<br>\$7,000 per family                               | \$7,000 per person<br>\$14,000 per family   |
| Annual Out-of-Pocket Limit  | \$2,500 per person<br>\$5,000 per family   | \$5,000 per person<br>\$10,000 per family  | \$3,500 per person<br>\$7,000 per family   | \$7,000 per person<br>\$14,000 per family  | \$5,000 per person<br>\$10,000 per family  | \$10,000 per person<br>\$20,000 per family   | \$2,400 per person<br>\$4,800 per family (out<br>of-pocket limit is non-<br>embedded) | \$4,800 per person<br>\$9,600 per family (out<br>of-pocket limit is non-<br>embedded)              | \$4,200 per person<br>+\$8,450 per family                              | \$7,000 per person<br>\$13,000 per family  | \$6,000 per person<br>\$12,000 per family                              | \$10,000 per person<br>\$20,000 per family  |
| 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   | 40% coinsurance plus any balance billing   | \$0 copay  | 45% coinsurance plus any balance billing   | \$0 copay  | 60% coinsurance plu<br>any balance billing  |
| Physician Services  |  |  |  |  |  |  |   |  |  |  |  |   |
| Office Visit  | \$30 copay   | 50% coinsurance plus any balance billing   | \$30 copay   | 50% coinsurance plus any balance billing   | \$30 copay   | 50% coinsurance plus any balance billing   | 15% coinsurance   | 40% coinsurance plus any balance billing   | 20% coinsurance  | 45% coinsurance plus any balance billing   | 40% coinsurance  | 60% coinsurance plu<br>any balance billing  |
| Diagnostic Services (outpatient)<br>(non-routine)   | 10% coinsurance  | 50% coinsurance plus any balance billing   | 20% coinsurance  | 50% coinsurance plus any balance billing   | 30% coinsurance  | 50% coinsurance plus any balance billing   | 15% coinsurance   | 40% coinsurance plus any balance billing   | 20% coinsurance  | 45% coinsurance plus any balance billing   | 40% coinsurance  | 60% coinsurance   |
| Specialist Care   | \$45 copay   | 50% coinsurance plus any balance billing   | \$45 copay   | 50% coinsurance plus any balance billing   | \$45 copay   | 50% coinsurance plus any balance billing   | 15% coinsurance   | 40% coinsurance plus any balance billing   | 20% coinsurance  | 45% coinsurance plus any balance billing   | 40% coinsurance  | 60% coinsurance plu<br>any balance billing  |
| Hospital Services   | 100/   | 500/   | 2004   |  | 2004   | 500/   | 450/  | 100/   | 200/   | 450/   | 100/   | 2004  |
| Inpatient Services (including inpatient maternity services)   | 10% coinsurance  | 50% coinsurance plus any balance billing   | 20% coinsurance  | 50% coinsurance plus any balance billing   | 30% coinsurance  | 50% coinsurance plus any balance billing   | 15% coinsurance   | 40% coinsurance plus any balance billing   | 20% coinsurance  | 45% coinsurance plus any balance billing   | 40% coinsurance  | 60% coinsurance plu<br>any balance billing  |
| Outpatient Surgery  | 10% coinsurance  | 50% coinsurance plus any balance billing   | 20% coinsurance  | 50% coinsurance plus any balance billing   | 30% coinsurance  | 50% coinsurance plus any balance billing   | 15% coinsurance   | 40% coinsurance plus any balance billing   | 20% coinsurance  | 45% coinsurance plus any balance billing   | 40% coinsurance  | 60% coinsurance plu<br>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  | 15% coinsurance   | Covered at in-network benefit level  | 20% coinsurance  | Covered at in-network benefit level  | 40% coinsurance  | Covered at in-netwo benefit level   |
| Ambulance Services  | 10% coinsurance  | Covered at in-network benefit level for emergency transport  | 20% coinsurance  | Covered at in-network benefit level for emergency transport  | 30% coinsurance  | Covered at in-network<br>benefit level for<br>emergency transport                                  | 15% coinsurance   | Covered at in-network<br>benefit level for<br>emergency transport                                  | 20% coinsurance  | Covered at in-network<br>benefit level for<br>emergency transport                                  | 40% coinsurance  | Covered at in-netwo<br>benefit level for<br>emergency transpor                                    |
| 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   | 15% coinsurance   | 40% coinsurance plus any balance billing   | 20% coinsurance  | 45% coinsurance plus any balance billing   | 40% coinsurance  | 60% coinsurance plu<br>any balance billing  |
| Inpatient Services  | 10% coinsurance  | 50% coinsurance plus any balance billing   | 20% coinsurance  | 50% coinsurance plus any balance billing   | 30% coinsurance  | 50% coinsurance plus<br>any balance billing  | 15% coinsurance   | 40% coinsurance plus any balance billing   | 20% coinsurance  | 45% coinsurance plus any balance billing   | 40% coinsurance  | 60% coinsurance plu<br>any balance billing  |
| Other Medical Services  |  |  |  |  |  |  |   |  |  |  |  |   |
| Durable Medical Equipment   | 10% coinsurance  | 50% coinsurance plus any balance billing   | 20% coinsurance  | 50% coinsurance plus any balance billing   | 30% coinsurance  | 50% coinsurance plus any balance billing   | 15% coinsurance   | 40% coinsurance plus any balance billing   | 20% coinsurance  | 45% coinsurance plus any balance billing   | 40% coinsurance  | 60% coinsurance plu<br>any balance billing  |
| Home Health Care<br>(210 visits per calendar year, combined<br>network and out-of-network)  | 10% coinsurance  | 50% coinsurance plus any balance billing   | 20% coinsurance  | 50% coinsurance plus any balance billing   | 30% coinsurance  | 50% coinsurance plus any balance billing   | 15% coinsurance   | 40% coinsurance plus any balance billing   | 20% coinsurance  | 45% coinsurance plus any balance billing   | 40% coinsurance  | 60% coinsurance plu<br>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<br>copay specialist<br>(includes speech,<br>physical, and<br>occupational) | 50% coinsurance plus<br>any balance billing<br>(includes speech,<br>physical, and<br>occupational) | \$30 copay PCP/\$45<br>copay specialist<br>(includes speech,<br>physical, and<br>occupational) | 50% coinsurance plus<br>any balance billing<br>(includes speech,<br>physical, and<br>occupational) | \$30 copay PCP/\$45<br>copay specialist<br>(includes speech,<br>physical, and<br>occupational) | 50% coinsurance plus<br>any balance billing<br>(includes speech,<br>physical, and<br>occupational) | 15% coinsurance<br>(includes speech,<br>physical, and<br>occupational)                | 40% coinsurance plus<br>any balance billing<br>(includes speech,<br>physical, and<br>occupational) | 20% coinsurance<br>(includes speech,<br>physical, and<br>occupational) | 45% coinsurance plus<br>any balance billing<br>(includes speech,<br>physical, and<br>occupational) | 40% coinsurance<br>(includes speech,<br>physical, and<br>occupational) | 60% coinsurance plu<br>any balance billing<br>(includes speech,<br>physical, and<br>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   | 20% coinsurance  | 50% coinsurance plus any balance billing   | 30% coinsurance  | 50% coinsurance plus any balance billing   | 15% coinsurance   | 40% coinsurance plus any balance billing   | 20% coinsurance  | 45% coinsurance plus any balance billing   | 40% coinsurance  | 60% coinsurance plu<br>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  | 15% coinsurance   | 15% coinsurance plus any balance billing   | 20% coinsurance  | 20% coinsurance plus any balance billing   | 40% coinsurance  | 40% coinsurance plu<br>any balance billing  |



| 2024 Medical Trust Health Plan              | BlueCard PPO 90                     |                                     | Anthem BCBS BlueCard PPO 80  Pharmacy Benefits Administered by Express Scripts |                                     | Anthem BCBS BlueCard PPO 70  Pharmacy Benefits Administered by Express Scripts |                                     | Anthem BCBS CDHP 15/HSA  Pharmacy Benefits Administered by Express Scripts  |   | Anthem BCBS CDHP 20/HSA  Pharmacy Benefits Administered by Express Scripts        |   | Anthem BCBS<br>CDHP 40/HSA  |   |
|---|-------------------------------------|-------------------------------------|--|-------------------------------------|--|-------------------------------------|---|---|---|---|---|---|
| 1107 - Diocese of Central Gulf Coast        |                                     |                                     |  |                                     |  |                                     |   |   |   |   |   |   |
|   |                                     |                                     |  |                                     |  |                                     |   |   |   |   | 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                                | None   | None                                | None   | None                                | \$1,600 per person<br>\$3,200 per family<br>(combined with<br>medical deductible)<br>(non-embedded<br>deductible) | \$1,600 per person<br>\$3,200 per family<br>(combined with<br>medical deductible)<br>(non-embedded<br>deductible) | \$3,200 per person<br>\$5,450 per family<br>(combined with<br>medical deductible) | \$3,200 per person<br>\$5,450 per family<br>(combined with<br>medical deductible) | \$3,500 per person<br>\$7,000 per family<br>(combined with<br>medical deductible) | \$3,500 per person<br>\$7,000 per family<br>(combined with<br>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                  | 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<br>\$40 min / \$80 max   | 25%; up to<br>\$100 min / \$200 max | 25%; up to<br>\$40 min / \$80 max  | 25%; up to<br>\$100 min / \$200 max | 25%; up to<br>\$40 min / \$80 max  | 25%; up to<br>\$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  |
| Tier 3: Non-Preferred Brand Name            | 40%; up to<br>\$80 min / \$160 max  | 40%; up to<br>\$200 min / \$400 max | 40%; up to<br>\$80 min / \$160 max   | 40%; up to<br>\$200 min / \$400 max | 40%; up to<br>\$80 min / \$160 max   | 40%; up to<br>\$200 min / \$400 max | You pay 50% after deductible  | You pay 50% after deductible  | You pay 50% after deductible  | You pay 50% after deductible  | You pay 50% after deductible  | You pay 50% after deductible  |
| Tier 4: Specialty Rx                        | 40%; up to<br>\$100 min / \$200 max | 40%; up to<br>\$250 min / \$500 max | 40%; up to<br>\$100 min / \$200 max  | 40%; up to<br>\$250 min / \$500 max | 40%; up to<br>\$100 min / \$200 max  | 40%; up to<br>\$250 min / \$500 max | You pay 50% after deductible  | You pay 50% after deductible  | You pay 50% after deductible  | You pay 50% after deductible  | You pay 50% after deductible  | You pay 50% after deductible  |
| Dispensing Limits Per Copayment             | Up to a 30-day supply               | 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<br>(retail) or<br>90-day supply<br>(mail order)   | Up to a 30-day supply<br>(retail) or<br>90-day supply<br>(mail order)             | Up to a 30-day supply<br>(retail) or<br>90-day supply<br>(mail order)             | Up to a 30-day supply<br>(retail) or<br>90-day supply<br>(mail order)             | Up to a 30-day suppl<br>(retail) or<br>90-day supply<br>(mail order)              |



| 2024 Medical Trust Health Plan  | Anthem BCBS<br>BlueCard PPO 90                         |  | Anthem BCBS BlueCard PPO 80                            |  |  | n BCBS<br>d PPO 70   | Anthem BCBS<br>CDHP 15/HSA                             |  | Anthem BCBS<br>CDHP 20/HSA                             |  |  | m BCBS<br>2 40/HSA  |  |
|---|--|--|--|--|--|--|--|--|--|--|--|---|--|
| 1107 - Diocese of Central Gulf Coast  Vision Benefits  Eye Examinations |  |  |  |  |  |  |  |  |  |  |  |   |  |
|   | Vision Benefits Administered by EyeMed                 |  | Vision Benefits Administered by EyeMed                 |  | Vision Benefits Administered by EyeMed                 |  | Vision Benefits Administered by EyeMed                 |  | Vision Benefits Administered by EyeMed                 |  |  |   |  |
|   | Network  | Out-of-Network   | Network  | Out-of-Network  |  |
|   | \$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<br>year)                           | \$10 copay   | Plan pays up to:<br>\$32 for single vision<br>\$46 for bifocal<br>\$57 for trifocal                | \$10 copay   | Plan pays up to:<br>\$32 for single vision<br>\$46 for bifocal<br>\$57 for trifocal                | \$10 copay   | Plan pays up to:<br>\$32 for single vision<br>\$46 for bifocal<br>\$57 for trifocal                | \$10 copay   | Plan pays up to:<br>\$32 for single vision<br>\$46 for bifocal<br>\$57 for trifocal                | \$10 copay   | Plan pays up to:<br>\$32 for single vision<br>\$46 for bifocal<br>\$57 for trifocal                | \$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   | 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 ler options that you elect from out-of-network providers, |  |
| Tint (solid and gradient)   | Up to \$15 copay                                       |  | Up to \$15 copay                                       | 1  | Up to \$15 copay                                       | 1   |  |
| Standard Scratch Resistance   | 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   |  |
| Standard Polycarbonate  | \$0 copay  | ]  | \$0 copay  |  | \$0 copay  | 1  | \$0 copay  |  | \$0 copay  | ]  | \$0 copay  | 1   |  |
| Standard Anti-Reflective Coating  | Up to \$45 copay                                       |  | Up to \$45 copay                                       |  | Up to \$45 copay                                       | ]  | Up to \$45 copay                                       |  | Up to \$45 copay                                       | 1  | Up to \$45 copay                                       | ]   |  |
| Disposable  | 20% off retail price                                   |  | 20% off retail price                                   |  | 20% off retail price                                   | ]  | 20% off retail price                                   |  | 20% off retail price                                   | 1  | 20% off retail price                                   | ]   |  |
| Frames (eligible once every calendar<br>year)                           | \$200 allowance, 20% off balance over \$200            | Plan pays up to \$47   | \$200 allowance, 20%<br>off balance<br>over \$200      | Plan pays up to \$47   | \$200 allowance, 20%<br>off balance<br>over \$200      | Plan pays up to \$47   | \$200 allowance, 20%<br>off balance<br>over \$200      | Plan pays up to \$47   | \$200 allowance, 20%<br>off balance<br>over \$200      | Plan pays up to \$47   | \$200 allowance, 20%<br>off balance<br>over \$200      | Plan pays up to \$47  |  |
| Contact Lenses (eligible once every c                                   | alendar year)  |  |  |  |  |  |  |  |  |  |  |   |  |
| Conventional  | \$200 allowance, 15%<br>off balance<br>over \$200      | Plan pays up to \$100  | \$200 allowance, 15%<br>off balance<br>over \$200      | Plan pays up to \$100  | \$200 allowance, 15% off balance over \$200            | Plan pays up to \$100  | \$200 allowance, 15%<br>off balance<br>over \$200      | Plan pays up to \$100  | \$200 allowance, 15%<br>off balance<br>over \$200      | Plan pays up to \$100  | \$200 allowance, 15%<br>off balance<br>over \$200      | Plan pays up to \$100   |  |
| Disposable  | \$200 allowance, then<br>you pay balance over<br>\$200 | Plan pays up to \$100  | \$200 allowance, then<br>you pay balance over<br>\$200 | Plan pays up to \$100  | \$200 allowance, then<br>you pay balance over<br>\$200 | Plan pays up to \$100  | \$200 allowance, then<br>you pay balance over<br>\$200 | Plan pays up to \$100  | \$200 allowance, then<br>you pay balance over<br>\$200 | Plan pays up to \$100  | \$200 allowance, then<br>you pay balance over<br>\$200 | Plan pays up to \$100   |  |



|   | Dental Benefits  Delta Dental                  |                                    |  |   |  |   |   |  |  |  |  |  |  |
|---|--|------------------------------------|--|---|--|---|---|--|--|--|--|--|--|
| 1107 - Diocese of Central Gulf  |  |                                    |  |   |  |   |   |  |  |  |  |  |  |
| Coast   |  | Basic PPO Plan                     |  | C   | Comprehensive PPO PI   | lan   | Premium 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 /<br>\$0 per family             | \$0 per person /<br>\$0 per family | \$0 per person /<br>\$0 per family   | \$0 per person /<br>\$0 per family  | \$0 per person /<br>\$0 per family   | \$100 per person /<br>\$300 per family  | \$0 per person /<br>\$0 per family  | \$0 per person /<br>\$0 per family   | \$50 per person /<br>\$150 per family  |  |  |  |  |
| Annual Benefit Maximum (Plan maximums cross-accumulate between the PPO Network, Premier Network, and out-of-network dentists) | \$2,000  | \$1,500                            | \$1,000  | \$2,500   | \$2,000  | \$1,500   | \$3,000   | \$2,500  | \$2,000  |  |  |  |  |
| Diagnostic and Preventive<br>Services<br>(e.g., exams, cleanings, x-rays,<br>sealants and space maintainers)                  | You pay \$0 (not subject to annual deductible) |                                    | You pay \$0 (not<br>subject to annual<br>deductible) plus any<br>balance billing | You pay \$0 (not subject to annual deductible)                                      |  | You pay \$0 (not<br>subject to annual<br>deductible) plus any<br>balance billing  | You pay \$0 (not subject to annual deductible)                                      |  | You pay \$0 (not<br>subject to annual<br>deductible) plus any<br>balance billing   |  |  |  |  |
| Basic Services (Includes fillings, simple extractions, root canals, oral surgery, and denture reline/repair/rebase)           | You pay 20% coinsurance                        | You pay 20%<br>coinsurance         | You pay 30%<br>coinsurance plus any<br>balance billing                           | You pay 15%<br>coinsurance  | You pay 15%<br>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   |  |  |  |  |
| Major Services<br>(Includes crowns, bridges, and<br>dentures)   | You pay 60%<br>coinsurance                     | You pay 60% coinsurance            | You pay 99%<br>coinsurance plus any<br>balance billing                           | You pay 50%<br>coinsurance  | You pay 50%<br>coinsurance   | You pay 60%<br>coinsurance plus any<br>balance billing  | You pay 15%<br>coinsurance  | You pay 15%<br>coinsurance   | You pay 25%<br>coinsurance plus any<br>balance billing   |  |  |  |  |
| Orthodontic Services  | Not covered. You pay 100%.                     | Not covered. You pay 100%.         | Not covered. You pay 100%.   | You pay 50%<br>coinsurance up to<br>individual lifetime<br>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 | You pay 50%<br>coinsurance up to<br>individual lifetime<br>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 plus any balance billing |  |  |  |  |

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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.