

2026 Medical Trust Health Plan 0114 - Diocese of Chicago	Anthem BCBS BlueCard PPO 80		Anthem BCBS BlueCard PPO 70		Anthem BCBS CDHP 20/HSA	
	Network	Out-of-Network	Network	Out-of-Network	Network	Out-of-Network
Annual Deductible (CDHPs have a combined medical & Rx deductible)	\$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	\$3,300 per person \$6,600 per family	\$3,300 per person \$6,600 per family
Annual Out-of-Pocket Limit	\$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	\$4,200 per person \$8,450 per family	\$7,000 per person \$13,000 per family
Preventive Care						
Preventive Services & Well-Child Care	\$0 copay	50% coinsurance	\$0 copay	50% coinsurance	\$0 copay	45% coinsurance
Physician Services						
Office Visit	\$30 copay	50% coinsurance	\$30 copay	50% coinsurance	20% coinsurance	45% coinsurance
Hospital Services						
Inpatient Services (including inpatient maternity services)	20% coinsurance	50% coinsurance	30% coinsurance	50% coinsurance	20% coinsurance	45% coinsurance
Outpatient Surgery	20% coinsurance	50% coinsurance	30% coinsurance	50% coinsurance	20% coinsurance	45% coinsurance
Emergency Room Care	\$250 copay	\$250 copay	\$250 copay	\$250 copay	20% coinsurance	20% coinsurance
Ambulance Services	20% coinsurance	20% coinsurance	30% coinsurance	30% coinsurance	20% coinsurance	20% coinsurance
Behavioral Health						
Outpatient Services	\$30 copay	30% coinsurance	\$30 copay	30% coinsurance	20% coinsurance	45% coinsurance
Inpatient Services	20% coinsurance	50% coinsurance	30% coinsurance	50% coinsurance	20% coinsurance	45% coinsurance
Other Medical Services						
Durable Medical Equipment	20% coinsurance	50% coinsurance	30% coinsurance	50% coinsurance	20% coinsurance	45% coinsurance
Home Health Care (210 visits per calendar year, combined network and out-of-network)	20% coinsurance	50% coinsurance	30% coinsurance	50% coinsurance	20% coinsurance	45% coinsurance
Outpatient Therapy (60 visits per calendar year per each type of therapy, combined network and out-of-network)	\$30 copay PCP/\$45 copay specialist (includes speech, physical, and occupational)	50% coinsurance (includes speech, physical, and occupational)	\$30 copay PCP/\$45 copay specialist (includes speech, physical, and occupational)	50% coinsurance (includes speech, physical, and occupational)	20% coinsurance (includes speech, physical, and occupational)	45% coinsurance (includes speech, physical, and occupational)
Skilled Nursing / Acute Rehabilitation Facility (60 days per calendar year, combined network and out-of-network)	20% coinsurance	50% coinsurance	30% coinsurance	50% coinsurance	20% coinsurance	45% coinsurance

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Urgent Care Services	\$50 copay	\$50 copay	\$50 copay	\$50 copay	20% coinsurance	20% coinsurance

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	Pharmacy Benefits Administered by Express Scripts		Pharmacy Benefits Administered by Express Scripts		Pharmacy Benefits Administered by Express Scripts	
Prescription Drug Benefits	Retail	Home Delivery	Retail	Home Delivery	Retail	Home Delivery
Annual Prescription Deductible (In-network)	None	None	None	None	\$3,300 per person \$6,600 per family (combined with medical deductible)	\$3,300 per person \$6,600 per family (combined with medical deductible)
Tier 1: Generic	Up to a \$5 copay	Up to a \$12 copay	Up to a \$5 copay	Up to a \$12 copay	You pay 15% after deductible	You pay 15% after deductible
Tier 2: Preferred Brand Name	Up to a \$35 copay	Up to a \$87 copay	Up to a \$35 copay	Up to a \$87 copay	You pay 25% after deductible	You pay 25% after deductible
Tier 3: Non-Preferred Brand Name	Up to a \$70 copay	Up to a \$175 copay	Up to a \$70 copay	Up to a \$175 copay	You pay 50% after deductible	You pay 50% after deductible
Tier 4: Specialty Rx	Up to a \$90 copay	Up to a \$225 copay	Up to a \$90 copay	Up to a \$225 copay	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 (retail) or 90-day supply (mail order)	Up to a 30-day supply (retail) or 90-day supply (mail order)

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	Vision Benefits Administered by EyeMed		Vision Benefits Administered by EyeMed		Vision Benefits Administered by EyeMed	
Vision Benefits	Network	Out-of-Network	Network	Out-of-Network	Network	Out-of-Network
Eye Examinations	\$0 copay	Plan pays up to \$30 for ophthalmologists or optometrists	\$0 copay	Plan pays up to \$30 for ophthalmologists or optometrists	\$0 copay	Plan pays up to \$30 for ophthalmologists or optometrists
Lenses (eligible once every calendar year)	\$10 copay	Plan pays up to: \$32 for single vision \$46 for bifocal \$57 for trifocal	\$10 copay	Plan pays up to: \$32 for single vision \$46 for bifocal \$57 for trifocal	\$10 copay	Plan pays up to: \$32 for single vision \$46 for bifocal \$57 for trifocal
Lens Options						
Standard progressive (add-on to bifocal)	Up to \$75 copay	Plan pays up to \$46	Up to \$75 copay	Plan pays up to \$46	Up to \$75 copay	Plan pays up to \$46
UV Coating	Up to \$15 copay	You are responsible for the cost of any lens options that you elect from out-of-network providers,	Up to \$15 copay	You are responsible for the cost of any lens options that you elect from out-of-network providers,	Up to \$15 copay	You are responsible for the cost of any lens options that you elect from out-of-network providers,
Tint (solid and gradient)	Up to \$15 copay		Up to \$15 copay		Up to \$15 copay	
Standard Scratch Resistance	Up to \$15 copay		Up to \$15 copay		Up to \$15 copay	
Standard Polycarbonate	\$0 copay		\$0 copay		\$0 copay	
Standard Anti-Reflective Coating	Up to \$45 copay		Up to \$45 copay		Up to \$45 copay	
Disposable	20% off retail price		20% off retail price		20% off retail price	
Frames (eligible once every calendar year)	\$200 allowance, 20% off balance over \$200	Plan pays up to \$47	\$200 allowance, 20% off balance over \$200	Plan pays up to \$47	\$200 allowance, 20% off balance over \$200	Plan pays up to \$47
Contact Lenses (eligible once every calendar year)						
Conventional	\$200 allowance, 15% off balance over \$200	Plan pays up to \$100	\$200 allowance, 15% off balance over \$200	Plan pays up to \$100	\$200 allowance, 15% off balance over \$200	Plan pays up to \$100
Disposable	\$200 allowance, then you pay balance over \$200	Plan pays up to \$100	\$200 allowance, then you pay balance over \$200	Plan pays up to \$100	\$200 allowance, then you pay balance over \$200	Plan pays up to \$100

0114 - Diocese of Chicago	Delta Dental								
	Basic PPO Plan			Comprehensive PPO Plan			Premium PPO Plan		
	<i>PPO Network</i>	<i>Premier Network</i>	<i>Out-of-Network</i>	<i>PPO Network</i>	<i>Premier Network</i>	<i>Out-of-Network</i>	<i>PPO Network</i>	<i>Premier Network</i>	<i>Out-of-Network</i>
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 <i>(Maximum cross applies across networks)</i>	\$2,000	\$1,500	\$1,000	\$2,500	\$2,000	\$1,500	\$3,000	\$2,500	\$2,000
Diagnostic and Preventive Services <i>(e.g., exams, cleanings, x-rays, sealants and space maintainers)</i>	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 <i>(Includes fillings, simple extractions, root canals, oral surgery, and denture relines/repair/rebase)</i>	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 <i>(Includes crowns, bridges, and dentures)</i>	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

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