2025 Medicel Trust Heelth Plan	BlueCard PPO 100		Anthem BCIBS BlueCard PPO 80				Anthem BCBS CDHP 15/HSA			hem BOBS IP 20/HSA		Olgna OAP PPO 100		Cigna OAP PPO 90		gna OAP PO 80	Cigna CDHP 15/HSA		Cigna CDHP 20/HSA	
1013 - Diocese of West Missouri																				
	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	\$1,650 per person \$3,300 per family (deductible is non- embedded)	\$3,300 per person \$6,600 per family (deductible is non- embedded)	\$3,300 per person \$6,600 per family	\$3,300 per person \$6,600 per family	\$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	\$1,650 per person \$3,300 per family (deductible is non- embedded)	\$3,300 per person \$6,600 per family (deductible is non- embedded)	\$3,300 per person \$6,600 per family	\$3,300 per person \$6,600 per family
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 farrily	\$2,400 per person \$4,800 per family (out of-pocket limit is non- embedded)	\$4,800 per person - \$9,600 per family (ou of-pocket limit is non- embedded)	\$4,200 per person - \$8,450 per family	\$7,000 per person \$13,000 per family	\$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	\$2,400 per person \$4,800 per family (out of-pocket limit is non- embedded)	\$4,800 per person \$9,600 per family (ou of-pocket limit is non- embedded)	\$4,200 per person - \$8,450 per family	\$7,000 per person \$13,000 per family
Preventive Care																				
Preventive Services & Well-Child Care Physician Services	\$0 copay	50% coinsurance	\$0 copay	50% coinsurance	\$0 copay	50% coinsurance	\$0 copay	40% coinsurance	\$0 copay	45% coinsurance	\$0 copay	50% coinsurance	\$0 copay	50% coinsurance	\$0 copay	50% coinsurance	\$0 copay	40% coinsurance	\$0 copay	45% coinsurance
Office Visit	\$30 copay	50% coinsurance	\$30 copay	50% coinsurance	\$30 copay	50% coinsurance	15% coinsurance	40% coinsurance	20% coinsurance	45% coinsurance	\$30 copay	50% coinsurance	\$30 copay	50% coinsurance	\$30 copay	50% coinsurance	15% coinsurance	40% coinsurance	20% coinsurance	45% coinsurance
Hospital Services																				
Inpatient Services (including inpatient maternity services)	\$250 copay	50% coinsurance	10% coinsurance	50% coinsurance	20% coinsurance	50% coinsurance	15% coinsurance	40% coinsurance	20% coinsurance	45% coinsurance	\$250 copay	50% coinsurance	10% coinsurance	50% coinsurance	20% coinsurance	50% coinsurance	15% coinsurance	40% coinsurance	20% coinsurance	45% coinsurance
Outpatient Surgery	\$200 copay	50% coinsurance	10% coinsurance	50% coinsurance	20% coinsurance	50% coinsurance	15% coinsurance	40% coinsurance	20% coinsurance	45% coinsurance	\$200 copay	50% coinsurance	10% coinsurance	60% coinsurance	20% coinsurance	50% coinsurance	15% coinsurance	40% coinsurance	20% coinsurance	45% coinsurance
Emergency Room Care	\$250 copay	\$250 copay	\$250 copay	\$250 copay	\$250 copay	\$250 copay	15% coinsurance	15% coinsurance	20% coinsurance	20% coinsurance	\$250 copay	\$250 copay	\$250 copay	\$250 copay	\$250 copay	\$250 copay	15% coinsurance	15% coinsurance	20% coinsurance	20% coinsurance
Ambulance Services	\$0 copay	\$0 copay	10% coinsurance	10% coinsurance	20% coinsurance	20% coinsurance	15% coinsurance	15% coinsurance	20% coinsurance	20% coinsurance	\$0 copay	\$0 copay	10% coinsurance	10% coinsurance	20% coinsurance	20% coinsurance	15% coinsurance	15% coinsurance	20% coinsurance	20% coinsurance
Behavioral Heelth																				
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	15% coinsurance 15% coinsurance	40% coinsurance 40% coinsurance	20% coinsurance 20% coinsurance	45% coinsurance 45% coinsurance	\$0 copay \$250 copay	30% coinsurance 50% coinsurance	\$30 copay 10% coinsurance	30% coinsurance 50% coinsurance	\$30 copay 20% coinsurance	30% coinsurance 50% coinsurance	15% coinsurance 15% coinsurance	40% coinsurance 40% coinsurance	20% coinsurance 20% coinsurance	45% coinsurance 45% coinsurance
Other Medical Services	azoo copay	50% COTISURATE	10% COnstraine	50% consulance	20% consulate	50% comparate	10% comparative	40% 001150/a/i08	20% 00150/2108	40% CONSUMICE	\$200 COpay	50% consulate	T0 % COILEGRANCE	50% consulated	20% 00150/a/08	50% COllisorance	10% consulation	40% consulate	20% 000501801800	40% collisidade
Durable Medical Equipment	\$0 copay	50% coinsurance	10% coinsurance	50% coinsurance	20% coinsurance	50% coinsurance	15% coinsurance	40% coinsurance	20% coinsurance	45% coinsurance	\$0 copay	50% coinsurance	10% coinsurance	50% coinsurance	20% coinsurance	50% coinsurance	15% coinsurance	40% coinsurance	20% coinsurance	45% coinsurance
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	15% coinsurance	40% coinsurance	20% coinsurance	45% coinsurance	\$0 copay	50% coinsurance	10% coinsurance	50% coinsurance	20% coinsurance	50% coinsurance	15% coinsurance	40% 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 (ncludes speech, physical, and	50% coinsurance (includes speech, physical, and occupational)	\$30 copay PCP/\$45 copay specialist (includes speech, physical, and	50% coinsurance (includes speech, physical, and occupational)	\$30 copay PCP)\$45 copay specialist (includes speech, physical, and	50% coinsurance (includes speech, physical, and occupational)	15% coinsurance (ncludes speech, physical, and occupational)	40% coinsurance (ncludes speech, physical, and occupational)	20% coinsurance (noludes speech, physical, and occupational)	45% coinsurance (includes speech, physical, and occupational)	\$30 copay PCP/\$45 copay specialist (includes speech, physical, and	50% coinsurance (includes speech, physical, and occupational)	\$30 copay PCP/\$45 copay specialist (includes speech, physical, and	50% coinsurance (includes speech, physical, and occupational)	\$30 copay PCP/\$45 copay specialist (includes speech, physical, and	50% coinsurance (includes speech, physical, and occupational)	15% coinsurance (includes speech, physical, and occupational)	40% 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)	\$0 copay	50% coinsurance	10% consurance	50% coinsurance	20% coinsurance	50% coinsurance	15% coinsurance	40% coinsurance	20% coinsurance	45% coinsurance	\$0 copay	50% coinsurance	10% coinsurance	50% coinsurance	20% coinsurance	50% coinsurance	15% coinsurance	40% coinsurance	20% coinsurance	45% coinsurance
Urgent Care Services	\$50 copay	\$50 copay	\$50 copay	\$50 copay	\$50 copay	\$50 copay	15% coinsurance	15% coinsurance	20% coinsurance	20% coinsurance	\$50 copay	\$50 copay	\$50 copay	\$50 copay	\$50 copay	\$50 copay	15% coinsurance	15% coinsurance	20% coinsurance	20% coinsurance

2025 Medical Trust Health Plan 1019 - Diocese of West Missouri				m BCBS rd PPO 90		em BCBS ard PPO 80		Nem BCBS IP 15/HSA		m BCBS 20/HSA		Na OAP O 100		14. OAP 10 90		ina OAP PO 80	CDHP	igna 15/HSA		kgna 20/HBA
	8	oripte	Phermecy Benefits A	alote	6	icripte		Administered by Express Scripts	8	atote	5	oripte	5	oripte		Soripte	5	siple		oripte
Prescription Drug Benefits	Retail	Home Delivery	Retail	Home Delivery	Retail	Home Delivery	Retai	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	None	\$1,650 per person \$3,300 per family (combined with medica deductible) (non-embedded	deductible) (non-embedded	\$3,300 per person \$6,600 per family (combined with medical deductible)	\$3,300 per person \$6,600 per family (combined with medical deductible)	None	None	None	None	None	None	\$1,650 per person \$3,300 per family (combined with medical deductible) (non-embedded	\$1,650 per person \$3,300 per family (combined with medical deductible) (non-embedded	\$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: Generio	Up to a \$5 copay	Up to a \$5 copay	Up to a \$5 copay	Up to a \$6 copay	Up to a \$5 copay	Up to a \$5 copay	deductible) You pay 15% after deductible	deductible) You pay 15% after deductible	You pay 15% after deductible	You pay 15% after deductible	Up to a \$5 copay	Up to a \$6 copay	Up to a \$5 copay	deductible You pay 15% after deductible	deductible You pay 15% after deductible	You pay 15% after deductible	You pay 15% after deductible			
Ther 2: Preferred Brand Name	Up to a \$35 copay	You pay 25% after deductible	You pay 25% after deductible	You pay 25% after deductible	You pay 25% after deductible	Up to a \$35 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	Up to a \$70 copay	You pay 50% after deductible	You pay 50% after deductible	You pay 50% after deductible	You pay 50% after deductible	Up to a \$70 copay	You pay 50% after deductible	You pay 50% after deductible	You pay 50% after deductible	You pay 50% after deductible										
Ther 4: Speciality Rx	Up to a \$90 copay	You pay 50% after deductible	You pay 50% after deductible	You pay 50% after deductible	You pay 50% after deductible	Up to a \$90 copay	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 30-day suppl (retail) or	y Up to a 30-day supply (retail) or	Up to a 30-day supply (retail) or	Up to a 30-day supply (retail) or	Up to a 30-day supply	Up to a 30-day supply (retail) or	Up to a 30-day supply (retail) or	Up to a 30-day supply (retail) or	Up to a 30-day supply (retail) or										

2025 Medical Trust Health Plan		m BCBS d PPO 100		m BCBS d PPO 90		m BCBS rd PPO 80		m BOBS 15/HBA		em BOBS P 20/HSA		NA CAP C 100		& OAP O 90		na OAP PO 80	Cigne. CDHP 15/HSA		Cigna CDHP 20/HSA	
1013 - Diocess of West Missouri																				
	Vision Benefits Ad	ministered by EyeMed	Vision Benefits Adr	ministered by EyeMed	Vision Benefits Ad	ministered by EyeMed	Vision Benefits Adi	ministered by EyeMed	Vision Benefits A	iministered by EyeMed	Vision Benefits Ac	ministered by EyeMed	Vision Benefits Ad	ministered by EyeMed	Vision Benefits Ac	iminialared by EyeMed	Vision Benefits A	dministered by EyeMed	Vision Benefits Ad	ministered by EyeMed
Vision Benefits	Network	Out-of-Network																		
Eye Examinations	\$0 сорау	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	\$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	s0 copay	Plan pays up to \$30 fo 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	\$0 copay	Plan pays up to \$30 for ophthalmologists or optometrists
Lenses (eligible once every calendar year)	\$10 copay	Plan pays up to: \$32 for single vision \$46 for bifocal \$57 for trifocal	\$10 copay	Plan pays up to: \$32 for single vision \$46 for bifocal \$57 for trifocal	\$10 copay	Plan pays up to: \$32 for single vision \$46 for bifocal \$57 for trifocal	\$10 copay	Plan pays up to: \$32 for single vision \$46 for bifocal \$57 for trifocal	\$10 copay	Plan pays up to: \$32 for single vision \$46 for bifocal \$57 for trifocal	\$10 copay	Plan pays up to: \$32 for single vision \$46 for bifocal \$57 for trifocal	\$10 copay	Plan pays up to: \$32 for single vision \$46 for bifocal \$57 for trifocal	\$10 copay	Plan pays up to: \$32 for single vision \$46 for bifocal \$57 for trifocal	\$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 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,	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	1	Up to \$15 copay	1	Up to \$15 copay		Up to \$15 copay	1	Up to \$15 copay		Up to \$15 copay		Up to \$15 copay		Up to \$15 copay	-	Up to \$15 copay		Up to \$15 copay	
Standard Scratch Resistance	Up to \$15 copay	1	Up to \$15 copay		Up to \$15 copay	-	Up to \$15 copay		Up to \$15 copay											
Standard Polycarbonate	\$0 copay	1	\$0 copay																	
	Up to \$45 copay		Up to \$45 copay		Up to \$45 copay		Up to \$45 copay		Up to \$45 copay		Up to \$45 copay		Up to \$45 copay		Up to \$45 copay		Up to \$45 copay		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	\$200 allowance, 20% off balance over \$200	Plan pays up to \$47	\$200 allowance, 20% off balance over \$200	Plan pays up to \$47	\$200 allowance, 20% off balance over \$200	Plan pays up to \$47	\$200 allowance, 20% off balance over \$200	Plan pays up to \$47	\$200 allowance, 20% off balance over \$200	Plan pays up to \$47	\$200 allowance, 20% off balance over \$200	Plan pays up to \$47	\$200 allowance, 20% off balance over \$200	Plan pays up to \$47	\$200 allowance, 20% off balance over \$200	Plan pays up to \$47	\$200 allowance, 20% off balance over \$200	Plan pays up to \$47
Contact Lenses (eligible once every calen	ider yeer)																			
	off balance over \$200		off balance		off balance		\$200 allowance, 15% off balance over \$200		off balance	Plan pays up to \$100	off balance over \$200		\$200 allowance, 15% off balance over \$200		off balance over \$200	Plan pays up to \$100	off balance	Plan pays up to \$100	off balance	Plan pays up to \$100
	\$200 allowance, then you pay balance over \$200	Plan pays up to \$100	\$200 allowance, then you pay balance over \$200	Plan pays up to \$100	\$200 allowance, then you pay balance over \$200	Plan pays up to \$100	\$200 allowance, then you pay balance over \$200	Plan pays up to \$100	\$200 allowance, then you pay balance over \$200	Plan pays up to \$100	\$200 allowance, then you pay balance over \$200	Plan pays up to \$100	\$200 allowance, then you pay balance over \$200	Plan pays up to \$100	\$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



			Delta Dental						
1013 - Diocese of West Missouri		Basic PPO Plan			Comprehensive PPO Plan			Premlum 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	\$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 (Maxmium cross applies across networks)	\$2,	000 \$1,50	0 \$1,000	\$2,500	\$2,000	\$1,500	\$3,000	\$2,500	\$2,000
Diagnostic and Preventive Services (e.g., exams, cleanings, x-rays, sealants and space maintainers)		You pay \$0 (not subject to annual deduct	Die)		You pay \$0 (not subject to annual deduc	tible)		fou pay \$0 (not subject to annual dedu	ctible)
Basic Services (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 (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
	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	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	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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