



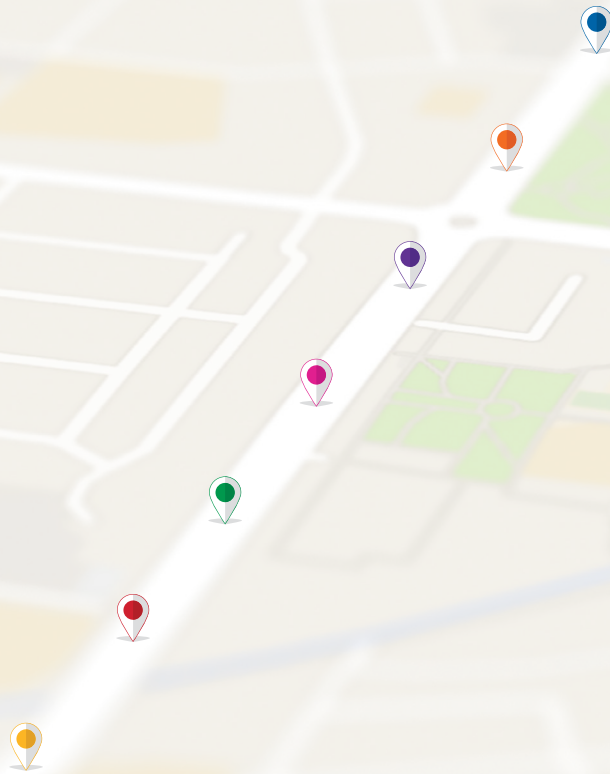
EPISCOPAL CHURCH  
MEDICAL TRUST

Annual  
Enrollment



2023 Guide

Planning Your Journey



CHURCH  
PENSION GROUP

Passionate About Our Purpose



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## Your Guide to Annual Enrollment

The Episcopal Church Medical Trust (Medical Trust) benefits are part of the journey to your overall well-being, ensuring that you have access to quality care. Use this guide to learn about the types of Medical Trust benefits available to you, key considerations when making your choices, and how to enroll. You can find additional resources and benefit details on [cpg.org](https://cpg.org).<sup>1</sup>

Since the benefit decisions you make may affect your whole family, please share Annual Enrollment information with other decision-makers in your household.



### What You Need to Know

- Look for a green envelope in the mail this fall. This will include a letter with important information for Annual Enrollment. Save this letter! It includes your **Client ID number**, which you will need to access the Annual Enrollment website.
- Some plans described in this guide may not be available in all locations or to all groups or dioceses. You will see which plans are available to you when you log on to the Annual Enrollment website.
- Coverage tiers, which range from single to family coverage, will depend on what is offered by your group or diocese. Please see your online enrollment form for the coverage tiers available to you. **The rates indicated on your online enrollment form may not necessarily be what your employer requires you to pay.**
- Please see your group administrator if you need to confirm your eligibility for benefits or that of a dependent.
- If you do not make changes or enroll by the deadline, your current benefits will continue and any rate changes will apply. **If your current health plan is not offered in 2023, you must select another plan in order to have medical benefits in 2023.**

### Glossary of Defined Terms

Please see the Uniform Glossary at [cpg.org/uniform-glossary](https://cpg.org/uniform-glossary) for the definitions of the following commonly used terms: *contributions, coinsurance, copayments, cost sharing, deductible, emergency medical conditions, health insurance, hospitalization, network, network provider, out-of-network provider, plan, prescription drug, and primary care physician.*

<sup>1</sup> Health plan benefit design information does not apply to fully insured plans (Hawaii Medical Service Association and Kaiser Permanente Washington) offered on a regional basis to select Participating Groups by the Medical Trust.



## Selecting Your 2023 Benefits

Annual Enrollment for 2023 Medical Trust active health benefits begins in October 2022. This is your opportunity to review and make changes to your Medical Trust benefits and to add or drop coverage for eligible dependents for the upcoming plan year. Be sure to take the time to review your options. You cannot make changes until the next Annual Enrollment period, unless you have a qualified Significant Life Event (as defined in the Plan Document Handbook), such as the birth of a child, marriage, or divorce.

Even if you do not plan to make any changes to your health benefits, it's a good idea to log in to your account and review your personal and dependent information, and make any necessary updates.

### Changes for 2023

#### *Prescription drug plan member cost sharing updates*

Effective January 1, 2023, the Medical Trust's prescription drug plan cost sharing will be updated for members. The updated prescription drug plan includes the following changes:

- The Standard Rx option will be coinsurance-based (vs. copays) with maximum amounts to protect members from excessive costs and minimums to drive plan savings.
- The Premium Rx option will continue to be based on copays; however, copay amounts for non-generic drugs will increase.
- All plan designs will add a new cost-sharing tier for Specialty drugs.

#### **Express Scripts (for Anthem & Cigna members)**

Depending on whether your employer group selects the Standard Rx or Premium Rx option, members enrolled in an Anthem or Cigna PPO plan will have the following cost sharing for prescription drug benefits:

<b>Standard Rx</b>	<b>Retail</b>	<b>Home Delivery</b>
Annual deductible (in-network)	None	None
Generic	Up to \$10 copay	Up to \$25 copay
Preferred brand name	25%; up to \$40 min and \$80 max	25%; up to \$100 min and \$200 max
Non-preferred brand name	40%; up to \$80 min and \$160 max	40%; up to \$200 min and \$400 max
Specialty	40%; up to \$100 min and \$200 max	40%; up to \$250 min and \$500 max
Dispensing limits	Up to 30-day supply copay	Up to 90-day supply copay

**Notes:**

- Anthem and Cigna Consumer-Directed Health Plan (CDHP) members will continue to have coinsurance-based prescription drug plan cost sharing with a combined medical and pharmacy deductible. Anthem and Cigna CDHPs will also introduce a Specialty Rx tier with 50% coinsurance after deductible.
- The Express Scripts prescription drug program will continue to maintain a retail refill limit policy. The retail refill limit requires that you use home delivery if you are prescribed a maintenance medication, rather than refilling multiple prescriptions for the same drug at a retail pharmacy. See the Plan Document Handbook for more information.

**Kaiser Permanente**

Members enrolled in the Kaiser Permanente EPO High and the Kaiser Permanente EPO 80 plans will have the following cost sharing for prescription drug benefits:

<b>Standard Rx</b>	<b>Retail</b>	<b>Home Delivery</b>
Annual deductible (in-network)	None	None
Generic	Up to \$5 copay	Up to \$5 for a 30-day supply or \$10 for a 90-day supply
Preferred brand name	Up to \$30 copay	Up to \$30 for a 30-day supply or \$60 for a 90-day supply
Non-preferred brand name	Up to \$70 copay	Up to \$70 for a 30-day supply or \$140 for a 90-day supply
Specialty	Up to \$90 copay	Up to \$90 for a 30-day supply or \$180 for a 90-day supply
Dispensing limits	Up to 30-day supply	Up to 90-day supply

**Note:** Kaiser CDHP members will continue to have coinsurance-based prescription drug plan cost sharing with a combined medical and pharmacy deductible. Kaiser CDHPs will also introduce a Specialty Rx tier of 50% coinsurance after deductible.

*Medical channel management for Anthem and Cigna plans*

Specialty medications are drugs that are used to treat complex conditions and illnesses, such as cancer, growth hormone deficiency, hemophilia, hepatitis C, immune deficiency, multiple sclerosis, and rheumatoid arthritis. These drugs usually require special handling, special administration, or intensive patient monitoring. Medications used to treat diabetes are not considered specialty medications. Whether they are administered by a healthcare professional, self-injected, or taken by mouth, specialty medications require an enhanced level of service.

The Medical Trust’s prescription drug program requires that certain specialty medications be accessed through Accredo Health Group, Inc., an Express Scripts specialty pharmacy, effective January 1, 2023. If a member is currently using such specialty medications through their medical benefit (i.e., through Anthem or Cigna), the member will be required to transfer those prescriptions to Accredo.

The list of medications subject to the program is available by calling Express Scripts at (800) 841-3361.

## *COVID-19 provisions*

The Medical Trust will continue to waive all copays, deductibles, and coinsurance for its members for healthcare services relating to the evaluation and testing for COVID-19 through at least December 31, 2023. In addition, the Medical Trust also will waive all copays, deductibles, and in-network coinsurance for its active members for healthcare services relating to the treatment of COVID-19 through at least December 31, 2023.<sup>2</sup>

## *Telehealth*

**Telehealth platforms for Active Members<sup>3</sup>**– You can access a medical professional through telehealth platforms offered by Anthem, Cigna, or Kaiser using your computer or mobile device. You will need high-speed internet access, a webcam or built-in camera, and audio capability. Please remember your personal healthcare provider may not participate on the vendor's telehealth platform.

For Anthem and Cigna PPO members and Kaiser EPO members, all services received via vendor telehealth platforms are available to you with no deductible, copay, or coinsurance through December 31, 2023. For CDHP members, while temporary legislation currently permits the Medical Trust to provide you with first-dollar coverage of vendor telehealth platform services, there is no guarantee that this relief will be extended beyond December 31, 2022. If Congress does not extend this relief, during 2023, you will be required to meet your deductible before carrier telehealth services will be covered with no copay or coinsurance.

- **Anthem Blue Cross Blue Shield** – Access [LiveHealthOnline.com](https://www.livehealthonline.com) or download the LiveHealth Online mobile app in the App Store® or Google Play™.
- **Cigna** – Access [MDLiveforCigna.com](https://www.mdliveforcigna.com) on your computer or download the MDLIVE mobile app by searching in the App Store® or Google Play™.
- **Kaiser Permanente** – Access Kaiser's telehealth platform services by calling the number on the back of your member ID card.

## *Virtual visits*

A virtual visit is an appointment with your personal healthcare provider carried out through an electronic medium of your provider's choice (e.g., Zoom, Skype, telephonic) but that is not offered through your health plan carrier's telehealth platform (e.g., Anthem LiveHealth Online, Cigna MDLive).

The Medical Trust will continue to allow claims for virtual visits with network and out-of-network providers that do not use a telehealth platform offered by Anthem or Cigna through December 31, 2023.

Virtual visits are covered at standard levels of benefits and member cost shares.

**Note:** Kaiser's healthcare model requires its members to use the Kaiser telehealth platform for telehealth services.

## *Hinge Health for Anthem and Cigna plans*

Hinge Health is available at no cost to Anthem and Cigna members effective October 1, 2022. Through the Hinge Health Digital Musculoskeletal (MSK) Clinic, participants have access to personalized MSK care programs depending on their specific MSK needs.

<sup>2</sup> This deductible waiver includes our HSA-qualified CDHPs as permitted by [IRS Notice 2020-15](#).

<sup>3</sup> Please note, telehealth can help with minor, non-life-threatening conditions. During a medical emergency, individuals should visit the nearest hospital or call 911 for assistance.

- **Prevention** – Program designed to increase education with regard to key strengthening and stretching activities around healthy habits. The Prevention program is software based and offered through the Hinge Health app.
- **Chronic** – Program designed to address long-term back and joint pain. It includes personalized app-guided exercise therapy sessions, one-on-one access to a personalized health coach, personalized education content, and behavioral health support. Participants in the chronic program may also be offered access to virtual sessions with a licensed physical therapist and/or the non-invasive ENSO High Frequency Impulse Therapy™ pain management device and service, as appropriate, for symptomatic relief.
- **Acute** – Program designed to address recent injuries. It includes live virtual sessions with a dedicated licensed physical therapist along with software-guided rehabilitation and education.
- **Surgery** – Program designed to address pre/post-surgery rehab for the most common MSK Surgeries. It includes personalized app-guided exercise therapy sessions, 1:1 access to a personalized health coach and physical therapist, personalized education content, and behavioral health support.
- **Expert Medical Opinion** – Service offering second opinions for elective MSK procedures.

For applicable programs, a participant may obtain up to six virtual physical therapy sessions per episode (with no cost share to the member) prior to in-person healthcare provider or physical therapy care.

State laws may limit access without a physician's referral.

To get started with Hinge Health, visit [hingehealth.com/ecmt](https://hingehealth.com/ecmt) to enroll.

If you have any questions regarding Hinge Health, email [help@hingehealth.com](mailto:help@hingehealth.com) or call (855) 902-2777.

*Increased EyeMed frames/contacts allowance*

Vision benefits offered through EyeMed's Insight Network provide coverage for an annual eye exam and cost savings on prescription glasses or contact lenses.

Effective January 1, 2023, the annual frames or contact lenses allowance will increase from \$150 to \$200.

*Fertility benefits*

The Medical Trust's Episcopal Health Plan includes benefits for the diagnosis and treatment of infertility. Covered health services include diagnostic and exploratory procedures to determine whether a member suffers from infertility. Covered fertilization services include artificial insemination, in vitro fertilization, GIFT (gamete intra-fallopian transfer), and ZIFT (zygote intra-fallopian transfer) procedures.

Currently, there is a lifetime benefit maximum of \$10,000 for services covered under the medical plan and \$10,000 for services covered under the pharmacy plan.

Effective January 1, 2023, the lifetime benefit maximum will be a combined \$50,000 for medical and pharmacy services.

In addition, the Medical Trust will provide standard fertility preservation services for individuals who must undergo medically necessary treatment that may cause iatrogenic infertility.

**Note:** Member cost shares (copays, coinsurance, and deductibles) apply; however, cost shares do not count against the lifetime benefit maximum.

*Hearing aid device benefits*

The Medical Trust's Episcopal Health Plan includes benefits for hearing aid devices.

Effective January 1, 2023, the benefit maximum for hearing aid devices will be a single \$3,000 maximum every three years. The benefit maximum for hearing aid devices will no longer have a per ear maximum (currently \$1,500 per ear).

**Note:** Member cost shares (copays, coinsurance, and deductibles) apply; however, cost shares do not count against the benefit maximums.

*Travel vaccinations*

Currently, the Medical Trust's Episcopal Health Plan excludes travel vaccines from coverage.

Effective January 1, 2023, the Medical Trust will cover travel vaccines for personal travel. Member cost sharing will follow the benefit plan design for immunizations.

*Deductible increase for Anthem and Cigna CDHP-15*

The Internal Revenue Service increased the minimum and maximum amounts that a high-deductible health plan (HDHP) may impose as a deductible.<sup>4</sup>

For 2023, the minimum amount that must be imposed as a deductible for self-only coverage under an HDHP is \$1,500. The minimum amount that must be imposed as a deductible for family coverage under an HDHP is \$3,000. The amounts for 2022 were \$1,400 and \$2,800, respectively.

Effective January 1, 2023, the Medical Trust's Anthem and Cigna CDHP-15 network deductible for self-only coverage will be \$1,500, and the network deductible for family coverage will be \$3,000. The out-of-network deductible for self-only coverage will be \$3,000, and the out-of-network deductible for family coverage will be \$6,000.

*Deductible increase for Anthem, Cigna, and Kaiser CDHP-20*

The Internal Revenue Service increased the minimum and maximum amounts that a high-deductible health plan (HDHP) may impose as a deductible.<sup>4</sup>

Effective January 1, 2023, the Medical Trust's Anthem, Cigna, and Kaiser CDHP-20 network deductible for self-only coverage will be \$3,000 and the network deductible for family coverage will remain \$5,450. The out-of-network deductible for self-only coverage will remain \$3,000 and the out-of-network deductible for family coverage will remain \$6,000.

<sup>4</sup> See [IRS Notice 2022-24](#).





## Health Plan Options



### Medicare Secondary Payer/ Small Employer Exception

Some groups have chosen to participate in the Episcopal Health Plan for Qualified Small Employer Exception (the SEE Plan). See page 8 for information.

### Preferred Provider Organization (PPO)

All Medical Trust health plans include medical, behavioral, pharmacy, and vision benefits, and provide care through a network of doctors and facilities that have contracted to offer services at reduced rates.

You may choose from the following types of health plans, depending on your group or diocese's offerings and the network access in your area:

- Preferred Provider Organization (PPO)
- Consumer-Directed Health Plan (CDHP)/Health Savings Account (HSA)
- Exclusive Provider Organization (EPO) (regional Kaiser plans only)<sup>5</sup>

You have the flexibility to visit any provider you choose—inside or outside of the plan's network. However, the plan pays greater benefits if you receive care from a network provider or facility.

You are responsible for ensuring that the services and care you receive are covered by your plan. If you use an out-of-network provider, you are often responsible for submitting your own claims and paying the difference between what your provider charges and what the plan covers.

### Consumer-Directed Health Plan/Health Savings Account (CDHP/HSA)

A CDHP is an HSA-qualified plan that works like a PPO. You can receive services from any provider, and you do not have to coordinate your care through a primary care physician (PCP). While the CDHP covers services in and out of the network, it provides strong financial incentives for you to use network providers. Despite the high deductible associated with a CDHP, most preventive care services received from network providers require no member cost share.

When you enroll in the CDHP, you can contribute tax-free to an HSA, which is a savings account for eligible healthcare expenses. Your employer may also contribute. Here's how the HSA works:

- You decide whether you want to contribute and how much, up to IRS maximums. You can change or stop your contributions any time during the year.
- Use the money in your HSA to pay for eligible healthcare expenses, including your annual deductible and medical, prescription, dental, and vision costs.
- You may also save the money in your HSA for future medical costs—including healthcare expenses in retirement.
- Your HSA is portable and will always belong to you, even if you change employers or retire.



### About the CDHP

- The Kaiser CDHP-20/HSA works like an EPO, with no out-of-network benefits except in emergencies.
- You pay the full cost of medical and pharmacy expenses until you meet the annual deductible.

<sup>5</sup> Some fully insured plans offered on a regional basis (Hawaii Medical Service Association and Kaiser Permanente Washington) provide an HMO option.



### To Contribute to an HSA

You must be enrolled in the Consumer-Directed Health Plan and cannot

- be covered by Medicare, TRICARE®, or other medical insurance;
- be claimed as a dependent on someone’s tax return; or
- be covered by your or your spouse’s traditional Flexible Spending Account.

### Exclusive Provider Organization (EPO)—Kaiser

### HSA Tax Advantages

There are several tax advantages when you contribute to an HSA:

1. You do not pay taxes on your contributions.
2. Withdrawals from your HSA are tax-free as long as they are used to pay for qualified medical expenses. Make sure you keep receipts for tax-reporting purposes.
3. You may earn tax-free interest, with certain restrictions, or investment earnings.

If you enroll in the EPO, you agree to use **only** Kaiser’s network of professionals and facilities. Kaiser does not cover the cost of services received from out-of-network providers, except in emergency situations. You are also responsible for ensuring that the services and care you receive are covered by your plan.

With the Kaiser plans, you are required to select a primary care physician (PCP).

### Medicare Secondary Payer/ Small Employer Exception

To participate in this program, you must satisfy all of these criteria:

- Be age 65 or older.
- Actively work for a qualified church or group that offers this choice.
- Be enrolled in Medicare Part A (or Medicare Part A and Part B).
- Choose a participating Anthem or Cigna plan.
- Be approved for the SEE Plan by Medicare.

If you enroll in the SEE Plan, Medicare will be the primary payer for Part A services. This program is also available for those enrolled in Medicare Part A and Part B. Once Medicare has paid its share, Anthem or Cigna pays claims as it would for any active member, minus the amounts paid by Medicare and you. It is anticipated that out-of-pocket costs will be lower for SEE Plan members and that employers may save in the cost of health benefits.

Eligible members approved by Medicare may enroll in the SEE Plan even if they have dependents who are under the age of 65 and do not have Medicare.

Eligible participants will receive details in the mail.

The SEE Plan is not available for members who enroll in a Kaiser plan.



### Summary of Benefits and Coverage

For an overview of benefits for each plan, access the *Summary of Benefits and Coverage* documents at [cpg.org/mtdocs](http://cpg.org/mtdocs). Paper copies are also available, free of charge, by calling (800) 480-9967, Monday to Friday, 8:30 AM to 8:00 PM ET.

## Health Plan Carriers



### Go Digital

No matter which plan you choose, you have online tools at your fingertips. Start by registering on your plan's website:

- Anthem: [anthem.com](https://www.anthem.com)
- Cigna: [mycigna.com](https://www.mycigna.com)
- Kaiser: [kp.org](https://www.kp.org)

After you register, download your plan's app to your mobile device from the App Store® or Google Play™ to find network providers and facilities, check claims status, download your Explanations of Benefits (EOB), find cost share information, and much more.

The Medical Trust offers the health plan options through three health plan carriers (not all may be available to you):

- Anthem
- Cigna
- Kaiser

We strive to provide consistent and equitable benefits to all members, regardless of health plan carrier. However, each health plan carrier has differences that may include prior authorization/precertification requirements, medical necessity guidelines, programs and processes, policies and procedures, provider networks, and health plan care management programs.

Following are some of the different programs available by health plan carriers.

See the 2022 Plan Document Handbook for more information about unique programs available from each health plan carrier.

## Anthem

### Anthem Health Guide

Anthem Health Guides provide you with enhanced member services support. You can contact a health guide with questions about benefits and programs for your health, to get help scheduling physician appointments, to compare costs for procedures, and more. Guides can connect you with knowledgeable health professionals to help you manage chronic conditions, deal with an illness, or provide support for emotional concerns such as anxiety or depression. Reach out to Member Services and health guides via phone, email, app, or even chat online.

### Virtual Second Opinion Program®

Facing a medical decision? The Virtual Second Opinion Program allows you access to highly specialized providers who can offer educational guidance for certain diagnoses, procedures, or courses of treatment.

### Blue Cross Blue Shield Global Core® Program

If you are traveling outside the United States and need medical care, call Anthem's Member Services to find out more about Blue Cross Blue Shield Global Core benefits.

### LiveHealth Online® Telehealth

With LiveHealth Online, you have a doctor by your side 24/7. LiveHealth Online lets you talk face-to-face with a provider through your mobile device or a computer with a webcam. No appointments, no driving, and no waiting at an urgent care center.

## Cigna

### Cigna One Guide®

One Guide combines digital technology with personalized customer service. With One Guide, you have the one-on-one support you need to take control of your health and your health spending. Whether it's choosing a plan, finding a provider, or exploring ways to improve your health, One Guide can help.

You can access a personal guide via app, chat, online, or phone, whenever you need guidance, support, or answers. To get started, just call the number on the back of your Cigna ID Card.

#### **MDLive® Telehealth**

MDLive for Cigna telehealth platform enables you to get the care you need—including most prescriptions—for a wide range of minor conditions. You can connect with board-certified providers via secure video chat or phone when, where, and how it works best for you.

#### **Kaiser Kaiser Telehealth**

Phone, interactive video, internet messaging applications, and email between members and their personal Kaiser network providers make it convenient to receive medically appropriate covered services.

### **Important: Deductibles and Out-of-Pocket Limits**

#### **Deductibles**

The out-of-pocket limit is the most you will pay for covered healthcare expenses for the calendar year. Similar to the deductible, if you cover family members, please note this:

- The Anthem Consumer-Directed Health Plan-15 (CDHP-15) and the Cigna CDHP-15 require that the family deductible first be met.
- With all other plans, once a member meets the individual deductible, the plan will begin to pay for that member. When the family deductible has been met, the plan will pay for all enrolled family members.

#### **Out-of-Pocket Limits**

The out-of-pocket limit is the most you will pay for covered healthcare expenses for the calendar year. Similar to the deductible, if you cover family members, please note this:

- The Anthem and Cigna CDHP-15 plans require that the family out-of-pocket limit be met.
- With all other plans, once a member meets the individual out-of-pocket limit, the plan will cover the full cost of eligible expenses for that member for the remainder of the calendar year. When the family out-of-pocket limit has been met, the plan will cover eligible costs for all enrolled family members.



## Prescription Drug Benefits

### Express Scripts Prescription Drug Program®

When you enroll in one of our **Anthem** or **Cigna** health plans, you will automatically have prescription drug coverage through the Express Scripts Prescription Drug Program.

Express Scripts prescription benefits are available in both retail pharmacies and via home delivery for ongoing, refillable prescriptions. You can realize savings in these ways:

- By requesting generic drugs whenever possible (your doctor can advise you on whether a generic medication is appropriate)
- By using home delivery for prescriptions you need on an ongoing basis

### Home Delivery

You can order up to 90 days of medication at one time, usually at a significant cost savings, through Express Scripts' home delivery service. The benefits of home delivery include automatic refills and reminders when your prescription is expiring. Use of home delivery is required for maintenance medications after the third fill at a retail pharmacy.

Visit [express-scripts.com](https://www.express-scripts.com) to price a medication, download the formulary, or find a participating retail pharmacy.

For more information, call Express Scripts Member Services at (800) 841-3361.

### Kaiser Prescription Drug Program

Members enrolled in a **Kaiser** plan receive prescription drug coverage through Kaiser. Call the number on the back of your Kaiser Member ID card for Kaiser pharmacy benefit questions.



## Other Plan Benefits<sup>6</sup>

### Vision Benefits

If you enroll in an Anthem, Cigna, or Kaiser plan offered through the Medical Trust, you will receive vision benefits through EyeMed Vision Care's Insight Network<sup>®</sup>.

Vision care benefits include an annual eye exam with no copay when you use a network provider, and prescription eyewear or contact lenses offered through a broad-based network of ophthalmologists, optometrists, and opticians at retail chains and independent provider locations. Certain calendar year benefit limitations apply. See the Plan Document Handbook for more information.

If you are already registered on the EyeMed site, visit [enrollwiththeyemed.com](https://enrollwiththeyemed.com) and use your EyeMed member account credentials to log in for details. Click "Need to register?" to create an EyeMed member account.

### Employee Assistance Program (EAP)

To help address your emotional, physical, family, and legal needs, the Medical Trust offers the Employee Assistance Program (EAP) managed by Cigna Behavioral Health. If you are enrolled in a Medical Trust health plan, the Cigna EAP is available to you and your household members at no cost to you. Your household members do not need to be enrolled in your health plan to use the Cigna EAP.

This benefit provides immediate help, referrals, and resources. The plan covers telephone consultations and up to 10 face-to-face counseling sessions per issue at no member cost. Cigna EAP services are confidential and available 24/7.

The Cigna EAP staff can provide the following:

- 24/7 phone access for behavioral health issues
- Referrals for in-person counseling
- Legal consultations
- Financial services and referrals
- Tips for balancing work and family
- Assistance finding childcare, senior care, and pet care

There are also online resources for issues such as these:

- Emotional well-being and life events
- Family and caregiving
- Health and wellness
- Daily living
- Disaster Resource Center

<sup>6</sup> These other plan benefits may not be available to members participating in fully insured plan options offered on a regional basis (Hawaii Medical Service Association and Kaiser Permanente Washington).

The Cigna EAP now includes access to **Talkspace® virtual behavioral health!**

- Connect with a licensed therapist or psychiatrist online, by video, or by text using Talkspace, available for Cigna EAP members, ages 13 and up.
- Visit [mycigna.com](https://mycigna.com) to access Talkspace virtual behavioral health.

To access the Cigna EAP, visit [mycigna.com](https://mycigna.com) or call (866) 395-7794.

## Health Advocate®

This program is like having your own healthcare navigator at no cost to you! Health Advocate offers help when you have questions about your medical care—from finding a doctor and scheduling an appointment to understanding treatment options for a medical condition to understanding your benefits or resolving a claim.

This service can help you navigate the healthcare system and make the most of your benefits. It is available for you, your dependents, your parents, and your parents-in-law (even if they do not live with you).

Call as often as you need and speak toll-free with a health advocate about your healthcare options. Your information is confidential. Your employer does not receive and does not have access to any of your confidential information. You will be asked to complete and submit forms to protect your privacy.

To access Health Advocate, visit [healthadvocate.com/ecmt](https://healthadvocate.com/ecmt) or call (866) 695-8622, Monday to Friday, 8:00 AM to 7:00 PM ET.

## Dental Benefits

The dental plans offered by the Medical Trust are administered by Cigna.<sup>7</sup>

The Cigna dental plans offer preventive care and three routine cleanings a year covered at 100% with no deductible when using Cigna's DPPO Advantage providers.

The Medical Trust offers three dental plans offering different coverage levels so that you can select the plan that best fits your family's needs. You may be offered one or all of these plans if your employer participates in the Medical Trust health plans. Ask your benefits administrator which, if any, your employer offers.

Access the dental provider directory at [mycigna.com](https://mycigna.com) or call (800) 244-6224.

See the dental Summaries of Benefits and Coverage at [cpg.org/mtdocs](https://cpg.org/mtdocs) for information on cost sharing for common services.

**Please note:** You may not add or drop dental coverage mid-year without a Significant Life Event or HIPAA Special Enrollment Event.

## Travel Assistance Services

When you enroll in a Medical Trust health plan, you have access to UnitedHealthcare Global Assistance®. This travel assistance program can help you with travel needs you encounter while you are outside the United States or 100 or more miles away from home.

The program includes these features:

- Assistance in obtaining medical treatment—Whether you need a local referral for treatment or evacuation due to a medical emergency, UnitedHealthcare Global Assistance staff will help make the arrangements
- Assistance with providing insurance information and medical records for treatment
- Assistance with replacement of prescriptions, medical devices, and corrective lenses

<sup>7</sup> Dental benefit design information does not apply to fully insured plans (Aetna Freedom Dental) offered on a regional basis to select Participating Groups by the Medical Trust.

- Assistance procuring emergency travel arrangements and replacement of lost or stolen travel documents
- Emergency fund transfers
- Destination profiles, which include health and security risks for more than 170 countries

**Important Note:** UnitedHealthcare Global Assistance is not responsible for your medical costs while you are traveling. If you incur costs, and depending on where you travel, you may be required to pay for your healthcare services.

If you have an emergency medical event while traveling, contact your health plan carrier using the number on your member ID card.

For more information about UnitedHealthcare Global Assistance services, please visit [members.uhcglobal.com](https://members.uhcglobal.com) or call (800) 527-0218.





## Choosing the Right Plan



### To Help You Make an Informed Choice

Your plan provides a *Summary of Benefits and Coverage* (SBC), which offers important details about the plan's benefits in a standard format, to help you compare options.

SBCs are available at [cpg.org/mtdocs](http://cpg.org/mtdocs). For a free paper copy, call (800) 480-9967, Monday to Friday, 8:30 AM to 8:00 PM ET.

We know that medical benefits are important to you and your family. There are several important considerations to help you choose the best health plan for you and your family and manage your costs when you need care:

- **Changes to healthcare usage in upcoming year**—Though it may be tempting to default to the same medical option year after year, healthcare needs change over time. During Annual Enrollment, consider how your healthcare needs might be different in the upcoming year. For example, are you expecting to have a baby or planning to have a medical procedure? As your needs change, the best plan for you may change as well. A good start is to review the current year's Explanations of Benefits (EOB) to see how much you used your benefits and consider how that might change for next year.
- **Pay now or pay later**—It might help to think of the plan options in terms of “pay now” or “pay later.” For example, your monthly contributions will be higher in plans with lower out-of-pocket costs, while your monthly contributions will be lower in plans that have higher cost shares. You should consider whether you prefer to pay higher monthly contributions for your coverage and less when you receive services, or to pay less each month with the prospect of paying more when you need services.
- **Network providers**—Your cost for healthcare will be higher if you use a doctor who is not in your plan's network. If you enroll in a Kaiser health plan, you pay the full cost of any non-emergency services provided by a doctor or facility that is not in the plan's network. Contact your health plan or visit its website to check whether your provider is in the plan's network.
- **Telehealth**—Telehealth allows you to connect with a board-certified provider for a wide variety of non-emergency conditions, and even get certain prescriptions from the safety and convenience of your own home. No appointment is necessary. If you are enrolled in a Medical Trust Consumer-Directed Health Plan (CDHP), you will pay a flat fee, depending on the type of visit. If you are not enrolled in a CDHP, you will pay the same copayment as an office visit. In all cases, you will know the cost before being placed in a virtual waiting room. In response to the COVID-19 pandemic, effective March 1, 2020, all services received via vendor telehealth platforms are available to you with no deductible, copay, or coinsurance through December 31, 2023.<sup>8</sup>

<sup>8</sup> For CDHP members, while temporary legislation currently permits the Medical Trust to provide you with first-dollar coverage of vendor telehealth platform services, there is no guarantee that this relief will be extended beyond December 31, 2022. If Congress does not extend this relief, during 2023, you will be required to meet your deductible before carrier telehealth services will be covered with no copay or coinsurance.

## How to Enroll

Before you go online to enroll, you should know your plan selections, have information for any dependents you are adding, and have your Client ID number handy. Your Client ID number is included in the letter that was mailed to your home in a green envelope.

When you are ready to enroll, log on to [cpg.org/annualenrollment](http://cpg.org/annualenrollment) and follow the instructions.

**If your current plan is not offered in 2023, you must choose a new plan in order to have medical coverage.** Also, be sure to verify and make any necessary corrections to your personal and dependent information, especially names, Social Security numbers, and addresses. If a dependent will turn age 30 in 2022, they can no longer be covered as dependents under a Medical Trust plan, unless they were disabled prior to age 25, as determined by the Medical Trust. However, the Medical Trust will allow dependent children who turn age 30 in 2022 to voluntarily continue medical and/or dental coverage on their own for up to 36 months commencing on January 1, 2023, through the Medical Trust's Extension of Benefits provision.

You can print a confirmation statement for your records after you make your selections. Please check your selections carefully before you complete the enrollment process.

Your new plan choice takes effect on January 1, 2023. You may receive new ID cards (if applicable) at this time. The Medical Trust can also print many ID cards, or you can print them from the vendor's website. Call Client Services for assistance at (800) 480-9967, Monday to Friday, 8:30 AM to 8:00 PM ET, or email [mtcustserv@cpg.org](mailto:mtcustserv@cpg.org).

## If You Do Not Enroll by the Deadline

If you miss the deadline and your current plan is still available for 2023, you will continue in the same plan with the same coverage tier as long as you continue to meet the plan's eligibility rules.

If you do not enroll by the deadline and your current plan is not offered in 2023, your medical benefits will end on December 31, 2022, and you cannot re-enroll until the next Annual Enrollment period unless you have a qualified Significant Life Event (as defined in the Plan Document Handbook).

## Learn More

For more information about the health plan(s) available to you, visit our vendors' websites:

### **Anthem**

[anthem.com](http://anthem.com)

### **Cigna Medical and Dental**

[mycigna.com](http://mycigna.com)

### **Cigna Behavioral Health**

(Employee Assistance Program)

[mycigna.com](http://mycigna.com)

### **Kaiser**

[kp.org](http://kp.org)

### **Express Scripts**

[express-scripts.com](http://express-scripts.com)

### **EyeMed**

Member services, general information, and "find a provider" search tool

[eyemedvisioncare.com/ecmt](http://eyemedvisioncare.com/ecmt)

### **Health Advocate**

[members.healthadvocate.com](http://members.healthadvocate.com)

### **UnitedHealthcare**

**Global Assistance**

[members.uhcglobal.com](http://members.uhcglobal.com)



## About The Episcopal Church Medical Trust

The Episcopal Church Medical Trust (Medical Trust) maintains a series of benefit Plans (each a Plan and collectively, the Plans) for the eligible Employees (and their Eligible Dependents) of the Protestant Episcopal Church in the United States of America (hereinafter, The Episcopal Church). Since 1978, the Plans sponsored by the Medical Trust have served the dioceses, parishes, schools, missionary districts, seminaries, and other institutions subject to the authority of The Episcopal Church. The Medical Trust serves thousands of active employees, retirees, and their eligible dependents. The Plans are intended to qualify as “church plans” within the meaning of Section 414(e) of the Internal Revenue Code, and are exempt from the requirements of the Employee Retirement Income Security Act of 1974, as amended (ERISA).

The Medical Trust funds certain of its benefit Plans through a trust fund known as The Episcopal Church Clergy and Employees’ Benefit Trust (ECCEBT).<sup>9</sup> The ECCEBT is intended to qualify as a Voluntary Employees’ Beneficiary Association (VEBA) under Section 501(c)(9) of the Internal Revenue Code. The purpose of the ECCEBT is to provide Benefits to eligible Employees, former Employees, and their Dependents in the event of illness or expenses for various types of medical care and treatment.

The mission of the Medical Trust is to “balance compassion and benefits with financial stewardship.” This is a unique mission in the world of healthcare benefits, and we believe that our experience and mission to serve The Episcopal Church offers a level of expertise that is unparalleled. If you have questions about any of our Plans, please don’t hesitate to contact us. We’re looking forward to serving you.

For more information about your Medical Trust benefits, please visit our website at [cpg.org](http://cpg.org), or call Client Services at (800) 480-9967, Monday to Friday, 8:30 AM to 8:00 PM ET.

### Eligibility

This *Annual Enrollment Guide* does not contain information on eligibility for plan participation. Should you need confirmation of your eligibility or related details, please see your group administrator.

<sup>9</sup> Church Pension Group Services Corporation is the sponsor of the benefit plans and is doing business under the name “The Episcopal Church Medical Trust.”



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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.*

*This material is not a substitute for professional medical advice or treatment. CPG does not provide any healthcare services and, therefore, cannot guarantee any results or outcomes. Always seek the advice of a healthcare professional with any questions about your personal healthcare, including diet and exercise.*

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