



Annual
Enrollment

2027 Guide
Planning Your Journey



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Your Guide to Annual Enrollment

The Episcopal Church Medical Trust (Medical Trust) provides access to care through benefits that support your well-being. Use this guide to learn about the types of benefits available to you from the Medical Trust, the factors you may want to consider when making your selections, and what you need to do to enroll. You can find additional details and resources at cpg.org.¹

Because the benefits you choose may affect your whole family, please share Annual Enrollment information with other decision-makers in your household.

What You Need to Know—and Do

- During Annual Enrollment, Quantum Health (Quantum) will be available at 866-871-0629 to help members enrolled—and eligible to enroll—in plans that use the Anthem and Cigna networks understand plan options and choose the right plan for themselves and their dependents.
- Look for a message in your inbox—not your mailbox—in early October containing the email address associated with your MyCPG Account and important information about Annual Enrollment.
- Read the “How to Enroll” section below to make your medical and dental plan selections.
- Some plans described in this guide may not be available in all locations or to all groups or dioceses. You will see the plans that are available to you when you sign in to [MyCPG Accounts](#) for Annual Enrollment.
- Available coverage tiers, from single to family coverage, depend on what your group or diocese offers. Check your online enrollment form to see the options available to you. The rates shown may not be the amount your employer requires you to pay. Contact your employer or benefits administrator to confirm your cost for coverage. If you need to verify your eligibility or that of your dependents, contact your group administrator.
- If you don’t make changes or enroll by the deadline, your current medical and/or dental benefits will continue, and any rate changes will apply. **If your current medical and/or dental plan is not being offered for 2027, you must select another plan(s) in order to have coverage next year through the Medical Trust.**

Glossary of Defined Terms

Please see the [Glossary of Health Coverage and Medical Terms](#) from the Centers for Medicare & Medicaid Services for definitions commonly used terms, including *coinsurance*, *copayment*, *cost sharing*, *deductible*, *emergency medical condition*, *hospitalization*, *network*, *network provider*, *out-of-network provider*, *out-of-pocket limit*, *plan*, *prescription drugs*, and *primary care physician*.

¹ The information in this guide is not intended for members covered by health insurance policies issued by the Hawaii Medical Service Association.



Selecting Your 2027 Benefits

Annual Enrollment for next year's Medical Trust health benefits begins in October 2026. This is your opportunity to review and make changes to your medical and/or dental benefits and to add or drop coverage for eligible dependents for the upcoming plan year.

Be sure to review your options and make your selections by your enrollment deadline. You won't be able to make changes until the next Annual Enrollment period, unless you experience a qualified Significant Life Event (as defined in the relevant Plan Document Handbook), such as marriage, divorce, or the birth of a child.

Changes for 2027

Rising healthcare costs continue to put pressure on health plan sponsors, employers, and individuals alike. For the Medical Trust, the price of healthcare has risen sharply since 2023. A key driver of higher costs has been the rapid growth in the use of GLP-1s for weight loss. The Medical Trust spent approximately \$1.5 million on these medications in 2023, and that figure was projected to increase to nearly \$9 million by 2027.

To manage plan resources responsibly on behalf of all participants and help ensure the long-term sustainability of our health plans, we have made a number of changes to our 2027 plan designs (detailed below), including eliminating coverage of GLP-1s for weight reduction. (We will continue to cover GLP-1s for the treatment of type 2 diabetes). As a result of these measures, we expect to limit the average increase in contribution rates to 13.3% for 2027, helping balance plan affordability with sustainability. Absent any action, average contribution rates for next year would have risen by 22.5%.

Deductible and Out-of-Pocket Maximum Increases for PPO Plan Options Using the Anthem and Cigna Networks and EPO Plan Options Using the Kaiser Network

Deductibles and out-of-pocket maximums will increase for 2027.

Anthem/Cigna PPO 100

Network individual deductibles will increase from \$0 to \$500, and network family deductibles will increase from \$0 to \$1,000. Out-of-network individual deductibles will increase from \$500 to \$1,000, and out-of-network family deductibles will increase from \$1,000 to \$2,000.

Network individual out-of-pocket maximums will increase from \$2,000 to \$3,500, and network family out-of-pocket maximums will increase from \$4,000 to \$7,000. Out-of-network individual out-of-pocket maximums will increase from \$4,000 to \$7,000, and out-of-network family out-of-pocket maximums will increase from \$8,000 to \$14,000.

Anthem/Cigna PPO 90

Network individual deductibles will increase from \$500 to \$1,000, and network family deductibles will increase from \$1,000 to \$2,000. Out-of-network individual deductibles will increase from \$1,000 to \$2,000, and out-of-network family deductibles will increase from \$2,000 to \$4,000.

Network individual out-of-pocket maximums will increase from \$2,500 to \$4,000, and network family out-of-pocket maximums will increase from \$5,000 to \$8,000. Out-of-network individual out-of-pocket maximums will increase from \$5,000 to \$8,000, and out-of-network family out-of-pocket maximums will increase from \$10,000 to \$16,000.

Anthem/Cigna PPO 80

Network individual deductibles will increase from \$1,000 to \$1,500, and network family deductibles will increase from \$2,000 to \$3,000. Out-of-network individual deductibles will increase from \$2,000 to \$3,000, and out-of-network family deductibles will increase from \$4,000 to \$6,000.

Network individual out-of-pocket maximums will increase from \$3,500 to \$5,000, and network family out-of-pocket maximums will increase from \$7,000 to \$10,000. Out-of-network individual out-of-pocket maximums will increase from \$7,000 to \$10,000, and out-of-network family out-of-pocket maximums will increase from \$14,000 to \$20,000.

Anthem/Cigna PPO 70

Network individual deductibles will remain at \$3,500, and network family deductibles will remain at \$7,000. Out-of-network individual deductibles will remain at \$7,000, and out-of-network family deductibles will remain at \$14,000.

Network individual out-of-pocket maximums will increase from \$5,000 to \$6,500, and network family out-of-pocket maximums will increase from \$10,000 to \$13,000. Out-of-network individual out-of-pocket maximums will increase from \$10,000 to \$13,000, and out-of-network family out-of-pocket maximums will increase from \$20,000 to \$26,000.

Kaiser EPO High

Network individual deductibles will increase from \$0 to \$500, and network family deductibles will increase from \$0 to \$1,000.

Network individual out-of-pocket maximums will increase from \$1,750 to \$3,500, and network family out-of-pocket maximums will increase from \$3,500 to \$7,000.

Kaiser EPO 90

Network individual deductibles will increase from \$250 to \$750, and network family deductibles will increase from \$500 to \$1,500.

Network individual out-of-pocket maximums will increase from \$2,500 to \$4,000, and network family out-of-pocket maximums will increase from \$5,000 to \$8,000.

Kaiser EPO 80

Network individual deductibles will increase from \$500 to \$1,000, and network family deductibles will increase from \$1,000 to \$2,000.

Network individual out-of-pocket maximums will increase from \$3,500 to \$5,000, and network family out-of-pocket maximums will increase from \$7,000 to \$10,000.

**Deductible and Out-of-Pocket
Maximum Increases for CDHPs
Using the Anthem, Cigna, and
Kaiser Networks**

Anthem/Cigna CDHP-15

Network deductibles for self-only coverage will increase from \$1,700 to \$2,200, and network deductibles for family coverage will increase from \$3,400 to \$4,400. Out-of-network deductibles for self-only coverage will increase from \$3,400 to \$4,400, and out-of-network deductibles for family coverage will increase from \$6,800 to \$8,800.

Network out-of-pocket maximums for self-only coverage will increase from \$2,400 to \$3,900, and network out-of-pocket maximums for family coverage will increase from \$4,800 to \$7,800. Out-of-network out-of-pocket maximums for self-only coverage will increase from \$4,800 to \$7,800, and out-of-network out-of-pocket maximums for family coverage will increase from \$9,600 to \$15,600.

Anthem/Cigna CDHP-20

Network individual deductibles will increase from \$3,400 to \$3,600, and network family deductibles will increase from \$6,800 to \$7,200. Out-of-network individual deductibles will increase from \$3,400 to \$7,200 and out-of-network family deductibles will increase from \$6,800 to \$14,400.

Network individual out-of-pocket maximums will increase from \$4,200 to \$5,000, and network family out-of-pocket maximums will increase from \$8,450 to \$10,000. Out-of-network individual out-of-pocket maximums will increase from \$7,000 to \$10,000, and out-of-network family out-of-pocket maximums will increase from \$13,000 to \$20,000.

Anthem/Cigna CDHP-40

Network individual deductibles will increase from \$3,500 to \$4,000, and network family deductibles will increase from \$7,000 to \$8,000. Out-of-network individual deductibles will increase from \$7,000 to \$8,000, and out-of-network family deductibles will increase from \$14,000 to \$16,000.

Network individual out-of-pocket maximums will increase from \$6,000 to \$7,500, and network family out-of-pocket maximums will increase from \$12,000 to \$15,000. Out-of-network individual out-of-pocket maximums will increase from \$10,000 to \$15,000, and out-of-network family out-of-pocket maximums will increase from \$20,000 to \$30,000.

Kaiser CDHP-20

Network individual deductibles will increase from \$3,400 to \$3,600, and network family deductibles will increase from \$6,800 to \$7,200.

Network individual out-of-pocket maximums will increase from \$4,200 to \$5,000, and network family out-of-pocket maximums will increase from \$8,450 to \$10,000.

**Primary Care, Specialty Visit, and
Urgent Care Copay Increases
for PPO Plan Options Using the
Anthem and Cigna Networks**

Anthem and Cigna PPO

Primary care visit copays will increase from \$30 to \$35, and specialist visit copays will increase from \$45 to \$50.

Urgent care visit copays will increase from \$50 to \$60.

**Primary Care, Specialty Visit, and
Urgent Care Copay Increases
for EPO Plan Options Using the
Kaiser Network**

Kaiser EPO High, 90, and 80

Primary care visit copays will increase from \$25 to \$30.

Urgent care visit copays will increase \$50 to \$60.

Kaiser EPO High

Specialist visit copays will increase from \$25 to \$45.

Kaiser EPO 90 and 80

Specialist visit copays will increase from \$35 to \$45.

Rx Copay Increases

PPO Standard Rx and EPO Rx copays for plan options using the Anthem, Cigna, and Kaiser networks will increase. PPO Standard Rx specialty drug coinsurance for plan options using the Anthem and Cigna networks will increase. For details, consult your plan's [Summary of Benefits and Coverage](#) (SBC) for 2027.

GLP-1 Coverage Changes and New Weight-Management Vendor

GLP-1s for weight loss, with or without comorbidities, will not be covered by our medical plans. GLP-1s will continue to be covered for type 2 diabetes treatment, subject to applicable prior authorization and utilization management requirements and other plan terms.

To provide weight-loss support, the Medical Trust will be making Digbi available cost-free to members enrolled in plan options that use the Anthem and Cigna networks. Digbi offers support for glucose health, digestive wellness, and weight reduction (with or without GLP-1s) through personalized guidance based on individual coaching and optional genetic and gut microbiome testing data.

Quantum Health can guide members enrolled in plan options that use the Anthem and Cigna networks on how to obtain GLP-1 medications directly from manufacturers at direct-to-consumer prices. Members will be responsible for the full cost of these drugs. To purchase GLP-1s through manufacturer platforms, members must continue to obtain GLP-1 prescriptions from their own healthcare providers, as Digbi does not prescribe GLP-1s.



Medical Plan Options

All Medical Trust medical plans include medical, pharmacy, behavioral, 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 medical plans, depending on your group's 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)—for regional Kaiser plans only

Preferred Provider Organization (PPO)

You can visit any provider you choose—inside or outside the plan's network. However, the plan generally covers more of the cost of care 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. You may also be required to pay the full amount to the provider at the time of service before you can submit your claim.

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

About the Kaiser 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.

A CDHP is an HSA-qualified plan. CDHPs that use the Anthem and Cigna networks function like a PPO: You can receive services from any provider, and you don't have to coordinate your care through a primary care provider (PCP). Although these CDHPs cover services in and out of network, they provide 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, like a PPO.

When you enroll in a CDHP, you can make pretax contributions to an HSA, which is a savings account for qualified medical expenses. Your employer may also contribute. Here's how HSAs work:

- You decide whether and how much to contribute, up to IRS maximums. You can change or stop your contributions at any time during the year.
- You may use the money in your HSA to pay for qualified medical 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 qualified medical expenses in retirement.
- Your HSA is portable and will always belong to you, even if you change employers or retire.

HSA Tax Advantages

To Contribute to an HSA

You must be enrolled in a CDHP and cannot

- be covered by Medicare, TRICARE®, or other medical insurance;
- be claimed as a dependent on anyone else's tax return; or
- be covered by a traditional healthcare Flexible Spending Account, either yours or your spouse's.

There are several tax advantages to contributing to an HSA:

1. You don't pay federal income taxes on your contributions, up to IRS maximums.
2. Withdrawals from your HSA are free from federal income tax as long as they are used to pay for qualified medical expenses. Make sure you keep receipts for tax-reporting purposes.
3. Once the applicable minimum balance is met, HSA funds may be invested. Earnings from the funds in the HSA account are not subject to federal income tax while in the account.

Exclusive Provider Organization (EPO)—Kaiser

If you enroll in an EPO plan, you agree to use only professionals and facilities in Kaiser's network. Kaiser does not cover the cost of services received from out-of-network providers, except in emergencies. 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 (MSP-SEE)

The Medical Trust provides the option for eligible employers to apply for the Medicare Secondary Payer (MSP) Small Employer Exception (SEE). If an employer applies and is approved for the exception, its eligible employees and their spouses can choose to participate in the MSP-SEE Plan.

To participate in the MSP-SEE Plan, you must satisfy all these criteria:

- Be age 65 or older
- Be actively working for a qualified employer that offers an MSP-SEE Plan
- Be enrolled in Medicare Part A (or both Parts A and B) on the basis of age alone
- Choose a participating plan that uses the Anthem or Cigna network
- Work for an employer whose Small Employer Exception application has been approved by the Centers for Medicare & Medicaid Services (CMS)

Summary of Benefits and Coverage

For an overview of benefits, consult each plan's *Summary of Benefits and Coverage* available at cpg.org/mtdocs. To request a free paper copy, call 800-480-9967, Monday to Friday, 8:30 AM to 8:00 PM ET.

If you enroll in the MSP-SEE Plan, Medicare will be the primary payer for Part A services. This plan is also available to those enrolled in Medicare Parts A and B. Once Medicare has paid its share, the MSP-SEE Plan pays claims as a Medical Trust plan otherwise would for any active member, minus the amounts paid by Medicare and you. As a result, out-of-pocket costs may be lower for MSP-SEE Plan members, and the cost of providing health benefits may be lower for employers.

Eligible members approved by CMS may enroll in the MSP-SEE Plan even if their dependents are under age 65 and don't have Medicare.

The Medical Trust will mail eligible members and/or their spouses information about the MSP-SEE Plan approximately a month before their 65th birthday.

The MSP-SEE Plan is not available to members who enroll in a Kaiser plan.



Medical Plan Networks

The Medical Trust offers medical plan options that use the following networks, not all of which may be available to you:

- Anthem
- Cigna
- Kaiser

We strive to provide consistent and equitable benefits to all members, regardless of medical plan network. However, depending on the network members use, the Medical Trust's plan options may differ in terms of prior authorization/precertification requirements, medical necessity guidelines, programs and processes, policies and procedures, provider networks, and medical plan care management programs.

Deductibles and Out-of-Pocket Limits

Deductibles—You pay the full cost of healthcare until you reach the plan's annual deductible. Then the plan begins to pay benefits. Please note that network and out-of-network deductibles accumulate separately for plans that use the Anthem and Cigna networks.

If you cover family members, please note the following:

- The Anthem Consumer-Directed Health Plan-15 (CDHP-15) and the Cigna CDHP-15 require that the family deductible be met before the plan begins to pay benefits.
- With all other plans, once a member meets the individual deductible, the plan begins paying benefits 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. For Anthem and Cigna plan options, network and out-of-network expenses are tracked separately and apply toward separate out-of-pocket limits.

As is the case with deductibles, if you cover family members, please note the following:

- The Anthem and Cigna CDHP-15 plans require that the family out-of-pocket limit be met before the plan begins to pay benefits.
- 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 medical plans that uses the **Anthem** or **Cigna** network, you will automatically have prescription drug coverage through the Express Scripts Prescription Drug Program.

Express Scripts prescription benefits are available at retail pharmacies and via home delivery for ongoing, refillable prescriptions. You can realize savings by

- requesting generic drugs whenever possible (your doctor can advise you on whether a generic medication is appropriate),
- using home delivery for prescriptions you need on an ongoing basis, and
- enrolling in the SaveOnSP Copay Assistance Program for certain specialty medications.²

Home Delivery—Through Express Scripts' home delivery service, you can order up to 90 days' worth of medication at a time, usually at a significant cost savings. 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 Service 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.

² The list of specialty pharmacy medications included in the program can be found at [SaveonSP.com/cpg](https://www.saveonsp.com/cpg). Learn more about SaveOnSP in the applicable *Plan Document Handbook*.



Other Plan Benefits

Vision Benefits

If you enroll in a Medical Trust plan that uses the Anthem, Cigna, or Kaiser network, you will receive vision benefits through EyeMed Vision Care's Insight Network®.

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.

For more information, see the applicable [Plan Document Handbook](#) or log in to eyemedvisioncare.com/ecmt with your EyeMed member account credentials (if you're already registered on the EyeMed site). To create an EyeMed member account, click on "Need to register?"

Employee Assistance Program (EAP)

To help address behavioral health and financial, legal, and everyday family needs, the Medical Trust offers the Employee Assistance Program (EAP), managed by Cigna Behavioral Health. If you're enrolled in a Medical Trust medical plan, the Cigna EAP is available to you and all members of your household—even if they're not enrolled in your medical plan—at no cost to you.

This confidential 24/7 service offers in-the-moment assistance, referrals, and access to community and other resources. It covers telephone consultations and up to 10 face-to-face counseling sessions per issue at no cost to the member.

The EAP staff can provide the following:

- Round-the-clock phone access for behavioral health issues
- Referrals for in-person counseling
- Referrals to network lawyers for a free 30-minute legal consultation
- Financial services and referrals
- Tips for balancing work and family
- Assistance finding childcare, senior care, and pet care

There are also online resources for

- emotional well-being and life transitions
- family and caregiving
- health and wellness
- daily living
- disaster recovery

To access the Cigna EAP, call Quantum at 866-871-0629. EAP-only members, call 866-395-7794 or visit mycigna.com.

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

- Connect with a licensed therapist or psychiatrist online, by video, or by text using Talkspace, available to Cigna EAP members ages 13 and up.
- To access Talkspace, visit mycigna.com.

Digbi Health

The Medical Trust provides eligible members whose plan options use the Anthem and Cigna networks with cost-free access to [Digbi Health](https://digbihealth.com). Digbi is a virtual care platform that addresses weight reduction, glucose and gastrointestinal health, and cardiometabolic conditions through one-on-one coaching and optional genetic and gut microbiome testing. Digbi does not prescribe medications. To learn more, email digbi@digbihealth.com or call 508-443-4424, Monday to Friday, 9:00 AM to 8:00 PM ET.

Dental Benefits

Our dental vendor, Delta Dental, has the largest network of dentists nationwide. You can access services in two networks (Delta Dental PPO™ and Delta Dental Premier®) or use out-of-network dentists. Your coinsurance, deductible, and maximum annual benefit will vary based on the network you use.

- Providers in both networks have agreed to contracted rates, and you won't be charged more than your expected share of the bill.³ Using the Delta Dental PPO network⁴ offers the highest annual maximum benefit, allowing you the most savings. Using an out-of-network dentist may result in higher out-of-pocket expenses.
- All three Delta Dental plan options cover
 - diagnostic and preventive care,
 - three dental cleanings a year (four under certain circumstances), and
 - basic and major restorative services, subject to applicable coinsurance, deductibles, limitations, and exclusions.
- The Basic Plan does not cover orthodontic services; the Comprehensive Plan does, and the Premium Plan has a higher in-network lifetime benefit for orthodontia.
- You can find a dental provider, check your benefits, and access other helpful resources at deltadentalins.com.

To learn more, visit cpg.org/deltadental or call 888-894-7059, Monday to Friday, 8:00 AM to 8:00 PM ET. For information about cost sharing, see the [Benefit Highlight Sheet](#) for each of the three Delta Dental plan options.

Travel Assistance Services

Medical Trust plan members have access to UnitedHealthcare Global Assistance®. When you are 100 or more miles away from home or traveling outside the United States, this program can

- arrange for you to obtain medical treatment, whether you need a local referral or an evacuation due to a medical emergency;
- provide insurance information and medical records to appropriate party or parties;

³ You are responsible for any applicable deductibles, coinsurance, amounts over annual or lifetime maximums, and charges for noncovered services. Out-of-network dentists may bill the difference between their usual fee and Delta Dental's maximum contract allowance.

⁴ You can still visit any licensed dentist, but your out-of-pocket costs may be higher if you choose a non-PPO dentist. Network dentists are paid contracted fees.

- replace your prescription medications, medical devices, and corrective lenses;
- procure emergency travel arrangements and replace lost or stolen travel documents;
- transfer emergency funds to you; and
- provide you destination profiles for over 170 countries, including health and security risk information.

IMPORTANT NOTE: UnitedHealthcare Global Assistance is **not** responsible for your medical costs while you're traveling. **If you incur costs for healthcare services, you may be required to pay for them.**

If you experience a medical emergency while traveling, contact your travel insurance carrier, if any, and the number on the back of your member ID card.

For more information about UnitedHealthcare Global Assistance services, please visit uhcglobal.com or call 800-527-0218.



Choosing the Right Plan

To Help You Make an Informed Choice

Consult the *Summary of Benefits and Coverage* (SBC), provided by the Medical Trust for each plan option. Available at cpg.org/mtdocs, these summaries include key benefit details in a format that allows you to easily compare options. 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. Below are three factors you should consider when determining which medical plan is best for you, your dependents, and your budget:

- **Changes to healthcare usage for the coming year**—Although 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 coming year. For example, are you expecting a baby or planning to undergo a medical procedure? As your needs change, the best plan for you may change as well. It's a good idea to review your current year's Explanations of Benefits (EOBs) to see how much you used your benefits and think about how that might change next year.
- **Pay now or pay later**—It might help you to think of your plan options in terms of "paying now" or "paying later." Your monthly contributions will generally be higher in plans with lower out-of-pocket costs and lower in plans with higher out-of-pocket costs. You should consider whether you prefer to pay more in contributions every month and less when you receive services or pay less for coverage each month and more when you receive services. Consider not only the costs you may pay when you use care, such as deductibles, copays, and coinsurance, but also the monthly contribution for each plan option. For example, depending on your employer's contribution level, the annual contributions for the lower-deductible plan option can exceed the higher-deductible plan option's out-of-pocket maximum. In that case, the higher-deductible plan option may be the better value for you.
- **Network providers**—Your healthcare costs will be higher if you use a doctor who is not in your plan's network. If you enroll in a Kaiser medical plan, you pay the full cost of any nonemergency service provided by a doctor or facility that is not in the plan's network. Contact Quantum Health or Kaiser (as applicable) or visit its website to check whether your provider is in the plan's network.

Plan(s) Going Away

If your existing medical and/or dental plan is not being offered in 2027, you must choose a new plan or plans in order to have medical and/or dental coverage through the Medical Trust next year. Also, be sure to verify and make any necessary corrections to your personal information and that of your dependent(s), particularly names, Social Security numbers, and addresses.

If you are eligible to enroll in a plan that uses the Anthem or Cigna network and need help with your medical plan selections, call Quantum at

866-871-0629, Monday to Friday, 8:30AM to 10:00 PM ET. Kaiser members should call the number on the back of their ID cards.

How to Enroll

Before you go online to enroll, review your personal information and be sure you understand your plan selections and have all the information necessary for any dependents you may be adding.

Have the email address associated with your MyCPG Account at hand. If you don't have a MyCPG Account, you can create one at cpg.org/mycpg.

Extension of Benefits

Dependents who turn 30 in 2026 cannot be covered as dependents under a Medical Trust plan, unless they became disabled before age 25 and continue to be disabled as determined by the Medical Trust. However, through its Extension of Benefits provision, the Medical Trust will allow dependent children who turn 30 in 2026 to voluntarily continue medical and/or dental coverage at their own expense for up to 36 months beginning on January 1, 2027.

Making Your Plan Selections

When you are ready to enroll, go to cpg.org/annualenrollment and click on "Log in to Enroll".

Step 1

Sign in to [MyCPG Accounts](#) with the email address we have on file for you. Instructions are also available in our [AE Going Digital Flyer](#).

Step 2

Click on "Annual Enrollment" and make your selections for 2027.

Step 3

Review your personal information, dependent information, and plan selections carefully.

Step 4

Print a confirmation statement for your records.

Your new plan selection(s) will take effect on January 1, 2027.

All members will receive new ID cards.

**If You Do Not Enroll by
the Deadline**

If you miss the deadline and your existing medical and/or dental plan **will** be available in 2027, you will continue in the same plan with the same coverage tier, provided you still meet the eligibility requirements. Any rate changes will apply.

If you don't enroll by the deadline and your current plan(s) **won't** be available in 2027, your medical and/or dental benefits will end on December 31, 2026, and you will not be able to re-enroll until the next Annual Enrollment period, unless you experience a qualified Significant Life Event (as defined in each Plan Document Handbook).

To Learn More

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

Cigna Behavioral Health (Employee Assistance Program)

mycigna.com

Delta Dental

deltadentalins.com

Digbi Health

go.digbihealth.ai/cpg

Express Scripts

express-scripts.com

EyeMed

eyemedvisioncare.com/ecmt

Kaiser

kp.org

Quantum Health

myquantumcare.org

UnitedHealthcare Global Assistance

uhcglobal.com



About The Episcopal Church Medical Trust

The Episcopal Church Medical Trust⁵ (the Medical Trust) maintains a series of benefit Plans (each, a Plan, and collectively, the Plans) for eligible individuals of The Episcopal Church and their eligible dependents. 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 (the ECCEBT). The ECCEBT is intended to qualify as a Voluntary Employees' Beneficiary Association (a 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 administer a comprehensive benefit plan that balances compassion with financial stewardship. This is a unique undertaking in the world of healthcare benefits, and we believe that given our experience and commitment to The Episcopal Church, we offer a level of expertise that is unparalleled. If you have questions about any of our Plans, please don't hesitate to contact us. We are always ready to serve you.

For more information about your Medical Trust benefits, visit 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 about eligibility for plan participation. Should you need confirmation of your eligibility or related details, please consult your group administrator.

⁵ Church Pension Group Services Corporation is the sponsor of the benefit plans and is doing business under the name "The Episcopal Church Medical Trust."

This material is provided for informational purposes only and should not be viewed as investment, tax, or other advice. It does not constitute a contract or an offer for any products or services. In the event of a conflict between this material and the official plan documents or insurance policies, any official plan documents or insurance policies will govern. The Church Pension Fund (CPF) and its affiliates (collectively, CPG) retain the right to amend, terminate, or modify the terms of any benefit plan and/or insurance policy described in this material at any time, for any reason, and, unless otherwise required by applicable law, without notice.

Church Pension Group Services Corporation (CPGSC), doing business as The Episcopal Church Medical Trust, maintains a series of health and welfare plans (the Plans) for eligible employees of The Episcopal Church (the Church) and their eligible dependents. 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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