

Annual Enrollment



Annual Enrollment Guide 2019

Benefits effective as of January 2019

ABOUT THE EPISCOPAL CHURCH MEDICAL TRUST

The Episcopal Church Medical Trust (Medical Trust) maintains a series of benefit plans (the “plans”) for the employees (and their 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 now serves more than 22,000 active employees and dependents; and over 9,000 retirees and their 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 some of its benefit plans through a trust fund known as the Episcopal Church Clergy and Employees’ Benefit Trust (ECCEBT)¹. 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 compassionate care with financial stewardship. This charge is unique in the world of healthcare benefits. Along with Church Pension Group’s (CPG) experience and mission to serve the Episcopal Church, it offers a level of expertise that is unparalleled. If you have questions about any of our plans, please do not hesitate to contact us. We are looking forward to serving you.

For more information, please visit our website at www.cpg.org; or call Client Services at (800) 480-9967, Monday – Friday, 8:30AM to 8:00 PM ET (excluding holidays).

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.

¹ Church Pension Group Services Corporation is the sponsor of the benefit plans and is doing business under the name “The Episcopal Church Medical Trust.”

SELECTING YOUR 2019 BENEFITS

The Annual Enrollment period for 2019 begins in October, 2018. This is the time of year when you have the opportunity to review and make changes to your benefits for the upcoming plan year. This is also a good time to review your personal and dependent information and make any necessary updates.

The Medical Trust has implemented a multi-year strategy of providing health options that deliver meaningful choice. We offer plans that enable you to make more informed decisions regarding your health, that promote wellness and preventive care, and that uphold our responsibility to be good financial stewards.

Effective January 1, 2019, several health plans will no longer be offered by the Medical Trust, including:

- Anthem 90/70 PPO
- Anthem 80/60 PPO
- Anthem 75/50 PPO
- Anthem 70 SLV PPO
- Anthem High Option PPO
- Anthem EPO 90
- Anthem EPO 80
- Cigna Open Access Plus
- Cigna Open Access Plus In-Network

These changes to our plan offerings result from our ongoing commitment to provide access to quality healthcare, offer meaningful choice, and manage benefit costs for our members. If you are enrolled in one of the plans listed above, you must choose a new plan during Annual Enrollment or you will not have coverage after December 31, 2018.

Health Advocate can offer assistance if you need help choosing a new plan. See page 21 for more information.

Your benefits program has been designed to work for you. The Medical Trust's plan options and coverage choices give you the flexibility you need to make enrollment decisions based on your individual and family needs.

It is important for you to consider carefully your plan choices for next year. Since the decisions you make during Annual Enrollment may affect your whole family, please make sure to share all Annual Enrollment information with the other decision-makers in your household. This guide is designed to assist you in that process. There are several important steps you should take to make your benefit selections.

- Read this *Annual Enrollment Guide* carefully to understand the plans the Medical Trust offers and the steps to follow to enroll in your 2019 benefits.
- Review the medical plan *Summaries of Benefits and Coverage* available at www.cpg.org or from your benefits administrator. The summaries provide more detailed information about the benefits and cost shares under each of the medical plan options for which you are eligible.
- Review the current year's Explanations of Benefits (EOBs) to see how much you used your benefits. Consider if there are any changes in the past year that have affected the coverage your family needs.
- Is it more advantageous for you to pay more in monthly contributions to have lower out-of-pocket expenses during the year? Or, is it better to pay lower monthly contributions and pay more when and if you actually need care during the year? Consider each plan's out-of-pocket limit.

Once you have reviewed your healthcare needs and selected the benefit plan that is best for you, you can access your personalized enrollment form online, using the user name and password for your CPG Web account.

WHAT'S INSIDE

The Medical Trust provides this *Annual Enrollment Guide* to help you make informed decisions about healthcare for yourself and your family.

The information provided in this *Annual Enrollment Guide* is intended only to summarize the benefits that are available to you. Please refer to the Plan Document Handbooks and the *Summaries of Benefits and Coverage* on www.cpg.org for an explanation of covered services, exclusions, and limitations.

Note that you may not be eligible for every plan described in this guide, as some options may not be available in all locations or to all groups. See your administrator for information on the plans available to you.

YOU'RE IN CHARGE

Whatever your medical plan, the following steps will help you become a better healthcare consumer and ensure your long-term health and wellness:

- **Stay well.** Get regular checkups, monitor your blood pressure, tell your doctor about all of your current medications, and get the recommended screen-ings for your age and gender. Make positive changes to your diet, commit to regular exercise, and eliminate risky behaviors such as smoking and heavy alcohol consumption.
- **Partner with your doctor.** Finding a doctor you trust and feel comfortable with is the first step toward good health. Once you have found a doctor who is right for you, work together to get the best care: prepare for your office visits with specific questions, listen carefully, and be sure to ask follow-up questions until you fully understand your medical issues.
- **Clarify your treatment options.** Research shows that many people receive medical treatments or surgeries that are unnecessary and even harmful to their health. At the same time, many people do not have the treatment or surgery they need or wait too long to seek medical care. When your doctor recommends a course of action, be sure you voice your questions, concerns, and preferences. Feel free to get a second opinion.
- **Learn more about your condition.** If you use the Internet to find health information, start by searching sites specializing in a particular disease or condition. For example, visit the American Heart Association website at www.americanheart.org, the American Academy of Allergy, Asthma and Immunology at www.aaaai.org, or the American Cancer Society at www.cancer.org.
- **Know what is covered by your plan.** Remember that any treatment you receive, even procedures that are covered by your plan, must be medically necessary or the claim may be denied. Consult your plan handbook and *Summary of Benefits and Coverage* to understand what your plan covers, what your cost shares are, and what your plan excludes. Although the plan handbook and summary cannot list every procedure or treatment option that is covered or excluded, they do contain the most commonly-used benefits. Call your health plan directly if you need more details or have any questions about your benefits.
- **Know where to go for care.** You have options and you can save time and money by accessing the right place for the care you need, such as your primary care provider (PCP), a retail health clinic, an urgent care clinic, or tele-medicine.
- **Get the most value from your prescription drug benefit.** For an occasional minor ailment such as joint pain, heartburn, or allergies, ask your doctor about over-the-counter treatments first. Request generic or preferred drugs when possible. Use a participating retail pharmacy, or better yet, use the home delivery program to reduce your costs even more.

- Visit the Health Learning Center at www.cpg.org/activehealthlearning. You will find information to help you improve your physical, mental, and emotional health, along with access to the resources available to you through the Medical Trust health plans.

MEDICAL PLAN OPTIONS

Medical coverage is important to everyone, whether or not you currently have any health issues. The Medical Trust plans provide preventive care benefits to keep you healthy and other benefits for when you are ill. The following types of medical plans are available depending on your participating group's offerings and the network access in your geographic region:

- Preferred Provider Organization (PPO) Plan
- Consumer-Directed Health Plan (CDHP)/Health Savings Account (HSA)
- Exclusive Provider Organization (EPO) Plan (regional Kaiser Permanente Plans only)

ABOUT THE PLANS

All Medical Trust plans provide care through a network of doctors, dentists, hospitals, pharmacies, laboratories, and other providers who have contracted to offer services at reduced rates. Each type of plan works a bit differently.

In the following pages, you will learn about the different plan designs, how they work, and what you need to think about to make the best decisions regarding your health coverage.

COMPARING ALTERNATE PLAN OPTIONS

When evaluating the plan options available to you, it is important to understand the trade-offs that differentiate the plans. Monthly contributions and out-of-pocket costs (when services are received) have an inverse relationship. In other words, certain plans may have lower out-of-pocket costs with higher monthly contributions, while others have higher out-of-pocket costs but lower monthly contributions. Using network providers usually lowers your out-of-pocket costs.

However, you may have instances where you need or prefer to seek care from an out-of-network provider. This freedom to choose out-of-network providers (unavailable to EPO participants, except in emergencies) usually results in higher out-of-pocket costs than when using network providers.

UNDERSTANDING THE PLAN DESIGNS

- **Preferred Provider Organization (PPO).** Under a PPO, you can receive services from any provider, without the need to coordinate your care through a PCP. A PPO gives you the flexibility to visit the providers 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. It is important to note that when you participate in a PPO, 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 will often be responsible for submitting your own claims and may be balance-billed.

- **Consumer-Directed Health Plan/Health Savings Account (CDHP/HSA).** A CDHP/HSA is a high deductible health plan that consists of two components: a traditional health plan to protect you against healthcare expenses (Consumer-Directed Health Plan) and a tax-advantaged savings vehicle (Health Savings Account).¹ With the exception of most preventive care, the benefits from your health plan begin after you meet your annual deductible.² Contributions to the HSA help you build savings for current and future medical expenses that fall within the deductible of the CDHP.

In order to understand the CDHP/HSA combination, it is important to see how its two components work. The CDHP/HSA combination allows you to take control of your day-to-day healthcare costs through a savings/reimbursement account that offers the protection of a traditional health plan and promotes preventive care.

- The CDHP works much like a PPO. You can receive services from any provider, and you do not have to coordinate your care through a PCP. While the CDHP covers services in and out of the network,³ the CDHP provides very strong financial incentives for you to use network providers. Despite the high deductible associated with a CDHP, most preventive care services require no copayment.
- The HSA is a savings account funded by you and/or your employer with a tax-favored status. You can open an HSA only if you are enrolled in a qualified CDHP. When you incur a medical expense, you can pay for it with your HSA funds. If you do not use the money in your HSA, the balance continues to grow with tax-free earnings to use for future medical expenses.
- Once money is deposited into your HSA, it is yours to spend as necessary. Unused dollars earn interest tax-free, with certain restrictions. If you change employers or retire, you can take your HSA with you. Withdrawals from your

¹ In general, you will not be eligible for the CDHP/HSA option if you have any other health coverage that would apply to services covered by the CDHP/HSA. For example, if your spouse has other health coverage through his or her employer, your spouse may not be eligible for coverage under the CDHP/HSA option. Also, participation in a flexible spending account (FSA) arrangement may limit your ability to obtain coverage under the CDHP/HSA option.

² The CDHP deductible is a combination of the medical and pharmacy deductible requirements. Therefore, to begin receiving benefits from your medical and prescription drug plans, you must meet one combined deductible.

³ The Kaiser CDHP-20/HSA works like an EPO, and therefore has no out-of-network benefits except in emergencies.

HSA are tax-free as long as they are used to pay for qualified medical expenses. Therefore, it is important that you maintain medical records for tax-reporting purposes.

- **Exclusive Provider Organization (EPO)— Kaiser Permanente.** When you select an EPO through Kaiser, you agree to use **only** Kaiser’s network of professionals and facilities. It is important to note that when you participate in an EPO, you are responsible for ensuring that the services and care you receive are covered by your plan. Kaiser does **not** cover the cost of services received from out-of-network providers, except in emergency situations. Kaiser requires you to select a primary care physician (PCP).

DEDUCTIBLES

The Anthem Consumer-Directed Health Plan-15 (CDHP-15) and the Cigna CDHP-15 have a non-embedded deductible. This means that if you have other family members on the plan, then the family deductible must be met before the plan begins to pay.

All other plans have an embedded deductible. 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 Anthem and Cigna CDHP-15 plans have a non-embedded out-of-pocket limit. If you have other family members on the plan, then the family out-of-pocket limit must be met.

All other plans have an embedded out-of-pocket limit. Each member need only meet the individual out-of-pocket limit until the family out-of-pocket limit has been met.

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.

It is important to evaluate your personal situation. Does it make more sense for you 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?

THE IMPORTANCE OF THE NETWORK

Another factor to consider when choosing a plan is access to providers. Usually, participation in an exclusive or limited-network plan means that your out-of-pocket costs are lower if you see a doctor in the network but higher if you see a doctor who is not in the network. The Kaiser plans, however, will not pay for *any* non-emergency services that you receive out of network. So, when choosing your plan, evaluate the importance of the cost and flexibility to choose an out-of-network provider.

COVERAGE TIERS AND COSTS

If you elect coverage under one of the plans, the coverage tiers available to you depend on what is offered by your group or diocese. Coverage tiers range from single coverage for yourself only to family coverage for you and all of your dependents. The cost of coverage varies based on the plan option and coverage tier you select.

Please see your online enrollment form for the specific coverage tiers available to you. **The rates indicated on your online enrollment form may not necessarily be what your employer requires you to pay.**

MEDICARE SECONDARY PAYER/SMALL EMPLOYER EXCEPTION

Some groups have elected to participate in the Episcopal Health Plan for Qualified Small Employer Exception Members (the SEE Plan). To participate in this program, you must be age 65 or older and actively working for a church or group that offers this choice. Additionally, you must be enrolled in Medicare Part A and choose a participating Anthem or Cigna plan.

If you are participating in the SEE Plan, Medicare will be the primary payer for Part A (hospitalization) services. Once Medicare has paid its share, claims are sent to Anthem, which pays the claims as it would for any active employee, minus the amounts paid by Medicare, your deductibles, and your cost shares.

This program is also available for those enrolled in Medicare Part B. More information will be mailed to eligible individual participants.

SUMMARIES OF BENEFITS AND COVERAGE

A high-level overview of benefits and cost shares appears in the *Summary of Benefits and Coverage* for each plan, available at www.cpg.org/mtdocs. A paper copy is also available, free of charge, by calling (800) 480-9967, 8:30AM – 8:00PM ET (excluding holidays).

PREScription DRUG BENEFITS

When you enroll in one of our Anthem or Cigna medical plans, you will automatically have prescription drug coverage through the Express Scripts Prescription Drug Program. This program includes a Formulary Management Program, which uses a three-tier copayment approach to covered drugs and is designed to control costs for you and the plan. The formulary includes FDA-approved drugs that have been placed in tiers based on their clinical effectiveness, safety, and cost.

- Generic drugs generally have the lowest cost share.
- Preferred drugs have a higher cost share.
- Non-preferred drugs and all non-sedating antihistamines have the highest cost share.

For 2019, there are two prescription drug benefit plans through Express Scripts for the Anthem and Cigna PPOs: the Standard Plan and the Premium Plan.

The Anthem and Cigna CDHPs each have their own prescription drug plans, also through Express Scripts.

Members enrolled in a Kaiser plan will receive their prescription drug benefits through Kaiser.

See your personalized Annual Enrollment page for your pre-determined plan option.

For more detailed information on the prescription drug plans, please see the *Summaries of Benefits and Coverage*.

EXCLUSIVE HOME DELIVERY (EXPRESS SCRIPTS)

To help manage overall costs for members and limit increases in prescription drug cost shares, the Express Scripts Prescription Drug Program maintains a mandatory home delivery program. The program requires that you participate in the home delivery program if you are prescribed a maintenance medication, rather than refilling multiple prescriptions for the same drug at a retail pharmacy.

Remember, the retail pharmacy program allows for a total of three fills of a maintenance medication at a retail pharmacy (the original fill and two refills). Additional fills will not be covered by the program at the retail level. Each fill can be for no more than a 30-day supply. You are allowed a total of only three fills, even if each is for less than 30 days.

In some circumstances, you may not be required to utilize the home delivery program. For example, there are certain categories of medications that are uniquely appropriate for refills at your local pharmacy (and are therefore exempt from the

retail refill limit provision, as outlined above). These would include anti-infectives (including antibiotics), medications to treat acute pain, and medications that require a new written prescription each time you need them, among others.

GENERIC MEDICATIONS

Generic medications meet the same standards of safety, purity, strength, and effectiveness as the brand-name drug. They have the same active ingredients and are manufactured according to the same strict federal regulations.

These drugs may differ in color, size, or shape, but the U.S. Food and Drug Administration (FDA) requires that the active ingredients have the same strength, purity, and quality as their brand-name counterparts.

For this reason, when there is a generic available, the plans will cover only the cost of the generic equivalent. If you decide to purchase the brand-name medication, you will be charged the generic cost share *and* the cost difference between the brand-name and the generic medication.

If you have questions or concerns about generic medications, or if you want to know if they are an option for you, speak to your physician or your pharmacist.

YOUR PLAN MAY HAVE COVERAGE LIMITS

Some prescription drugs used for cosmetic purposes may not be covered, or a medication might be limited to a certain number of pills or total dosage within a specific time period.

If you submit a prescription for a drug that has coverage limits, your pharmacist will tell you that approval is needed before the prescription can be filled. The pharmacist will give you or your doctor a toll-free number to call. If you use Express Scripts Home Delivery, your doctor will be contacted directly.

When a coverage limit is reached, more information is needed to determine whether your continued use of the medication meets your plan's extended coverage conditions. Express Scripts will notify you and your doctor of the decision in writing. If coverage is approved, the letter will indicate the amount of time for which extended coverage is valid. If continued coverage is denied, an explanation will be provided, along with instructions on how to submit an appeal.

ADDITIONAL INFORMATION

It is always up to you and your doctor to decide which prescriptions are best for you. You are never required to use generic drugs or drugs that are on the Express

Scripts formulary list. If you prefer, you can use non-formulary brand-name drugs and pay a higher cost share.

Drugs included on the formulary list are updated frequently. (Note that some drugs listed on the formulary may not be covered due to plan exclusions and limitations.) To find the most up-to-date list of covered drugs, visit Express Scripts at www.express-scripts.com, or call their member services department at (800) 841-3361. You can also use their website or member services telephone number to locate a retail pharmacy.

PAPER CLAIMS REIMBURSEMENT

If you use a non-participating retail pharmacy, you must pay the full price and file a claim for reimbursement. You will be reimbursed based on plan rules and what the plan would have paid at a participating pharmacy, less your applicable cost share. See your plan handbook for more information about filing claims for reimbursement for prescription drugs purchased at retail pharmacies.

OTHER PLAN BENEFITS

VISION BENEFITS

If you enroll in one of the Medical Trust’s plans, you will receive vision benefits through EyeMed Vision Care’s Insight Network. The vision care benefits include an annual eye examination with no copay when you use a network provider, and a benefit towards the purchase of prescription eyewear or contact lenses⁴ offered through a broad-based network of ophthalmologists, optometrists, and opticians at retail chains and independent provider locations.

The services described in the following chart are covered once every calendar year. The chart below is for descriptive purposes only. For more complete information regarding your vision coverage, please refer to the vision *Summary of Benefits and Coverage* available at www.cpg.org.

Benefit Description	Network	Out-of-Network
Eye Examinations	You pay \$0	Plan pays up to \$30 for ophthalmologists or optometrists
Lenses	You pay \$10 for single, bifocal or trifocal; \$75 copay for standard progressive ⁵ lenses	Plan pays up to: \$32 for single vision \$46 for bifocal and standard progressive \$57 for trifocal
Lens Options UV Coating Tint (Solid and Gradient) Standard Scratch Resistance Standard Polycarbonate Standard Anti-Reflective ⁶ Other Add-ons and Services	You pay up to \$15 You pay up to \$15 You pay up to \$15 You pay \$0 You pay up to \$45 20% off retail price	You are responsible for the cost of any lens options that you elect from out-of-network providers
Frames	Up to \$150 allowance, 20% off balance over \$150	Plan pays up to \$47
Contact Lenses Conventional/Disposable	Up to \$150 allowance, 15% off balance over \$150	Plan pays up to \$100

When you use EyeMed Insight Network providers, you do not need to submit a claim. Your EyeMed provider will submit claims for you. You are responsible for the copayment and any non-covered expenses at the time you receive services.

⁴ Cost of contact fitting is not covered.

⁵ Benefits are available for premium progressive lenses. Visit eyemedvisioncare.com for more information.

⁶ Benefits are available for premium anti-reflective coating. Visit eyemedvisioncare.com for more information.

Please keep in mind that many plans may offer limited vision coverage through their networks. Check with your plan for details.

For more information about EyeMed, and to see a list of EyeMed providers, please visit www.enrollwitheyemed.com/access, or call EyeMed toll-free at (866) 723-0596.

BEHAVIORAL HEALTH BENEFITS

Your emotional well-being is vital to the health of the Episcopal Church. That is why the Medical Trust has partnered with Cigna Behavioral Health to administer behavioral health benefits for the majority* of our Medical Trust plans.

Cigna will provide clinical support, customer service, and behavioral health claims processing for the inpatient and outpatient behavioral health benefits for members enrolled in many of our active plans.* Through our partnership with Cigna, members have access to an integrated behavioral health program that includes mental health, substance use disorder, and employee assistance benefits. Coverage for colleague group facilitators is also available through Cigna.

Cigna's nationwide network of behavioral health providers includes more than 70,000 independent psychiatrists, psychologists, pastoral counselors, and clinical social workers, as well as more than 6,000 facilities and clinics.

***Members enrolled in the Anthem Consumer-Directed Health Plans or the Kaiser Permanente Plans, as well as fully-insured plans, do not receive their behavioral health benefits through Cigna. Please see your plan handbook for details on your behavioral health benefits.**

EMPLOYEE ASSISTANCE PROGRAM (EAP)

Managed by Cigna Behavioral Health (CBH), the Employee Assistance Program (EAP) offers an array of services designed to assist you with work, life, and family issues. It is available to all members and members of their household⁷ enrolled in any active Medical Trust medical plan. EAP services are free, confidential, and available 24/7, through www.mycigna.com or by phone.

EAP services include these:

- Phone and website access **24/7**
- **In-person counseling** (up to 10 sessions per issue/per year with \$0 copay)
- **Immediate help** during a crisis

⁷ Household members do not need to be enrolled in the member's medical plan to use the EAP.

- **Local resources** in your community on a wide range of topics, including elder and child care providers, support groups, and so much more
- **Tips and guidance** to help balance work with family life, including a free legal or financial consultation
- **The Healthy Rewards® Member Discount Program**, offering discounts on weight management and nutrition programs, tobacco cessation programs, healthy lifestyle product discounts, and alternative medicine, such as acupuncture, chiropractic, and massage therapy

To access the Cigna EAP services, visit the EAP website at www.mycigna.com or call (866) 395-7794.

HEALTH ADVOCATE

Healthcare help is just a phone call away.

The Medical Trust provides the services of Health Advocate, a program composed mainly of registered nurses, backed up by a team of experts. These personal advocates help our members navigate and facilitate medical and administrative issues within the healthcare system. Eligible members, their spouses, dependent children, parents, and parents-in-law are covered by this service.

Health advocates can be invaluable guides as you choose a new health plan. They can help you understand your options, check the networks for your doctors or specialists, and clarify your cost shares in the plans you are considering.

Services also include:

- Finding qualified providers anywhere in the country
- Resolving insurance claims or billing issues
- Finding elder-care services
- Expediting appointments with hard-to-reach specialists
- Negotiating billing/payment arrangements
- Navigating a complex healthcare system

This program is like having your own healthcare assistant at no cost to you! Call as often as you need to and speak toll-free with a health advocate about an insurance or healthcare issue. 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 their website at www.healthadvocate.com/ecmt or call (866) 695-8622. Offices are open weekdays, 8:00AM to 7:00PM ET.

DENTAL BENEFITS

Many diseases produce oral signs and symptoms. So regular dental visits do more than just brighten your smile—they can be important to your overall health.

The dental plans offered by the Medical Trust are administered by Cigna. These plans offer both network and out-of-network coverage. You will be able to take advantage of discounted prices for dental care through an extensive network of over 135,000 providers. Each dental plan includes three annual cleanings and associated oral examinations. There is no deductible for network services when using a DPPO Advantage provider.

Some providers contract with Cigna to provide services to members as part of the Cigna Dental PPO (“DPPO”) Network. Cigna's network consists of two tiers of contracted providers. The first tier, Cigna DPPO Advantage, offers the highest discounts, and because the contracted rate results in savings to both you and the plans, you are reimbursed at a higher level if you use Cigna DPPO Advantage providers. Cigna DPPO Advantage providers are also referred to as network providers. The second tier of Cigna's network, the Cigna DPPO, still offers contracted rates, but these discounts are lower than with Cigna DPPO Advantage.

The term out-of-network refers to dental care providers that do not participate in the network. Cigna DPPO providers and out-of-network providers are reimbursed at the same level of benefits.

You can access the dental provider directory at www.mycigna.com or by calling toll-free at (800) 244-6224.

See the dental summaries of benefits and coverage at www.cpg.org/mtdocs for information on cost sharing for common services.

AMPLIFON HEARING HEALTH CARE

The Medical Trust offers access to Amplifon network discounts for hearing aids and supplies through more than 1,400 Amplifon affiliates across the U.S. These discounts are also available to your extended family members, who may also receive these discounts by mentioning that they are related to a member of a Medical Trust health plan.

For more information about the Amplifon network, or for a listing of their providers in your area, call Amplifon at (866) 349-9055, or visit www.amplifonusa.com.

TRAVEL ASSISTANCE SERVICES

When you enroll in a Medical Trust medical plan, you have access to UnitedHealthcare Global Assistance. This comprehensive travel emergency assistance pro-gram can help you with emergency medical or travel needs you encounter while you are 100 or more miles away from home. You do not need to enroll, and there is no additional contribution for this service, which is provided to you alongside your medical benefits.

UnitedHealthcare Global Assistance is available 24 hours a day, seven days a week. Its highly trained, multi-lingual coordinators work with an extensive information and communication system to provide you with critical assistance. You will have access to worldwide medical and dental referrals, replacement of prescription medication and corrective lenses, and various other travel-related medical services.

Please note, UnitedHealthcare Global Assistance is not responsible for your medical costs while you are traveling. If costs are incurred, and depending on where you travel, you may be required to pay for your healthcare services.

If the services are covered under your medical plan, you can submit them as medical plan claims for reimbursement. Your medical plan handbook and *Summary of Benefits and Coverage* will determine what is covered by your plan and how to submit a claim.

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

TAKING ACTION – CHOOSING THE RIGHT PLAN

The Important Role of Healthcare Consumers

The Medical Trust know that being an informed consumer is key to receiving the best possible care while containing medical costs, so we have included some tips below to help you to get the most out of your health plan.

Being a good consumer means making informed decisions about a variety of healthcare issues, from the type of health plan you select to health-related lifestyle choices, such as diet and exercise. This means actively managing your health and the care you receive—becoming educated, asking questions, and taking an active role in decisions affecting you and your family.

Things to consider when selecting a medical plan:

- Which plan type best meets your needs? The Medical Trust offers three kinds of plans: PPOs and CDHPs. EPOs are available in areas served by Kaiser Permanente. These are described earlier in this guide.
- Are you generally healthy and make few trips to the doctor? Or do you have certain medical conditions that require visits to a specialist and several prescriptions?
- Have your needs changed? If you are starting a family, for instance, or you want to put an eligible adult child on your health plan, another choice may work better for you.
- Before deciding to choose a different plan, make sure that your doctors and specialists are in its network. Also consider whether you would like the option to see providers not in the plan's network.
- Compare the costs of the plans. Maybe a lower contribution (premium) and a higher deductible works better for you. Also consider your cost share amount.
- If you are covered under another plan (a spouse's plan, for instance), consider the plan's benefits and costs. You should also understand the provisions for coordination of benefits between plans.

You can access the *Glossary of Health Coverage and Medical Terms* at www.cpg.org/uniform-glossary.

ENROLLING ONLINE

Once you have read this enrollment guide, learned about the plan options and cost shares available to you through your employer, and researched the best choices for you and your family in 2019, you will be ready to enroll online.

How Does Annual Enrollment Work?

- You will receive a letter in the mail this fall including the timeframe when the Annual Enrollment website will be open. Save this letter! It includes your Client ID number, which you will need to access the site. The letter also includes a link to our online Annual Enrollment website, where you will find instructions to make your healthcare benefit selections for 2019.
- To help you make an informed choice, your plan provides a *Summary of Benefits and Coverage* (SBC), which offers important information about any health coverage option in a standard format, to help you compare across options. Each SBC is available at www.cpg.org/mtdocs. For a free paper copy, call (800) 480-9967, 8:30AM – 8:00PM ET.
- Have your letter with you, and know your plan selections when you go online. Remember to include your plan and coverage tier selections when you enroll. (See NOTE below.)
- If your current plan is not being offered in 2019, you must go online and choose a new plan. 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 turned age 30 in 2018, he or she can no longer be covered under a Medical Trust plan unless he or she was determined to be disabled by the Medical Trust prior to attaining age 25.
- You can print a confirmation statement for your records after you make your coverage selections. Once you have completed the process, you will not be able to go back online and make any other changes. If you need to make any corrections or changes after completing the process, you will have to contact your group administrator or CPG's Client Services call center, so carefully check your selections.
- Your new plan choice takes effect on January 1, 2019. You may receive new ID cards (if applicable) at this time. Do not panic if they are delayed, as many ID cards can be printed by the Medical Trust or from the vendor's website. Call CPG's Client Services call center for assistance at (800) 480-9967, Monday — Friday from 8:30AM to 8:00PM ET (excluding holidays), or email mtcustserv@cpg.org. You can also download your ID card to your mobile device using your plan's app.

NOTE: Only the plans listed on your online Annual Enrollment form are available to you. However, an employer may occasionally cover only the costs of *one* of the plans, not all of them. Check with your administrator to be certain of which plans are available to your group and what your 2019 rates will be.

IF YOU DO NOT COMPLETE AN ONLINE ANNUAL ENROLLMENT FORM

If you do not enroll by the deadline and your current plan is still available for 2019, you will continue in the same plan with the same coverage tier. If you do not enroll by the deadline and your current plan is *not* offered in 2019, however, your medical benefits will be terminated as of December 31, 2018, and you cannot re-enroll in a plan until the next Annual Enrollment period, or when you incur a significant life event (as defined in the Plan Document Handbook).

TO LEARN MORE

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

ANTHEM

www.anthem.com

CIGNA MEDICAL AND DENTAL

www.mycigna.com

CIGNA BEHAVIORAL HEALTH (MENTAL HEALTH & EMPLOYEE ASSISTANCE PROGRAM)

www.mycigna.com

KAISER PERMANENTE

www.kp.org

EXPRESS SCRIPTS

www.express-scripts.com

EYEMED

Member Services

www.eyemedvisioncare.com/ecmt

Website and generic phone number for pre-enrollment information

www.enrollwitheyemed.com/access

HEALTH ADVOCATE

www.healthadvocate.com/ecmt

AMPLIFON

www.amplifonusa.com

UNITEDHEALTHCARE GLOBAL ASSISTANCE

<https://members.uhcglobal.com>

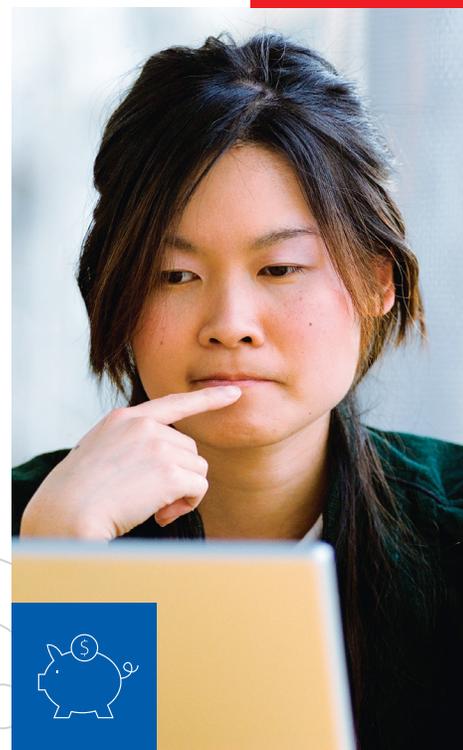
Does Annual Enrollment leave you dazed and confused?

Turn to Health Advocate

Understanding your health benefits can be confusing and time-consuming—especially if your benefits are changing. Health Advocate can answer your benefits questions and help you learn the ins and outs so you can get the most out of your coverage.

Our benefits experts can:

- **Check the networks.** If you have doctors or specialists you like, we can check to make sure they're in the network. If not, we can help you locate a new in-network provider, transfer your medical records, and even make appointments.
- **Explain your share of the costs.** Plans are required to state how much you'll pay out of pocket. We can help you understand the maze of copays, coinsurance and cost-sharing.
- **Make sure your drugs are covered.** We can check to see if the plan's list of covered medications includes those you take regularly, especially if they are expensive.
- **Factor in your dependents.** If you have children under age 30 they can be on your insurance, regardless of their coverage, dependent or marital status. Just a reminder: Policies can no longer exclude people because of pre-existing conditions.



We're not an insurance company. West's Health Advocate Solutions is not a direct healthcare provider, and is not affiliated with any insurance company or third party provider.

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Turn to us—we can help.



866.695.8622

Email: answers@HealthAdvocate.com
Web: HealthAdvocate.com/cpg

Download the app today!



HealthAdvocateSM

Disclaimer

The Plan(s) described in this document are sponsored and administered by the Church Pension Group Services Corporation ("CPGSC"), also known as the Episcopal Church Medical Trust (the "Medical Trust"). The Plans that are self-funded are funded by the Episcopal Church Clergy and Employees' Benefit Trust ("ECCEBT"), a voluntary employees' beneficiary association within the meaning of section 501(c)(9) of the Internal Revenue Code.

This document contains only a partial description of the Plans intended for informational purposes only. It should not be viewed as a contract, an offer of coverage, or investment, tax, medical, or other advice. In the event of a conflict between this document and the official Plan documents (summary of benefits and coverage, Plan Document Handbook), the official Plan documents will govern.

The Church Pension Fund and its affiliates, including but not limited to the Medical Trust and ECCEBT (collectively, "CPG"), retain the right to amend, terminate, or modify the terms of the Plans, as well as any post-retirement health subsidy, at any time, for any reason and unless required by law, without notice.

The Plans are church plans within the meaning of section 3(33) of the Employee Retirement Income Security Act and section 414(e) of the Internal Revenue Code. Not all Plans are available in all areas of the United States, and not all Plans are available on both a self-funded and fully insured basis. The Plans do not cover all healthcare expenses, and Members should read the official Plan document carefully to determine which benefits are covered, as well as any applicable exclusions, limitations, and procedures.

CPG does not provide any healthcare services and therefore cannot guarantee any results or outcomes. Healthcare providers and vendors are independent contractors in private practice and are neither employees nor agents of CPG. The availability of any particular provider cannot be guaranteed, and provider network composition is subject to change.

NOTICE OF NONDISCRIMINATION

The Episcopal Church Medical Trust (the Medical Trust) complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. The Medical Trust does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex.

The Medical Trust:

- Provides free aids and services to people with disabilities to communicate effectively with us, such as qualified interpreters and written information in other formats such as large print materials
- Provides free language services to people whose primary language is not English, such as information written in other languages

If you need these services, contact Thomas DeCaneo, Civil Rights Coordinator. If you believe that the Medical Trust has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can obtain a copy of the grievance procedures or file a grievance with: Thomas DeCaneo, Civil Rights Coordinator, Church Pension Group, 19 East 34th Street, New York, NY 10016, Phone: 212-592-6345, Fax: 212-592-9487, Email: tdecaneo@cpg.org. You can file a grievance by mail, fax, or email. If you need help filing a grievance, Thomas DeCaneo, Civil Rights Coordinator is available to help you.

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights electronically through the Office for Civil Rights Complaint Portal, available at <https://ocrportal.hhs.gov/ocr/portal/lobby.jsf>, or by mail or phone at: U.S. Department of Health and Human Services, 200 Independence Avenue SW., Room 509F, HHH Building, Washington, DC 20201, 1-800-368-1019, 1-800-537-7697(TDD).

Complaint forms are available at <http://www.hhs.gov/ocr/office/file/index.html>.

ATENCIÓN: Si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-800-480-9967.

주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 1-800-480-9967.

برقم اتصل بالمجان لك تتوافر اللغوية المساعدة خدمات فان، اللغة اذكر تتحدث كنت إذا: ملحوظة
1-800-480-9967.

ATENÇÃO: Se fala português, encontram-se disponíveis serviços linguísticos, grátis. Ligue para 1-800-480-9967.

ATTENZIONE: In caso la lingua parlata sia l'italiano, sono disponibili servizi di assistenza linguistica gratuiti. Chiamare il numero 1-800-480-9967.

注意：如果您使用繁體中文，您可以免費獲得語言援助服務。請致電 1-800-480-9967。

PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tumawag sa 1-800-480-9967.

ATANSYON: Si w pale Kreyòl Ayisyen, gen sèvis èd pou lang ki disponib gratis pou ou. Rele 1-800-480-9967.

UWAGA: Jeżeli mówisz po polsku, możesz skorzystać z bezpłatnej pomocy językowej. Zadzwoń pod numer 1-800-480-9967.

ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Rufnummer: 1-800-480-9967.

CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số 1-800-480-9967.

ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните 1-800-480-9967.

ATTENTION : Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le 1-800-480-9967.

注意事項：日本語を話される場合、無料の言語支援をご利用いただけます。 1-800-480-9967。

شما برای رایگان بصورت زبانی تسهیلات، کنید می گفتگو فارسی زبان به اگر: توجه
بگیرید تماس با. باشد می فراهم 1-800-480-9967