



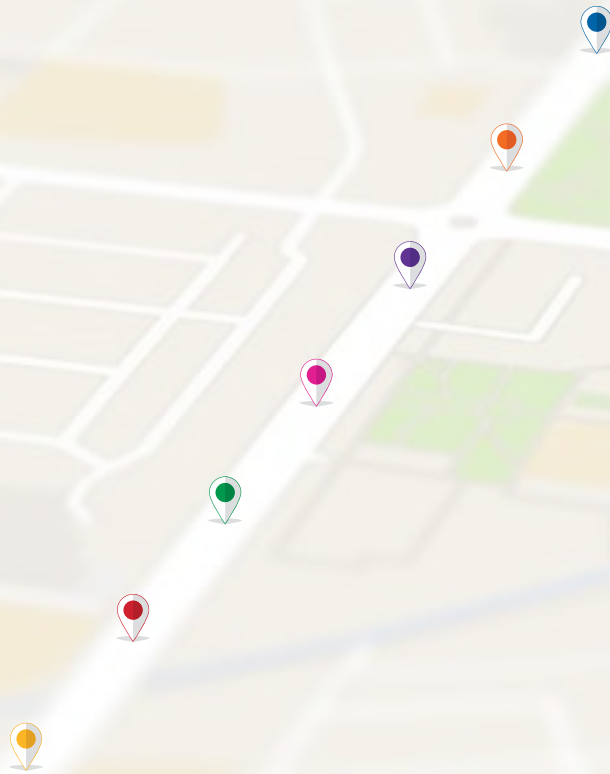
EPISCOPAL CHURCH
MEDICAL TRUST

Annual
Enrollment



2022 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.

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 brochure with important information for Annual Enrollment. Save this brochure! 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 2022, you must select another plan in order to have medical benefits in 2022.**

Glossary of Defined Terms

Please see the Uniform Glossary at 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.*



Selecting Your 2022 Benefits

Annual Enrollment for 2022 Medical Trust active health benefits begins in October 2021. 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 2022

Hours-based eligibility

The Medical Trust will simplify the Episcopal Health Plan (EHP) eligibility criteria by eliminating the exempt/non-exempt status criteria and will move to an hours-based eligibility criteria for active employees. You will be eligible to enroll in the EHP, regardless of whether you are an exempt or non-exempt employee, if you are normally scheduled to work 1,000 or more compensated hours per plan year. You will receive information on the Medical Trust's Extension of Benefits program if your coverage is terminated due to this change. **Please see your group administrator if you need to confirm your eligibility.**

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, 2022. 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, 2022.¹

Telehealth platforms for Active Members²

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. All services received via vendor telehealth platforms are available to you with no deductible, copay, or coinsurance through December 31, 2022.

- **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, 2022.

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.

Cigna Dental modernization

To ensure that members have high-quality, comprehensive dental benefits, the Medical Trust has reviewed and modernized its dental plan offering with Cigna.

Effective January 1, 2022, the Medical Trust's Cigna Dental plans will include coverage for Exparel, a long-lasting, non-opioid pain management medication for patients having oral surgery. Unlike systemic medications, Exparel works directly at the surgical site to numb nerves that cause pain; it is not a narcotic, and it is not addictive.

In addition, the Medical Trust is reclassifying osseous surgery, currently considered a Major Restorative Service, as a Basic Restorative Service for all of its Cigna Dental plan offerings. This means that the Medical Trust's Cigna Dental plans will reimburse these services at a higher rate starting in 2022.

There will be no change to the Medical Trust's Cigna Dental plan Annual Maximums or the plan's network for 2022 as a result of the plan modernization. These benefit design updates will have minimal impact on plan premiums.

Cigna EAP

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

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

¹ This deductible waiver includes our HSA-qualified CDHPs as permitted by IRS Notice 2020-15.

² 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.



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 5 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)

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 provider (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 if 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.



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 you 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 PCP.

Medicare Secondary Payer/ Small Employer Exception

To participate in this program, you must satisfy 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. Paper copies are also available, free of charge, by calling (800) 480-9967, 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 2021 Plan Document Handbook for more information about unique programs available from each health plan carrier.

Anthem

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 travelling 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 Treatment Decision Support Coaching®

Cigna Treatment Decision Support Coaching provides unbiased information and education on treatment options for common health conditions.

MDLive® telehealth

MDLive for Cigna telehealth platform lets you get the care you need—including most prescriptions—for a wide range of minor conditions. Now you can connect with board-certified providers via secure video chat or phone, without leaving your home or office, when, where, and how it works best for you.

Kaiser

Kaiser telehealth

Interactive visits between members and their personal Kaiser network providers using phone, interactive video, internet messaging applications, and email are intended to make it more convenient to receive medically appropriate covered services.

Important: 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. 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 before the plan begins to pay for any of its members.
- 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 the following 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

Vision Benefits

If you enroll in a Medical Trust plan, 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. See the Plan Document Handbook for more information.

If you are already registered on the EyeMed site, visit eyemedvisioncare.com/ecmt 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 unlimited 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 and senior care

There are also online resources on such issues as the following:

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

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 to access Talkspace virtual behavioral health

To access the Cigna EAP, visit 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 or call (866) 695-8622. Offices are open weekdays, 8:00 AM to 7:00 PM ET.

Dental Benefits

The dental plans offered by the Medical Trust are administered by Cigna.

The Medical Trust offers no-cost-share preventive care and three checkups a year 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 or call (800) 244-6224.

See the dental *Summaries of Benefits and Coverage* at cpg.org/mtdocs for information on cost sharing for common services.

Please note: You may not drop or add dental coverage mid-year.

Travel Assistance Services

When you enroll in a Medical Trust health plan, you have access to UnitedHealthcare Global Assistance®. This comprehensive travel emergency assistance program can help you with emergency medical or 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
- Replacement of prescriptions, medical devices, and corrective lenses
- Emergency travel arrangements and replacement of lost or stolen travel documents
- Emergency fund transfers
- Destination profiles, which include health and security risks for over 170 countries

Please 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.

For more information about UnitedHealthcare Global Assistance services, please visit 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 across options.

SBCs are available at cpg.org/mtdocs. For a free paper copy, call (800) 480-9967, 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 if your provider is in the plan's network.
- **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, 2022.

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 brochure that was mailed to your home in a green envelope.

When you are ready to enroll, log on to cpg.org/annualenrollment and follow the instructions.

If your current plan is not offered in 2022, 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 2021, 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 2021 to voluntarily continue medical and/or dental coverage on their own for up to 36 months commencing on January 1, 2022, 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. **Once you have completed the process, you will not be able to go back online and make any changes.** To make a correction or change after completing the process, contact your group administrator or CPG's Client Services call center.

Your new plan choice takes effect on January 1, 2022. 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 CPG's Client Services for assistance at (800) 480-9967, Monday to Friday from 8:30 AM to 8:00 PM ET, or email mtcustserv@cpg.org.

If You Do Not Enroll by the Deadline

If you miss the deadline and your current plan is still available for 2022, 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 are no longer eligible to participate in the plan effective January 1, 2022, as a result of the change in our eligibility rules, you may voluntarily continue medical and/or dental coverage on your own for up to 36 months commencing on January 1, 2022, through the Medical Trust's Extension of Benefits provision.

If you do not enroll by the deadline and your current plan is not offered in 2022, your medical benefits will end on December 31, 2021, 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).

To Learn More

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

Anthem

anthem.com

Cigna Medical and Dental

mycigna.com

Cigna Behavioral Health

(Employee Assistance Program)

mycigna.com

Kaiser

kp.org

Express Scripts

express-scripts.com

EyeMed

Member Services

eyemedvisioncare.com/ecmt

Website with general information and "find a provider" search tool

eyemedvisioncare.com/ecmt

Health Advocate

members.healthadvocate.com

UnitedHealthcare

Global Assistance

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 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 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 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 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 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, 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.

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.”



EPISCOPAL CHURCH
MEDICAL TRUST

19 East 34th Street
New York, NY 1001
(800) 480-9967
cpg.org

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 (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.