The Episcopal Church Medical Trust

Open Enrollment Guide

Benefits effective as of January 1, 2016

EPISCOPAL CHURCH
MEDICAL TRUST

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 has 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 certain of its benefit plans through a trust fund known as the Episcopal Church Clergy and Employees' Benefit Trust (ECCEBT)*. 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 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, please visit our website at www.cpg.org; or call Client Services at (800) 480-9967.

ELIGIBILITY

The Open Enrollment Guide does not contain information on eligibility for plan participation. Should you need confirmation of your eligibility, please see your group administrator for eligibility details.

**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 2016 Benefits

As our Open Enrollment period begins, The Episcopal Church Medical Trust (Medical Trust) will continue to provide you with health plans and benefits that make good sense for you and your family.

The Medical Trust is embarking on a multi-year strategy of simplifying your health options. We are offering plans that help you make more informed decisions regarding your health and medical treatment, that promote wellness and preventive care, and that balance our responsibility to be good financial stewards.

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

Open Enrollment provides an opportunity for you to consider your current health plan and compare its benefits to other plans offered, which will allow you to select the one that best meets your needs for the coming year.

It's important for you to carefully consider your plan choices for next year. 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 Open Enrollment Guide carefully to understand the plans the Medical Trust offers and the steps to follow to enroll in your 2016 benefits.
- Review the medical plan Summaries of Benefits and Coverage available online or from your benefits administrator. The summaries provide more detailed information about the available benefits under each of the medical plan options for which you're eligible.
- Review last 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 impacted 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? (We call this "pay now or pay later.") Consider each plan's out-of-pocket maximum.

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 login name and password in your open enrollment letter.

WHAT'S INSIDE

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

In this guide you will find important highlights of:

- Medical plan options
- Prescription drug benefits
- Behavioral health benefits
- Vision benefits
- Dental benefits
- Travel assistance services
- Health Advocate

Please note that you may not be eligible for all of the plans described in this guide, as some options may not be available in all locations or to all groups. Additionally, this guide does not describe any regional or local medical plan options that your group or diocese may offer.

Your Role in the Value of Your Healthcare

Whatever your medical plan, the following steps will help you to 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 the medications you're taking, and get the recommended screenings for your age and gender. Make positive changes to your diet, commit to regular exercise, and eliminate risky behaviors such as smoking.
- Partner with your doctor. Finding a doctor you trust and feel comfortable with is the first step toward good health. Once you've found a doctor that's right for you, work together to get the best care: prepare for your office visits, listen, ask questions, and learn all you can about your medical issues.
- Understand your treatment options. Research shows that millions of people receive medical treatments or surgeries that are unnecessary and even harmful to their health. At the same time, many people don't get the treatment or surgery they need or wait too long to seek medical care. When your doctor makes a recommendation, be sure you voice your questions, concerns, and preferences. Get a second opinion if warranted.
- Learn more about your condition. If you use the Internet to find health information, start by searching sites specializing in a disease or condition. For example, if you're interested researching heart disease, visit the American Heart Association website at www.americanheart.org; the American Academy of Allergy, Asthma and Immunology website at www.aaaai.org has information on asthma and allergies; the American Cancer Society website at www.cancer.org specializes in information about cancer.
- 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 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 detail or have any questions about your benefits.
- 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 mail-order program to reduce your costs even more.
- Visit the Medical Trust's wellness center at www.cpg.org/wellness. Join our Small Change, Big Difference Campaign and sample 100 different small steps you can take to be healthier, including our video series with health coach Peter K offering practical tips to feel better, eat healthier, and reduce stress.

By taking care of your health today, you will be safeguarding your health for years to come.

Medical Plan Options

Medical coverage is important to everyone. The plans offered by the Medical Trust provide preventive care benefits to keep you healthy, and other benefits to help when you are ill. The Medical Trust offers the following types of medical plans, available depending on your participating group's offerings and network access in your geographic location:

- Preferred Provider Organization (PPO) Plan
- Exclusive Provider Organization (EPO) Plan
- Health Maintenance Organization (HMO) Plan
- Point-of-Service (POS) Plan
- High Deductible Health Plan (HDHP)/Health Savings Account (HSA)

About the Plans

All of the 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 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 low out-of-pocket costs with high 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 HMO and EPO participants, except in emergencies) usually results in higher out-of-pocket costs than using network providers.

Understanding the Plan Designs

- Preferred provider Organization (PPO). Under a PPO, you can receive services from any provider, without coordinating your care through a primary care physician (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's 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'll often be responsible for submitting your own claims and may be balance-billed.

- Exclusive Provider Organization (EPO). When you select an EPO, you agree to use only the plan's network of professionals and facilities. It's 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. An EPO does not cover the cost of services received from nonparticipating providers, except in emergency situations. However, unlike most local HMOs, an EPO uses a national network. You are not required to select a primary care physician*.

- Health Maintenance Organization (HMO). Under an HMO, you agree to use the healthcare professionals and facilities associated with that HMO and you must select a primary care physician to coordinate your care. Except in emergencies, HMOs do not cover the cost of services you receive from doctors or other providers outside of the HMO's network. With an HMO, there are no deductibles or claim forms. After a copayment for each office visit, most medical expenses are covered at 100%.

- Point-of-Service. Under a POS plan, you will receive benefits similar to an HMO, but with an out-of-network option. Our POS Plans are open-access, meaning you aren't required to choose a PCP. Most network services have a small copayment or coinsurance.

- High Deductible Health Plan/Health Savings Account (HDHP/HSA). With an HDHP/HSA your coverage consists of two components: a traditional health plan to protect you against healthcare expenses (High Deductible Health Plan) and a tax-advantaged savings vehicle (Health Savings Account).** With the exception of preventive care, the benefits from your health plan (HDHP) begin after you meet your annual deductible***. Contributions to the HSA help you build savings for current and future medical expenses that fall within the deductible of the HDHP.

**The Kaiser Plans are built on an HMO platform, and therefore, require the selection of a PCP.*

***In general, you will not be eligible for the HDHP/HSA option if you have any other health coverage that would apply to services covered by the HDHP/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 HDHP/HSA option. Also, participation in a flexible spending account (FSA) arrangement may limit your ability to obtain coverage under the HDHP/HSA option.*

****The HDHP 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.*

In order to understand the HDHP/HSA combination, it is important to see how its two components work. The HDHP/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 HDHP 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 HDHP covers services in and out of the network, like the PPO, the HDHP provides very strong financial incentives for you to use network providers. Despite the high deductible associated with an HDHP, certain 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 only open an HSA if you are enrolled in a qualified high deductible health plan. 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's yours until you spend it. 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 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.

Deductibles

With the exception of the Anthem High Deductible Plan (HDP) 15, all plans have an embedded deductible. What this means is that once a member meets the individual deductible, the plan will begin to pay benefits for that member. Once the family deductible has been met, the plan will pay for benefits for all enrolled members in that family.

The Anthem HDP 15 Plan has a non-embedded deductible. If you have spousal or family coverage under this plan, then the family deductible must be met before benefits are paid for any enrolled member. If you have single coverage under the Anthem HDP 15, then you need meet only the individual deductible.

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 are going to be higher for 90/70 designs than 80/60 or 75/50 designs. However, your out-of-pocket costs when receiving services are higher in the 80/60 and 75/50 plans.

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 month-to-month with the risk 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. HMOs and EPOs, for example, will not pay for any non-emergency services that you receive out of network. When choosing your plan, evaluate the importance of the freedom to choose your own doctor.

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 you 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.

Medical Plan Coverage Provisions

Now that you understand how the plans work, you can use the following charts to compare the benefits and coverage provisions of each plan. The dollar amounts and percentages in the charts are your cost share.

Medicare Secondary payer/Small Employer Exception

Some groups have elected to participate in the Medicare Secondary Payer/Small Employer Exception (MSP/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 Blue Cross and Blue Shield plan.

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

This program is also available for those enrolled in Medicare Part B.

More information will be mailed to the individual participants affected.

Please note that some of the options described in this Open Enrollment Guide may not be available in all locations or to all groups. Your personalized online enrollment form indicates the plan options available to you. Local managed care plans are not included in this guide.

Plan Type	PPO					
Plan Design	PPO 90/70	PPO 80/60	PPO 75/50	High Option	PPO 70 SLV	Choice Plus PPO
Plan Partner	Anthem BCBS	Anthem BCBS	Anthem BCBS	Anthem BCBS	Anthem BCBS	United Healthcare
PCP Selection Required	No	No	No	No	No	No
Referral Required for Specialty Care	No	No	No	No	No	No
Network Individual/ Family Deductible	$250/$500	$500/$1,000	$900/$1,800	$200/$500	$3,000/$6,000	$0/$0
Network Individual/ Family Out-of-Pocket (OOP) Maximum (Including Deductibles)	$1,750/$3,500	$2,500/$5,000	$4,100/$8,200	$2,200/$4,500	$4,000/$8,000	$2,000/$4,000
Network Medical Member Coinsurance	10%	20%	25%	0%	30%	0%
Network Lab & X-Ray Coinsurance/ Copayment	20%	20%	25%	$30	30%	$25
Routine Physical Copayment	$0	$0	$0	$0	$0	$0
Office Visit Copayment (PCP)	$25	$25	$35	$30	$35	$25
Office Visit Copayment (Specialist)	$25	$25	$45	$30	$45	$25
Out-of-Network Hospital Benefits Available?	Yes	Yes	Yes	Yes	Yes	Yes
Network Inpatient Admission Copayment	$100/$600 per day/maximum	$100/$600 per day/maximum	$100/$600 per day/maximum	$150 per admission	$100/$600 per day/maximum	$100/$600 per day/maximum
Network Inpatient Admission Member Coinsurance After Copayment	10%	20%	25%	0%	30%	0%
Network Inpatient Coinsurance Subject to Annual Deductible?	No	No	No	No	No	No
Network Outpatient Surgery Copayment/ Member Coinsurance	10%	20%	25%	$150	30%	$200
Out-of-Network Individual/Family Deductible	$500/$1,000	$1,000/$2,000	$1,800/$3,600	$500/$1,000	$6,000/$12,000	$500/$1,500
Out-of-Network Individual/Family OOP Maximum	$4,000/$8,000	$5,500/$11,000	$6,400/$12,800	$3,000/$6,000	$8,000/$16,000	$2,100/$6,300
Out-of-Network Member Coinsurance	30%	40%	50%	30%	50%	30%
Network Mental Health/ Substance Abuse Outpatient	$20 (through Cigna)	$20 (through Cigna)	$20 (through Cigna)	$20 (through Cigna)	$20 (through Cigna)	$20 (through Cigna)
Network Mental Health/ Substance Abuse Inpatient	$100/$600 per day/maximum (through Cigna)	$100/$600 per day/maximum (through Cigna)	$100/$600 per day/maximum (through Cigna)	$150 per admission (through Cigna)	$100/$600 per day/maximum (through Cigna)	$100/$600 per day/maximum (through Cigna)

Plan Type	EPO		
Plan Design	Choice EPO	EPO 90	EPO 80
Plan Partner	United Healthcare	Anthem BCBS/ Aetna Select EPO	Anthem BCBS
PCP Selection Required	No	No	No
Referral Required for Specialty Care	No	No	No
Network Individual/ Family Deductible	$0/$0	$200/$500	$350/$700
Network Individual/Family Out-of-Pocket (OOP) Maximum (Including Deductibles)	$2,000/$4,000	$1,700/$3,500	$2,350/$4,700
Network Medical Member Coinsurance	0%	10%	20%
Network Lab & X-Ray Coinsurance/ Copayment	$25	20%	20%
Routine Physical Co-payment	$0	$0	$0
Office Visit Copayment (PCP)	$25	$25	$25
Office Visit Copayment (Specialist)	$25	$25	$25
Out-of-Network Hospital Benefits Avail-able?	No	No	No
Network Inpatient Admission Copayment	$100/$600 per day/maximum	$0	$0
Network Inpatient Admission Member Coinsurance After Copayment	0%	10%	20%
Network Inpatient Coinsurance Subject to Annual Deductible?	N/A	Yes	Yes
Network Outpatient Surgery Copayment/ Member Coinsurance	$150	10%	20%
Out-of-Network Individual/Family De-ductible	N/A	N/A	N/A
Out-of-Network Indi-vidual/ Family OOP Maximum (Excludes Deductibles)	N/A	N/A	N/A
Out-of-Network Member Coinsurance	N/A	N/A	N/A
Network Mental Health/ Substance Abuse Outpatient	$20 (through Cigna)	$20 (through Cigna)	$20 (through Cigna)
Network Mental Health/ Substance Abuse Inpatient	$100/$600 per day/maximum (through Cigna)	10% (through Cigna)	20% (through Cigna)

Plan Type	EPO			
Plan Design	Open Access Plus (In-Network)	High Option EPO	Mid Option EPO	EPO 80
Plan Partner	Cigna	Kaiser Permanente	Kaiser Permanente	Kaiser Permanente
PCP Selection Required	No	Yes	Yes	Yes
Referral Required for Specialty Care	No	Yes	Yes	Yes
Network Individual/ Family Deductible	$0/$0	$0/$0	$0/$0	$500/$1,000
Network Individual/Family Out-of-Pocket (OOP) Maximum (Including Deductibles)	$2,000/$4,000	$1,500/$3,000	$2,000/$4,000	$3,500/$7,000
Network Medical Member Coinsurance	0%	0%	0%	20%
Network Lab & X-Ray Coinsurance/ Copayment	$0	$0	$0/$100 for High Tech (MRI, CT, PET, etc)	20%
Routine Physical Co-payment	$0	$0	$0	$0
Office Visit Copayment (PCP)	$25	$20	$20	$25
Office Visit Copayment (Specialist)	$25	$20	$30	$35
Out-of-Network Hospital Benefits Available?	No	No	No	No
Network Inpatient Admission Copayment	$250 per admission	$0	$250	$0
Network Inpatient Admission Member Coinsurance After Copayment	0%	0%	0%	20%
Network Inpatient Coinsurance Subject to Annual Deductible?	N/A	N/A	N/A	Yes
Network Outpatient Surgery Copayment/ Member Coinsurance	$250	$20	$100	20%
Out-of-Network Individual/Family Deductible	N/A	N/A	N/A	N/A
Out-of-Network Individual/ Family OOP Maximum (Excludes Deductibles)	N/A	N/A	N/A	N/A
Out-of-Network Member Coinsurance	N/A	N/A	N/A	N/A
Network Mental Health/ Substance Abuse Outpatient	$20 (through Cigna)	$20 individual/ $10 group	$20 individual/ $10 group	$25 Individual/ $12 group
Network Mental Health/ Substance Abuse Inpatient	$150 copay per admission (through Cigna)	$0	$250 per admission	20%

Plan Type	HMO	POS		HDHP/HSA		
Plan Design	National HMO	Choice POS II	Open Access Plus	HDHP/HSA	HDP – 15 *	HDP - 40
Plan Partner	Aetna	Aetna	Cigna	Anthem BCBS/ Cigna	Anthem BCBS	Anthem BCBS
PCP Selection Required	Yes	No	No	No	No	No
Referral Required for Specialty Care	Yes	No	No	No	No	No
Network Individual/ Family Deductible	$0/$0	$250/$500	$500/$1,000	$2,700/$5,450 (medical & pre-scription drugs)	$1,400/$2,800 (medical & pre-scription drugs)	$3,500/$7,000 (medical & pre-scription drugs)
Network Individual/Family Out-of-Pocket (OOP) Maximum (Including Deductibles)	$2,000/$4,000	$1,750/$3,500	$2,500/$5,000	$4,200/$8,450 (medical & pre-scription drugs)	$2,400/$4,800 (medical & pre-scription drugs)	$6,000/$12,000 (medical & pre-scription drugs)
Network Medical Member Coinsurance	0%	10%	20%	20%	15%	40%
Network Lab & X-Ray Coinsurance/ Copayment	$25	20%	20%	20%	15%	40%
Routine Physical Copayment	$0	$0	$0	$0	$0	$0
Office Visit Copayment (PCP)	$25	$25	$25	20%	15%	40%
Office Visit Copayment (Specialist)	$25	$25	$25	20%	15%	40%
Out-of-Network Hospital Benefits Available?	No	Yes	Yes	Yes	Yes	Yes
Network Inpatient Admission Copayment	$150 per day/$600 maximum	$100 per day/$600 maximum	$250 per admission	Part of network deductible	Part of network deductible	Part of network deductible
Network Inpatient Admission Member Coinsurance After Copayment	0%	10%	20%	20%	15%	40%
Network Inpatient Admission Subject to Annual Deductible?	N/A	No	Yes	Yes	Yes	Yes
Network Outpatient Surgery Copayment/ Member Coinsurance	$250	10%	20%	20%	15%	40%
Out-of-Network Individual/Family Deductible	N/A	$500/$1,000	$1,000/$2,000	$3,000/$6,000	$2,800/$5,600	$7,000/$14,000
Out-of-Network Indi-vidual/ Family OOP Maximum (Excludes Deductibles)	N/A	$4,000/$8,000	$5,500/$11,000	$4,000/$7,000	$4,800/$9,600	$10,000/$20,000
Out-of-Network Member Coinsurance	N/A	30%	40%	45%	40%	60%
Network Mental Health/ Substance Abuse Outpatient	$20 (through Cigna)	$20 (through Cigna)	$20 (through Cigna)	20%	15%	40%
Network Mental Health/ Substance Abuse Inpatient	$150 per day/$600 Maximum (through Cigna)	$100 per day/$600 maximum (through Cigna)	$150 per admission (through Cigna)	20%	15%	40%

* The HDP-15 plan has a non-embedded deductible. This means if you have spousal or family coverage, the family deductible must be met before the plan begins to pay for benefits for any member enrolled in the plan. If you have single coverage, then only the individual deductible must be met. Preventive care is not subject to the deductible in any plan offered by the Medical Trust.

PRESCRIPTION DRUG BENEFITS

When you enroll in one of our medical plan options for Anthem BCBS, Cigna, Aetna, or UnitedHealthcare, you'll 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 all FDA-approved drugs that have been placed in tiers based on their clinical effectiveness, safety, and cost.

- Tier 1 includes primarily generic drugs (smallest copayment)
- Tier 2 includes preferred drugs (middle copayment)
- Tier 3 includes non-preferred drugs and all non-sedating antihistamines (highest copayment)

For 2016, there are two prescription drug benefit plans through Express Scripts: the Standard Plan and the Premium Plan. (The HDHP/HSA and the Kaiser Permanente EPO Plans have their own prescription drug plans.) See your personalized open enrollment page for your predetermined plan option.

Please see the Summaries of Benefits and Coverage for information on the prescription drug plans offered by Kaiser Permanente.

Standard Prescription Drug (Rx) Plan*

	Retail Prescription Drugs	Mail-Order Prescription Drugs
Annual Rx Deductible	$50 per individual	N/A
Tier 1: Generic	You pay up to $10	You pay up to $25
Tier 2: Formulary Brand-Name	You pay up to $35	You pay up to $90
Tier 3: Non-Formulary Brand-Name and Brand Non-Sedating Antihistamines	You pay up to $60	You pay up to $150
Dispensing Limits Per Copayment	Up to a 30-day supply	Up to a 90-day supply

Premium Prescription Drug (Rx) Plan*

	Retail Prescription Drugs	Mail-Order Prescription Drugs
Annual Rx Deductible	$50 per individual	N/A
Tier 1: Generic	You pay up to $5	You pay up to $12
Tier 2: Formulary Brand-Name	You pay up to $25	You pay up to $70
Tier 3: Non-Formulary Brand-Name and Brand Non-Sedating Antihistamines	You pay up to $45	You pay up to $110
Dispensing Limits Per Copayment	Up to a 30-day supply	Up to a 90-day supply

HDHP/HSA Prescription Drug (Rx) Plan

	Retail and Mail-Order Prescription Drugs
Network Rx Deductible (combined with Medical Deductible)	$2,700/5,450
Tier 1: Generic	15% after deductible
Tier 2: Formulary Brand-Name	25% after deductible
Tier 3: Non-Formulary Brand-Name and Brand Non-Sedating Antihistamines	50% after deductible

HDHP-15 Prescription Drug (Rx) Plan

	Retail and Mail-Order Prescription Drugs
Network Rx Deductible (combined with Medical Deductible)	$1,400/$2,800
Tier 1: Generic	15% after deductible
Tier 2: Formulary Brand-Name	25% after deductible
Tier 3: Non-Formulary Brand-Name and Brand Non-Sedating Antihistamines	50% after deductible

HDHP-40 Prescription Drug (Rx) Plan

	Retail and Mail-Order Prescription Drugs
Network Rx Deductible (combined with Medical Deductible)	$3,500/$7,000
Tier 1: Generic	15% after deductible
Tier 2: Formulary Brand-Name	25% after deductible
Tier 3: Non-Formulary Brand-Name and Brand Non-Sedating Antihistamines	50% after deductible

Coverage of Non-Sedating Antihistamines

The non-sedating antihistamine drug category has the highest copayment, regardless of the drug's formulary status. This change is a result of medications previously being available only by prescription now being available over the counter. For example, if you prefer to take the medication Clarinex rather than buying Claritin over the counter, you pay the third-tier copayment.

Prescription Deductible

The Prescription Drug Program has a separate annual deductible of $50 per individual for retail prescriptions. (Please note, this does not apply to the HDHP/ HSAs, where the pharmacy and medical plan deductibles are combined.) This annual Prescription Drug Program retail deductible does not apply to mail-order prescriptions, so you can begin receiving full mail-order program benefits without first meeting the

annual retail deductible. Keep this money-saving fact in mind if you or a covered dependent will be receiving any maintenance medications during the coming calendar year. The pharmacy benefit out-of-pocket maximum runs separately from your medical out-of-pocket maximum.

Exclusive Home Delivery

To help manage overall costs for members and limit dramatic increases to prescription drug copayments, the Prescription Drug Program maintains a mandatory mail program. The mandatory mail program requires that you participate in the mail-order 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. Note you are only allowed a total of three fills, even if each is for less than 30 days.

If you or a covered dependent receives a prescription for a maintenance medication and you do not use the mail-order program, your prescriptions may not be covered.

In some circumstances, you may not be required to utilize the mail-order program. For example, there are certain categories of medications that are uniquely appropriate for multiple refills at your local pharmacy (and are therefore exempt from the retail refill limit provision, as outlined above). If you have a prescription for any of the following medications, the Express Scripts Prescription Drug Program allows you to receive multiple refills at your local retail pharmacy:

- Anti-infectives, including antibiotics (Amoxicillin, Biaxin), antivirals (Zovirax, Famvir), antifungals (Diflucan), and drops used in the eyes and ears (Polsporin Opth, Cipro Otic). Please note that drops must be prescribed specifically to treat infection. For example, glaucoma drops are not covered.
- Prescription cough medications, including Phenergan with Codeine, Tessalon, and Tussionex
- Medications to treat acute pain, both narcotic (Vicodin, Percodan, etc.) and non-narcotic (Darvocet). Please note that long-term pain medications, such as NSAIDs, do not meet the necessary retail requirements.
- Medications that require a new written prescription each time you need them, as refills are prohibited by federal law (e.g., Percodan, Ritalin, and Nembutal)
- Medications used to treat both attention deficit disorder (Ritalin, Cylert) and narcolepsy (Dexedrine)

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.

Generic 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 only cover the cost of the generic equivalent, even if you decide to purchase the brand-name medication. You will be charged the generic copayment *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

Your plan may have certain coverage limits. For example, 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 By Mail, your doctor will be contacted directly.

When a coverage limit is reached, more information is needed to determine whether your use of the medication meets your plan's coverage conditions. We 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 coverage is valid. If 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 copayment.

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 copayment. 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'll receive vision benefits through EyeMed Vision Care. The vision care benefits include an annual eye examination 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.

EyeMed gives you the choice of using network or out-of-network providers, but your costs will be higher out-of-network.

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 official Plan Document Handbook for your medical plan.

The benefits described in this chart do not apply to regional and local medical plans that may be offered by your group.

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	Plan pays up to: $32 for single vision $46 for bifocal $57 for trifocal
Lens Options		
UV Coating	You pay up to $15	You are responsible for the cost of any lens options that you elect from out-of-network providers
Tint (Solid and Gradient)	You pay up to $15	
Standard Scratch Resistance	You pay up to $15	
Standard Polycarbonate	You pay $0	
Standard Anti-Reflective Coating	You pay up to $45	
Standard Progressive (add-on to Bifocal)	You pay up to $75	
Other Add-ons and Services	20% off retail price	
Frames	$130 allowance, 20% off balance over $130	Plan pays up to $47
Contact Lenses		
Conventional	$130 allowance, 15% off balance over $130	Plan pays up to $100
Disposable	$130 allowance, Then you pay balance over $130	Plan pays up to $100

When you use EyeMed network providers, you don't need to submit a claim. Your EyeMed provider will submit claims for you. You're responsible for the copayment and any noncovered expenses at the time you receive services.

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 Church. That's why the Medical Trust has partnered with Cigna to administer the Mental Health and Substance Abuse 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 mental health benefits for members enrolled in our active plans.* Through our partnership with Cigna, members have access to an integrated behavioral health program that includes mental health, substance abuse, and employee assistance benefits. Coverage for colleague group facilitators is also available through Cigna.

Cigna's nationwide network of mental 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 Blue Cross and Blue Shield High Deductible Plans and 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)

The Employee Assistance Program (EAP), managed by Cigna Behavioral Health (CBH), is available to all members and their dependents* enrolled in any active medical plan. The EAP offers an array of services designed to assist you with work, life, and family issues. EAP services are free, confidential, and available 24/7, through the CBH website or by phone.

EAP Services include:

- Phone and website access 24/7
- In-person counseling (up to 10 sessions per issue with $0 copay)
- Immediate help during a crisis
- 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 offers discounts on weight management and nutrition programs; tobacco cessation programs; alternative medicine such as acupuncture, chiropractic, and massage therapy; and healthy lifestyle product discounts.

**Dependents do not need to be enrolled in the member's medical plan to use the EAP.*

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

Health Advocate

Healthcare help is just a phone call away.

The Episcopal Church Medical Trust provides the services of Health Advocate to 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.

Personal health advocates, typically registered nurses, backed up by a team of experts, help members navigate the healthcare system, including, but not limited to:

- Finding the best doctors or facilities
- Resolving insurance claims or billing issues
- Finding elder care services
- Scheduling appointments with hard-to-reach specialists
- Navigating a complex healthcare system

It's like having your own healthcare assistant at no cost to you! Call as often as you need and speak toll-free with a personal 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.

To access Health Advocate, visit their website at www.members.healthadvocate.com or call (866) 695-8622. Offices are open weekdays 8:00AM to 7:00PM.

DENTAL BENEFITS

The dental plans available to you 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.

You may choose from the three dental plans described below during open enrollment. Please refer to the chart to compare the coverage levels available in each plan.

You can access the dental provider directory via the Internet at www.cigna.com, or by calling the toll-free number at (800) 244-6224.

Feature	Dental & Orthodontia PPO Plan	Basic Dental PPO Plan	Preventive Dental PPO Plan
Out-of-Network Annual Deductible	$25 Individual $75 Family	$50 Individual $150 Family	No Deductible
Annual Benefit Maximum	$2,000 Individual	$2,000 Individual	$1,500 Individual
Preventive & Diagnostic Services (e.g., oral exams, three cleanings, x-rays, emergency care to relieve pain)	You pay 0% (not subject to annual deductible)	You pay 0% (not subject to annual deductible)	You pay 0% (also includes sealants to age 14)
Basic Restorative Services	You pay 15% (and all amounts above the annual benefit maximum) *Includes fillings, root canal therapy, periodontal scaling and root planing, denture adjustments and repairs, extractions, and anesthetics*	You pay 15% (and all amounts above the annual benefit maximum) *Includes fillings, root canal therapy, periodontal scaling and root planing, denture adjustments and repairs, extractions, and anesthetics*	You pay 20% (and all amounts above the annual benefit maximum) *Includes only fillings, denture adjustments and repairs*
Major Restorative Services	You pay 15% (and all amounts above the annual benefit maximum) *Includes crowns, dentures, oral surgery, osseous surgery, night guards, dental implants, and bridges*	You pay 50% (and all amounts above the annual benefit maximum) *Includes crowns, dentures, oral surgery, osseous surgery, night guards, dental implants, and bridges*	You pay 99% (and all amounts above the annual benefit maximum) *Includes crowns, dentures, oral surgery, osseous surgery, bridges, and root canal therapy*
Orthodontia	You pay 50% ($1,500 individual lifetime maximum)	Not covered	You pay 99% (and all amounts above the annual benefit maximum)

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 Amplifon discounts by mentioning that they are related to you, and identifying you as a member of an Episcopal Church Medical Trust health plan.

For more information about the Amplifon network, or for a listing of Amplifon 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 the services provided by UnitedHealthcare Global Assistance. UnitedHealthcare Global Assistance can help you with emergency medical or travel needs you may encounter when you are 100 or more miles away from home. This service is provided to you alongside your medical benefits. You do not need to enroll, and there is no additional contribution for this service.

UnitedHealthcare Global Assistance provides a comprehensive emergency medical assistance program 24 hours a day, 7 days a week. Their highly trained, multilingual coordinators work with an extensive information and communication system to provide you with assistance you may need while traveling. With assistance from UnitedHealthcare Global 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 upon 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's covered by your plan and how to submit a claim.

For more information about UnitedHealthcare Global Assistance services, please visit their website at https://members.uhcglobal.com or call their toll-free number at (800) 527-0218.

TAKING ACTION – CHOOSING THE PLAN THAT'S RIGHT FOR YOU

The Important Role of Healthcare Consumers

Key Questions to Ask About Your Care

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

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 like diet and exercise. Being a good healthcare consumer 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.

Questions to consider when selecting a medical plan:

Your Overall Situation

- How much coverage (medical, prescription drug, dental, etc.) do you and your family really need?
- Are there any changes in the past year that have impacted the coverage your family needs? For example, a child who is no longer a dependent, a marriage or divorce, a new job or a layoff?

Choice of Providers

- Do you like to see any doctor you choose, or are you comfortable using a defined network of doctors in exchange for increased benefits?
- Are there enough of the kinds of doctors you want to see in the network?

Provider Availability

- Where will you go for care? Are there facilities near where you work or live?
- How does the plan handle care when you are away from home?

Coverage Under Another Plan

- Are you or your family members covered under another medical plan? If so, what are the plan benefits, and how much do they cost?
- What are the coordination of benefits provisions? Which plan is the primary plan?

Covered Benefits

- What benefits are limited or not covered? Is there a good match between what is provided and what you think you will need? For example, if you have a chronic disease, is there a special program for that illness? Will the plan provide the medicines and equipment you may need? Find out what types of care and procedures the plan will—and won't—pay for.

Costs

- Do you anticipate significant medical expenses in the coming year? Review last year's Explanations of Benefits (EOBs) to see how much you used your benefits. To get a true idea of what your costs will be under each plan, consider each plan's:

    - Contributions
    - Deductibles
    - Copays
    - Out-of-pocket maximum (the total you must pay before the plan pays 100%)
    - Annual benefit maximums
    - Network. If you use doctors outside a plan's network, how much more will you pay to get care?
    - Exclusions. If a plan does not cover certain services or care that you think you will need, how much will you have to pay?
    - Contributions. "Pay now or pay later?" 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?

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 rates available to you through your employer, and researched the best choices for you and your family in 2016, you will be ready to enroll online.

How Does Open Enrollment Work?

- You will receive a letter in the mail this fall that will list the time frame when the site will be open for your use. Save this letter! It includes Client ID number, which you will need to access the Open Enrollment website. The letter also includes instructions for using our online Open Enrollment website to make your healthcare benefit selections for 2016.
- To help you make an informed choice, your plan makes available a Summary of Benefits and Coverage (SBC), which summarizes important information about any health coverage option in a standard format, to help you compare across options. The SBC is available on the web at: **www.cpg.org/mtdocs**. A paper copy is also available, free of charge, by calling (800) 480-9967 (a toll-free number).
- 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.)
- Be sure to verify and make any necessary corrections, to your personal and dependent information.
- You can print a confirmation statement for your records after you make your coverage selections. Once you've 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 you've completed the process, you will have to contact your group administrator or the Client Engagement call center, so carefully check your selections.
- Your new plan choice takes effect on January 1, 2016. You may receive new ID cards (if applicable) at this time. Don't panic if they are delayed as many ID cards can be printed by the Medical Trust or from the vendor's website. Call our Client Services call center for assistance at (800) 480-9967, Monday through Friday from 8:30 am to 8:00 pm ET, or you can email mtcustserv@cpg.org.

NOTE: Only the plans listed on your online open enrollment form are available to you. However, occasionally an employer may only cover 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 2016 rates will be.

If You Do Not Complete an Online Open Enrollment Form

Only you know which benefit decisions are right for you. If you do not enroll by the deadline and your current plan is still available for 2016, you will continue in the

same plan with the same coverage tier. If your current plan is not offered in 2016, your medical benefits may be terminated.

To Learn More

To learn more about the health plan(s) available to you, visit our vendors' websites.

Aetna
www.aetna.com

Cigna Medical and Dental
www.cigna.com

Cigna Behavioral Health (Mental Health & Employee Assistance Program)
www.cignabehavioral.com

Anthem Blue Cross and Blue Shield
www.anthem.com

Kaiser Permanente
www.kp.org

UnitedHealthcare
www.myuhc.com

Express Scripts
www.express-scripts.com

EyeMed
Member Services
www.eyemedvisioncare.com
Website and generic phone number for pre-enrollment information
www.enrollwitheyemed.com/access

Health Advocate
www.members.healthadvocate.com

Amplifon
www.amplifonusa.com

UnitedHealthcare Global Assistance
https://members.uhcglobal.com

The Plan(s) described in this handbook 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 handbook contains only a partial description of the Plans intended for informational purposes only. It should be not be viewed as a contract, an offer of coverage, or investment, tax, medical, or other advice.

The Church Pension Fund and its affiliates, including but not limited to the Medical Trust, CPGSC 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.