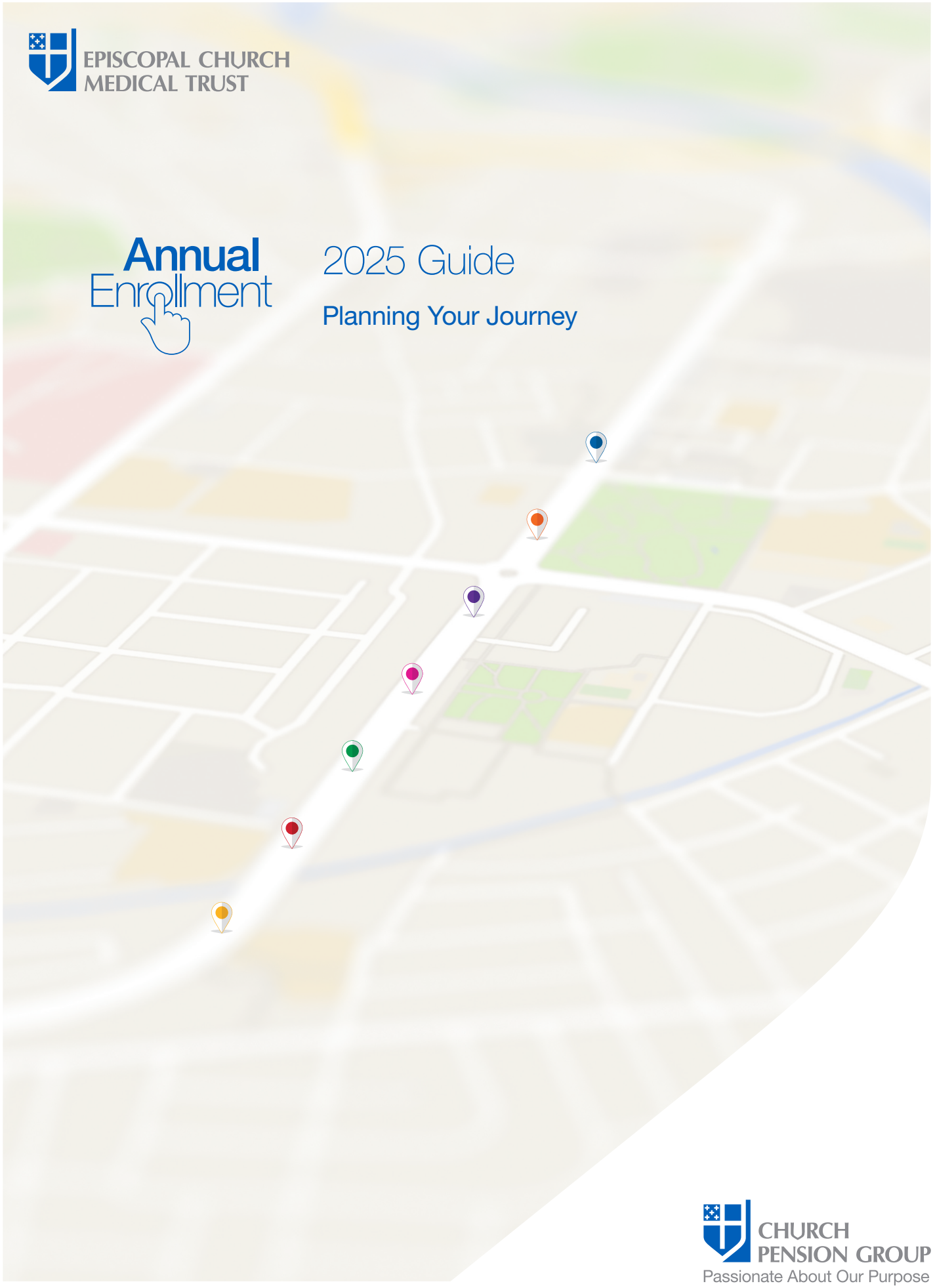
EPISCOPAL CHURCH
MEDICAL TRUST

Annual Enrollment 2025 Guide

Planning Your Journey



CHURCH
PENSION GROUP
Passionate About Our Purpose

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Your Guide to Annual Enrollment

Benefits from The Episcopal Church Medical Trust (Medical Trust) are fundamental stepping stones on your journey to overall well-being, ensuring that you have access to quality care. Use this guide to learn about the types of benefits available to you from the Medical Trust, the factors you may want to consider when making your selections, and the steps you need to take to enroll. You can find additional details and resources at *cpg.org*.[1]

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

What You Need to Know

- **The Medical Trust is adding healthcare coordination services via Quantum Health (Quantum) to its medical plans that use the Anthem and Cigna networks.** With clinical expertise, in-depth knowledge of the healthcare industry, and 25 years' experience, Quantum will help members make the most of their benefits beginning January 1, 2025. During Annual Enrollment, Quantum will be available at 866-871-0629 to help members enrolled—and eligible to enroll—in plans that use the Anthem and Cigna networks understand plan options and choose the right plan for themselves and their dependents.
- Look for a green envelope in the mail this fall. It will contain a letter with important information about Annual Enrollment. Save this letter. It includes the email address and Client Number associated with your MyCPG Account.
- Read the **How to Enroll** section below to make your medical and dental plan selections.
- Some plans described in this guide may not be available in all locations or to all groups or dioceses. You will see which plans are available to you when you sign in to *MyCPG Accounts* for Annual Enrollment.
- 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 contact your group administrator if you need to confirm your eligibility for benefits and the eligibility of your dependent(s).
- If you don't make changes or enroll by the deadline, your current medical and/or dental benefits will continue, and any rate changes will apply. **If your current medical and/or dental plan is *not* offered in 2025, you must select another plan or plans in order to have coverage next year through the Medical Trust.**

Glossary of Defined Terms

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

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

Selecting Your 2025 Benefits

Annual Enrollment for next year's Medical Trust health benefits begins in October 2024. This is your opportunity to review and make changes to your medical and/or dental benefits and to add or drop coverage for eligible dependents for the upcoming plan year.

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

Changes for 2025

Deductible Increase for Anthem and Cigna CDHP-15

The IRS increased the minimum amount that a high-deductible health plan (HDHP) must impose as a deductible.[2] (Note that the Medical Trust refers to HDHPs as CDHPs.)

For 2025, the minimum amounts that must be imposed as deductibles under an HDHP are $1,650 for self-only coverage and $3,300 for family coverage. The amounts for 2024 were $1,600 and $3,200, respectively.

Effective January 1, 2025, the Medical Trust's Anthem and Cigna CDHP-15 network deductibles will be $1,650 for self-only coverage and $3,300 for family coverage. The 2024 network deductibles were $1,600 for self-only coverage and $3,200 for family coverage. The out-of-network deductibles will be $3,300 for self-only coverage and $6,600 for family coverage. The 2024 out-of-network deductibles were $3,200 and $6,400, respectively.

Deductible Increase for Anthem, Cigna, and Kaiser CDHP-20

The IRS increased the minimum amount that a high-deductible health plan (HDHP) must impose as a deductible.[2] (Note that the Medical Trust refers to HDHPs as CDHPs.)

For 2025, the minimum amounts that must be imposed as deductibles under an HDHP are $1,650 for self-only coverage and $3,300 for family coverage. The amounts for 2024 were $1,600 and $3,200, respectively.

Effective January 1, 2025, the Medical Trust's Anthem, Cigna, and Kaiser CDHP-20 network deductibles will be $3,300 for self-only coverage and $6,600 for family coverage. The 2024 amounts were $3,200 for self-only coverage and $5,450 for family coverage.

The out-of-network deductibles will be $3,300 for self-only coverage and $6,600 for family coverage. The 2024 amounts were $3,200 for self-only coverage and $6,000 for family coverage.

[2] See *IRS Rev. Procedure 2024-25*.

Quantum Health

The Medical Trust is adding healthcare coordination services via Quantum Health (Quantum) to its medical plans that use the Anthem and Cigna networks.*

With clinical expertise, in-depth knowledge of the healthcare industry, and 25 years' experience, Quantum will help members enrolled in plans that use the Anthem and Cigna networks make the most of their medical, prescription (Express Scripts), vision (EyeMed), and behavioral health benefits and the Employee Assistance Plan (EAP).

As a single point of contact for members and providers, Quantum also eases the administrative burden associated with healthcare.

Please note that Health Advocate's services will not be available after December 31, 2024. Quantum will begin care coordination services on January 1, 2025, and manage the transition of any open cases for members enrolled in plans using the Anthem or Cigna networks.

**Members covered by Kaiser Permanente already have comprehensive services as part of their plans and will not use Quantum's services. Neither will members enrolled only in a dental plan (through Delta Dental), a disability policy (through Aflac), and/or the standalone EAP.*

Members whose plans use the Anthem and Cigna networks will be able to access the following services through Quantum.

Teladoc

On January 1, Teladoc will replace both the MDLIVE and LiveHealth Online platforms currently available to members whose plans use the Anthem and Cigna networks, respectively. A fully integrated virtual care platform, Teladoc offers primary, behavioral health, acute, chronic, specialty, and complex care services, all seamlessly accessed via Quantum Health.

Magellan

The Medical Trust is introducing Magellan Healthcare, a service that provides a holistic approach to behavioral healthcare management by collaborating with members to help them successfully address their mental health. Magellan's services include outreach to members while in treatment, continuing care plans, support and resources, education, and crisis intervention.

Expert Cancer Review and Personal Precision Oncology Management

The Medical Trust will provide members and their treating oncologists support from renowned oncologists for any type of cancer, including from oncologists who specialize in rare, complex cancers and work on breakthrough therapies. Their support will include case reviews and clinical collaboration with the treating physician.

EncircleRx

In 2023, GLP-1 agonists (drugs that lower blood sugar levels and promote weight loss) accounted for 9.3% of the Medical Trust's prescription drug costs. This was a 295% increase over 2022 in our costs for GLP-1 agonists used as weight-loss medications. During the same period, our peers in the Church Benefits Association's coalition with Express Scripts experienced a 193% increase in the cost of these drugs when used for losing weight.

To manage these costs and ensure these drugs are used appropriately, the Medical Trust is introducing the EncircleRx program with Express Scripts, which

- ensures that medical data and documentation are on file for the use of GLP-1 in diabetes,
- increases GLP-1 monitoring to reduce waste in the system, and
- establishes higher BMI requirements to target those populations most impacted.

Health Plan Options

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

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

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

Preferred Provider Organization (PPO)

You have the flexibility to visit any provider you choose—inside or outside of the plan's network. However, the plan generally pays higher 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. CDHPs that use the Anthem and Cigna networks function like a PPO: You can receive services from any provider, and you don't have to coordinate your care through a primary care provider (PCP). Although these CDHPs cover services in and out of the network, they provide strong financial incentives for you to use network providers. Despite the high deductible associated with a CDHP, most preventive care services received from network providers require no member cost share.

When you enroll in the CDHP, you make pre-tax contributions to an HSA, which is a savings account for qualified medical expenses. Your employer may also contribute. Here's how an HSA works:

- You decide whether you want to contribute and how much, up to IRS maximums. You can change or stop your contributions any time during the year.
- You may use the money in your HSA to pay for qualified medical expenses, including your annual deductible and medical, prescription, dental, and vision costs.

About the Kaiser CDHP

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

You pay the full cost of medical and pharmacy expenses until you meet the annual deductible.

To Contribute to an HSA

You must be enrolled in a CDHP and cannot

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

- You may also save the money in your HSA for future medical costs, including qualified medical expenses in retirement.
- Your HSA is portable and will always belong to you, even if you change employers or retire.

HSA Tax Advantages

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

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

Exclusive Provider Organization (EPO)—Kaiser

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

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

Medicare Secondary Payer/Small Employer Exception (MSP/SEE)

Summary of Benefits and Coverage

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

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

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

- be age 65 or older,
- be actively working for a qualified employer that offers a SEE Plan,
- be enrolled in Medicare Part A (or Medicare Parts A and B) on the basis of age only,
- choose a participating plan that uses the Anthem or Cigna network, and
- The Centers for Medicare and Medicaid Services (CMS) has approved your employer's small employer exception application.

If you enroll in the SEE Plan, Medicare will be the primary payer for Part A services. This program is also available to those enrolled in Medicare Parts A and B. Once Medicare has paid its share, the SEE Plan pays claims as a Medical Trust plan otherwise 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 on the cost of health benefits.

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

Approximately a month before their 65th birthday, the Medical Trust will mail eligible members and/or their spouses information about the SEE Plan.

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

Health Plan Networks

To Contact Quantum's Dedicated Team, Call 866-871-0629, Monday to Friday, 8:30 AM to 10:00 PM EST.

Beginning January 1, 2025, you can

- visit MyCPG Accounts where you can create—and subsequently access—a Quantum account, and
- go to *MyQuantumCare.org*, where your eligible spouse and/or dependent(s) can set up their Quantum accounts.

The Medical Trust offers medical plan options through three health plan networks (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, depending on the network members use, the Medical Trust's plan options may differ in terms of prior authorization/precertification requirements, medical necessity guidelines, programs and processes, policies and procedures, provider networks, and health plan care management programs.

Deductibles and Out-of-Pocket Limits

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

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

Out-of-Pocket Limits—The out-of-pocket limit is the most you will pay for covered healthcare expenses for the calendar year. Please note that network and out-of-network out-of-pocket limits accumulate separately for plans that use the Anthem and Cigna networks. As is the case with deductibles, if you cover family members, please note that:

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

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

- requesting generic drugs whenever possible (your doctor can advise you on whether a generic medication is appropriate),
- using home delivery for prescriptions you need on an ongoing basis, and
- enrolling in the SaveOnSP Copay Assistance Program for certain specialty medications.[3]

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

Visit *express-scripts.com* to price a medication, download the formulary, or find a participating retail pharmacy.

For more information, call Express Scripts Member Service at 800-841-3361.

Kaiser Prescription Drug Program

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

[3] The list of specialty pharmacy medications included in the program can be found at *SaveonSP.com/cpg*. Learn more about SaveOnSP in the applicable *Plan Document Handbook*.

Other Plan Benefits

Vision Benefits

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

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

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

Employee Assistance Program (EAP)

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

This confidential 24/7 service offers immediate help, referrals, and access to other resources. The plan covers telephone consultations and up to 10 face-to-face counseling sessions per issue at no member cost.

The EAP staff can provide:

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

There are also online resources for:

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

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

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

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

Dental Benefits

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

- Providers in both networks have agreed to contracted rates, and you won't be charged more than your expected share of the bill.[4] **Using the Delta Dental PPO network[5] offers the highest annual maximum benefit, allowing you the most savings.** Using an out-of-network dentist may result in higher out-of-pocket expenses.
- All three Delta Dental plan options cover
  - diagnostic and preventive care;
  - three dental cleanings a year (four under certain circumstances);
  - basic and major restorative services, subject to applicable coinsurance, deductibles, limitations, and exclusions.
- The Basic Plan option does not cover orthodontic services; the Comprehensive Plan options does; and the Premium Plan option has a higher in-network lifetime benefit for orthodontia.
- You can find a dental provider, check your benefits, and access other helpful resources at *deltadentalins.com*.

Learn more at *cpg.org/deltadental* at or by calling 888-894-7059. For information on cost sharing, see Delta Dental's *Summaries of Benefits and Coverage* at *cpg.org/mtdocs*.

Travel Assistance Services

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

- arrange for you to obtain medical treatment, whether you need a local referral or an evacuation due to a medical emergency;
- provide insurance information and medical records to appropriate party(ies);
- replace your prescription medications, medical devices, and corrective lenses;
- procure emergency travel arrangements and replace lost or stolen travel documents;
- transfer emergency funds to you; and
- provide you destination profiles for over 170 countries, including health and security risk information

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

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

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

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

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

Choosing the Right Plan

Medical

To Help You Make an Informed Choice

Consult the *Summaries of Benefits and Coverage* (SBC), provided by the Medical Trust. Available at *cpg.org/mtdocs*, these summaries include important benefit details in a format that allows you to easily compare options. For a free copy, call 800-480-9967, Monday to Friday, 8:30 AM to 8:00 PM ET.

We know that medical benefits are important to you and your family. Below are three factors you should consider to determine which health plan is the best for you and your dependents and to manage costs when you need care:

- **Changes to healthcare usage for the coming year**—Although it may be tempting to default to the same medical option year after year, healthcare needs change over time. During Annual Enrollment, consider how your healthcare needs might be different in the coming year. For example, are you expecting a baby or planning to undergo a medical procedure? As your needs change, the best plan for you may change as well. It's a good idea to review your current year's Explanations of Benefits (EOB) to see how much you used your benefits and think about how that might change for next year.
- **Pay now or pay later**—It might help to think of your plan options in terms of "paying now" or "paying later." Your monthly contributions will be higher in plans with lower out-of-pocket costs and lower in plans with higher out-of-pocket costs. You should consider whether you prefer to pay higher contributions every month and less when you receive services or pay less for coverage every month and more when you receive services.
- **Network providers**—Your healthcare costs will be higher if you use a doctor who is not in your plan's network. If you enroll in a Kaiser health plan, you pay the full cost of any nonemergency service provided by a doctor or facility that is not in the plan's network. Contact your health plan or visit its website to check whether your provider is in the plan's network.

Plan(s) Going Away

If your current medical and/or dental plan is not being offered in 2025, you must choose a new plan or plans in order to have medical and/or dental coverage through the Medical Trust next year. Also, be sure to verify and make any necessary corrections to your personal information and that of your dependent(s), particularly names, Social Security numbers, and addresses.

If you are eligible to enroll in a plan that uses the Anthem or Cigna network and need help with your medical plan selections, call Quantum at 866-871-0629, Monday to Friday, 8:30 AM to 10:00 PM EST. Kaiser members should call the number on the back of their ID cards.

How to Enroll

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

Have both the email address associated with your MyCPG Account and your Client Number at hand. They were included in the letter we mailed to your home in a green envelope.

Extension of Benefits

Dependents who turn 30 in 2024 cannot be covered as dependents under a Medical Trust plan unless they are disabled and became disabled before age 25, as determined by the Medical Trust. However, through its Extension of Benefits provision, the Medical Trust will allow dependent children who turn 30 in 2024 to voluntarily continue medical and/or dental coverage at their own expense for up to 36 months beginning on January 1, 2025.

Making Your Plan Selections

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

Step 1
Sign in to MyCPG Accounts with the email address included in the letter we mailed you in a green envelope. Then click "Get Started."

- If you didn't see an email address in the letter or you haven't accessed your account since 2022, select "Create Account" and follow the prompts.
  - Use your Client Number (included in the letter mailed in a green envelope). The number can make it easier to verify your identity during the account setup process.

Step 2
Click on "Annual Enrollment" and make your selections for 2025.

Step 3
Review your personal information, dependent information, and plan selections carefully.

Step 4
Print a confirmation statement for your records.

Your new plan selection(s) will take effect on January 1, 2025.

If you choose a plan that uses the Anthem or Cigna network, you will receive new ID cards in December with a NEW PLAN NUMBER, which next year you MUST share with your doctors, pharmacists, and other providers—except dentists—as your old card will not work after December 31, 2024. If you have any questions, call Quantum at 866-871-0629, Monday to Friday, 8:30 AM to 10:00 PM EST.

Kaiser members may receive new ID cards.

If You Do Not Enroll by the Deadline

If you miss the deadline and your existing medical and/or dental plan will be available in 2025, you will continue in the same plan with the same coverage tier, provided you still meet the eligibility requirements. Any rate changes will apply.

If you don't enroll by the deadline and your current plan(s) will not be available in 2025, your medical and/or dental benefits will end on December 31, 2024, and you will not be able to re-enroll until the next Annual Enrollment period, unless you experience a qualified Significant Life Event (as defined in the Plan Document Handbooks).

To Learn More

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

Cigna Behavioral Health (Employee Assistance Program)
mycigna.com

Delta Dental
deltadentalins.com

Kaiser
kp.org

Express Scripts
express-scripts.com

EyeMed
eyemedvisioncare.com/ecmt

Health Advocate
members.healthadvocate.com

Health Advocate's services will not be available after December 31, 2024. Quantum will begin care coordination services on January 1, 2025, and manage the transition of any open cases for members enrolled in plans using the Anthem or Cigna networks.

Quantum Health (as of January 1, 2025)
myquantumcare.org

UnitedHealthcare Global Assistance
worldwatch.uhcglobal.com

About The Episcopal Church Medical Trust

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

The Medical Trust funds certain of its benefit Plans through a trust fund known as The Episcopal Church Clergy and Employees' Benefit Trust (the "ECCEBT").[6] The ECCEBT is intended to qualify as a Voluntary Employees' Beneficiary Association (a "VEBA") under Section 501(c)(9) of the Internal Revenue Code. The purpose of the ECCEBT is to provide benefits to eligible employees, former employees, and their dependents in the event of illness or expenses for various types of medical care and treatment.

The mission of the Medical Trust is to administer a comprehensive benefit plan while balancing compassion with financial stewardship. This is a unique mission in the world of healthcare benefits, and we believe that our experience and mission to serve The Episcopal Church offer a level of expertise that is unparalleled. If you have questions about any of our Plans, please don't hesitate to contact us. We're looking forward to serving you.

For more information about your Medical Trust benefits, visit *cpg.org* or call Client Services at 800-480-9967, Monday to Friday, 8:30 AM to 8:00 PM ET.

Eligibility

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

[6] 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

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