

The Episcopal Church Medical Trust Enrollment Guide



2009

It's Easy to Enroll in Your 2009 Health Benefits

It's time for you to start thinking about the coverages you would like for next year. The Episcopal Church Medical Trust ("the Medical Trust") provides this Enrollment Guide to help you make informed decisions about health care benefits for yourself and your family. Please read this Guide carefully.

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Your Role in the Value of Your Health Care

If you've watched the news or read the paper lately, chances are you know that today's world is one of constantly rising health care costs. And while the Medical Trust, insurance companies, and even the government can play a role in managing those costs and ensuring that people receive cost-effective and comprehensive care, it's also up to you to influence your own individual costs and outcomes. So what can you do?

Whether you choose a Plan offered by the Medical Trust or not, consider taking these steps as a start to becoming a better health care consumer and ensuring your long-term health and wellness:

- **Partner with your doctor.** Finding a doctor you trust and feel comfortable with is the first step toward ensuring good health. But once you've found that person, how can you work together to get the best care? Prepare for your office visits, listen and ask questions, learn all you can about your medical issues, and learn about wellness and preventive care.
 - **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. When your doctor makes a recommendation, be sure you voice your questions, concerns, and preferences.
 - **Learn more about your condition.** If you use the Internet to find health information, start by searching specialized sites connected with certain diseases. For example, if you're interested in heart disease, visit the American Heart Association website at www.americanheart.org; asthma and allergies, visit the American Academy of Allergy, Asthma and Immunology website at www.aaaai.org; or cancer, visit the American Cancer Society website at www.cancer.org.
- Keep in mind that websites offer general information that may not necessarily be accurate or relevant to your particular circumstances. Be sure to discuss any findings with your health care provider.
- **Get the most value from your prescription drug benefit.** While many factors that drive prescription drug increases are out of your control, there are steps you can take to save money. For an occasional minor ailment such as joint pain, heartburn, or allergies, ask your doctor if you can try an over-the-counter treatment 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.
 - **Stay well.** If you want to stay healthy and live a longer, healthier life, it is helpful to know your health risks and how to manage them. 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. Also consider exercising regularly and quitting smoking.

Your Benefits Program

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.

Who Is Eligible for Coverage

The Episcopal Church Medical Trust maintains a series of benefit plans for the employees (and their beneficiaries) of the Protestant Episcopal Church in the United States of America. The Medical Trust funds certain of its benefit plans through a trust fund, known as the Episcopal Church Clergy and Employees' Benefit Trust ("ECCEBT")*.

As the Medical Trust exclusively serves ecclesiastic societies, dioceses, missionary districts, and other bodies subject to the authority of the Church, **the following individuals are eligible for coverage under the Medical Trust's Pre-65 Plans:**

- Individuals age 55 or older who:
 - were employed by the Episcopal Church for five or more continuous years, and
 - were enrolled in a Medical Trust or group-sponsored health plan at the time of retirement, and
 - are eligible to receive a pension from their church employer, if a pension plan was made available by the employer, even if they chose not to begin collecting a benefit at the time of separation, and
 - are not eligible for any other non-Medical Trust group-sponsored health plan or Medicare.
- Non-Medicare-eligible spouses or domestic partners of retirees enrolled in a retiree health plan through the Medical Trust.
- Surviving spouses and surviving domestic partners who are not eligible for any other non-Medical Trust group-sponsored health plan or Medicare.
 - Surviving spouses and domestic partners who are not enrolled in the Medical Trust at the time of the pre-65 retiree's death cannot enroll, unless they are beneficiaries of The Church Pension Fund or the pre-65 retiree met the lay beneficiary rules.
 - Surviving spouses and domestic partners (and their dependents) who leave the Medical Trust because they are eligible for medical coverage through their employer may return to the Medical Trust if they lose their non-Medical Trust coverage, as long as there has been no break in medical coverage.
- Surviving children who meet the criteria in the following section on Eligible Dependents.
- Employees who take disability retirement through The Church Pension Fund, but do not qualify for Medicare. (An employee who retires due to a disability should apply for Medicare benefits through his or her local Social Security Office. Until the time a disabled retiree is eligible for Medicare, the early/disabled retiree would be eligible.)

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

Eligible Dependents:

- Your spouse or your qualifying domestic partner
- Children who are: younger than 30 years of age; unmarried; without his or her own dependents; living at home with the parent(s) or enrolled as a full-time student; and not covered under another group health plan or receiving Social Security benefits.*
- Your unmarried children, regardless of age, who are physically or mentally disabled and incapable of self-support, provided the disability began before age 19 (or age 25 for full-time students), when coverage would have otherwise ended. Satisfactory proof of disability must be submitted within 30 days after the end of the month in which the child reaches the age limit that is otherwise applicable. If the dependent child is physically or mentally disabled on the date his or her coverage would otherwise end, the child's eligibility will be extended for as long as the employee is covered, the disability continues, and the child continues to qualify for coverage in all aspects other than age. The Plans may require, at any time, a physician's statement certifying the physical or mental disability.
- A "disability" for purposes of the Plans for pre-65 retirees shall be determined, in the sole discretion of the Medical Trust, pursuant to the definition of disability under the Church Pension Fund Clergy Pension Plan.

The following individuals are not eligible for coverage under the Medical Trust's Pre-65 Plans:

- Active employees and their dependents.
- Early retirees and their dependents who become active employees at the Episcopal Church or any other employer, including self-employed individuals.
- Full-time seminarians from a participating Episcopal seminary and their dependents.
- Retired employees and their dependents who are Medicare-eligible.
- Clergy who were deposed prior to becoming eligible to receive a pension.
- Employees who voluntarily terminate employment prior to becoming eligible to receive a pension.
- Spouses and dependents of Medicare-eligible retirees who are eligible for other employer group health plans.
- Retirees age 65 or older who have opted out of Social Security and are therefore not Medicare-eligible, unless they were enrolled in the Plan prior to January 1, 2007. (Under certain circumstances, members of religious communities and clergy are allowed to waive their rights to Social Security.)

Children eligible for coverage include natural children, stepchildren, legally adopted children or children for whom a petition to the court for adoption has been submitted, and your domestic partner's children (if applicable to your group). Some plans may restrict coverage to include only those children who live in their service area.

Eligible children may also include recipients under an approved Qualified Medical Child Support Order (QMCSO).

Note that there may be circumstances in which an individual who is eligible for coverage under a Plan as a dependent does not qualify as your dependent for Federal income tax purposes. In those cases, the cost of providing Plan coverage to that individual will be imputed income to you for Federal income tax purposes.

* Verification of status is required for adult children (age 19 and over).

Health Plan Options

Medical coverage is important to everyone. The Plans offered by the Medical Trust provide preventive care benefits to keep you healthy, and many other benefits to help during those times when you are not. The Medical Trust offers the following types of medical Plans, depending on your geographic location:

- Preferred Provider Organization (PPO) Plan
- Exclusive Provider Organization (EPO) Plan
- Health Maintenance Organization (HMO) Plan

About the Plans

All of the Medical Trust Plans provide care through a network of doctors, hospitals, pharmacies, laboratories, and other providers who have agreed to offer services at reduced rates. In the following pages you will learn how each plan differs, and what you will need to think about in order to make the best decisions regarding your health coverage.

Comparing Alternate Plan Options

When evaluating your Plan options, it is important to understand the trade-offs that differentiate the Plans. Monthly premiums and out-of-pocket costs (when services are received) have an inverse relationship. That is, certain Plans may have low out-of-pocket costs with high monthly premiums and vice versa. Using in-network providers can benefit you by lowering 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 (unavailable to HMO and EPO participants) may result in a higher out-of-pocket cost than that of an in-network provider.

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 premiums are going to be higher in the EPO 90 Plan than in the PPO 75/50 Plan. However, your out-of-pocket costs when receiving services are higher in the 75/50 Plan. It is important to think about your personal health care needs. Determine whether it makes sense to pay for more coverage with higher monthly payments or pay less from month to month with the risk of paying more only when you need services.

The Importance of the Network

Another factor to consider when choosing a Plan is access to providers. Participation in an exclusive or limited network Plan often means that your out-of-pocket costs are low if you see a doctor in the network but high 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 the network. When choosing your plan, evaluate the importance of freedom when it comes to choosing your doctor.

Understanding the Plan Designs

It is important to note that you are responsible for ensuring that the services and care you receive are covered by whichever plan you choose.

- **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 an in-network provider or facility. If you use an out-of-network provider, you’ll often be responsible for submitting your own claims.
- **Under an EPO**, you agree to use only the Plan’s network of professionals and facilities. The EPO works a lot like an HMO—for example, the EPO does not cover the cost of services received from nonparticipating providers, except in emergency situations. However, unlike most local HMOs, the EPO uses a national network and you are not required to select a PCP.
- **Under an HMO**, you agree to use the health care professionals and facilities associated with that HMO. Except in emergencies, HMOs don’t 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%. You must select a PCP to coordinate your care.

Comparing Your Medical Plan Options

Feature	PPO	EPO	HMO
How the Plan Works	A PPO Plan works like an indemnity Plan, the primary difference being that you will pay less out-of-pocket when care is obtained from a network provider.	Comprehensive health care services are available to members for coinsurance or a copayment only when a network provider is used, except in emergency situations.	Comprehensive health care services are available to members for a small copayment only when a network provider is used, except in emergency situations.
Using the Plan Network	When you use network providers, you pay a copayment for office visits, and the Plan pays higher benefits after a deductible for other in-network care. The coverage level is lower outside of the network, and you must meet a higher non-network deductible before benefits begin.	The Medical Trust EPO Plans use the same network as our national PPO Plans. However, an EPO generally does not pay benefits for non-emergency services you receive outside of the Plan’s network.	An HMO generally does not pay benefits for services you receive outside of the HMO’s network. Also, you must follow the HMO’s procedures for referrals in order to have your services covered. You also must elect a PCP when you enroll in an HMO.

The Role of Your PCP

It isn't always easy to know how to make the best use of your medical Plan. Having someone to guide you through the process of getting health care can make your decisions easier. In most HMOs, you must choose a PCP for each covered family member. Even though it is not required, if you participate in a PPO or EPO Plan, you may wish to utilize a PCP's services to help you manage your care. PCPs can be internists, pediatricians, or general practitioners... the choice is yours. It's your PCP's responsibility to know you and your health care needs. When you need care beyond what your PCP can provide, your PCP will refer you to a specialist or hospital, coordinating any treatment that is recommended.

Your PCP is also an important source of communication about your health and benefits. Generally, when your health plan becomes involved in evaluating your doctor's recommended treatment, referrals, or special circumstances, all communication goes back to your PCP. Your PCP then helps you make educated decisions about your options.

Choosing Your PCP

Your current physician may already be a PCP in the network you choose, in which case your choice will be quite easy. However, if you don't have a doctor, or are looking to find a new one, provider directories are available on the health Plans' websites. You can also contact the Medical Trust or your local benefits administrator for assistance.

Medical Plan Coverage Provisions

Now that you understand how the Plans work, you can use this chart to compare the benefits and coverage provisions of each Plan.

Plan Design	HMO	HMO	PPO 75/50	EPO 90
Plan Partner	Aetna*	CIGNA*	Empire BCBS	Empire BCBS
PCP Selection Required?	Yes	Yes	No	No
Referral Required for Specialty Care?	Yes	Yes	No	No
Network Individual/ Family Deductible	\$0/\$0	\$0/\$0	\$900/\$1,800	\$100/\$250
Network Individual/ Family Out-of-Pocket (OOP) Maximum (Excluding Deductibles)	\$0/\$0	\$0/\$0	\$2,700/\$5,400	\$1,000/\$2,000
Network Medical Member Coinsurance	0%	0%	25%	10%
Network Lab & X-Ray Coinsurance/Copayment	\$20	\$0	25%	20%
Routine Physical Copayment	\$10	\$10	\$10 PCP \$10 Specialist	\$10
Office Visit Copayment (PCP)	\$20	\$20	\$35	\$25
Office Visit Copayment (Specialist)	\$20	\$20	\$45	\$25
Non-Network Hospital Benefits Available?	No	No	Yes	No
Network Inpatient Admission Subject to Annual Deductible?	N/A	N/A	No	Yes
Network Inpatient Admission Deductible	\$150 per day/ \$600 maximum	\$350 per admission	\$100/\$600 per day/maximum	\$0
Network Inpatient Admission Member Coinsurance After Deductible	0%	0%	25%	10%
Outpatient Surgery Copayment/ Member Coinsurance	\$250	\$250	25%	10%
Non-Network Individual/ Family Deductible	N/A	N/A	\$1,800/\$3,600	N/A
Non-Network Individual/ Family OOP Maximum (Excludes Deductibles)	N/A	N/A	\$5,400/\$10,800	N/A
Non-Network Member Coinsurance	N/A	N/A	50%	N/A
Mental Health Benefit	Aetna	CIGNA Behavioral Health	CIGNA Behavioral Health	CIGNA Behavioral Health

*Aetna and CIGNA HMOs not available in all areas.

Prescription Drug Benefits

When you enroll in one of our medical Plan options, you'll automatically have coverage for prescription drugs through the Medco 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); and Tier 3 includes non-preferred drugs and all non-sedating antihistamines (highest copayment).

Standard Prescription Drug Benefit Plan

	RETAIL PRESCRIPTION DRUGS	MAIL-ORDER PRESCRIPTION DRUGS
Annual Prescription 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 \$30.	You pay up to \$70.
Tier 3: Non-Formulary Brand-Name and Brand Non-Sedating Antihistamines	You pay up to \$50.	You pay up to \$120.
Dispensing Limits Per Copayment	Up to a 30-day supply.	Up to a 90-day supply
Prescription Smoking Cessation Drugs Annual Maximum	1 cycle of therapy per individual.	

Coverage of Brand Non-Sedating Antihistamines

The brand non-sedating antihistamine drug category has the highest copayment, regardless of the drug's formulary status. This change is a result of the drug Claritin 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. **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.** You may want to keep this in mind if you or a covered dependent will be receiving any maintenance medications during the coming calendar year.

Retail Refill Limit

To help manage overall program costs and limit dramatic increases to prescription drug copayments, the Prescription Drug Program will maintain a retail refill limit. The retail refill limit 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.

Keep in mind, the retail pharmacy program allows for a total of three fills of a maintenance medication at a retail pharmacy (one original fill and two refills). Additional fills will not be covered by the program. Each fill can be for no more than a 30-day supply. Note that you are 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 after the three-fill limit, your prescriptions may not be covered and may cost you the full price.

In some circumstances, you may not be required to utilize the mail-order program. For example, there are several 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 Medco 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, this does not apply to glaucoma drops.
- 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 and Nembutal).
- Medications used to treat both attention deficit disorder (Ritalin, Cylert) and narcolepsy (Dexedrine).
- Medications whose sole use is to treat cancer.

Generic Medications

Generic medications and their brand-name counterparts 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, the Plans will cover the cost of the generic equivalent if you purchase a brand-name medication when there is a generic available. 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 medication, speak to your physician or your pharmacist, and he or she will be able to help you.

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 amount (such as the 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 *Medco By Mail*, your doctor will be contacted directly.

When a coverage limit is triggered, 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.

Paper Claims Reimbursement for Non-Network Retail Purchases

You must pay the full price at the pharmacy and file a claim for reimbursement. You will be reimbursed according to what the Plan would have paid at a participating pharmacy, less your applicable copayment. See the "Pharmacy Benefits" section of your Plan Handbook for more information about filing claims for reimbursement for prescription drugs purchased at retail pharmacies.

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 Medco formulary list. If you prefer, you can use non-formulary brand-name drugs and pay a higher copayment.

It is also important to note that drugs included on the formulary list are routinely updated. To find the most up-to-date list of covered drugs, visit Medco at www.medco.com, or call their member services department at (800) 841-3361. It should be noted that all drugs listed on the formulary may not be covered due to Plan exclusions and limitations. You can also use Medco's website or member services telephone number to locate the retail pharmacy nearest you.

Travel Assistance Services

When you enroll in a Medical Trust medical Plan, you have access to the services provided by MEDEX Assistance Corporation. MEDEX can help you with emergency medical or travel needs you may encounter when you are 100 or more miles away from home.

MEDEX Assistance Corporation provides a comprehensive emergency medical assistance program 24 hours a day, 7 days a week. Their highly trained, multi-lingual coordinators work with an extensive information and communication system to provide you with assistance you may need while traveling. With MEDEX's 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.

This service is provided to you alongside your medical benefits. You do not need to enroll, and there is no additional premium charge for this service. ***Please note, MEDEX 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 health care 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 Schedule of Benefits will determine what's covered by your Plan and how to submit a claim.

If you are enrolled in an Empire BlueCross BlueShield Plan, we also encourage you to use your Blue Card network finder at www.bcbs.com/healthtravel/finder.html to locate in-network providers and facilities.

Additional Information

For more information about Medex services please visit their website at www.medexassist.com, or call their toll-free number at (800) 527-0218.

Vision Benefits

If you enroll in one of the Medical Trust's Plans, you'll receive vision benefits through EyeMed Vision Care. You can receive care from providers participating in the network, or you can choose to use out-of-network providers. However, you will be reimbursed at a higher level if you use providers who participate in the EyeMed network. The services described below are covered as described **once per 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.

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—single vision \$46—bifocal \$57—trifocal
Lens Options UV Coating Tint (Solid and Gradient) Standard Scratch Resistance Standard Polycarbonate Standard Anti-Reflective Coating Standard Progressive (Add-On to Bifocal) Other Add-Ons and Services	You pay up to \$15 You pay up to \$15 You pay up to \$15 You pay \$0 You pay up to \$45 You pay up to \$65 20% off retail price	You are responsible for the cost of any lens options that you elect from out-of-network providers
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

* You are eligible to receive lenses and frames **or** contact lenses once per calendar year.

When you use EyeMed network providers, you will not need to submit a claim. Your EyeMed provider will submit claims on your behalf. You will pay the copayment and any noncovered expenses at the time you receive services.

Please keep in mind that the HMO Plan may offer additional limited vision coverage through the network. Check with your Plan for details.

For More Information

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

Mental Health Benefits

Your emotional well-being is vital to the health of the Church. That's why the Medical Trust has partnered with CIGNA Behavioral Health (CBH). Mental health and substance abuse benefits will be administered by CBH for the majority of our Medical Trust plans.

CIGNA will administer the inpatient and outpatient mental health benefits for members enrolled in our plans.* Through our partnership with CBH, members will have access to an integrated behavioral health program that includes mental health, substance abuse and employee assistance benefits. CBH will provide clinical support, customer service and behavioral health claims processing for these plan members.

CIGNA Behavioral Health's nationwide network of providers includes more than 47,000 independent psychiatrists, psychologists, pastoral counselors and clinical social workers and more than 4,000 facilities and clinics. CIGNA Behavioral Health and the Episcopal Church Medical Trust share the same basic values of compassionate care for all of our members.

*except members enrolled in the Aetna HMO Plan.

Mental Health/Substance Abuse Benefits for members enrolled in Medical Trust Medical Plans except the Aetna HMO Plan.

COVERED SERVICE	COPAYMENT/COINSURANCE	ADDITIONAL LIMITATIONS AND EXPLANATIONS
Outpatient Visits	Network \$25 per visit	For in-network services, the first 20 sessions per calendar year do not need to be preauthorized and may be used without first contacting CIGNA. Authorization is required beginning with the 21st session.
	Non-Network 30%	For out-of-network services, all sessions must be preauthorized. Contact CIGNA before beginning treatment with a non-network provider. Coverage is 70% of usual and customary charges.
Inpatient	Network \$100 per day (\$600 maximum per admission)	You must contact CIGNA prior to any inpatient hospitalization or other inpatient services for authorization. Failure to precertify will result in reduction of benefits to 50%. There is no out-of-network benefit for inpatient services.

CIGNA Behavioral Health Member Services toll-free number: (800) 926-2273. Website: www.CIGNABehavioral.com

Mental Health/Substance Abuse Benefits for members enrolled in the Aetna HMO.

COVERED SERVICE	COPAYMENT/COINSURANCE	ADDITIONAL LIMITATIONS AND EXPLANATIONS
Outpatient Visits	Network \$25 per visit	Certain services must be precertified by Aetna. Your participating provider is responsible for obtaining this approval.
	Non-Network 30%	For out-of-network services, all sessions must be preauthorized. Contact the Episcopal Church Medical Trust Mental Health Line before beginning treatment with a non-network provider.
Inpatient	Network \$150 per day (\$600 maximum per admission)	You must contact Aetna prior to any inpatient hospitalization or other inpatient services for authorization. There is no out-of-network benefit for inpatient services.

Aetna Behavioral Health: (800) 755-2422.

Episcopal Church Medical Trust Mental Health Line: (800) 806-0478

Employee Assistance Program (EAP)

The Episcopal Church Medical Trust has added the Employee Assistance Program (EAP) to our mental health benefits package. This program, managed by CIGNA Behavioral Health, is available to all members enrolled in any early retiree medical plan and covers a vast array of family and personal services. The program is designed to assist our members with information, educational materials, resources, referrals, and ongoing support.

EAP services are available 24 hours a day, 7 days a week through the CIGNA Behavioral Health website or by phone. All services are free and confidential. Equipped with many tools, the EAP staff members are trained to provide you with a multitude of services including: help finding daycare services for your children, support for managing stress, information on adoption, assistance in researching nursing homes, etc. Life can be challenging and stressful. Everyone needs support from time to time.

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

Health Advocate

The Episcopal Church Medical Trust is pleased to provide the Health Advocate program to all of our pre-65 retiree medical plan members. Health Advocate is a program that helps members navigate and facilitate medical and administrative issues in the health care system. Eligible pre-65 retirees and their spouses, domestic partners, and dependent children are covered by this service. Additionally, the parents and parents-in-law of the pre-65 retiree are also eligible to use Health Advocate if the need should arise.

Health Advocate's services are provided by Personal Health Advocates, typically registered nurses, backed up by a team of medical directors and administrative experts who will:

- Identify leading health care providers and institutions anywhere in the country,
- Arrange and schedule appointments,
- Sort out claims questions, billing and payment arrangements and related administrative issues,
- Schedule specialized treatment and tests,
- Answer questions about test results, treatment recommendations and medications recommended by your physician,
- Assist in the transfer of medical records, x-rays and lab results,
- Arrange for home care equipment following discharge from a hospital,
- Protect the privacy of your medical and health care information and ensure its confidentiality, and
- Foster communication and benefits coordination between physicians and insurance companies.

To access Health Advocate's services, simply call (866) 695-8622 (toll-free) and you or a covered family member will be connected to your own Personal Health Advocate. It's that easy!

Dental Plan Options

The dental Plans available to you are administered by CIGNA. 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.

All three Plans allow you to see the provider of your choice. You can receive care from providers participating in the network, or you can choose to use out-of-network providers. However, you will be reimbursed at a higher level if you use providers who participate in the CIGNA network.

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.

Dental Plan Comparison Chart*

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

*This chart contains only a partial, general description of the Plans.

Have You Thought About...

Before choosing your Plan option, here are some things to think about. Considering these items may help you when making your benefit elections.

- **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?
- **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 or procedures the Plan won't pay for.
- **Provider availability.** Where will you go for care? Are these places near where you work or live? How does the Plan handle care when you are away from home?
- **Costs.** To get a true idea of what your costs will be under each Plan, look at how much you will pay for your premium and other costs. Are there deductibles you must pay before the Plan begins to help cover your costs? After you have met your deductible, how much of the costs will the Plan pay? Does this amount vary by the type of service, doctor, or health facility used? Are there copayments you must pay for certain services, such as doctor visits? If you use doctors outside a Plan's network, how much more will you pay to get care? If a Plan does not cover certain services or care that you think you will need, how much will you have to pay?

Reasons to Contact the Medical Trust

Changing Your Coverage During the Year

You can make changes to your coverages during the plan year only if you lose or gain coverage as the result of a significant life event, as defined by the Medical Trust. You can change the affected benefits provided you notify your group administrator within 30 days of the life event. However, the benefit change you make must be consistent with your status change.

Significant life events include:

- Marriage.
- Divorce, legal separation, or annulment of marriage.
- Death of a spouse or child.
- Birth, adoption, or petition to the court for adoption.
- Qualification or termination of a domestic partnership. Domestic partner coverage is available to those who meet the eligibility criteria of the Medical Trust for those pre-65 retirees in dioceses and institutions that offer domestic partner coverage through the Medical Trust.
- Termination or commencement of employment by the member, the member's spouse, or the member's child, including a switch between part-time and full-time, or commencement or return from an unpaid leave of absence.
- Change in dependent status for the member's child.
- Change in residence or work site for the member, the member's spouse, or the member's child (i.e., changes residence into or out of a network-only Plan's service area).
- Significant change in cost or a significant curtailment of health coverage for the member, the member's spouse, or the member's child.
- When the member, the member's spouse, or the member's child becomes entitled to either Medicaid or Medicare.
- Change in status (e.g., from active to early retiree or retiree, or from retiree or early retiree to active).
- Meeting or exceeding a lifetime limit on benefits.

If you are notified by your Plan that your dependent's coverage has been discontinued, or if you independently notify the Medical Trust of a change, you must still contact your group administrator to make the change.

The Plans described in this document (collectively, the "Plans") 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"), which is a voluntary employees' beneficiary association within the meaning of section 501(c)(9) of the Internal Revenue Code.

This document contains only a partial, general description of the Plans. It is provided for informational purposes only and should not be viewed as a contract, an offer of coverage, or investment, tax, medical, or other advice. In the event of a conflict between this document and the official Plan documents (schedule of benefits, summary Plan description, booklet, booklet-certificate), the official Plan documents will govern. The Church Pension Fund and CPGSC (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, without notice and for any reason.

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 health care expenses, and Plan participants should read the official Plan documents carefully to determine which benefits are covered, as well as any applicable exclusions, limitations, and procedures.

All benefits under the Plans are subject to applicable laws, regulations, and policies. Except for the Preventive Dental PPO Plan, and the Travel Protection Benefit, all such benefits are subject to coordination of benefits. The Plans are subrogated to all of the rights of a Plan participant against any party liable for such participant's illness or injury, to the extent of the reasonable value of the benefits provided to such participant under the Plans. The Plans may assert this right independently of a Plan participant, and such participant is obligated to cooperate with the Medical Trust in order to protect the Plans' subrogation rights.

CPG does not provide any health care services and therefore cannot guarantee any results or outcomes. Health care 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.

If you are a Plan participant, call the number on your ID card for more information about the Plan in which you are enrolled. All other individuals should call (866) 273-4545.

For More Information

Here are some additional resources, should you have any questions after reviewing the information in this Enrollment Guide.

For Questions About...	You Should Contact...
The Episcopal Church Medical Trust	www.cpg.org (866) 273-4545 (Monday through Friday, 8:30 a.m.—7:00 p.m. EST)
Aetna	www.aetna.com HMO: (877) 380-8584 (Monday through Friday, 8:00 a.m.—6:00 p.m. EST)
Empire BlueCross BlueShield	www.empireblue.com/medicaltrust (800) 352-3152 (Monday through Friday, 9:00 a.m.—8:00 p.m. EST)
Medco Prescription Drug Benefits	www.medco.com (800) 841-3361 (24 Hours a Day, 7 Days a Week)
CIGNA Behavioral Health (& EAP)	www.CignaBehavioral.com (800) 926-2273 (24 Hours a Day, 7 Days a Week)
The Episcopal Church Medical Trust Mental Health/Substance Abuse Supplement (for Aetna HMO only)	www.cpg.org (800) 806-0478 (Monday through Friday, 8:30 a.m.—5:00 p.m. EST)
EyeMed Vision Care	www.enrollwiththeyemed.com/access (866) 723-0596 (Monday through Saturday, 8:00 a.m.—11:00 p.m. Sunday, 11:00 a.m.—8:00 p.m. EST)
CIGNA (Dental)	www.cigna.com (800) 244-6224 (Monday through Friday, 9:00 a.m.—5:00 p.m. EST)
MEDEX Assistance Corporation	www.medexassist.com (800) 527-0218 (from U.S., Canada, Puerto Rico, Virgin Islands, and Bermuda) (410) 453-6330 (call collect)
Health Advocate	www.HealthAdvocate.com (866) 695-8622 (Monday through Friday, 8:00 a.m.—7:00 p.m. EST)