CHURCH PENSION GROUP
Serving the Episcopal Church and its People

Episcopal Diocese of Los Angeles

Healthcare Benefit Information

2023

Church Pension Group
Integrated Benefits Account Management Services

EPISCOPAL CHURCH MEDICAL TRUST

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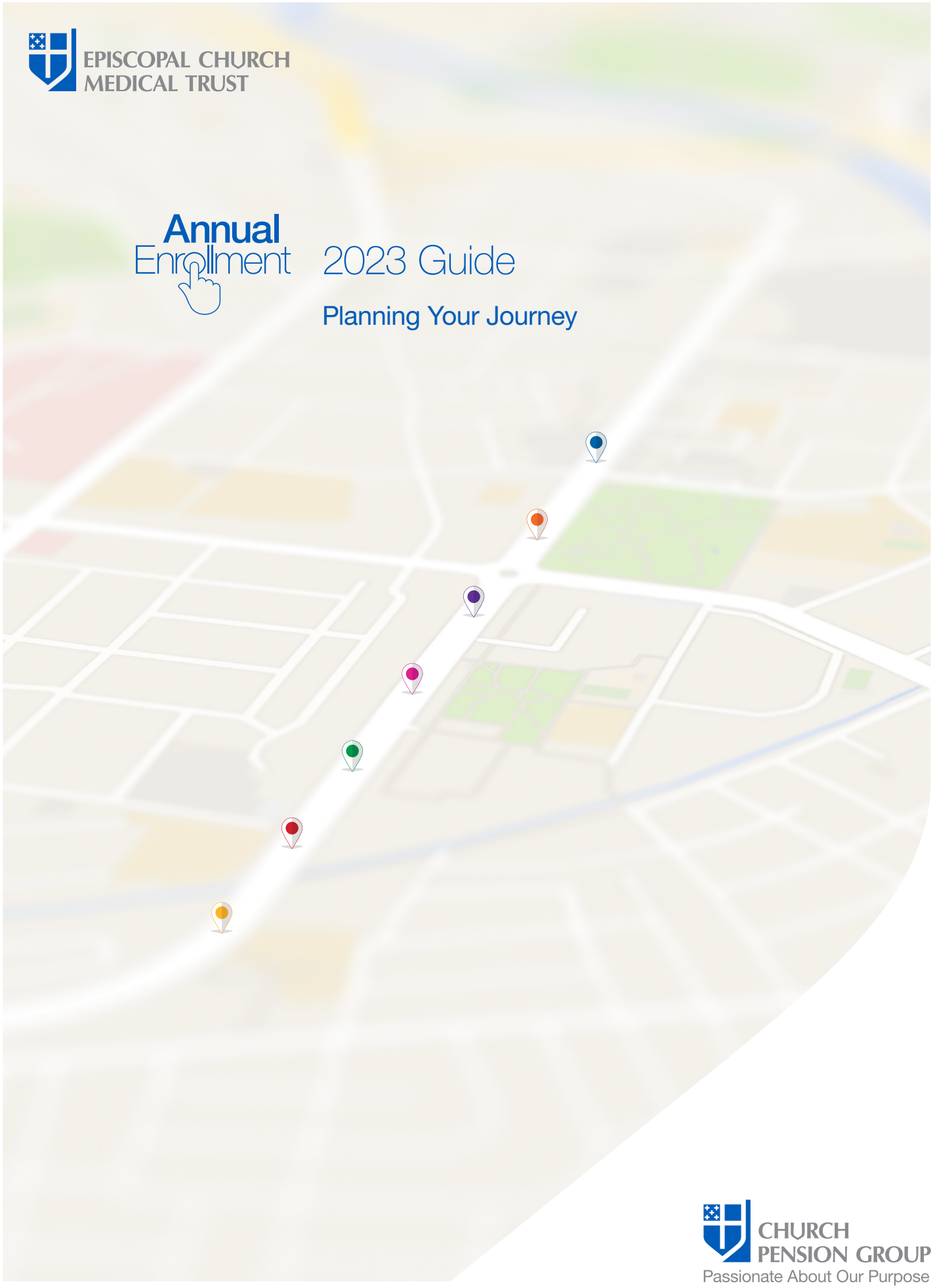
EPISCOPAL CHURCH MEDICAL TRUST

Annual Enrollment 2023 Guide

Planning Your Journey



CHURCH PENSION GROUP
Passionate About Our Purpose

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Your Guide to Annual Enrollment

The Episcopal Church Medical Trust (Medical Trust) benefits are part of the journey to your overall well-being, ensuring that you have access to quality care. Use this guide to learn about the types of Medical Trust benefits available to you, key considerations when making your choices, and how to enroll. You can find additional resources and benefit details on *cpg.org*.[1]

Since the benefit decisions you make may affect your whole family, please share Annual Enrollment information with other decision-makers in your household.

What You Need to Know

- Look for a green envelope in the mail this fall. This will include a letter with important information for Annual Enrollment. Save this letter! It includes your **Client ID number**, which you will need to access the Annual Enrollment website.
- Some plans described in this guide may not be available in all locations or to all groups or dioceses. You will see which plans are available to you when you log on to the Annual Enrollment website.
- Coverage tiers, which range from single to family coverage, will depend on what is offered by your group or diocese. Please see your online enrollment form for the coverage tiers available to you. **The rates indicated on your online enrollment form may not necessarily be what your employer requires you to pay.**
- Please see your group administrator if you need to confirm your eligibility for benefits or that of a dependent.
- If you do not make changes or enroll by the deadline, your current benefits will continue and any rate changes will apply. **If your current health plan is not offered in 2023, you must select another plan in order to have medical benefits in 2023.**

Glossary of Defined Terms

Please see the Uniform Glossary at *cpg.org/uniform-glossary* for the definitions of the following commonly used terms: *contributions, coinsurance, copayments, cost sharing, deductible, emergency medical conditions, health insurance, hospitalization, network, network provider, out-of-network provider, plan, prescription drug, and primary care physician.*

[1] *Health plan benefit design information does not apply to fully insured plans (Hawaii Medical Service Association and Kaiser Permanente Washington) offered on a regional basis to select Participating Groups by the Medical Trust.*

Selecting Your 2023 Benefits

Annual Enrollment for 2023 Medical Trust active health benefits begins in October 2022. This is your opportunity to review and make changes to your Medical Trust benefits and to add or drop coverage for eligible dependents for the upcoming plan year. Be sure to take the time to review your options. You cannot make changes until the next Annual Enrollment period, unless you have a qualified Significant Life Event (as defined in the Plan Document Handbook), such as the birth of a child, marriage, or divorce.

Even if you do not plan to make any changes to your health benefits, it's a good idea to log in to your account and review your personal and dependent information, and make any necessary updates.

Changes for 2023

Prescription drug plan member cost sharing updates

Effective January 1, 2023, the Medical Trust's prescription drug plan cost sharing will be updated for members. The updated prescription drug plan includes the following changes:

- The Standard Rx option will be coinsurance-based (vs. copays) with maximum amounts to protect members from excessive costs and minimums to drive plan savings.
- The Premium Rx option will continue to be based on copays; however, copay amounts for non-generic drugs will increase.
- All plan designs will add a new cost-sharing tier for Specialty drugs.

Express Scripts (for Anthem & Cigna members)
Depending on whether your employer group selects the Standard Rx or Premium Rx option, members enrolled in an Anthem or Cigna PPO plan will have the following cost sharing for prescription drug benefits:

Standard Rx	Retail	Home Delivery
Annual deductible (in-network)	None	None
Generic	Up to $10 copay	Up to $25 copay
Preferred brand name	25%; up to $40 min and $80 max	25%; up to $100 min and $200 max
Non-preferred brand name	40%; up to $80 min and $160 max	40%; up to $200 min and $400 max
Specialty	40%; up to $100 min and $200 max	40%; up to $250 min and $500 max
Dispensing limits	Up to 30-day supply copay	Up to 90-day supply copay

Notes:

- Anthem and Cigna Consumer-Directed Health Plan (CDHP) members will continue to have coinsurance-based prescription drug plan cost sharing with a combined medical and pharmacy deductible. Anthem and Cigna CDHPs will also introduce a Specialty Rx tier with 50% coinsurance after deductible.
- The Express Scripts prescription drug program will continue to maintain a retail refill limit policy. The retail refill limit requires that you use home delivery if you are prescribed a maintenance medication, rather than refilling multiple prescriptions for the same drug at a retail pharmacy. See the Plan Document Handbook for more information.

Kaiser Permanente

Members enrolled in the Kaiser Permanente EPO High and the Kaiser Permanente EPO 80 plans will have the following cost sharing for prescription drug benefits:

Standard Rx	Retail	Home Delivery
Annual deductible (in-network)	None	None
Generic	Up to $5 copay	Up to $5 for a 30-day supply or $10 for a 90-day supply
Preferred brand name	Up to $30 copay	Up to $30 for a 30-day supply or $60 for a 90-day supply
Non-preferred brand name	Up to $70 copay	Up to $70 for a 30-day supply or $140 for a 90-day supply
Specialty	Up to $90 copay	Up to $90 for a 30-day supply or $180 for a 90-day supply
Dispensing limits	Up to 30-day supply	Up to 90-day supply

Note: Kaiser CDHP members will continue to have coinsurance-based prescription drug plan cost sharing with a combined medical and pharmacy deductible. Kaiser CDHPs will also introduce a Specialty Rx tier of 50% coinsurance after deductible.

Medical channel management for Anthem and Cigna plans

Specialty medications are drugs that are used to treat complex conditions and illnesses, such as cancer, growth hormone deficiency, hemophilia, hepatitis C, immune deficiency, multiple sclerosis, and rheumatoid arthritis. These drugs usually require special handling, special administration, or intensive patient monitoring. Medications used to treat diabetes are not considered specialty medications. Whether they are administered by a healthcare professional, self-injected, or taken by mouth, specialty medications require an enhanced level of service.

The Medical Trust's prescription drug program requires that certain specialty medications be accessed through Accredo Health Group, Inc., an Express Scripts specialty pharmacy, effective January 1, 2023. If a member is currently using such specialty medications through their medical benefit (i.e., through Anthem or Cigna), the member will be required to transfer those prescriptions to Accredo.

The list of medications subject to the program is available by calling Express Scripts at (800) 841-3361.

COVID-19 provisions

The Medical Trust will continue to waive all copays, deductibles, and coinsurance for its members for healthcare services relating to the evaluation and testing for COVID-19 through at least December 31, 2023. In addition, the Medical Trust also will waive all copays, deductibles, and in-network coinsurance for its active members for healthcare services relating to the treatment of COVID-19 through at least December 31, 2023.[2]

Telehealth

Telehealth platforms for Active Members[3]– You can access a medical professional through telehealth platforms offered by Anthem, Cigna, or Kaiser using your computer or mobile device. You will need high-speed internet access, a webcam or built-in camera, and audio capability. Please remember your personal healthcare provider may not participate on the vendor's telehealth platform.

For Anthem and Cigna PPO members and Kaiser EPO members, all services received via vendor telehealth platforms are available to you with no deductible, copay, or coinsurance through December 31, 2023. For CDHP members, while temporary legislation currently permits the Medical Trust to provide you with first-dollar coverage of vendor telehealth platform services, there is no guarantee that this relief will be extended beyond December 31, 2022. If Congress does not extend this relief, during 2023, you will be required to meet your deductible before carrier telehealth services will be covered with no copay or coinsurance.

- **Anthem Blue Cross Blue Shield** – Access *LiveHealthOnline.com* or download the LiveHealth Online mobile app in the App Store® or Google Play™.
- **Cigna** – Access *MDLiveforCigna.com* on your computer or download the MDLIVE mobile app by searching in the App Store® or Google Play™.
- **Kaiser Permanente** – Access Kaiser's telehealth platform services by calling the number on the back of your member ID card.

Virtual visits

A virtual visit is an appointment with your personal healthcare provider carried out through an electronic medium of your provider's choice (e.g., Zoom, Skype, telephonic) but that is not offered through your health plan carrier's telehealth platform (e.g., Anthem LiveHealth Online, Cigna MDLive).

The Medical Trust will continue to allow claims for virtual visits with network and out-of-network providers that do not use a telehealth platform offered by Anthem or Cigna through December 31, 2023.

Virtual visits are covered at standard levels of benefits and member cost shares.

Note: Kaiser's healthcare model requires its members to use the Kaiser telehealth platform for telehealth services.

Hinge Health for Anthem and Cigna plans

Hinge Health is available at no cost to Anthem and Cigna members effective October 1, 2022. Through the Hinge Health Digital Musculoskeletal (MSK) Clinic, participants have access to personalized MSK care programs depending on their specific MSK needs.

[2] *This deductible waiver includes our HSA-qualified CDHPs as permitted by IRS Notice 2020-15.*

[3] *Please note, telehealth can help with minor, non-life-threatening conditions. During a medical emergency, individuals should visit the nearest hospital or call 911 for assistance.*

- **Prevention** – Program designed to increase education with regard to key strengthening and stretching activities around healthy habits. The Prevention program is software based and offered through the Hinge Health app.
- **Chronic** – Program designed to address long-term back and joint pain. It includes personalized app-guided exercise therapy sessions, one-on-one access to a personalized health coach, personalized education content, and behavioral health support. Participants in the chronic program may also be offered access to virtual sessions with a licensed physical therapist and/or the non-invasive ENSO High Frequency Impulse Therapy™ pain management device and service, as appropriate, for symptomatic relief.
- **Acute** – Program designed to address recent injuries. It includes live virtual sessions with a dedicated licensed physical therapist along with software-guided rehabilitation and education.
- **Surgery** – Program designed to address pre/post-surgery rehab for the most common MSK Surgeries. It includes personalized app-guided exercise therapy sessions, 1:1 access to a personalized health coach and physical therapist, personalized education content, and behavioral health support.
- **Expert Medical Opinion** – Service offering second opinions for elective MSK procedures.

For applicable programs, a participant may obtain up to six virtual physical therapy sessions per episode (with no cost share to the member) prior to in-person healthcare provider or physical therapy care.

State laws may limit access without a physician's referral.

To get started with Hinge Health, visit *hingehealth.com/ecmt* to enroll. If you have any questions regarding Hinge Health, email *help@hingehealth.com* or call (855) 902-2777.

Increased EyeMed frames/contacts allowance

Vision benefits offered through EyeMed's Insight Network provide coverage for an annual eye exam and cost savings on prescription glasses or contact lenses.

Effective January 1, 2023, the annual frames or contact lenses allowance will increase from $150 to $200.

Fertility benefits

The Medical Trust's Episcopal Health Plan includes benefits for the diagnosis and treatment of infertility. Covered health services include diagnostic and exploratory procedures to determine whether a member suffers from infertility. Covered fertilization services include artificial insemination, in vitro fertilization, GIFT (gamete intra-fallopian transfer), and ZIFT (zygote intra-fallopian transfer) procedures.

Currently, there is a lifetime benefit maximum of $10,000 for services covered under the medical plan and $10,000 for services covered under the pharmacy plan.

Effective January 1, 2023, the lifetime benefit maximum will be a combined $50,000 for medical and pharmacy services.

In addition, the Medical Trust will provide standard fertility preservation services for individuals who must undergo medically necessary treatment that may cause iatrogenic infertility.

Note: Member cost shares (copays, coinsurance, and deductibles) apply; however, cost shares do not count against the lifetime benefit maximum.

Hearing aid device benefits

The Medical Trust's Episcopal Health Plan includes benefits for hearing aid devices.

Effective January 1, 2023, the benefit maximum for hearing aid devices will be a single $3,000 maximum every three years. The benefit maximum for hearing aid devices will no longer have a per ear maximum (currently $1,500 per ear).

Note: Member cost shares (copays, coinsurance, and deductibles) apply; however, cost shares do not count against the benefit maximums.

Travel vaccinations

Currently, the Medical Trust's Episcopal Health Plan excludes travel vaccines from coverage.

Effective January 1, 2023, the Medical Trust will cover travel vaccines for personal travel. Member cost sharing will follow the benefit plan design for immunizations.

Deductible increase for Anthem and Cigna CDHP-15

The Internal Revenue Service increased the minimum and maximum amounts that a high-deductible health plan (HDHP) may impose as a deductible.[4]

For 2023, the minimum amount that must be imposed as a deductible for self-only coverage under an HDHP is $1,500. The minimum amount that must be imposed as a deductible for family coverage under an HDHP is $3,000. The amounts for 2022 were $1,400 and $2,800, respectively.

Effective January 1, 2023, the Medical Trust's Anthem and Cigna CDHP-15 network deductible for self-only coverage will be $1,500, and the network deductible for family coverage will be $3,000. The out-of-network deductible for self-only coverage will be $3,000, and the out-of-network deductible for family coverage will be $6,000.

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

The Internal Revenue Service increased the minimum and maximum amounts that a high-deductible health plan (HDHP) may impose as a deductible.[4]

Effective January 1, 2023, the Medical Trust's Anthem, Cigna, and Kaiser CDHP-20 network deductible for self-only coverage will be $3,000 and the network deductible for family coverage will remain $5,450. The out-of-network deductible for self-only coverage will remain $3,000 and the out-of-network deductible for family coverage will remain $6,000.

[4] *See IRS Notice 2022-24.*

Health Plan Options

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

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

- Preferred Provider Organization (PPO)
- Consumer-Directed Health Plan (CDHP)/Health Savings Account (HSA)
- Exclusive Provider Organization (EPO) (regional Kaiser plans only)[5]

Medicare Secondary Payer/ Small Employer Exception

Some groups have chosen to participate in the Episcopal Health Plan for Qualified Small Employer Exception (the SEE Plan). See page 8 for information.

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 pays greater benefits if you receive care from a network provider or facility.

You are responsible for ensuring that the services and care you receive are covered by your plan. If you use an out-of-network provider, you are often responsible for submitting your own claims and paying the difference between what your provider charges and what the plan covers.

Consumer-Directed Health Plan/Health Savings Account (CDHP/HSA)

A CDHP is an HSA-qualified plan that works like a PPO. You can receive services from any provider, and you do not have to coordinate your care through a primary care physician (PCP). While the CDHP covers services in and out of the network, it provides strong financial incentives for you to use network providers. Despite the high deductible associated with a CDHP, most preventive care services received from network providers require no member cost share.

When you enroll in the CDHP, you can contribute tax-free to an HSA, which is a savings account for eligible healthcare expenses. Your employer may also contribute. Here's how the HSA works:

- You decide whether you want to contribute and how much, up to IRS maximums. You can change or stop your contributions any time during the year.
- Use the money in your HSA to pay for eligible healthcare expenses, including your annual deductible and medical, prescription, dental, and vision costs.
- You may also save the money in your HSA for future medical costs—including healthcare expenses in retirement.
- Your HSA is portable and will always belong to you, even if you change employers or retire.

About the CDHP

- The Kaiser CDHP-20/HSA works like an EPO, with no out-of-network benefits except in emergencies.
- You pay the full cost of medical and pharmacy expenses until you meet the annual deductible.

[5] *Some fully insured plans offered on a regional basis (Hawaii Medical Service Association and Kaiser Permanente Washington) provide an HMO option.*

To Contribute to an HSA

You must be enrolled in the Consumer-Directed Health Plan and cannot

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

HSA Tax Advantages

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

1. You do not pay taxes on your contributions.
2. Withdrawals from your HSA are tax-free as long as they are used to pay for qualified medical expenses. Make sure you keep receipts for tax-reporting purposes.
3. You may earn tax-free interest, with certain restrictions, or investment earnings.

Exclusive Provider Organization (EPO)—Kaiser

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

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

Medicare Secondary Payer/ Small Employer Exception

To participate in this program, you must satisfy all of these criteria:

- Be age 65 or older.
- Actively work for a qualified church or group that offers this choice.
- Be enrolled in Medicare Part A (or Medicare Part A and Part B).
- Choose a participating Anthem or Cigna plan.
- Be approved for the SEE Plan by Medicare.

If you enroll in the SEE Plan, Medicare will be the primary payer for Part A services. This program is also available for those enrolled in Medicare Part A and Part B. Once Medicare has paid its share, Anthem or Cigna pays claims as it would for any active member, minus the amounts paid by Medicare and you. It is anticipated that out-of-pocket costs will be lower for SEE Plan members and that employers may save in the cost of health benefits.

Eligible members approved by Medicare may enroll in the SEE Plan even if they have dependents who are under the age of 65 and do not have Medicare.

Eligible participants will receive details in the mail.

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

Summary of Benefits and Coverage

For an overview of benefits for each plan, access the *Summary of Benefits and Coverage* documents at *cpg.org/mtdocs*. Paper copies are also available, free of charge, by calling (800) 480-9967, Monday to Friday, 8:30 AM to 8:00 PM ET.

Health Plan Carriers

The Medical Trust offers the health plan options through three health plan carriers (not all may be available to you):

- Anthem
- Cigna
- Kaiser

We strive to provide consistent and equitable benefits to all members, regardless of health plan carrier. However, each health plan carrier has differences that may include prior authorization/precertification requirements, medical necessity guidelines, programs and processes, policies and procedures, provider networks, and health plan care management programs.

Following are some of the different programs available by health plan carriers.

See the 2022 Plan Document Handbook for more information about unique programs available from each health plan carrier.

Go Digital

No matter which plan you choose, you have online tools at your fingertips. Start by registering on your plan's website:

- Anthem: *anthem.com*
- Cigna: *mycigna.com*
- Kaiser: *kp.org*

After you register, download your plan's app to your mobile device from the App Store® or Google Play™ to find network providers and facilities, check claims status, download your Explanations of Benefits (EOB), find cost share information, and much more.

Anthem

Anthem Health Guide

Anthem Health Guides provide you with enhanced member services support. You can contact a health guide with questions about benefits and programs for your health, to get help scheduling physician appointments, to compare costs for procedures, and more. Guides can connect you with knowledgeable health professionals to help you manage chronic conditions, deal with an illness, or provide support for emotional concerns such as anxiety or depression. Reach out to Member Services and health guides via phone, email, app, or even chat online.

Virtual Second Opinion Program®

Facing a medical decision? The Virtual Second Opinion Program allows you access to highly specialized providers who can offer educational guidance for certain diagnoses, procedures, or courses of treatment.

Blue Cross Blue Shield Global Core® Program

If you are traveling outside the United States and need medical care, call Anthem's Member Services to find out more about Blue Cross Blue Shield Global Core benefits.

LiveHealth Online® Telehealth

With LiveHealth Online, you have a doctor by your side 24/7. LiveHealth Online lets you talk face-to-face with a provider through your mobile device or a computer with a webcam. No appointments, no driving, and no waiting at an urgent care center.

Cigna

Cigna One Guide®

One Guide combines digital technology with personalized customer service. With One Guide, you have the one-on-one support you need to take control of your health and your health spending. Whether it's choosing a plan, finding a provider, or exploring ways to improve your health, One Guide can help.

You can access a personal guide via app, chat, online, or phone, whenever you need guidance, support, or answers. To get started, just call the number on the back of your Cigna ID Card.

MDLive® Telehealth

MDLive for Cigna telehealth platform enables you to get the care you need—including most prescriptions—for a wide range of minor conditions. You can connect with board-certified providers via secure video chat or phone when, where, and how it works best for you.

Kaiser

Kaiser Telehealth

Phone, interactive video, internet messaging applications, and email between members and their personal Kaiser network providers make it convenient to receive medically appropriate covered services.

Important: Deductibles and Out-of-Pocket Limits

Deductibles

The out-of-pocket limit is the most you will pay for covered healthcare expenses for the calendar year. Similar to the deductible, if you cover family members, please note this:

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

Out-of-Pocket Limits

The out-of-pocket limit is the most you will pay for covered healthcare expenses for the calendar year. Similar to the deductible, if you cover family members, please note this:

- The Anthem and Cigna CDHP-15 plans require that the family out-of-pocket limit be met.
- With all other plans, once a member meets the individual out-of-pocket limit, the plan will cover the full cost of eligible expenses for that member for the remainder of the calendar year. When the family out-of-pocket limit has been met, the plan will cover eligible costs for all enrolled family members.

Prescription Drug Benefits

Express Scripts Prescription Drug Program®

When you enroll in one of our **Anthem** or **Cigna** health plans, you will automatically have prescription drug coverage through the Express Scripts Prescription Drug Program.

Express Scripts prescription benefits are available in both retail pharmacies and via home delivery for ongoing, refillable prescriptions. You can realize savings in these ways:

- By requesting generic drugs whenever possible (your doctor can advise you on whether a generic medication is appropriate)
- By using home delivery for prescriptions you need on an ongoing basis

Home Delivery

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

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

For more information, call Express Scripts Member Services at (800) 841-3361.

Kaiser Prescription Drug Program

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

Other Plan Benefits[6]

Vision Benefits

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

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

If you are already registered on the EyeMed site, visit *enrollwitheyemed.com* and use your EyeMed member account credentials to log in for details. Click "Need to register?" to create an EyeMed member account.

Employee Assistance Program (EAP)

To help address your emotional, physical, family, and legal needs, the Medical Trust offers the Employee Assistance Program (EAP) managed by Cigna Behavioral Health. If you are enrolled in a Medical Trust health plan, the Cigna EAP is available to you and your household members at no cost to you. Your household members do not need to be enrolled in your health plan to use the Cigna EAP.

This benefit provides immediate help, referrals, and resources. The plan covers telephone consultations and up to 10 face-to-face counseling sessions per issue at no member cost. Cigna EAP services are confidential and available 24/7.

The Cigna EAP staff can provide the following:

- 24/7 phone access for behavioral health issues
- Referrals for in-person counseling
- Legal consultations
- Financial services and referrals
- Tips for balancing work and family
- Assistance finding childcare, senior care, and pet care

There are also online resources for issues such as these:

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

[6] *These other plan benefits may not be available to members participating in fully insured plan options offered on a regional basis (Hawaii Medical Service Association and Kaiser Permanente Washington).*

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

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

To access the Cigna EAP, visit *mycigna.com* or call (866) 395-7794.

Health Advocate®

This program is like having your own healthcare navigator at no cost to you! Health Advocate offers help when you have questions about your medical care—from finding a doctor and scheduling an appointment to understanding treatment options for a medical condition to understanding your benefits or resolving a claim.

This service can help you navigate the healthcare system and make the most of your benefits. It is available for you, your dependents, your parents, and your parents-in-law (even if they do not live with you).

Call as often as you need and speak toll-free with a health advocate about your healthcare options. Your information is confidential. Your employer does not receive and does not have access to any of your confidential information. You will be asked to complete and submit forms to protect your privacy.

To access Health Advocate, visit *healthadvocate.com/ecmt* or call (866) 695-8622, Monday to Friday, 8:00 AM to 7:00 PM ET.

Dental Benefits

The dental plans offered by the Medical Trust are administered by Cigna.[7]

The Cigna dental plans offer preventive care and three routine cleanings a year covered at 100% with no deductible when using Cigna's DPPO Advantage providers.

The Medical Trust offers three dental plans offering different coverage levels so that you can select the plan that best fits your family's needs. You may be offered one or all of these plans if your employer participates in the Medical Trust health plans. Ask your benefits administrator which, if any, your employer offers.

Access the dental provider directory at *mycigna.com* or call (800) 244-6224.

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

Please note: You may not add or drop dental coverage mid-year without a Significant Life Event or HIPAA Special Enrollment Event.

Travel Assistance Services

When you enroll in a Medical Trust health plan, you have access to UnitedHealthcare Global Assistance®. This travel assistance program can help you with travel needs you encounter while you are outside the United States or 100 or more miles away from home.

The program includes these features:

- Assistance in obtaining medical treatment—Whether you need a local referral for treatment or evacuation due to a medical emergency, UnitedHealthcare Global Assistance staff will help make the arrangements
- Assistance with providing insurance information and medical records for treatment
- Assistance with replacement of prescriptions, medical devices, and corrective lenses

[7] *Dental benefit design information does not apply to fully insured plans (Aetna Freedom Dental) offered on a regional basis to select Participating Groups by the Medical Trust.*

- Assistance procuring emergency travel arrangements and replacement of lost or stolen travel documents
- Emergency fund transfers
- Destination profiles, which include health and security risks for more than 170 countries

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

If you have an emergency medical event while traveling, contact your health plan carrier using the number on your member ID card.

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

Choosing the Right Plan

To Help You Make an Informed Choice

Your plan provides a *Summary of Benefits and Coverage* (SBC), which offers important details about the plan's benefits in a standard format, to help you compare options.

SBCs are available at *cpg.org/mtdocs*. For a free paper 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. There are several important considerations to help you choose the best health plan for you and your family and manage your costs when you need care:

- **Changes to healthcare usage in upcoming year**—Though it may be tempting to default to the same medical option year after year, healthcare needs change over time. During Annual Enrollment, consider how your healthcare needs might be different in the upcoming year. For example, are you expecting to have a baby or planning to have a medical procedure? As your needs change, the best plan for you may change as well. A good start is to review the current year's Explanations of Benefits (EOB) to see how much you used your benefits and consider how that might change for next year.
- **Pay now or pay later**—It might help to think of the plan options in terms of "pay now" or "pay later." For example, your monthly contributions will be higher in plans with lower out-of-pocket costs, while your monthly contributions will be lower in plans that have higher cost shares. You should consider whether you prefer to pay higher monthly contributions for your coverage and less when you receive services, or to pay less each month with the prospect of paying more when you need services.
- **Network providers**—Your cost for healthcare will be higher if you use a doctor who is not in your plan's network. If you enroll in a Kaiser health plan, you pay the full cost of any non-emergency services provided by a doctor or facility that is not in the plan's network. Contact your health plan or visit its website to check whether your provider is in the plan's network.
- **Telehealth**—Telehealth allows you to connect with a board-certified provider for a wide variety of non-emergency conditions, and even get certain prescriptions from the safety and convenience of your own home. No appointment is necessary. If you are enrolled in a Medical Trust Consumer-Directed Health Plan (CDHP), you will pay a flat fee, depending on the type of visit. If you are not enrolled in a CDHP, you will pay the same copayment as an office visit. In all cases, you will know the cost before being placed in a virtual waiting room. In response to the COVID-19 pandemic, effective March 1, 2020, all services received via vendor telehealth platforms are available to you with no deductible, copay, or coinsurance through December 31, 2023.[8]

[8] *For CDHP members, while temporary legislation currently permits the Medical Trust to provide you with first-dollar coverage of vendor telehealth platform services, there is no guarantee that this relief will be extended beyond December 31, 2022. If Congress does not extend this relief, during 2023, you will be required to meet your deductible before carrier telehealth services will be covered with no copay or coinsurance.*

How to Enroll

Before you go online to enroll, you should know your plan selections, have information for any dependents you are adding, and have your Client ID number handy. Your Client ID number is included in the letter that was mailed to your home in a green envelope.

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

If your current plan is not offered in 2023, you must choose a new plan in order to have medical coverage. Also, be sure to verify and make any necessary corrections to your personal and dependent information, especially names, Social Security numbers, and addresses. If a dependent will turn age 30 in 2022, they can no longer be covered as dependents under a Medical Trust plan, unless they were disabled prior to age 25, as determined by the Medical Trust. However, the Medical Trust will allow dependent children who turn age 30 in 2022 to voluntarily continue medical and/or dental coverage on their own for up to 36 months commencing on January 1, 2023, through the Medical Trust's Extension of Benefits provision.

You can print a confirmation statement for your records after you make your selections. Please check your selections carefully before you complete the enrollment process.

Your new plan choice takes effect on January 1, 2023. You may receive new ID cards (if applicable) at this time. The Medical Trust can also print many ID cards, or you can print them from the vendor's website. Call Client Services for assistance at (800) 480-9967, Monday to Friday, 8:30 AM to 8:00 PM ET, or email *mtcustserv@cpg.org*.

If You Do Not Enroll by the Deadline

If you miss the deadline and your current plan is still available for 2023, you will continue in the same plan with the same coverage tier as long as you continue to meet the plan's eligibility rules.

If you do not enroll by the deadline and your current plan is not offered in 2023, your medical benefits will end on December 31, 2022, and you cannot re-enroll until the next Annual Enrollment period unless you have a qualified Significant Life Event (as defined in the Plan Document Handbook).

Learn More

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

Anthem
anthem.com

Cigna Medical and Dental
mycigna.com

Cigna Behavioral Health
(Employee Assistance Program)
mycigna.com

Kaiser
kp.org

Express Scripts
express-scripts.com

EyeMed
Member services, general information, and "find a provider" search tool
eyemedvisioncare.com/ecmt

Health Advocate
members.healthadvocate.com

UnitedHealthcare Global Assistance
members.uhcglobal.com

About The Episcopal Church Medical Trust

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

The Medical Trust funds certain of its benefit Plans through a trust fund known as The Episcopal Church Clergy and Employees' Benefit Trust (ECCEBT).[9] 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 compassion and benefits with financial stewardship." This is a unique mission in the world of healthcare benefits, and we believe that our experience and mission to serve The Episcopal Church offers a level of expertise that is unparalleled. If you have questions about any of our Plans, please don't hesitate to contact us. We're looking forward to serving you.

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

Eligibility

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

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

EPISCOPAL CHURCH
MEDICAL TRUST

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

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EPISCOPAL CHURCH MEDICAL TRUST

2023 Medical Trust Health Plan Diocese of Los Angeles	Anthem BCBS BlueCard PPO 100		Anthem BCBS BlueCard PPO 90		Anthem BCBS BlueCard PPO 80		Anthem BCBS BlueCard PPO 70	
	Network	Out-of-Network	Network	Out-of-Network	Network	Out-of-Network	Network	Out-of-Network
Annual Deductible (CDHPs have a combined medical & Rx deductible)	$0 per person $0 per family	$500 per person $1,000 per family	$500 per person $1,000 per family	$1,000 per person $2,000 per family	$1,000 per person $2,000 per family	$2,000 per person $4,000 per family	$3,500 per person $7,000 per family	$7,000 per person $14,000 per family
Annual Out-of-Pocket Limit	$2,000 per person $4,000 per family	$4,000 per person $8,000 per family	$2,500 per person $5,000 per family	$5,000 per person $10,000 per family	$3,500 per person $7,000 per family	$7,000 per person $14,000 per family	$5,000 per person $10,000 per family	$10,000 per person $20,000 per family
Preventive Care								
Preventive Services & Well-Child Care	$0 copay	50% coinsurance	$0 copay	50% coinsurance	$0 copay	50% coinsurance	$0 copay	50% coinsurance
Physician Services								
Office Visit	$30 copay	50% coinsurance	$30 copay	50% coinsurance	$30 copay	50% coinsurance	$30 copay	50% coinsurance
Diagnostic Services (outpatient)	$0 copay	50% coinsurance	10% coinsurance	50% coinsurance	20% coinsurance	50% coinsurance	30% coinsurance	50% coinsurance
Specialist Care	$45 copay	50% coinsurance	$45 copay	50% coinsurance	$45 copay	50% coinsurance	$45 copay	50% coinsurance
Hospital Services								
Inpatient Services (including inpatient maternity services)	$250 copay	50% coinsurance	10% coinsurance	50% coinsurance	20% coinsurance	50% coinsurance	30% coinsurance	50% coinsurance
Outpatient Surgery	$200 copay	50% coinsurance	10% coinsurance	50% coinsurance	20% coinsurance	50% coinsurance	30% coinsurance	50% coinsurance
Emergency Room Care	$250 copay	$250 copay	$250 copay	$250 copay	$250 copay	$250 copay	$250 copay	$250 copay
Ambulance Services	$0 copay	$0 copay	10% coinsurance	10% coinsurance	20% coinsurance	20% coinsurance	30% coinsurance	30% coinsurance
Behavioral Health								
Outpatient Services	$0 copay	30% coinsurance	$30 copay	30% coinsurance	$30 copay	30% coinsurance	$30 copay	30% coinsurance
Inpatient Services	$250 copay	50% coinsurance	10% coinsurance	50% coinsurance	20% coinsurance	50% coinsurance	30% coinsurance	50% coinsurance
Other Medical Services								
Durable Medical Equipment	$0 copay	50% coinsurance	10% coinsurance	50% coinsurance	20% coinsurance	50% coinsurance	30% coinsurance	50% coinsurance
Home Health Care (210 visits per calendar year, combined network and out-of-network)	$0 copay	50% coinsurance	10% coinsurance	50% coinsurance	20% coinsurance	50% coinsurance	30% coinsurance	50% coinsurance
Outpatient Therapy (60 visits per calendar year per each type of therapy, combined network and out-of-network)	$30 copay PCP/$45 copay specialist (includes speech, physical, and occupational)	50% coinsurance (includes speech, physical, and occupational)	$30 copay PCP/$45 copay specialist (includes speech, physical, and occupational)	50% coinsurance (includes speech, physical, and occupational)	$30 copay PCP/$45 copay specialist (includes speech, physical, and occupational)	50% coinsurance (includes speech, physical, and occupational)	$30 copay PCP/$45 copay specialist (includes speech, physical, and occupational)	50% coinsurance (includes speech, physical, and occupational)
Skilled Nursing / Acute Rehabilitation Facility (60 days per calendar year, combined network and out-of-network)	$0 copay	50% coinsurance	10% coinsurance	50% coinsurance	20% coinsurance	50% coinsurance	30% coinsurance	50% coinsurance
Urgent Care Services	$50 copay	$50 copay	$50 copay	$50 copay	$50 copay	$50 copay	$50 copay	$50 copay

EPISCOPAL CHURCH MEDICAL TRUST

2023 Medical Trust Health Plan 0430 - Diocese of Los Angeles	Anthem BCBS BlueCard PPO 100		Anthem BCBS BlueCard PPO 90		Anthem BCBS BlueCard PPO 80		Anthem BCBS BlueCard PPO 70	
	Pharmacy Benefits Administered by Express Scripts		Pharmacy Benefits Administered by Express Scripts		Pharmacy Benefits Administered by Express Scripts		Pharmacy Benefits Administered by Express Scripts	
Prescription Drug Benefits	**Retail**	**Home Delivery**	**Retail**	**Home Delivery**	**Retail**	**Home Delivery**	**Retail**	**Home Delivery**
Annual Prescription Deductible (in-network)	None	None	None	None	None	None	None	None
Tier 1: Generic	Up to a $10 copay	Up to a $25 copay	Up to a $10 copay	Up to a $25 copay	Up to a $10 copay	Up to a $25 copay	Up to a $10 copay	Up to a $25 copay
Tier 2: Preferred Brand Name	25%; up to $40 min / $80 max	25%; up to $100 min / $200 max	25%; up to $40 min / $80 max	25%; up to $100 min / $200 max	25%; up to $40 min / $80 max	25%; up to $100 min / $200 max	25%; up to $40 min / $80 max	25%; up to $100 min / $200 max
Tier 3: Non-Preferred Brand Name	40%; up to $80 min / $160 max	40%; up to $200 min / $400 max	40%; up to $80 min / $160 max	40%; up to $200 min / $400 max	40%; up to $80 min / $160 max	40%; up to $200 min / $400 max	40%; up to $80 min / $160 max	40%; up to $200 min / $400 max
Tier 4: Specialty Rx	40%; up to $100 min / $200 max	40%; up to $250 min / $500 max	40%; up to $100 min / $200 max	40%; up to $250 min / $500 max	40%; up to $100 min / $200 max	40%; up to $250 min / $500 max	40%; up to $100 min / $200 max	40%; up to $250 min / $500 max
Dispensing Limits Per Copayment	Up to a 30-day supply	Up to a 90-day supply	Up to a 30-day supply	Up to a 90-day supply	Up to a 30-day supply	Up to a 90-day supply	Up to a 30-day supply	Up to a 90-day supply

EPISCOPAL CHURCH MEDICAL TRUST

2023 Medical Trust Health Plan 0430 - Diocese of Los Angeles	Anthem BCBS BlueCard PPO 100		Anthem BCBS BlueCard PPO 90		Anthem BCBS BlueCard PPO 80		Anthem BCBS BlueCard PPO 70	
	Vision Benefits Administered by EyeMed		Vision Benefits Administered by EyeMed		Vision Benefits Administered by EyeMed		Vision Benefits Administered by EyeMed	
Vision Benefits	**Network**	**Out-of-Network**	**Network**	**Out-of-Network**	**Network**	**Out-of-Network**	**Network**	**Out-of-Network**
Eye Examinations	$0 copay	Plan pays up to $30 for ophthalmologists or optometrists	$0 copay	Plan pays up to $30 for ophthalmologists or optometrists	$0 copay	Plan pays up to $30 for ophthalmologists or optometrists	$0 copay	Plan pays up to $30 for ophthalmologists or optometrists
Lenses (eligible once every calendar year)	$10 copay	Plan pays up to: $32 for single vision $46 for bifocal $57 for trifocal	$10 copay	Plan pays up to: $32 for single vision $46 for bifocal $57 for trifocal	$10 copay	Plan pays up to: $32 for single vision $46 for bifocal $57 for trifocal	$10 copay	Plan pays up to: $32 for single vision $46 for bifocal $57 for trifocal
Lens Options								
Standard progressive (add-on to bifocal)	Up to $75 copay	Plan pays up to $46	Up to $75 copay	Plan pays up to $46	Up to $75 copay	Plan pays up to $46	Up to $75 copay	Plan pays up to $46
UV Coating	Up to $15 copay	You are responsible for the cost of any lens options that you elect from out-of-network providers,	Up to $15 copay	You are responsible for the cost of any lens options that you elect from out-of-network providers,	Up to $15 copay	You are responsible for the cost of any lens options that you elect from out-of-network providers,	Up to $15 copay	You are responsible for the cost of any lens options that you elect from out-of-network providers,
Tint (solid and gradient)	Up to $15 copay		Up to $15 copay		Up to $15 copay		Up to $15 copay	
Standard Scratch Resistance	Up to $15 copay		Up to $15 copay		Up to $15 copay		Up to $15 copay	
Standard Polycarbonate	$0 copay		$0 copay		$0 copay		$0 copay	
Standard Anti-Reflective Coating	Up to $45 copay		Up to $45 copay		Up to $45 copay		Up to $45 copay	
Disposable	20% off retail price		20% off retail price		20% off retail price		20% off retail price	
Frames (eligible once every calendar year)	$200 allowance, 20% off balance over $200	Plan pays up to $47	$200 allowance, 20% off balance over $200	Plan pays up to $47	$200 allowance, 20% off balance over $200	Plan pays up to $47	$200 allowance, 20% off balance over $200	Plan pays up to $47
Contact Lenses (eligible once every calendar year)								
Conventional	$200 allowance, 15% off balance over $200	Plan pays up to $100	$200 allowance, 15% off balance over $200	Plan pays up to $100	$200 allowance, 15% off balance over $200	Plan pays up to $100	$200 allowance, 15% off balance over $200	Plan pays up to $100
Disposable	$200 allowance, then you pay balance over $200	Plan pays up to $100	$200 allowance, then you pay balance over $200	Plan pays up to $100	$200 allowance, then you pay balance over $200	Plan pays up to $100	$200 allowance, then you pay balance over $200	Plan pays up to $100

EPISCOPAL CHURCH MEDICAL TRUST

2023 Medical Trust Health Plan 0430 - Diocese of Los Angeles	Anthem BCBS CDHP 15/HSA		Anthem BCBS CDHP 20/HSA		Anthem BCBS CDHP 40/HSA	
	Network	Out-of-Network	Network	Out-of-Network	Network	Out-of-Network
Annual Deductible (CDHPs have a combined medical & Rx deductible)	$1,500 per person $3,000 per family (deductible is non-embedded)	$3,000 per person $6,000 per family (deductible is non-embedded)	$3,000 per person $5,450 per family	$3,000 per person $6,000 per family	$3,500 per person $7,000 per family	$7,000 per person $14,000 per family
Annual Out-of-Pocket Limit	$2,400 per person $4,800 per family (out-of-pocket limit is non-embedded)	$4,800 per person $9,600 per family (out-of-pocket limit is non-embedded)	$4,200 per person $8,450 per family	$7,000 per person $13,000 per family	$6,000 per person $12,000 per family	$10,000 per person $20,000 per family
Preventive Care						
Preventive Services & Well-Child Care	$0 copay	40% coinsurance	$0 copay	45% coinsurance	$0 copay	60% coinsurance
Physician Services						
Office Visit	15% coinsurance	40% coinsurance	20% coinsurance	45% coinsurance	40% coinsurance	60% coinsurance
Diagnostic Services (outpatient)	15% coinsurance	40% coinsurance	20% coinsurance	45% coinsurance	40% coinsurance	60% coinsurance
Specialist Care	15% coinsurance	40% coinsurance	20% coinsurance	45% coinsurance	40% coinsurance	60% coinsurance
Hospital Services						
Inpatient Services (including inpatient maternity services)	15% coinsurance	40% coinsurance	20% coinsurance	45% coinsurance	40% coinsurance	60% coinsurance
Outpatient Surgery	15% coinsurance	40% coinsurance	20% coinsurance	45% coinsurance	40% coinsurance	60% coinsurance
Emergency Room Care	15% coinsurance	15% coinsurance	20% coinsurance	20% coinsurance	40% coinsurance	40% coinsurance
Ambulance Services	15% coinsurance	15% coinsurance	20% coinsurance	20% coinsurance	40% coinsurance	40% coinsurance
Behavioral Health						
Outpatient Services	15% coinsurance	40% coinsurance	20% coinsurance	45% coinsurance	40% coinsurance	60% coinsurance
Inpatient Services	15% coinsurance	40% coinsurance	20% coinsurance	45% coinsurance	40% coinsurance	60% coinsurance
Other Medical Services						
Durable Medical Equipment	15% coinsurance	40% coinsurance	20% coinsurance	45% coinsurance	40% coinsurance	60% coinsurance
Home Health Care (210 visits per calendar year, combined network and out-of-network)	15% coinsurance	40% coinsurance	20% coinsurance	45% coinsurance	40% coinsurance	60% coinsurance
Outpatient Therapy (60 visits per calendar year per each type of therapy, combined network and out-of-network)	15% coinsurance (includes speech, physical, and occupational)	40% coinsurance (includes speech, physical, and occupational)	20% coinsurance (includes speech, physical, and occupational)	45% coinsurance (includes speech, physical, and occupational)	40% coinsurance (includes speech, physical, and occupational)	60% coinsurance (includes speech, physical, and occupational)
Skilled Nursing / Acute Rehabilitation Facility (60 days per calendar year, combined network and out-of-network)	15% coinsurance	40% coinsurance	20% coinsurance	45% coinsurance	40% coinsurance	60% coinsurance
Urgent Care Services	15% coinsurance	15% coinsurance	20% coinsurance	20% coinsurance	40% coinsurance	40% coinsurance

EPISCOPAL CHURCH MEDICAL TRUST

2023 Medical Trust Health Plan 0430 - Diocese of Los Angeles	Anthem BCBS CDHP 15/HSA		Anthem BCBS CDHP 20/HSA		Anthem BCBS CDHP 40/HSA	
	Pharmacy Benefits Administered by Express Scripts		Pharmacy Benefits Administered by Express Scripts		Pharmacy Benefits Administered by Express Scripts	
Prescription Drug Benefits	**Retail**	**Home Delivery**	**Retail**	**Home Delivery**	**Retail**	**Home Delivery**
Annual Prescription Deductible (in-network)	$1,500 per person $3,000 per family (combined with medical deductible) (non-embedded deductible)	$1,500 per person $3,000 per family (combined with medical deductible) (non-embedded deductible)	$3,000 per person $5,450 per family (combined with medical deductible)	$3,000 per person $5,450 per family (combined with medical deductible)	$3,500 per person $7,000 per family (combined with medical deductible)	$3,500 per person $7,000 per family (combined with medical deductible)
Tier 1: Generic	You pay 15% after deductible	You pay 15% after deductible	You pay 15% after deductible	You pay 15% after deductible	You pay 15% after deductible	You pay 15% after deductible
Tier 2: Preferred Brand Name	You pay 25% after deductible	You pay 25% after deductible	You pay 25% after deductible	You pay 25% after deductible	You pay 25% after deductible	You pay 25% after deductible
Tier 3: Non-Preferred Brand Name	You pay 50% after deductible	You pay 50% after deductible	You pay 50% after deductible	You pay 50% after deductible	You pay 50% after deductible	You pay 50% after deductible
Tier 4: Specialty Rx	You pay 50% after deductible	You pay 50% after deductible	You pay 50% after deductible	You pay 50% after deductible	You pay 50% after deductible	You pay 50% after deductible
Dispensing Limits Per Copayment	Up to a 30-day supply (retail) or 90-day supply	Up to a 30-day supply (retail) or 90-day supply	Up to a 30-day supply (retail) or 90-day supply	Up to a 30-day supply (retail) or 90-day supply	Up to a 30-day supply (retail) or 90-day supply	Up to a 30-day supply (retail) or 90-day supply

EPISCOPAL CHURCH MEDICAL TRUST

2023 Medical Trust Health Plan 0430 - Diocese of Los Angeles	Anthem BCBS CDHP 15/HSA		Anthem BCBS CDHP 20/HSA		Anthem BCBS CDHP 40/HSA	
	Vision Benefits Administered by EyeMed		Vision Benefits Administered by EyeMed		Vision Benefits Administered by EyeMed	
Vision Benefits	**Network**	**Out-of-Network**	**Network**	**Out-of-Network**	**Network**	**Out-of-Network**
Eye Examinations	$0 copay	Plan pays up to $30 for ophthalmologists or optometrists	$0 copay	Plan pays up to $30 for ophthalmologists or optometrists	$0 copay	Plan pays up to $30 for ophthalmologists or optometrists
Lenses (eligible once every calendar year	$10 copay	Plan pays up to: $32 for single vision $46 for bifocal $57 for trifocal	$10 copay	Plan pays up to: $32 for single vision $46 for bifocal $57 for trifocal	$10 copay	Plan pays up to: $32 for single vision $46 for bifocal $57 for trifocal
Lens Options						
Standard progressive (add-on to bifocal)	Up to $75 copay	Plan pays up to $46	Up to $75 copay	Plan pays up to $46	Up to $75 copay	Plan pays up to $46
UV Coating	Up to $15 copay	You are responsible for the cost of any lens options that you elect from out-of-network providers,	Up to $15 copay	You are responsible for the cost of any lens options that you elect from out-of-network providers,	Up to $15 copay	You are responsible for the cost of any lens options that you elect from out-of-network providers,
Tint (solid and gradient)	Up to $15 copay		Up to $15 copay		Up to $15 copay	
Standard Scratch Resistance	Up to $15 copay		Up to $15 copay		Up to $15 copay	
Standard Polycarbonate	$0 copay		$0 copay		$0 copay	
Standard Anti-Reflective Coating	Up to $45 copay		Up to $45 copay		Up to $45 copay	
Disposable	20% off retail price		20% off retail price		20% off retail price	
Frames (eligible once every calendar year)	$200 allowance, 20% off balance over $200	Plan pays up to $47	$200 allowance, 20% off balance over $200	Plan pays up to $47	$200 allowance, 20% off balance over $200	Plan pays up to $47
Contact Lenses (eligible once every cale						
Conventional	$200 allowance, 15% off balance over $200	Plan pays up to $100	$200 allowance, 15% off balance over $200	Plan pays up to $100	$200 allowance, 15% off balance over $200	Plan pays up to $100
Disposable	$200 allowance, then you pay balance over $200	Plan pays up to $100	$200 allowance, then you pay balance over $200	Plan pays up to $100	$200 allowance, then you pay balance over $200	Plan pays up to $100

EPISCOPAL CHURCH MEDICAL TRUST

2023 Medical Trust Health Plan 0430 - Diocese of Los Angeles	Kaiser EPO High		Kaiser EPO 80		Kaiser CDHP 20/HSA	
	Network	Out-of-Network	Network	Out-of-Network	Network	Out-of-Network
Annual Deductible (CDHPs have a combined medical & Rx deductible)	$0 per person $0 per family	Not Applicable	$500 per person $1,000 per family	Not Applicable	$3,000 per person $5,450 per family	Not Applicable
Annual Out-of-Pocket Limit	$1,750 per person $3,500 per family	Not Applicable	$3,500 per person $7,000 per family	Not Applicable	$4,200 per person $8,450 per family	Not Applicable
Preventive Care						
Preventive Services & Well-Child Care	$0 copay	Not Applicable	$0 copay	Not Applicable	$0 copay	Not Applicable
Physician Services						
Office Visit	$25 copay	Not Applicable	$25 copay	Not Applicable	20% coinsurance	Not Applicable
Diagnostic Services (outpatient)	$50 copay	Not Applicable	20% coinsurance	Not Applicable	20% coinsurance	Not Applicable
Specialist Care	$25 copay	Not Applicable	$35 copay	Not Applicable	20% coinsurance	Not Applicable
Hospital Services						
Inpatient Services (including inpatient maternity services)	$100 per day copay to maximum of $600	Not Applicable	20% coinsurance	Not Applicable	20% coinsurance	Not Applicable
Outpatient Surgery	$100 copay	Not Applicable	20% coinsurance	Not Applicable	20% coinsurance	Not Applicable
Emergency Room Care	$100 copay	Not Applicable	20% coinsurance	Not Applicable	20% coinsurance	Not Applicable
Ambulance Services	$0 copay	Not Applicable	20% coinsurance	Not Applicable	20% coinsurance	Not Applicable
Behavioral Health						
Outpatient Services	$25 copay per visit for	Not Applicable	$25 copay per visit for	Not Applicable	20% coinsurance	Not Applicable
Inpatient Services	$100 per day copay to	Not Applicable	20% coinsurance	Not Applicable	20% coinsurance	Not Applicable
Other Medical Services						
Durable Medical Equipment	$0 copay	Not Applicable	20% coinsurance	Not Applicable	20% coinsurance	Not Applicable
Home Health Care (210 visits per calendar year, combined network and out-of-network)	$0 copay	Not Applicable	$0 copay	Not Applicable	$0 copay	Not Applicable
Outpatient Therapy (60 visits per calendar year per each type of therapy, combined network and out-of-network)	$25 copay (includes speech, physical, and occupational)	Not Applicable	$25 copay (includes speech, physical, and occupational)	Not Applicable	20% coinsurance (includes speech, physical, and occupational)	Not Applicable
Skilled Nursing / Acute Rehabilitation Facility (60 days per calendar year, combined network and out-of-network)	$0 copay	Not Applicable	20% coinsurance	Not Applicable	20% coinsurance	Not Applicable
Urgent Care Services	$50 copay	Not Applicable	$50 copay	Not Applicable	20% coinsurance	Not Applicable

EPISCOPAL CHURCH MEDICAL TRUST

2023 Medical Trust Health Plan 0430 - Diocese of Los Angeles	Kaiser EPO High		Kaiser EPO 80		Kaiser CDHP 20/HSA	
	Pharmacy Benefits Administered by Kaiser		Pharmacy Benefits Administered by Kaiser		Pharmacy Benefits Administered by Kaiser	
Prescription Drug Benefits	Retail	Home Delivery	Retail	Home Delivery	Retail	Home Delivery
Annual Prescription Deductible (in-network)	None	None	None	None	$3,000 per person $5,450 per family (combined with medical deductible)	$3,000 per person $5,450 per family (combined with medical deductible)
Tier 1: Generic	Up to a $5 copay	Up to a $10 copay for a 30-day supply or $20 for up to a 90-day supply	Up to a $5 copay	Up to a $10 copay for a 30-day supply or $20 for up to a 90-day supply	You pay 15% after deductible	You pay 15% after deductible
Tier 2: Preferred Brand Name	Up to a $30 copay	Up to a $30 copay for a 30-day supply or $60 for up to a 90-day supply	Up to a $30 copay	Up to a $30 copay for a 30-day supply or $60 for up to a 90-day supply	You pay 25% after deductible	You pay 25% after deductible
Tier 3: Non-Preferred Brand Name	Up to a $70 copay	Up to a $70 copay for a 30-day supply or $140 for up to a 90-day supply	Up to a $70 copay	Up to a $70 copay for a 30-day supply or $140 for up to a 90-day supply	You pay 50% after deductible	You pay 50% after deductible
Tier 4: Specialty Rx	Up to a $90 copay	Up to a $90 copay for a 30-day supply or $180 for up to a 90-day supply	Up to a $90 copay	Up to a $90 copay for a 30-day supply or $180 for up to a 90-day supply	You pay 50% after deductible	You pay 50% after deductible
Dispensing Limits Per Copayment	Up to a 30-day supply	Up to a 90-day supply	Up to a 30-day supply	Up to a 90-day supply	Up to a 30-day supply (retail) or 90-day supply	Up to a 30-day supply (retail) or 90-day supply

EPISCOPAL CHURCH MEDICAL TRUST

2023 Medical Trust Health Plan 0430 - Diocese of Los Angeles	Kaiser EPO High		Kaiser EPO 80		Kaiser CDHP 20/HSA	
	Vision Benefits Administered by EyeMed		Vision Benefits Administered by EyeMed		Vision Benefits Administered by EyeMed	
Vision Benefits	**Network**	**Out-of-Network**	**Network**	**Out-of-Network**	**Network**	**Out-of-Network**
Eye Examinations	$0 copay	Plan pays up to $30 for ophthalmologists or optometrists	$0 copay	Plan pays up to $30 for ophthalmologists or optometrists	$0 copay	Plan pays up to $30 for ophthalmologists or optometrists
Lenses (eligible once every calendar year	$10 copay	Plan pays up to: $32 for single vision $46 for bifocal $57 for trifocal	$10 copay	Plan pays up to: $32 for single vision $46 for bifocal $57 for trifocal	$10 copay	Plan pays up to: $32 for single vision $46 for bifocal $57 for trifocal
Lens Options						
Standard progressive (add-on to bifocal)	Up to $75 copay	Plan pays up to $46	Up to $75 copay	Plan pays up to $46	Up to $75 copay	Plan pays up to $46
UV Coating	Up to $15 copay	You are responsible for the cost of any lens options that you elect from out-of-network providers,	Up to $15 copay	You are responsible for the cost of any lens options that you elect from out-of-network providers,	Up to $15 copay	You are responsible for the cost of any lens options that you elect from out-of-network providers,
Tint (solid and gradient)	Up to $15 copay		Up to $15 copay		Up to $15 copay	
Standard Scratch Resistance	Up to $15 copay		Up to $15 copay		Up to $15 copay	
Standard Polycarbonate	$0 copay		$0 copay		$0 copay	
Standard Anti-Reflective Coating	Up to $45 copay		Up to $45 copay		Up to $45 copay	
Disposable	20% off retail price		20% off retail price		20% off retail price	
Frames (eligible once every calendar year)	$200 allowance, 20% off balance over $200	Plan pays up to $47	$200 allowance, 20% off balance over $200	Plan pays up to $47	$200 allowance, 20% off balance over $200	Plan pays up to $47
Contact Lenses (eligible once every cale						
Conventional	$200 allowance, 15% off balance over $200	Plan pays up to $100	$200 allowance, 15% off balance over $200	Plan pays up to $100	$200 allowance, 15% off balance over $200	Plan pays up to $100
Disposable	$200 allowance, then you pay balance over $200	Plan pays up to $100	$200 allowance, then you pay balance over $200	Plan pays up to $100	$200 allowance, then you pay balance over $200	Plan pays up to $100

EPISCOPAL CHURCH MEDICAL TRUST

Dental Benefits

0430 - Diocese of Los Angeles	Cigna Dental					
	Preventive Dental PPO Plan		Basic Dental PPO Plan		Dental & Orthodontia PPO Plan	
	DPPO Advantage	*DPPO and Out-of-Network*	*DPPO Advantage*	*DPPO and Out-of-Network*	*DPPO Advantage*	*DPPO and Out-of-Network*
Deductible	$0 per person / $0 per family	$0 per person / $0 per family	$0 per person / $0 per family	$50 per person / $150 per family	$0 per person / $0 per family	$25 per person / $75 per family
Annual Benefit Limit	$1,500		$2,000		$2,000	
Preventive and Diagnostic Services (e.g., oral exams, 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 (not subject to annual deductible)	
Basic Restorative Services (Includes fillings, root canal therapy, oral surgery, osseous surgery, and denture adjustments and repairs)	You pay 20% coinsurance	You pay 20% coinsurance	You pay 15% coinsurance	You pay 15% coinsurance after deductible	You pay 15% coinsurance	You pay 15% coinsurance after deductible
Major Restorative Services (Includes crowns, dentures, and bridges)	You pay 99% coinsurance	You pay 99% coinsurance	You pay 50% coinsurance	You pay 50% coinsurance after deductible	You pay 15% coinsurance	You pay 15% coinsurance after deductible
Orthodontia Services	Not covered. You pay 100%.	Not covered. You pay 100%.	Not covered. You pay 100%.	Not covered. You pay 100%.	You pay 50% coinsurance up to individual lifetime benefit limit of $1,500	You pay 50% coinsurance up to individual lifetime benefit limit of $1,500 after deductible

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' benefit 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, a confirmation of eligibility, or investment, tax, medical or other advice. In the event of a conflict between this document and the official Plan documents (summary of benefits and coverage, Plan Document Handbook), the official Plan documents will govern. The Church Pension Fund and 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, for any reason, and, unless required by law, without notice.

Church Pension Group Services Corporation (“CPGSC”), doing business as The Episcopal Church Medical Trust, maintains a series of health and welfare plans (the “Plans”) for eligible employees (and their eligible dependents) of The Episcopal Church (the “Church”). The Medical Trust serves only eligible Episcopal employers. The Plans that are self-funded are funded by the Episcopal Church Clergy and Employees’ Benefit Trust, a voluntary employees’ beneficiary association within the meaning of section 501(c)(9) of the Internal Revenue Code.

The Plans are church plans within the meaning of section 3(33) of the Employee Retirement Income Security Act of 1974, as amended, and section 414(e) of the Internal Revenue Code. Not all Plans are available in all areas of the United States or outside the United States, and not all Plans are available on both a self-funded and fully insured basis. Additionally, the Plan may be exempt from federal and state laws that may otherwise apply to health insurance arrangements. The Plans do not cover all healthcare expenses, so members should read the official Plan documents carefully to determine which benefits are covered, as well as any applicable exclusions, limitations, and procedures.

All benefits under the Plans are subject to applicable laws, regulations and policies.

Except for the Preventive Dental PPO Plan, all such benefits are subject to coordination of benefits. The Plans are subrogated to all the rights of a Plan participant against any party liability for such participant's illness or injury, to the extent of the reasonable value of the benefits provided to such a 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.

The Summary of Benefits and Coverage (SBC) document will help you choose a health plan. The SBC shows you how you and the plan would share the cost for covered health care services. NOTE: Information about the cost of this plan (called the premium) will be provided separately. This is only a summary. For more information about your coverage, or to get a copy of the complete terms of coverage, visit www.cpg.org/mtdocs or call (800) 480-9967. For general definitions of common terms, such as allowed amount, balance billing, coinsurance, copayment, deductible, provider, or other underlined terms, see the Glossary. You can view the Glossary at www.cpg.org/uniform-glossary or call (800) 480-9967 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	Network: $3,500 Individual / $7,000 Family Out-of-Network: $7,000 Individual / $14,000 Family	Generally, you must pay all of the costs from providers up to the deductible amount before this plan begins to pay. If you have other family members on the plan, each family member must meet their own individual deductible until the total amount of deductible expenses paid by all family members meets the overall family deductible. The network and out-of-network deductibles accumulate separately.
Are there services covered before you meet your deductible?	Yes, for example, network preventive care and certain COVID-19 expenses.	This plan covers some items and services even if you haven't yet met the deductible amount. But a copayment or coinsurance may apply. See a list of preventive services at healthcare.gov/coverage/preventive-care-benefits.**
Are there other deductibles for specific services?	No.	You don't have to meet deductibles for specific services.
What is the out-of-pocket limit for this plan?	Network: $5,000 Individual / $10,000 Family Out-of-Network: $10,000 Individual / $20,000 Family	The out-of-pocket limit is the most you could pay in a year for covered services. If you have other family members in this plan, they have to meet their own out-of-pocket limits until the overall family out-of-pocket limit has been met. The network and out-of-network out-of-pocket limits accumulate separately.
What is not included in the out-of-pocket limit?	Contributions, (premiums), balance-billing charges, penalties, copays for certain specialty pharmacy drugs considered non-essential health benefits and healthcare this plan doesn't cover.	Even though you pay these expenses, they don't count toward the out-of-pocket limit.
Will you pay less if you use a network provider?	Yes. See www.anthem.com or call (844) 812-9207 for a list of network providers.	This plan uses a provider network. You will pay less if you use a provider in the plan's network. You will pay the most if you use an out-of-network provider, and you might receive a bill from a provider for the difference between the provider's charge and what your plan pays (balance billing). Be aware, your network provider might use an out-of-network provider for some services (such as lab work). Check with your provider before you get services.
Do you need a referral to see a specialist?	No.	You can see the specialist you choose without a referral.

All copayment and coinsurance costs shown in this chart are after your deductible has been met, if a deductible applies.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	$30 copay/visit Deductible does not apply	50% coinsurance	None.
	Specialist visit	$45 copay/visit Deductible does not apply	50% coinsurance	None.
	Preventive care/screening/ immunization	No charge.	50% coinsurance	You may have to pay for services that aren't preventive. Ask your provider if the services needed are preventive. Then check what your plan will pay for. See a list of preventive services at healthcare.gov/coverage/preventive-care-benefits.
If you have a test	Diagnostic test (x-ray, blood work)	30% coinsurance Deductible does not apply	50% coinsurance	None.
	Imaging (CT/PET scans, MRIs)	30% coinsurance Deductible does not apply	50% coinsurance	None.
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	30% coinsurance	50% coinsurance	None.
	Physician/surgeon fees	30% coinsurance	50% coinsurance	None.
If you need immediate medical attention	Emergency room care	$250 copay/visit Deductible does not apply	$250 copay/visit Deductible does not apply	The $250 copay will be waived if you are admitted to the hospital as an inpatient within 24 hours.**
	Emergency medical transportation	30% coinsurance	30% coinsurance	None.
	Urgent care	$50 copay/visit Deductible does not apply	$50 copay/visit Deductible does not apply	None.

* For more information about limitations and exceptions, see the plan or policy document at www.cpg.org.

** See Page 5 for important information about evaluation, testing and treatment of COVID-19, and telehealth services.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you have a hospital stay	Facility fee (e.g., hospital room)	30% coinsurance	50% coinsurance	Prior authorization is required.**
	Physician/surgeon fees	30% coinsurance	50% coinsurance	
If you need mental health, behavioral health, or substance abuse services	Outpatient services	$30 PCP / $45 specialist copay/visit Deductible does not apply	30% coinsurance Deductible does not apply	None.
	Inpatient services	30% coinsurance Deductible does not apply	50% coinsurance	Prior authorization is required.
If you are pregnant	Office visits	$30 PCP / $45 specialist copay/visit Deductible does not apply	50% coinsurance	Copay applies only to the initial visit to confirm pregnancy.
	Childbirth/delivery professional services	30% coinsurance	50% coinsurance	Well-newborn care is covered. Newborn must be enrolled in the plan within 30 days of birth.
	Childbirth/delivery facility services	30% coinsurance	50% coinsurance	
If you need help recovering or have other special health needs	Home health care	30% coinsurance	50% coinsurance	Limited to 210 visits per plan year. Prior authorization is required.
	Rehabilitation services	$30 PCP / $45 specialist copay/visit Deductible does not apply	50% coinsurance	Benefits include speech/hearing, physical, and occupational therapy. Limited to 60 visits per plan year, combined facility and office, per each of the three therapies.
	Habilitation services	$30 PCP / $45 specialist copay/visit Deductible does not apply	50% coinsurance	
	Skilled nursing care	30% coinsurance	50% coinsurance	Limited to 60 days per plan year, combined with acute rehabilitation. Prior authorization is required.
	Durable medical equipment	30% coinsurance	50% coinsurance	None.
	Hospice services	No charge.	50% coinsurance	Prior authorization is required.

* For more information about limitations and exceptions, see the plan or policy document at www.cpg.org.
** See Page 5 for important information about evaluation, testing and treatment of COVID-19, and telehealth services.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If your child needs dental or eye care	Children's eye exam	Not covered.	Not covered.	Vision benefits are available through EyeMed Vision Care
	Children's glasses	Not covered.	Not covered.	
	Children's dental check-up	Not covered.	Not covered.	

Common Medical Event	Services You May Need	What You Will Pay				Limitations, Exceptions, & Other Important Information *
		Standard Prescription Plan		Premium Prescription Plan		
		Retail	Home Delivery	Retail	Home Delivery	
If you need drugs to treat your illness or condition More information about prescription drug coverage is available at www.express-scripts.com	Generic drugs	Up to $10	Up to $25	Up to $5	Up to $12	Deductible does not apply. You may get up to a 30-day supply when using a retail pharmacy, and up to a 90-day supply when using home delivery.[1] See "Important Questions" regarding the Plan's out-of-pocket limit on page 1. For a complete list of non-essential specialty medications, see SaveonSP.com/cpg.
	Preferred brand drugs	25%; up to $40 min / $80 max	25%; up to $100 min / $200 max	Up to $35	Up to $87	
	Non-preferred brand drugs	40%; up to $80 min / $160 max	40%; up to $200 min / $400 max	Up to $70	Up to $175	
	Specialty drugs	40%; up to $100 min / $200 max	40%; up to $250 min / $500 max	Up to $90	Up to $225	

Excluded Services & Other Covered Services:

Services Your Plan Generally Does NOT Cover (Check your policy or plan document for more information and a list of any other excluded services.)

- Cosmetic surgery
- Dental care (Adult)
- Long-term care
- Routine eye care (Adult)
- Routine foot care (unless related to diabetes or certain other conditions)
- Weight loss programs

Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your plan document.)

- Acupuncture (limit 20 visits per year)
- Bariatric surgery (if Medically Necessary)
- Chiropractic care (limit 20 visits per year)
- Hearing aids (limit $3,000 every three years)
- Infertility treatment ($50,000 lifetime maximum)
- Non-emergency care when traveling outside the U.S.[2]
- Private duty nursing (only through home healthcare benefit)

[1] The prescription drug plan maintains a retail refill limit policy. The retail refill limit requires that you use home delivery if you are prescribed a maintenance medication. In some circumstances, you may not be required to use home delivery. See the plan document at www.cpg.org.

[2] Coverage for non-emergency care when traveling outside the U.S. applies only to services available through the medical benefit administered by Anthem Blue Cross and Blue Shield. Non-emergency services outside the U.S. are not available through the prescription drug benefit administered by Express Scripts.

* For more information about limitations and exceptions, see the plan or policy document at www.cpg.org.

** See Page 5 for important information about evaluation, testing and treatment of COVID-19, and telehealth services.

COVID-19 Evaluation, Testing and Treatment, and Telehealth Services: The Medical Trust will waive all copays, deductibles, and coinsurance for its members for healthcare services relating to the evaluation and testing for COVID-19. In addition, the Medical Trust will waive all copays, deductibles, and in-network coinsurance for its active members for healthcare services relating to the treatment of COVID-19. The Medical Trust will also waive all copays, deductibles, and coinsurance for all telehealth services received through its third-party administrators' telehealth platforms. The Medical Trust will also allow claims for virtual visits with network and out-of-network providers who do not use a telehealth platform offered by Anthem Blue Cross and Blue Shield, but standard deductibles, copays, and coinsurance will apply.

Your Rights to Continue Coverage: The Plan's Extension of Benefits program is similar, but not identical, to the healthcare continuation coverage provided under Federal law (known as COBRA) for non-church plans. Because the Plan is a church plan as described under Section 3(33) of ERISA, the Plan is exempt from COBRA requirements[3]. Nonetheless, subscribers and/or their enrolled dependents will have the opportunity to continue benefits for a limited time in certain instances when coverage through the health plan would otherwise cease. Individuals who elect to continue coverage must pay for the coverage. Call (800) 480-9967 for more information.

Your Grievance and Appeals Rights: There are agencies that can help if you have a complaint against your plan for a denial of a claim. This complaint is called a grievance or appeal. For more information about your rights, look at the explanation of benefits you will receive for that medical claim. Your plan documents also provide complete information on how to submit a claim, appeal, or a grievance for any reason to your plan. For more information about your rights, this notice, or assistance, contact Anthem Blue Cross and Blue Shield or Express Scripts, as appropriate.

Does this plan provide Minimum Essential Coverage? Yes
Minimum Essential Coverage generally includes plans, health insurance available through the Marketplace or other individual market policies, Medicare, Medicaid, CHIP, TRICARE, and certain other coverage. If you are eligible for certain types of Minimum Essential Coverage, you may not be eligible for the premium tax credit.

Does this plan meet the Minimum Value Standards? Yes
If your plan doesn't meet the Minimum Value Standards, you may be eligible for a premium tax credit to help you pay for a plan through the Marketplace.

Language Access Services:

Spanish (Español): Para obtener asistencia en Español, llame al (800) 480-9967.

Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa (800) 480-9967.

Chinese (中文): 如果需要中文的帮助，请拨打这个号码(800) 480-9967.

Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' (800) 480-9967.

*To see examples of how this **plan** might cover costs for a sample medical situation, see the next section.*

[3] Under Section 4980B(d) of the Code and Treasury Regulation Section 54.4980 B-2, Q. and A. No. 4.

* For more information about limitations and exceptions, see the plan or policy document at www.cpg.org.
** See Page 5 for important information about evaluation, testing and treatment of COVID-19, and telehealth services.

About these Coverage Examples:

This is not a cost estimator. Treatments shown are just examples of how this plan might cover medical care. Your actual costs will be different depending on the actual care you receive, the prices your providers charge, and many other factors. Focus on the cost-sharing amounts (deductibles, copayments and coinsurance) and excluded services under the plan. Use this information to compare the portion of costs you might pay under different health plans. Please note these coverage examples are based on self-only coverage.

Peg is Having a Baby
(9 months of in-network pre-natal care and a hospital delivery)

The plan's overall deductible	$3,500
Specialist *[cost sharing]*	$45
Hospital (facility) *[cost sharing]*	30%
Other *[cost sharing]*	30%

This EXAMPLE event includes services like:
Specialist office visits *(prenatal care)*
Childbirth/Delivery Professional Services
Childbirth/Delivery Facility Services
Diagnostic tests *(ultrasounds and blood work)*
Specialist visit *(anesthesia)*

Total Example Cost	$12,700

In this example, Peg would pay:

Cost Sharing	
Deductibles	$3,500
Copayments	$0
Coinsurance	$1,500
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	$5,060

Managing Joe's Type 2 Diabetes
(a year of routine in-network care of a well-controlled condition)

The plan's overall deductible	$3,500
Specialist *[cost sharing]*	$45
Hospital (facility) *[cost sharing]*	30%
Other *[cost sharing]*	30%

This EXAMPLE event includes services like:
Primary care physician office visits *(including disease education)*
Diagnostic tests *(blood work)*
Prescription drugs
Durable medical equipment *(glucose meter)*

Total Example Cost	$5,600

In this example, Joe would pay:

Cost Sharing	
Deductibles	$800
Copayments	$500
Coinsurance	$800
What isn't covered	
Limits or exclusions	$20
The total Joe would pay is	$2,120

Mia's Simple Fracture
(in-network emergency room visit and follow up care)

The plan's overall deductible	$3,500
Specialist *[cost sharing]*	$45
Hospital (facility) *[cost sharing]*	30%
Other *[cost sharing]*	30%

This EXAMPLE event includes services like:
Emergency room care *(including medical supplies)*
Diagnostic test *(x-ray)*
Durable medical equipment *(crutches)*
Rehabilitation services *(physical therapy)*

Total Example Cost	$2,800

In this example, Mia would pay:

Cost Sharing	
Deductibles	$1,200
Copayments	$600
Coinsurance	$30
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	$1,830

The plan would be responsible for the other costs of these EXAMPLE covered services.

The Summary of Benefits and Coverage (SBC) document will help you choose a health plan. The SBC shows you how you and the plan would share the cost for covered health care services. NOTE: Information about the cost of this plan (called the premium) will be provided separately. This is only a summary. For more information about your coverage, or to get a copy of the complete terms of coverage, visit www.cpg.org/mtdocs or call (800) 480-9967. For general definitions of common terms, such as allowed amount, balance billing, coinsurance, copayment, deductible, provider, or other underlined terms, see the Glossary. You can view the Glossary at www.cpg.org/uniform-glossary or call (800) 480-9967 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	Network: $1,000 Individual / $2,000 Family Out-of-Network: $2,000 Individual / $4,000 Family	Generally, you must pay all of the costs from providers up to the deductible amount before this plan begins to pay. If you have other family members on the plan, each family member must meet their own individual deductible until the total amount of deductible expenses paid by all family members meets the overall family deductible. The network and out-of-network deductibles accumulate separately.
Are there services covered before you meet your deductible?	Yes, for example, network preventive care and certain COVID-19 expenses.	This plan covers some items and services even if you haven't yet met the deductible amount. But a copayment or coinsurance may apply. See a list of preventive services at healthcare.gov/coverage/preventive-care-benefits.**
Are there other deductibles for specific services?	No.	You don't have to meet deductibles for specific services.
What is the out-of-pocket limit for this plan?	Network: $3,500 Individual / $7,000 Family Out-of-Network: $7,000 Individual / $14,000 Family	The out-of-pocket limit is the most you could pay in a year for covered services. If you have other family members in this plan, they have to meet their own out-of-pocket limits until the overall family out-of-pocket limit has been met. The network and out-of-network out-of-pocket limits accumulate separately.
What is not included in the out-of-pocket limit?	Contributions, (premiums), balance-billing charges, penalties, copays for certain specialty pharmacy drugs considered non-essential health benefits and healthcare this plan doesn't cover.	Even though you pay these expenses, they don't count toward the out-of-pocket limit.
Will you pay less if you use a network provider?	Yes. See www.anthem.com or call (844) 812-9207 for a list of network providers.	This plan uses a provider network. You will pay less if you use a provider in the plan's network. You will pay the most if you use an out-of-network provider, and you might receive a bill from a provider for the difference between the provider's charge and what your plan pays (balance billing). Be aware, your network provider might use an out-of-network provider for some services (such as lab work). Check with your provider before you get services.
Do you need a referral to see a specialist?	No.	You can see the specialist you choose without a referral.

All copayment and coinsurance costs shown in this chart are after your deductible has been met, if a deductible applies.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	$30 copay/visit Deductible does not apply	50% coinsurance	None.
	Specialist visit	$45 copay/visit Deductible does not apply	50% coinsurance	None.
	Preventive care/screening/ immunization	No charge.	50% coinsurance	You may have to pay for services that aren't preventive. Ask your provider if the services needed are preventive. Then check what your plan will pay for. See a list of preventive services at healthcare.gov/coverage/preventive-care-benefits.
If you have a test	Diagnostic test (x-ray, blood work)	20% coinsurance Deductible does not apply	50% coinsurance	None.
	Imaging (CT/PET scans, MRIs)	20% coinsurance Deductible does not apply	50% coinsurance	None.
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	20% coinsurance	50% coinsurance	None.
	Physician/surgeon fees	20% coinsurance	50% coinsurance	None.
If you need immediate medical attention	Emergency room care	$250 copay/visit Deductible does not apply	$250 copay/visit Deductible does not apply	The $250 copay will be waived if you are admitted to the hospital as an inpatient within 24 hours.**
	Emergency medical transportation	20% coinsurance	20% coinsurance	None.
	Urgent care	$50 copay/visit Deductible does not apply	$50 copay/visit Deductible does not apply	None.

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** See Page 5 for important information about evaluation, testing and treatment of COVID-19, and telehealth services.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you have a hospital stay	Facility fee (e.g., hospital room)	20% coinsurance	50% coinsurance	Prior authorization is required.**
	Physician/surgeon fees	20% coinsurance	50% coinsurance	
If you need mental health, behavioral health, or substance abuse services	Outpatient services	$30 PCP / $45 specialist copay/visit Deductible does not apply	30% coinsurance Deductible does not apply	None.
	Inpatient services	20% coinsurance Deductible does not apply	50% coinsurance	Prior authorization is required.
If you are pregnant	Office visits	$30 PCP / $45 specialist copay/visit Deductible does not apply	50% coinsurance	Copay applies only to the initial visit to confirm pregnancy.
	Childbirth/delivery professional services	20% coinsurance	50% coinsurance	Well-newborn care is covered. Newborn must be enrolled in the plan within 30 days of birth.
	Childbirth/delivery facility services	20% coinsurance	50% coinsurance	
If you need help recovering or have other special health needs	Home health care	20% coinsurance	50% coinsurance	Limited to 210 visits per plan year. Prior authorization is required.
	Rehabilitation services	$30 PCP / $45 specialist copay/visit Deductible does not apply	50% coinsurance	Benefits include speech/hearing, physical, and occupational therapy. Limited to 60 visits per plan year, combined facility and office, per each of the three therapies.
	Habilitation services	$30 PCP / $45 specialist copay/visit Deductible does not apply	50% coinsurance	
	Skilled nursing care	20% coinsurance	50% coinsurance	Limited to 60 days per plan year, combined with acute rehabilitation. Prior authorization is required.
	Durable medical equipment	20% coinsurance	50% coinsurance	None.
	Hospice services	No charge.	50% coinsurance	Prior authorization is required.

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Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If your child needs dental or eye care	Children's eye exam	Not covered.	Not covered.	Vision benefits are available through EyeMed Vision Care
	Children's glasses	Not covered.	Not covered.	
	Children's dental check-up	Not covered.	Not covered.	

Common Medical Event	Services You May Need	What You Will Pay				Limitations, Exceptions, & Other Important Information *
		Standard Prescription Plan		Premium Prescription Plan		
		Retail	Home Delivery	Retail	Home Delivery	
If you need drugs to treat your illness or condition More information about prescription drug coverage is available at www.express-scripts.com	Generic drugs	Up to $10	Up to $25	Up to $5	Up to $12	Deductible does not apply. You may get up to a 30-day supply when using a retail pharmacy, and up to a 90-day supply when using home delivery.[1] See "Important Questions" regarding the Plan's out-of-pocket limit on page 1. For a complete list of non-essential specialty medications, see SaveonSP.com/cpg.
	Preferred brand drugs	25%; up to $40 min / $80 max	25%; up to $100 min / $200 max	Up to $35	Up to $87	
	Non-preferred brand drugs	40%; up to $80 min / $160 max	40%; up to $200 min / $400 max	Up to $70	Up to $175	
	Specialty drugs	40%; up to $100 min / $200 max	40%; up to $250 min / $500 max	Up to $90	Up to $225	

Excluded Services & Other Covered Services:

Services Your Plan Generally Does NOT Cover (Check your policy or plan document for more information and a list of any other excluded services.)

- Cosmetic surgery
- Dental care (Adult)
- Long-term care
- Routine eye care (Adult)
- Routine foot care (unless related to diabetes or certain other conditions)
- Weight loss programs

Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your plan document.)

- Acupuncture (limit 20 visits per year)
- Bariatric surgery (if Medically Necessary)
- Chiropractic care (limit 20 visits per year)
- Hearing aids (limit $3,000 every three years)
- Infertility treatment ($50,000 lifetime maximum)
- Non-emergency care when traveling outside the U.S.[2]
- Private duty nursing (only through home healthcare benefit)

[1] The prescription drug plan maintains a retail refill limit policy. The retail refill limit requires that you use home delivery if you are prescribed a maintenance medication. In some circumstances, you may not be required to use home delivery. See the plan document at www.cpg.org.

[2] Coverage for non-emergency care when traveling outside the U.S. applies only to services available through the medical benefit administered by Anthem Blue Cross and Blue Shield. Non-emergency services outside the U.S. are not available through the prescription drug benefit administered by Express Scripts.

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COVID-19 Evaluation, Testing and Treatment, and Telehealth Services: The Medical Trust will waive all copays, deductibles, and coinsurance for its members for healthcare services relating to the evaluation and testing for COVID-19. In addition, the Medical Trust will waive all copays, deductibles, and in-network coinsurance for its active members for healthcare services relating to the treatment of COVID-19. The Medical Trust will also waive all copays, deductibles, and coinsurance for all telehealth services received through its third-party administrators' telehealth platforms. The Medical Trust will also allow claims for virtual visits with network and out-of-network providers who do not use a telehealth platform offered by Anthem Blue Cross and Blue Shield, but standard deductibles, copays, and coinsurance will apply.

Your Rights to Continue Coverage: The Plan's Extension of Benefits program is similar, but not identical, to the healthcare continuation coverage provided under Federal law (known as COBRA) for non-church plans. Because the Plan is a church plan as described under Section 3(33) of ERISA, the Plan is exempt from COBRA requirements[3]. Nonetheless, subscribers and/or their enrolled dependents will have the opportunity to continue benefits for a limited time in certain instances when coverage through the health plan would otherwise cease. Individuals who elect to continue coverage must pay for the coverage. Call (800) 480-9967 for more information.

Your Grievance and Appeals Rights: There are agencies that can help if you have a complaint against your plan for a denial of a claim. This complaint is called a grievance or appeal. For more information about your rights, look at the explanation of benefits you will receive for that medical claim. Your plan documents also provide complete information on how to submit a claim, appeal, or a grievance for any reason to your plan. For more information about your rights, this notice, or assistance, contact Anthem Blue Cross and Blue Shield or Express Scripts, as appropriate.

Does this plan provide Minimum Essential Coverage? Yes
Minimum Essential Coverage generally includes plans, health insurance available through the Marketplace or other individual market policies, Medicare, Medicaid, CHIP, TRICARE, and certain other coverage. If you are eligible for certain types of Minimum Essential Coverage, you may not be eligible for the premium tax credit.

Does this plan meet the Minimum Value Standards? Yes
If your plan doesn't meet the Minimum Value Standards, you may be eligible for a premium tax credit to help you pay for a plan through the Marketplace.

Language Access Services:

Spanish (Español): Para obtener asistencia en Español, llame al (800) 480-9967.

Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa (800) 480-9967.

Chinese (中文): 如果需要中文的帮助，请拨打这个号码(800) 480-9967.

Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' (800) 480-9967.

*To see examples of how this **plan** might cover costs for a sample medical situation, see the next section.*

[3] Under Section 4980B(d) of the Code and Treasury Regulation Section 54.4980 B-2, Q. and A. No. 4.

* For more information about limitations and exceptions, see the plan or policy document at www.cpg.org.
** See Page 5 for important information about evaluation, testing and treatment of COVID-19, and telehealth services.

About these Coverage Examples:

This is not a cost estimator. Treatments shown are just examples of how this plan might cover medical care. Your actual costs will be different depending on the actual care you receive, the prices your providers charge, and many other factors. Focus on the cost-sharing amounts (deductibles, copayments and coinsurance) and excluded services under the plan. Use this information to compare the portion of costs you might pay under different health plans. Please note these coverage examples are based on self-only coverage.

Peg is Having a Baby
(9 months of in-network pre-natal care and a hospital delivery)

The plan's overall deductible	$1,000
Specialist *[cost sharing]*	$45
Hospital (facility) *[cost sharing]*	20%
Other *[cost sharing]*	20%

This EXAMPLE event includes services like:
Specialist office visits *(prenatal care)*
Childbirth/Delivery Professional Services
Childbirth/Delivery Facility Services
Diagnostic tests *(ultrasounds and blood work)*
Specialist visit *(anesthesia)*

Total Example Cost	$12,700

In this example, Peg would pay:

Cost Sharing	
Deductibles	$1,000
Copayments	$10
Coinsurance	$2,300
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	$3,370

Managing Joe's Type 2 Diabetes
(a year of routine in-network care of a well-controlled condition)

The plan's overall deductible	$1,000
Specialist *[cost sharing]*	$45
Hospital (facility) *[cost sharing]*	20%
Other *[cost sharing]*	20%

This EXAMPLE event includes services like:
Primary care physician office visits *(including disease education)*
Diagnostic tests *(blood work)*
Prescription drugs
Durable medical equipment *(glucose meter)*

Total Example Cost	$5,600

In this example, Joe would pay:

Cost Sharing	
Deductibles	$800
Copayments	$500
Coinsurance	$800
What isn't covered	
Limits or exclusions	$20
The total Joe would pay is	$2,120

Mia's Simple Fracture
(in-network emergency room visit and follow up care)

The plan's overall deductible	$1,000
Specialist *[cost sharing]*	$45
Hospital (facility) *[cost sharing]*	20%
Other *[cost sharing]*	20%

This EXAMPLE event includes services like:
Emergency room care *(including medical supplies)*
Diagnostic test *(x-ray)*
Durable medical equipment *(crutches)*
Rehabilitation services *(physical therapy)*

Total Example Cost	$2,800

In this example, Mia would pay:

Cost Sharing	
Deductibles	$1,000
Copayments	$600
Coinsurance	$70
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	$1,670

The plan would be responsible for the other costs of these EXAMPLE covered services.

The Summary of Benefits and Coverage (SBC) document will help you choose a health plan. The SBC shows you how you and the plan would share the cost for covered health care services. NOTE: Information about the cost of this plan (called the premium) will be provided separately. This is only a summary. For more information about your coverage, or to get a copy of the complete terms of coverage, visit www.cpg.org/mtdocs or call (800) 480-9967. For general definitions of common terms, such as allowed amount, balance billing, coinsurance, copayment, deductible, provider, or other underlined terms, see the Glossary. You can view the Glossary at www.cpg.org/uniform-glossary or call (800) 480-9967 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	Network: $500 Individual / $1,000 Family Out-of-Network: $1,000 Individual / $2,000 Family	Generally, you must pay all of the costs from providers up to the deductible amount before this plan begins to pay. If you have other family members on the plan, each family member must meet their own individual deductible until the total amount of deductible expenses paid by all family members meets the overall family deductible. The network and out-of-network deductibles accumulate separately.
Are there services covered before you meet your deductible?	Yes, for example, network preventive care and certain COVID-19 expenses.	This plan covers some items and services even if you haven't yet met the deductible amount. But a copayment or coinsurance may apply. See a list of preventive services at healthcare.gov/coverage/preventive-care-benefits.**
Are there other deductibles for specific services?	No.	You don't have to meet deductibles for specific services.
What is the out-of-pocket limit for this plan?	Network: $2,500 Individual / $5,000 Family. Out-of-Network: $5,000 Individual / $10,000 Family	The out-of-pocket limit is the most you could pay in a year for covered services. If you have other family members in this plan, they have to meet their own out-of-pocket limits until the overall family out-of-pocket limit has been met. The network and out-of-network out-of-pocket limits accumulate separately.
What is not included in the out-of-pocket limit?	Contributions, (premiums), balance-billing charges, penalties, copays for certain specialty pharmacy drugs considered non-essential health benefits and healthcare this plan doesn't cover.	Even though you pay these expenses, they don't count toward the out-of-pocket limit.
Will you pay less if you use a network provider?	Yes. See www.anthem.com or call (844) 812-9207 for a list of network providers.	This plan uses a provider network. You will pay less if you use a provider in the plan's network. You will pay the most if you use an out-of-network provider, and you might receive a bill from a provider for the difference between the provider's charge and what your plan pays (balance billing). Be aware, your network provider might use an out-of-network provider for some services (such as lab work). Check with your provider before you get services.
Do you need a referral to see a specialist?	No.	You can see the specialist you choose without a referral.

All copayment and coinsurance costs shown in this chart are after your deductible has been met, if a deductible applies.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	$30 copay/visit Deductible does not apply	50% coinsurance	None.
	Specialist visit	$45 copay/visit Deductible does not apply	50% coinsurance	None.
	Preventive care/screening/ immunization	No charge.	50% coinsurance	You may have to pay for services that aren't preventive. Ask your provider if the services needed are preventive. Then check what your plan will pay for. See a list of preventive services at healthcare.gov/coverage/preventive-care-benefits.
If you have a test	Diagnostic test (x-ray, blood work)	10% coinsurance Deductible does not apply	50% coinsurance	None.
	Imaging (CT/PET scans, MRIs)	10% coinsurance Deductible does not apply	50% coinsurance	None.
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	10% coinsurance	50% coinsurance	None.
	Physician/surgeon fees	10% coinsurance	50% coinsurance	None.
If you need immediate medical attention	Emergency room care	$250 copay/visit Deductible does not apply	$250 copay/visit Deductible does not apply	The $250 copay will be waived if you are admitted to the hospital as an inpatient within 24 hours.**
	Emergency medical transportation	10% coinsurance	10% coinsurance	None.
	Urgent care	$50 copay/visit Deductible does not apply	$50 copay/visit Deductible does not apply	None.

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** See Page 5 for important information about evaluation, testing and treatment of COVID-19, and telehealth services.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you have a hospital stay	Facility fee (e.g., hospital room)	10% coinsurance	50% coinsurance	Prior authorization is required.**
	Physician/surgeon fees	10% coinsurance	50% coinsurance	
If you need mental health, behavioral health, or substance abuse services	Outpatient services	$30 PCP / $45 specialist copay/visit Deductible does not apply	30% coinsurance Deductible does not apply	None.
	Inpatient services	10% coinsurance Deductible does not apply	50% coinsurance	Prior authorization is required.
If you are pregnant	Office visits	$30 PCP / $45 specialist copay/visit Deductible does not apply	50% coinsurance	Copay applies only to the initial visit to confirm pregnancy.
	Childbirth/delivery professional services	10% coinsurance	50% coinsurance	Well-newborn care is covered. Newborn must be enrolled in the plan within 30 days of birth.
	Childbirth/delivery facility services	10% coinsurance	50% coinsurance	
If you need help recovering or have other special health needs	Home health care	10% coinsurance	50% coinsurance	Limited to 210 visits per plan year. Prior authorization is required.
	Rehabilitation services	$30 PCP / $45 specialist copay/visit Deductible does not apply	50% coinsurance	Benefits include speech/hearing, physical, and occupational therapy. Limited to 60 visits per plan year, combined facility and office, per each of the three therapies.
	Habilitation services	$30 PCP / $45 specialist copay/visit Deductible does not apply	50% coinsurance	
	Skilled nursing care	10% coinsurance	50% coinsurance	Limited to 60 days per plan year, combined with acute rehabilitation. Prior authorization is required.
	Durable medical equipment	10% coinsurance	50% coinsurance	None.
	Hospice services	No charge.	50% coinsurance	Prior authorization is required.

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Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If your child needs dental or eye care	Children's eye exam	Not covered.	Not covered.	Vision benefits are available through EyeMed Vision Care
	Children's glasses	Not covered.	Not covered.	
	Children's dental check-up	Not covered.	Not covered.	

Common Medical Event	Services You May Need	What You Will Pay				Limitations, Exceptions, & Other Important Information *
		Standard Prescription Plan		Premium Prescription Plan		
		Retail	Home Delivery	Retail	Home Delivery	
If you need drugs to treat your illness or condition More information about prescription drug coverage is available at www.express-scripts.com	Generic drugs	Up to $10	Up to $25	Up to $5	Up to $12	Deductible does not apply. You may get up to a 30-day supply when using a retail pharmacy, and up to a 90-day supply when using home delivery.[1] See "Important Questions" regarding the Plan's out-of-pocket limit on page 1. For a complete list of non-essential specialty medications, see SaveonSP.com/cpg.
	Preferred brand drugs	25%; up to $40 min / $80 max	25%; up to $100 min / $200 max	Up to $35	Up to $87	
	Non-preferred brand drugs	40%; up to $80 min / $160 max	40%; up to $200 min / $400 max	Up to $70	Up to $175	
	Specialty drugs	40%; up to $100 min / $200 max	40%; up to $250 min / $500 max	Up to $90	Up to $225	

Excluded Services & Other Covered Services:

Services Your Plan Generally Does NOT Cover (Check your policy or plan document for more information and a list of any other excluded services.)

- Cosmetic surgery
- Dental care (Adult)
- Long-term care
- Routine eye care (Adult)
- Routine foot care (unless related to diabetes or certain other conditions)
- Weight loss programs

Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your plan document.)

- Acupuncture (limit 20 visits per year)
- Bariatric surgery (if Medically Necessary)
- Chiropractic care (limit 20 visits per year)
- Hearing aids (limit $3,000 every three years)
- Infertility treatment ($50,000 lifetime maximum)
- Non-emergency care when traveling outside the U.S.[2]
- Private duty nursing (only through home healthcare benefit)

[1] The prescription drug plan maintains a retail refill limit policy. The retail refill limit requires that you use home delivery if you are prescribed a maintenance medication. In some circumstances, you may not be required to use home delivery. See the plan document at www.cpg.org.

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Minimum Essential Coverage generally includes plans, health insurance available through the Marketplace or other individual market policies, Medicare, Medicaid, CHIP, TRICARE, and certain other coverage. If you are eligible for certain types of Minimum Essential Coverage, you may not be eligible for the premium tax credit.

Does this plan meet the Minimum Value Standards? Yes
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*To see examples of how this **plan** might cover costs for a sample medical situation, see the next section.*

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Peg is Having a Baby
(9 months of in-network pre-natal care and a hospital delivery)

The plan's overall deductible	$500
Specialist *[cost sharing]*	$45
Hospital (facility) *[cost sharing]*	10%
Other *[cost sharing]*	10%

This EXAMPLE event includes services like:
Specialist office visits *(prenatal care)*
Childbirth/Delivery Professional Services
Childbirth/Delivery Facility Services
Diagnostic tests *(ultrasounds and blood work)*
Specialist visit *(anesthesia)*

Total Example Cost	$12,700

In this example, Peg would pay:

Cost Sharing	
Deductibles	$500
Copayments	$10
Coinsurance	$1,200
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	$1,770

Managing Joe's Type 2 Diabetes
(a year of routine in-network care of a well-controlled condition)

The plan's overall deductible	$500
Specialist *[cost sharing]*	$45
Hospital (facility) *[cost sharing]*	10%
Other *[cost sharing]*	10%

This EXAMPLE event includes services like:
Primary care physician office visits *(including disease education)*
Diagnostic tests *(blood work)*
Prescription drugs
Durable medical equipment *(glucose meter)*

Total Example Cost	$5,600

In this example, Joe would pay:

Cost Sharing	
Deductibles	$500
Copayments	$500
Coinsurance	$800
What isn't covered	
Limits or exclusions	$20
The total Joe would pay is	$1,820

Mia's Simple Fracture
(in-network emergency room visit and follow up care)

The plan's overall deductible	$500
Specialist *[cost sharing]*	$45
Hospital (facility) *[cost sharing]*	10%
Other *[cost sharing]*	10%

This EXAMPLE event includes services like:
Emergency room care *(including medical supplies)*
Diagnostic test *(x-ray)*
Durable medical equipment *(crutches)*
Rehabilitation services *(physical therapy)*

Total Example Cost	$2,800

In this example, Mia would pay:

Cost Sharing	
Deductibles	$500
Copayments	$600
Coinsurance	$80
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	$1,180

The plan would be responsible for the other costs of these EXAMPLE covered services.

The Summary of Benefits and Coverage (SBC) document will help you choose a health plan. The SBC shows you how you and the plan would share the cost for covered health care services. NOTE: Information about the cost of this plan (called the premium) will be provided separately. This is only a summary. For more information about your coverage, or to get a copy of the complete terms of coverage, visit www.cpg.org/mtdocs or call (800) 480-9967. For general definitions of common terms, such as allowed amount, balance billing, coinsurance, copayment, deductible, provider, or other underlined terms, see the Glossary. You can view the Glossary at www.cpg.org/uniform-glossary or call (800) 480-9967 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	Network: $0 Individual / $0 Family Out-of-Network: $500 Individual / $1,000 Family	Generally, you must pay all of the costs from providers up to the deductible amount before this plan begins to pay. If you have other family members on the plan, each family member must meet their own individual deductible until the total amount of deductible expenses paid by all family members meets the overall family deductible. The network and out-of-network deductibles accumulate separately.
Are there services covered before you meet your deductible?	Yes, for example, emergency room care, urgent care, and certain COVID-19 expenses.	This plan covers some items and services even if you haven't yet met the deductible amount. But a copayment or coinsurance may apply. See a list of preventive services at healthcare.gov/coverage/preventive-care-benefits.**
Are there other deductibles for specific services?	No.	You don't have to meet deductibles for specific services.
What is the out-of-pocket limit for this plan?	Network: $2,000 Individual / $4,000 Family Out-of-Network: $4,000 Individual / $8,000 Family	The out-of-pocket limit is the most you could pay in a year for covered services. If you have other family members in this plan, they have to meet their own out-of-pocket limits until the overall family out-of-pocket limit has been met. The network and out-of-network out-of-pocket limits accumulate separately.
What is not included in the out-of-pocket limit?	Contributions, (premiums), balance-billing charges, penalties, copays for certain specialty pharmacy drugs considered non-essential health benefits and healthcare this plan doesn't cover.	Even though you pay these expenses, they don't count toward the out-of-pocket limit.
Will you pay less if you use a network provider?	Yes. See www.anthem.com or call (844) 812-9207 for a list of network providers.	This plan uses a provider network. You will pay less if you use a provider in the plan's network. You will pay the most if you use an out-of-network provider, and you might receive a bill from a provider for the difference between the provider's charge and what your plan pays (balance billing). Be aware, your network provider might use an out-of-network provider for some services (such as lab work). Check with your provider before you get services.
Do you need a referral to see a specialist?	No.	You can see the specialist you choose without a referral.

All copayment and coinsurance costs shown in this chart are after your deductible has been met, if a deductible applies.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	$30 copay/visit	50% coinsurance	None.
	Specialist visit	$45 copay/visit	50% coinsurance	None.
	Preventive care/screening/ immunization	No charge.	50% coinsurance	You may have to pay for services that aren't preventive. Ask your provider if the services needed are preventive. Then check what your plan will pay for. See a list of preventive services at healthcare.gov/ coverage/preventive-care-benefits.
If you have a test	Diagnostic test (x-ray, blood work)	No charge.	50% coinsurance	None.
	Imaging (CT/PET scans, MRIs)	No charge.	50% coinsurance	None.
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	$200 copay/visit	50% coinsurance	None.
	Physician/surgeon fees	No charge.	50% coinsurance	None.
If you need immediate medical attention	Emergency room care	$250 copay/visit	$250 copay/visit Deductible does not apply	The $250 copay will be waived if you are admitted to the hospital as an inpatient within 24 hours.**
	Emergency medical transportation	No charge.	No charge.	None.
	Urgent care	$50 copay/visit	$50 copay/visit Deductible does not apply	None.
If you have a hospital stay	Facility fee (e.g., hospital room)	$250 copay/visit	50% coinsurance	Prior authorization is required.**
	Physician/surgeon fees	No charge.	50% coinsurance	

* For more information about limitations and exceptions, see the plan or policy document at www.cpg.org.
** See Page 5 for important information about evaluation, testing and treatment of COVID-19, and telehealth services.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you need mental health, behavioral health, or substance abuse services	Outpatient services	No charge.	30% coinsurance	None.
	Inpatient services	$250 copay/visit	50% coinsurance	Prior authorization is required.
If you are pregnant	Office visits	$30 PCP / $45 specialist copay/visit	50% coinsurance	Copay applies only to the initial visit to confirm pregnancy.
	Childbirth/delivery professional services	No charge.	50% coinsurance	Well-newborn care is covered. Newborn must be enrolled in the plan within 30 days of birth.
	Childbirth/delivery facility services	$250 copay/visit	50% coinsurance	Well-newborn care is covered. Newborn must be enrolled in the plan within 30 days of birth.
If you need help recovering or have other special health needs	Home health care	No charge.	50% coinsurance	Limited to 210 visits per plan year. Prior authorization is required.
	Rehabilitation services	$30 PCP / $45 specialist copay/visit	50% coinsurance	Benefits include speech/hearing, physical, and occupational therapy. Limited to 60 visits per plan year, combined facility and office, per each of the three therapies.
	Habilitation services	$30 PCP / $45 specialist copay/visit	50% coinsurance	
	Skilled nursing care	No charge.	50% coinsurance	Limited to 60 days per plan year, combined with acute rehabilitation. Prior authorization is required.
	Durable medical equipment	No charge.	50% coinsurance	None.
	Hospice services	No charge.	50% coinsurance	Prior authorization is required.
If your child needs dental or eye care	Children's eye exam	Not covered.	Not covered.	Vision benefits are available through EyeMed Vision Care
	Children's glasses	Not covered.	Not covered.	
	Children's dental check-up	Not covered.	Not covered.	

* For more information about limitations and exceptions, see the plan or policy document at www.cpg.org.

** See Page 5 for important information about evaluation, testing and treatment of COVID-19, and telehealth services.

Common Medical Event	Services You May Need	What You Will Pay				Limitations, Exceptions, & Other Important Information *
		Standard Prescription Plan		Premium Prescription Plan		
		Retail	Home Delivery	Retail	Home Delivery	
If you need drugs to treat your illness or condition More information about prescription drug coverage is available at www.express-scripts.com	Generic drugs	Up to $10	Up to $25	Up to $5	Up to $12	You may get up to a 30-day supply when using a retail pharmacy, and up to a 90-day supply when using home delivery.[1] See "Important Questions" regarding the Plan's out-of-pocket limit on page 1. For a complete list of non-essential specialty medications, see SaveonSP.com/cpg.
	Preferred brand drugs	25%; up to $40 min / $80 max	25%; up to $100 min / $200 max	Up to $35	Up to $87	
	Non-preferred brand drugs	40%; up to $80 min / $160 max	40%; up to $200 min / $400 max	Up to $70	Up to $175	
	Specialty drugs	40%; up to $100 min / $200 max	40%; up to $250 min / $500 max	Up to $90	Up to $225	

Excluded Services & Other Covered Services:

Services Your Plan Generally Does NOT Cover (Check your policy or plan document for more information and a list of any other excluded services.)

- Cosmetic surgery
- Dental care (Adult)
- Long-term care
- Routine eye care (Adult)
- Routine foot care (unless related to diabetes or certain other conditions)
- Weight loss programs

Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your plan document.)

- Acupuncture (limit 20 visits per year)
- Bariatric surgery (if Medically Necessary)
- Chiropractic care (limit 20 visits per year)
- Hearing aids (limit $3,000 every three years)
- Infertility treatment ($50,000 lifetime maximum)
- Non-emergency care when traveling outside the U.S.[2]
- Private duty nursing (only through home healthcare benefit)

[1] The prescription drug plan maintains a retail refill limit policy. The retail refill limit requires that you use home delivery if you are prescribed a maintenance medication. In some circumstances, you may not be required to use home delivery. See the plan document at www.cpg.org.

[2] Coverage for non-emergency care when traveling outside the U.S. applies only to services available through the medical benefit administered by Anthem Blue Cross and Blue Shield. Non-emergency services outside the U.S. are not available through the prescription drug benefit administered by Express Scripts.

* For more information about limitations and exceptions, see the plan or policy document at www.cpg.org.

** See Page 5 for important information about evaluation, testing and treatment of COVID-19, and telehealth services.

COVID-19 Evaluation, Testing and Treatment, and Telehealth Services: The Medical Trust will waive all copays, deductibles, and coinsurance for its members for healthcare services relating to the evaluation and testing for COVID-19. In addition, the Medical Trust will waive all copays, deductibles, and in-network coinsurance for its active members for healthcare services relating to the treatment of COVID-19. The Medical Trust will also waive all copays, deductibles, and coinsurance for all telehealth services received through its third-party administrators' telehealth platforms. The Medical Trust will also allow claims for virtual visits with network and out-of-network providers who do not use a telehealth platform offered by Anthem Blue Cross and Blue Shield, but standard deductibles, copays, and coinsurance will apply.

Your Rights to Continue Coverage: The Plan's Extension of Benefits program is similar, but not identical, to the healthcare continuation coverage provided under Federal law (known as COBRA) for non-church plans. Because the Plan is a church plan as described under Section 3(33) of ERISA, the Plan is exempt from COBRA requirements[3]. Nonetheless, subscribers and/or their enrolled dependents will have the opportunity to continue benefits for a limited time in certain instances when coverage through the health plan would otherwise cease. Individuals who elect to continue coverage must pay for the coverage. Call (800) 480-9967 for more information.

Your Grievance and Appeals Rights: There are agencies that can help if you have a complaint against your plan for a denial of a claim. This complaint is called a grievance or appeal. For more information about your rights, look at the explanation of benefits you will receive for that medical claim. Your plan documents also provide complete information on how to submit a claim, appeal, or a grievance for any reason to your plan. For more information about your rights, this notice, or assistance, contact Anthem Blue Cross and Blue Shield or Express Scripts, as appropriate.

Does this plan provide Minimum Essential Coverage? Yes
Minimum Essential Coverage generally includes plans, health insurance available through the Marketplace or other individual market policies, Medicare, Medicaid, CHIP, TRICARE, and certain other coverage. If you are eligible for certain types of Minimum Essential Coverage, you may not be eligible for the premium tax credit.

Does this plan meet the Minimum Value Standards? Yes
If your plan doesn't meet the Minimum Value Standards, you may be eligible for a premium tax credit to help you pay for a plan through the Marketplace.

Language Access Services:

Spanish (Español): Para obtener asistencia en Español, llame al (800) 480-9967.

Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa (800) 480-9967.

Chinese (中文): 如果需要中文的帮助，请拨打这个号码(800) 480-9967.

Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' (800) 480-9967.

*To see examples of how this **plan** might cover costs for a sample medical situation, see the next section.*

[3] Under Section 4980B(d) of the Code and Treasury Regulation Section 54.4980 B-2, Q. and A. No. 4.

* For more information about limitations and exceptions, see the plan or policy document at www.cpg.org.
** See Page 5 for important information about evaluation, testing and treatment of COVID-19, and telehealth services.

About these Coverage Examples:

This is not a cost estimator. Treatments shown are just examples of how this plan might cover medical care. Your actual costs will be different depending on the actual care you receive, the prices your providers charge, and many other factors. Focus on the cost-sharing amounts (deductibles, copayments and coinsurance) and excluded services under the plan. Use this information to compare the portion of costs you might pay under different health plans. Please note these coverage examples are based on self-only coverage.

Peg is Having a Baby
(9 months of in-network pre-natal care and a hospital delivery)

The plan's overall deductible	$0
Specialist *[cost sharing]*	$45
Hospital (facility) *[cost sharing]*	$250
Other *[cost sharing]*	0%

This EXAMPLE event includes services like:
Specialist office visits *(prenatal care)*
Childbirth/Delivery Professional Services
Childbirth/Delivery Facility Services
Diagnostic tests *(ultrasounds and blood work)*
Specialist visit *(anesthesia)*

Total Example Cost	$12,700

In this example, Peg would pay:

Cost Sharing	
Deductibles	$0
Copayments	$300
Coinsurance	$0
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	$360

Managing Joe's Type 2 Diabetes
(a year of routine in-network care of a well-controlled condition)

The plan's overall deductible	$0
Specialist *[cost sharing]*	$45
Hospital (facility) *[cost sharing]*	$250
Other *[cost sharing]*	0%

This EXAMPLE event includes services like:
Primary care physician office visits *(including disease education)*
Diagnostic tests *(blood work)*
Prescription drugs
Durable medical equipment *(glucose meter)*

Total Example Cost	$5,600

In this example, Joe would pay:

Cost Sharing	
Deductibles	$0
Copayments	$500
Coinsurance	$800
What isn't covered	
Limits or exclusions	$20
The total Joe would pay is	$1,320

Mia's Simple Fracture
(in-network emergency room visit and follow up care)

The plan's overall deductible	$0
Specialist *[cost sharing]*	$45
Hospital (facility) *[cost sharing]*	$250
Other *[cost sharing]*	0%

This EXAMPLE event includes services like:
Emergency room care *(including medical supplies)*
Diagnostic test *(x-ray)*
Durable medical equipment *(crutches)*
Rehabilitation services *(physical therapy)*

Total Example Cost	$2,800

In this example, Mia would pay:

Cost Sharing	
Deductibles	$0
Copayments	$600
Coinsurance	$0
What isn't covered	
Limits or exclusions	$40
The total Mia would pay is	$640

The plan would be responsible for the other costs of these EXAMPLE covered services.

EPISCOPAL CHURCH MEDICAL TRUST

Anthem Consumer-Directed Health Plan-15/Health Savings Account

Summary of Benefits and Coverage: What this Plan Covers & What You Pay for Covered Services

Coverage Period: 01/01/2023 – 12/31/2023

Coverage for: All tiers | Plan Type: PPO

The Summary of Benefits and Coverage (SBC) document will help you choose a health plan. The SBC shows you how you and the plan would share the cost for covered health care services. NOTE: Information about the cost of this plan (called the premium) will be provided separately. This is only a summary. For more information about your coverage, or to get a copy of the complete terms of coverage, visit www.cpg.org/mtdocs or call (800) 480-9967. For general definitions of common terms, such as allowed amount, balance billing, coinsurance, copayment, deductible, provider, or other underlined terms, see the Glossary. You can view the Glossary at www.cpg.org/uniform-glossary or call (800) 480-9967 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	Network: $1,500 Individual / $3,000 Family Out-of-Network: $3,000 Individual / $6,000 Family	Generally, you must pay all of the costs from providers up to the deductible amount before this plan begins to pay. If you have other family members on the plan, the overall family deductible must be met before the plan begins to pay. The network and out-of-network deductibles accumulate separately.
Are there services covered before you meet your deductible?	Yes, for example, certain COVID-19 expenses.	This plan covers some items and services even if you haven't yet met the deductible amount. But a copayment or coinsurance may apply. See a list of preventive services at healthcare.gov/coverage/preventive-care-benefits.**
Are there other deductibles for specific services?	No.	You don't have to meet deductibles for specific services.
What is the out-of-pocket limit for this plan?	Network: $2,400 Individual / $4,800 Family Out-of-Network: $4,800 Individual / $9,600 Family	The out-of-pocket limit is the most you could pay in a year for covered services. If you have other family members in this plan, the overall family out-of-pocket limit must be met. The network and out-of-network out-of-pocket limits accumulate separately.
What is not included in the out-of-pocket limit?	Contributions, (premiums), balance-billing charges, penalties, and healthcare this plan doesn't cover.	Even though you pay these expenses, they don't count toward the out-of-pocket limit.
Will you pay less if you use a network provider?	Yes. See www.anthem.com or call (844) 812-9207 for a list of network providers.	This plan uses a provider network. You will pay less if you use a provider in the plan's network. You will pay the most if you use an out-of-network provider, and you might receive a bill from a provider for the difference between the provider's charge and what your plan pays (balance billing). Be aware, your network provider might use an out-of-network provider for some services (such as lab work). Check with your provider before you get services.
Do you need a referral to see a specialist?	No.	You can see the specialist you choose without a referral.

All copayment and coinsurance costs shown in this chart are after your deductible has been met, if a deductible applies.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	15% coinsurance	40% coinsurance	None.
	Specialist visit	15% coinsurance	40% coinsurance	None.
	Preventive care/screening/ immunization	No charge.	40% coinsurance	You may have to pay for services that aren't preventive. Ask your provider if the services needed are preventive. Then check what your plan will pay for. See a list of preventive services at healthcare.gov/ coverage/preventive-care-benefits.
If you have a test	Diagnostic test (x-ray, blood work)	15% coinsurance	40% coinsurance	None.
	Imaging (CT/PET scans, MRIs)	15% coinsurance	40% coinsurance	None.
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	15% coinsurance	40% coinsurance	None.
	Physician/surgeon fees	15% coinsurance	40% coinsurance	None.
If you need immediate medical attention	Emergency room care	15% coinsurance	15% coinsurance	**
	Emergency medical transportation	15% coinsurance	15% coinsurance	None.
	Urgent care	15% coinsurance	15% coinsurance	None.
If you have a hospital stay	Facility fee (e.g., hospital room)	15% coinsurance	40% coinsurance	Prior authorization is required.**
	Physician/surgeon fees	15% coinsurance	40% coinsurance	
If you need mental health, behavioral health, or substance abuse services	Outpatient services	15% coinsurance	40% coinsurance	None.
	Inpatient services	15% coinsurance	40% coinsurance	Prior authorization is required.
If you are pregnant	Office visits	15% coinsurance	40% coinsurance	None.

* For more information about limitations and exceptions, see the plan or policy document at www.cpg.org.

** See Page 5 for important information about evaluation, testing and treatment of COVID-19, and telehealth services.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
	Childbirth/delivery professional services	15% coinsurance	40% coinsurance	Well-newborn care is covered. Newborn must be enrolled in the plan within 30 days of birth.
	Childbirth/delivery facility services	15% coinsurance	40% coinsurance	Well-newborn care is covered. Newborn must be enrolled in the plan within 30 days of birth.
If you need help recovering or have other special health needs	Home health care	15% coinsurance	40% coinsurance	Limited to 210 visits per plan year. Prior authorization is required.
	Rehabilitation services	15% coinsurance	40% coinsurance	Benefits include speech/hearing, physical, and occupational therapy. Limited to 60 visits per plan year, combined facility and office, per each of the three therapies.
	Habilitation services	15% coinsurance	40% coinsurance	
	Skilled nursing care	15% coinsurance	40% coinsurance	Limited to 60 days per plan year, combined with acute rehabilitation. Prior authorization is required.
	Durable medical equipment	15% coinsurance	40% coinsurance	None.
	Hospice services	15% coinsurance	40% coinsurance	Prior authorization is required.
If your child needs dental or eye care	Children's eye exam	Not covered.	Not covered.	Vision benefits are available through EyeMed Vision Care
	Children's glasses	Not covered.	Not covered.	
	Children's dental check-up	Not covered.	Not covered.	

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information *
		Retail	Home Delivery	
If you need drugs to treat your illness or condition More information about prescription drug coverage is available at www.express-scripts.com	Generic drugs	15% (after deductible)		You may get up to a 30-day supply when using a retail pharmacy, and up to a 90-day supply when using home delivery.[1] Your prescription deductible and out-of-pocket limit is combined with your medical deductible and out-of-pocket limit.
	Preferred brand drugs	25% (after deductible)		
	Non-preferred brand drugs	50% (after deductible)		
	Specialty drugs	50% (after deductible)		

Excluded Services & Other Covered Services:

[1] The prescription drug plan maintains a retail refill limit policy. The retail refill limit requires that you use home delivery if you are prescribed a maintenance medication. In some circumstances, you may not be required to use home delivery. See the plan document at www.cpg.org.

* For more information about limitations and exceptions, see the plan or policy document at www.cpg.org.

** See Page 5 for important information about evaluation, testing and treatment of COVID-19, and telehealth services.

Services Your Plan Generally Does NOT Cover (Check your policy or plan document for more information and a list of any other excluded services.)		
• Cosmetic surgery	• Dental care (Adult)	• Long-term care
• Routine eye care (Adult)	• Routine foot care (unless related to diabetes or certain other conditions)	• Weight loss programs

Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your plan document.)		
• Acupuncture (limit 20 visits per year)	• Bariatric surgery (if Medically Necessary)	• Chiropractic care (limit 20 visits per year)
• Hearing aids (limit $3,000 every three years)	• Infertility treatment ($50,000 lifetime maximum)	• Non-emergency care when traveling outside the U.S.[2]
• Private duty nursing (only through home healthcare benefit)		

[2] Coverage for non-emergency care when traveling outside the U.S. applies only to services available through the medical benefit administered by Anthem Blue Cross and Blue Shield. Non-emergency services outside the U.S. are not available through the prescription drug benefit administered by Express Scripts.

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Your Rights to Continue Coverage: The Plan's Extension of Benefits program is similar, but not identical, to the healthcare continuation coverage provided under Federal law (known as COBRA) for non-church plans. Because the Plan is a church plan as described under Section 3(33) of ERISA, the Plan is exempt from COBRA requirements[3]. Nonetheless, subscribers and/or their enrolled dependents will have the opportunity to continue benefits for a limited time in certain instances when coverage through the health plan would otherwise cease. Individuals who elect to continue coverage must pay for the coverage. Call (800) 480-9967 for more information.

Your Grievance and Appeals Rights: There are agencies that can help if you have a complaint against your plan for a denial of a claim. This complaint is called a grievance or appeal. For more information about your rights, look at the explanation of benefits you will receive for that medical claim. Your plan documents also provide complete information on how to submit a claim, appeal, or a grievance for any reason to your plan. For more information about your rights, this notice, or assistance, contact Anthem Blue Cross and Blue Shield or Express Scripts, as appropriate.

Does this plan provide Minimum Essential Coverage? Yes
Minimum Essential Coverage generally includes plans, health insurance available through the Marketplace or other individual market policies, Medicare, Medicaid, CHIP, TRICARE, and certain other coverage. If you are eligible for certain types of Minimum Essential Coverage, you may not be eligible for the premium tax credit.

Does this plan meet the Minimum Value Standards? Yes
If your plan doesn't meet the Minimum Value Standards, you may be eligible for a premium tax credit to help you pay for a plan through the Marketplace.

Language Access Services:

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Chinese (中文): 如果需要中文的帮助，请拨打这个号码(800) 480-9967.

Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' (800) 480-9967.

*To see examples of how this **plan** might cover costs for a sample medical situation, see the next section.*

[3] Under Section 4980B(d) of the Code and Treasury Regulation Section 54.4980 B-2, Q. and A. No. 4.

* For more information about limitations and exceptions, see the plan or policy document at www.cpg.org.
** See Page 5 for important information about evaluation, testing and treatment of COVID-19, and telehealth services.

About these Coverage Examples:

This is not a cost estimator. Treatments shown are just examples of how this plan might cover medical care. Your actual costs will be different depending on the actual care you receive, the prices your providers charge, and many other factors. Focus on the cost-sharing amounts (deductibles, copayments and coinsurance) and excluded services under the plan. Use this information to compare the portion of costs you might pay under different health plans. Please note these coverage examples are based on self-only coverage.

Peg is Having a Baby
(9 months of in-network pre-natal care and a hospital delivery)

The plan's overall deductible	$1,500
Specialist *[cost sharing]*	15%
Hospital (facility) *[cost sharing]*	15%
Other *[cost sharing]*	15%

This EXAMPLE event includes services like:
Specialist office visits *(prenatal care)*
Childbirth/Delivery Professional Services
Childbirth/Delivery Facility Services
Diagnostic tests *(ultrasounds and blood work)*
Specialist visit *(anesthesia)*

Total Example Cost	$12,700

In this example, Peg would pay:

Cost Sharing	
Deductibles	$1,500
Copayments	$0
Coinsurance	$900
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	$2,460

Managing Joe's Type 2 Diabetes
(a year of routine in-network care of a well-controlled condition)

The plan's overall deductible	$1,500
Specialist *[cost sharing]*	15%
Hospital (facility) *[cost sharing]*	15%
Other *[cost sharing]*	15%

This EXAMPLE event includes services like:
Primary care physician office visits *(including disease education)*
Diagnostic tests *(blood work)*
Prescription drugs
Durable medical equipment *(glucose meter)*

Total Example Cost	$5,600

In this example, Joe would pay:

Cost Sharing	
Deductibles	$1,500
Copayments	$0
Coinsurance	$900
What isn't covered	
Limits or exclusions	$20
The total Joe would pay is	$2,420

Mia's Simple Fracture
(in-network emergency room visit and follow up care)

The plan's overall deductible	$1,500
Specialist *[cost sharing]*	15%
Hospital (facility) *[cost sharing]*	15%
Other *[cost sharing]*	15%

This EXAMPLE event includes services like:
Emergency room care *(including medical supplies)*
Diagnostic test *(x-ray)*
Durable medical equipment *(crutches)*
Rehabilitation services *(physical therapy)*

Total Example Cost	$2,800

In this example, Mia would pay:

Cost Sharing	
Deductibles	$1,500
Copayments	$0
Coinsurance	$200
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	$1,700

The plan would be responsible for the other costs of these EXAMPLE covered services.

The Summary of Benefits and Coverage (SBC) document will help you choose a health plan. The SBC shows you how you and the plan would share the cost for covered health care services. NOTE: Information about the cost of this plan (called the premium) will be provided separately. This is only a summary. For more information about your coverage, or to get a copy of the complete terms of coverage, visit www.cpg.org/mtdocs or call (800) 480-9967. For general definitions of common terms, such as allowed amount, balance billing, coinsurance, copayment, deductible, provider, or other underlined terms, see the Glossary. You can view the Glossary at www.cpg.org/uniform-glossary or call (800) 480-9967 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	Network: $3,000 Individual / $5,450 Family Out-of-Network: $3,000 Individual / $6,000 Family	Generally, you must pay all of the costs from providers up to the deductible amount before this plan begins to pay. If you have other family members on the plan, each family member must meet their own individual deductible until the total amount of deductible expenses paid by all family members meets the overall family deductible. The network and out-of-network deductibles accumulate separately.
Are there services covered before you meet your deductible?	Yes, for example, certain COVID-19 expenses.	This plan covers some items and services even if you haven't yet met the deductible amount. But a copayment or coinsurance may apply. See a list of preventive services at healthcare.gov/coverage/preventive-care-benefits.**
Are there other deductibles for specific services?	No.	You don't have to meet deductibles for specific services.
What is the out-of-pocket limit for this plan?	Network: $4,200 Individual / $8,450 Family Out-of-Network: $7,000 Individual / $13,000 Family	The out-of-pocket limit is the most you could pay in a year for covered services. If you have other family members in this plan, they have to meet their own out-of-pocket limits until the overall family out-of-pocket limit has been met. The network and out-of-network out-of-pocket limits accumulate separately.
What is not included in the out-of-pocket limit?	Contributions, (premiums), balance-billing charges, penalties, and healthcare this plan doesn't cover.	Even though you pay these expenses, they don't count toward the out-of-pocket limit.
Will you pay less if you use a network provider?	Yes. See www.anthem.com or call (844) 812-9207 for a list of network providers.	This plan uses a provider network. You will pay less if you use a provider in the plan's network. You will pay the most if you use an out-of-network provider, and you might receive a bill from a provider for the difference between the provider's charge and what your plan pays (balance billing). Be aware, your network provider might use an out-of-network provider for some services (such as lab work). Check with your provider before you get services.
Do you need a referral to see a specialist?	No.	You can see the specialist you choose without a referral.

All copayment and coinsurance costs shown in this chart are after your deductible has been met, if a deductible applies.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	20% coinsurance	45% coinsurance	None.
	Specialist visit	20% coinsurance	45% coinsurance	None.
	Preventive care/screening/ immunization	No charge.	45% coinsurance	You may have to pay for services that aren't preventive. Ask your provider if the services needed are preventive. Then check what your plan will pay for. See a list of preventive services at healthcare.gov/ coverage/preventive-care-benefits.
If you have a test	Diagnostic test (x-ray, blood work)	20% coinsurance	45% coinsurance	None.
	Imaging (CT/PET scans, MRIs)	20% coinsurance	45% coinsurance	None.
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	20% coinsurance	45% coinsurance	None.
	Physician/surgeon fees	20% coinsurance	45% coinsurance	None.
If you need immediate medical attention	Emergency room care	20% coinsurance	20% coinsurance	**
	Emergency medical transportation	20% coinsurance	20% coinsurance	None.
	Urgent care	20% coinsurance	20% coinsurance	None.
If you have a hospital stay	Facility fee (e.g., hospital room)	20% coinsurance	45% coinsurance	Prior authorization is required.**
	Physician/surgeon fees	20% coinsurance	45% coinsurance	
If you need mental health, behavioral health, or substance abuse services	Outpatient services	20% coinsurance	45% coinsurance	None.
	Inpatient services	20% coinsurance	45% coinsurance	Prior authorization is required.
If you are pregnant	Office visits	20% coinsurance	45% coinsurance	None.

* For more information about limitations and exceptions, see the plan or policy document at www.cpg.org.

** See Page 5 for important information about evaluation, testing and treatment of COVID-19, and telehealth services.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
	Childbirth/delivery professional services	20% coinsurance	45% coinsurance	Well-newborn care is covered. Newborn must be enrolled in the plan within 30 days of birth.
	Childbirth/delivery facility services	20% coinsurance	45% coinsurance	Well-newborn care is covered. Newborn must be enrolled in the plan within 30 days of birth.
If you need help recovering or have other special health needs	Home health care	20% coinsurance	45% coinsurance	Limited to 210 visits per plan year. Prior authorization is required.
	Rehabilitation services	20% coinsurance	45% coinsurance	Benefits include speech/hearing, physical, and occupational therapy. Limited to 60 visits per plan year, combined facility and office, per each of the three therapies.
	Habilitation services	20% coinsurance	45% coinsurance	
	Skilled nursing care	20% coinsurance	45% coinsurance	Limited to 60 days per plan year, combined with acute rehabilitation. Prior authorization is required.
	Durable medical equipment	20% coinsurance	45% coinsurance	None.
	Hospice services	20% coinsurance	45% coinsurance	Prior authorization is required.
If your child needs dental or eye care	Children's eye exam	Not covered.	Not covered.	Vision benefits are available through EyeMed Vision Care
	Children's glasses	Not covered.	Not covered.	
	Children's dental check-up	Not covered.	Not covered.	

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information *
		Retail	Home Delivery	
If you need drugs to treat your illness or condition More information about prescription drug coverage is available at www.express-scripts.com	Generic drugs	15% (after deductible)		You may get up to a 30-day supply when using a retail pharmacy, and up to a 90-day supply when using home delivery.[1] Your prescription deductible and out-of-pocket limit is combined with your medical deductible and out-of-pocket limit.
	Preferred brand drugs	25% (after deductible)		
	Non-preferred brand drugs	50% (after deductible)		
	Specialty drugs	50% (after deductible)		

[1] The prescription drug plan maintains a retail refill limit policy. The retail refill limit requires that you use home delivery if you are prescribed a maintenance medication. In some circumstances, you may not be required to use home delivery. See the plan document at www.cpg.org.

* For more information about limitations and exceptions, see the plan or policy document at www.cpg.org.

** See Page 5 for important information about evaluation, testing and treatment of COVID-19, and telehealth services.

Excluded Services & Other Covered Services:

Services Your Plan Generally Does NOT Cover (Check your policy or plan document for more information and a list of any other excluded services.)		
• Cosmetic surgery	• Dental care (Adult)	• Long-term care
• Routine eye care (Adult)	• Routine foot care (unless related to diabetes or certain other conditions)	• Weight loss programs

Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your plan document.)		
• Acupuncture (limit 20 visits per year)	• Bariatric surgery (if Medically Necessary)	• Chiropractic care (limit 20 visits per year)
• Hearing aids (limit $3,000 every three years)	• Infertility treatment ($50,000 lifetime maximum)	• Non-emergency care when traveling outside the U.S.[2]
• Private duty nursing (only through home healthcare benefit)		

[2] Coverage for non-emergency care when traveling outside the U.S. applies only to services available through the medical benefit administered by Anthem Blue Cross and Blue Shield. Non-emergency services outside the U.S. are not available through the prescription drug benefit administered by Express Scripts.

* For more information about limitations and exceptions, see the plan or policy document at www.cpg.org.

** See Page 5 for important information about evaluation, testing and treatment of COVID-19, and telehealth services.

COVID-19 Evaluation, Testing and Treatment, and Telehealth Services: The Medical Trust will waive all copays, deductibles, and coinsurance for its members for healthcare services relating to the evaluation and testing for COVID-19. In addition, the Medical Trust will waive all copays, deductibles, and in-network coinsurance for its active members for healthcare services relating to the treatment of COVID-19. The Medical Trust will also waive all copays and coinsurance after deductible for all telehealth services received through its third-party administrators' telehealth platforms. The Medical Trust will also allow claims for virtual visits with network and out-of-network providers who do not use a telehealth platform offered by Anthem Blue Cross and Blue Shield, but standard deductibles, copays, and coinsurance will apply.

Your Rights to Continue Coverage: The Plan's Extension of Benefits program is similar, but not identical, to the healthcare continuation coverage provided under Federal law (known as COBRA) for non-church plans. Because the Plan is a church plan as described under Section 3(33) of ERISA, the Plan is exempt from COBRA requirements[3]. Nonetheless, subscribers and/or their enrolled dependents will have the opportunity to continue benefits for a limited time in certain instances when coverage through the health plan would otherwise cease. Individuals who elect to continue coverage must pay for the coverage. Call (800) 480-9967 for more information.

Your Grievance and Appeals Rights: There are agencies that can help if you have a complaint against your plan for a denial of a claim. This complaint is called a grievance or appeal. For more information about your rights, look at the explanation of benefits you will receive for that medical claim. Your plan documents also provide complete information on how to submit a claim, appeal, or a grievance for any reason to your plan. For more information about your rights, this notice, or assistance, contact Anthem Blue Cross and Blue Shield or Express Scripts, as appropriate.

Does this plan provide Minimum Essential Coverage? Yes
Minimum Essential Coverage generally includes plans, health insurance available through the Marketplace or other individual market policies, Medicare, Medicaid, CHIP, TRICARE, and certain other coverage. If you are eligible for certain types of Minimum Essential Coverage, you may not be eligible for the premium tax credit.

Does this plan meet the Minimum Value Standards? Yes
If your plan doesn't meet the Minimum Value Standards, you may be eligible for a premium tax credit to help you pay for a plan through the Marketplace.

Language Access Services:

Spanish (Español): Para obtener asistencia en Español, llame al (800) 480-9967.

Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa (800) 480-9967.

Chinese (中文): 如果需要中文的帮助，请拨打这个号码(800) 480-9967.

Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' (800) 480-9967.

*To see examples of how this **plan** might cover costs for a sample medical situation, see the next section.*

[3] Under Section 4980B(d) of the Code and Treasury Regulation Section 54.4980 B-2, Q. and A. No. 4.

* For more information about limitations and exceptions, see the plan or policy document at www.cpg.org.
** See Page 5 for important information about evaluation, testing and treatment of COVID-19, and telehealth services.

About these Coverage Examples:

This is not a cost estimator. Treatments shown are just examples of how this plan might cover medical care. Your actual costs will be different depending on the actual care you receive, the prices your providers charge, and many other factors. Focus on the cost-sharing amounts (deductibles, copayments and coinsurance) and excluded services under the plan. Use this information to compare the portion of costs you might pay under different health plans. Please note these coverage examples are based on self-only coverage.

Peg is Having a Baby
(9 months of in-network pre-natal care and a hospital delivery)

The plan's overall deductible	$3,000
Specialist *[cost sharing]*	20%
Hospital (facility) *[cost sharing]*	20%
Other *[cost sharing]*	20%

This EXAMPLE event includes services like:
Specialist office visits *(prenatal care)*
Childbirth/Delivery Professional Services
Childbirth/Delivery Facility Services
Diagnostic tests *(ultrasounds and blood work)*
Specialist visit *(anesthesia)*

Total Example Cost	$12,700

In this example, Peg would pay:

Cost Sharing	
Deductibles	$3,000
Copayments	$0
Coinsurance	$1,200
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	$4,260

Managing Joe's Type 2 Diabetes
(a year of routine in-network care of a well-controlled condition)

The plan's overall deductible	$3,000
Specialist *[cost sharing]*	20%
Hospital (facility) *[cost sharing]*	20%
Other *[cost sharing]*	20%

This EXAMPLE event includes services like:
Primary care physician office visits *(including disease education)*
Diagnostic tests *(blood work)*
Prescription drugs
Durable medical equipment *(glucose meter)*

Total Example Cost	$5,600

In this example, Joe would pay:

Cost Sharing	
Deductibles	$3,000
Copayments	$0
Coinsurance	$600
What isn't covered	
Limits or exclusions	$20
The total Joe would pay is	$3,620

Mia's Simple Fracture
(in-network emergency room visit and follow up care)

The plan's overall deductible	$3,000
Specialist *[cost sharing]*	20%
Hospital (facility) *[cost sharing]*	20%
Other *[cost sharing]*	20%

This EXAMPLE event includes services like:
Emergency room care *(including medical supplies)*
Diagnostic test *(x-ray)*
Durable medical equipment *(crutches)*
Rehabilitation services *(physical therapy)*

Total Example Cost	$2,800

In this example, Mia would pay:

Cost Sharing	
Deductibles	$2,800
Copayments	$0
Coinsurance	$0
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	$2,800

The plan would be responsible for the other costs of these EXAMPLE covered services.

EPISCOPAL CHURCH MEDICAL TRUST

Anthem Consumer-Directed Health Plan-40/Health Savings Account

Summary of Benefits and Coverage: What this Plan Covers & What You Pay for Covered Services

Coverage Period: 01/01/2023 – 12/31/2023

Coverage for: All tiers | Plan Type: PPO

The Summary of Benefits and Coverage (SBC) document will help you choose a health plan. The SBC shows you how you and the plan would share the cost for covered health care services. NOTE: Information about the cost of this plan (called the premium) will be provided separately. This is only a summary. For more information about your coverage, or to get a copy of the complete terms of coverage, visit www.cpg.org/mtdocs or call (800) 480-9967. For general definitions of common terms, such as allowed amount, balance billing, coinsurance, copayment, deductible, provider, or other underlined terms, see the Glossary. You can view the Glossary at www.cpg.org/uniform-glossary or call (800) 480-9967 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	Network: $3,500 Individual / $7,000 Family Out-of-Network: $7,000 Individual / $14,000 Family	Generally, you must pay all of the costs from providers up to the deductible amount before this plan begins to pay. If you have other family members on the plan, each family member must meet their own individual deductible until the total amount of deductible expenses paid by all family members meets the overall family deductible. The network and out-of-network deductibles accumulate separately.
Are there services covered before you meet your deductible?	Yes, for example, certain COVID-19 expenses.	This plan covers some items and services even if you haven't yet met the deductible amount. But a copayment or coinsurance may apply. See a list of preventive services at healthcare.gov/coverage/preventive-care-benefits.**
Are there other deductibles for specific services?	No.	You don't have to meet deductibles for specific services.
What is the out-of-pocket limit for this plan?	Network: $6,000 Individual / $12,000 Family Out-of-Network: $10,000 Individual / $20,000 Family	The out-of-pocket limit is the most you could pay in a year for covered services. If you have other family members in this plan, they have to meet their own out-of-pocket limits until the overall family out-of-pocket limit has been met. The network and out-of-network out-of-pocket limits accumulate separately.
What is not included in the out-of-pocket limit?	Contributions, (premiums), balance-billing charges, penalties, and healthcare this plan doesn't cover.	Even though you pay these expenses, they don't count toward the out-of-pocket limit.
Will you pay less if you use a network provider?	Yes. See www.anthem.com or call (844) 812-9207 for a list of network providers.	This plan uses a provider network. You will pay less if you use a provider in the plan's network. You will pay the most if you use an out-of-network provider, and you might receive a bill from a provider for the difference between the provider's charge and what your plan pays (balance billing). Be aware, your network provider might use an out-of-network provider for some services (such as lab work). Check with your provider before you get services.
Do you need a referral to see a specialist?	No.	You can see the specialist you choose without a referral.

All copayment and coinsurance costs shown in this chart are after your deductible has been met, if a deductible applies.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	40% coinsurance	60% coinsurance	None.
	Specialist visit	40% coinsurance	60% coinsurance	None.
	Preventive care/screening/ immunization	No charge.	60% coinsurance	You may have to pay for services that aren't preventive. Ask your provider if the services needed are preventive. Then check what your plan will pay for. See a list of preventive services at healthcare.gov/ coverage/preventive-care-benefits.
If you have a test	Diagnostic test (x-ray, blood work)	40% coinsurance	60% coinsurance	None.
	Imaging (CT/PET scans, MRIs)	40% coinsurance	60% coinsurance	None.
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	40% coinsurance	60% coinsurance	None.
	Physician/surgeon fees	40% coinsurance	60% coinsurance	None.
If you need immediate medical attention	Emergency room care	40% coinsurance	40% coinsurance	**
	Emergency medical transportation	40% coinsurance	40% coinsurance	None.
	Urgent care	40% coinsurance	40% coinsurance	None.
If you have a hospital stay	Facility fee (e.g., hospital room)	40% coinsurance	60% coinsurance	Prior authorization is required.**
	Physician/surgeon fees	40% coinsurance	60% coinsurance	
If you need mental health, behavioral health, or substance abuse services	Outpatient services	40% coinsurance	60% coinsurance	None.
	Inpatient services	40% coinsurance	60% coinsurance	Prior authorization is required.

* For more information about limitations and exceptions, see the plan or policy document at www.cpg.org.

** See Page 5 for important information about evaluation, testing and treatment of COVID-19, and telehealth services.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you are pregnant	Office visits	40% coinsurance	60% coinsurance	None.
	Childbirth/delivery professional services	40% coinsurance	60% coinsurance	Well-newborn care is covered. Newborn must be enrolled in the plan within 30 days of birth.
	Childbirth/delivery facility services	40% coinsurance	60% coinsurance	Well-newborn care is covered. Newborn must be enrolled in the plan within 30 days of birth.
If you need help recovering or have other special health needs	Home health care	40% coinsurance	60% coinsurance	Limited to 210 visits per plan year. Prior authorization is required.
	Rehabilitation services	40% coinsurance	60% coinsurance	Benefits include speech/hearing, physical, and occupational therapy. Limited to 60 visits per plan year, combined facility and office, per each of the three therapies.
	Habilitation services	40% coinsurance	60% coinsurance	
	Skilled nursing care	40% coinsurance	60% coinsurance	Limited to 60 days per plan year, combined with acute rehabilitation. Prior authorization is required.
	Durable medical equipment	40% coinsurance	60% coinsurance	None.
	Hospice services	40% coinsurance	60% coinsurance	Prior authorization is required.
If your child needs dental or eye care	Children's eye exam	Not covered.	Not covered.	Vision benefits are available through EyeMed Vision Care
	Children's glasses	Not covered.	Not covered.	
	Children's dental check-up	Not covered.	Not covered.	

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information *
		Retail	Home Delivery	
If you need drugs to treat your illness or condition More information about prescription drug coverage is available at www.express-scripts.com	Generic drugs	15% (after deductible)		You may get up to a 30-day supply when using a retail pharmacy, and up to a 90-day supply when using home delivery.[1] Your prescription deductible and out-of-pocket limit is combined with your medical deductible and out-of-pocket limit.
	Preferred brand drugs	25% (after deductible)		
	Non-preferred brand drugs	50% (after deductible)		
	Specialty drugs	50% (after deductible)		

[1] The prescription drug plan maintains a retail refill limit policy. The retail refill limit requires that you use home delivery if you are prescribed a maintenance medication. In some circumstances, you may not be required to use home delivery. See the plan document at www.cpg.org.

* For more information about limitations and exceptions, see the plan or policy document at www.cpg.org.

** See Page 5 for important information about evaluation, testing and treatment of COVID-19, and telehealth services.

Excluded Services & Other Covered Services:

Services Your Plan Generally Does NOT Cover (Check your policy or plan document for more information and a list of any other excluded services.)		
• Cosmetic surgery	• Dental care (Adult)	• Long-term care
• Routine eye care (Adult)	• Routine foot care (unless related to diabetes or certain other conditions)	• Weight loss programs

Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your plan document.)		
• Acupuncture (limit 20 visits per year)	• Bariatric surgery (if Medically Necessary)	• Chiropractic care (limit 20 visits per year)
• Hearing aids (limit $3,000 every three years)	• Infertility treatment ($50,000 lifetime maximum)	• Non-emergency care when traveling outside the U.S.[2]
• Private duty nursing (only through home healthcare benefit)		

[2] Coverage for non-emergency care when traveling outside the U.S. applies only to services available through the medical benefit administered by Anthem Blue Cross and Blue Shield. Non-emergency services outside the U.S. are not available through the prescription drug benefit administered by Express Scripts.

* For more information about limitations and exceptions, see the plan or policy document at www.cpg.org.

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COVID-19 Evaluation, Testing and Treatment, and Telehealth Services: The Medical Trust will waive all copays, deductibles, and coinsurance for its members for healthcare services relating to the evaluation and testing for COVID-19. In addition, the Medical Trust will waive all copays, deductibles, and in-network coinsurance for its active members for healthcare services relating to the treatment of COVID-19. The Medical Trust will also waive all copays and coinsurance after deductible for all telehealth services received through its third-party administrators' telehealth platforms. The Medical Trust will also allow claims for virtual visits with network and out-of-network providers who do not use a telehealth platform offered by Anthem Blue Cross and Blue Shield, but standard deductibles, copays, and coinsurance will apply.

Your Rights to Continue Coverage: The Plan's Extension of Benefits program is similar, but not identical, to the healthcare continuation coverage provided under Federal law (known as COBRA) for non-church plans. Because the Plan is a church plan as described under Section 3(33) of ERISA, the Plan is exempt from COBRA requirements[3]. Nonetheless, subscribers and/or their enrolled dependents will have the opportunity to continue benefits for a limited time in certain instances when coverage through the health plan would otherwise cease. Individuals who elect to continue coverage must pay for the coverage. Call (800) 480-9967 for more information.

Your Grievance and Appeals Rights: There are agencies that can help if you have a complaint against your plan for a denial of a claim. This complaint is called a grievance or appeal. For more information about your rights, look at the explanation of benefits you will receive for that medical claim. Your plan documents also provide complete information on how to submit a claim, appeal, or a grievance for any reason to your plan. For more information about your rights, this notice, or assistance, contact Anthem Blue Cross and Blue Shield or Express Scripts, as appropriate.

Does this plan provide Minimum Essential Coverage? Yes
Minimum Essential Coverage generally includes plans, health insurance available through the Marketplace or other individual market policies, Medicare, Medicaid, CHIP, TRICARE, and certain other coverage. If you are eligible for certain types of Minimum Essential Coverage, you may not be eligible for the premium tax credit.

Does this plan meet the Minimum Value Standards? Yes
If your plan doesn't meet the Minimum Value Standards, you may be eligible for a premium tax credit to help you pay for a plan through the Marketplace.

Language Access Services:

Spanish (Español): Para obtener asistencia en Español, llame al (800) 480-9967.

Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa (800) 480-9967.

Chinese (中文): 如果需要中文的帮助，请拨打这个号码(800) 480-9967.

Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' (800) 480-9967.

*To see examples of how this **plan** might cover costs for a sample medical situation, see the next section.*

[3] Under Section 4980B(d) of the Code and Treasury Regulation Section 54.4980 B-2, Q. and A. No. 4.

* For more information about limitations and exceptions, see the plan or policy document at www.cpg.org.
** See Page 5 for important information about evaluation, testing and treatment of COVID-19, and telehealth services.

About these Coverage Examples:

This is not a cost estimator. Treatments shown are just examples of how this plan might cover medical care. Your actual costs will be different depending on the actual care you receive, the prices your providers charge, and many other factors. Focus on the cost-sharing amounts (deductibles, copayments and coinsurance) and excluded services under the plan. Use this information to compare the portion of costs you might pay under different health plans. Please note these coverage examples are based on self-only coverage.

Peg is Having a Baby
(9 months of in-network pre-natal care and a hospital delivery)

The plan's overall deductible	$3,500
Specialist *[cost sharing]*	40%
Hospital (facility) *[cost sharing]*	40%
Other *[cost sharing]*	40%

This EXAMPLE event includes services like:
Specialist office visits *(prenatal care)*
Childbirth/Delivery Professional Services
Childbirth/Delivery Facility Services
Diagnostic tests *(ultrasounds and blood work)*
Specialist visit *(anesthesia)*

Total Example Cost	$12,700

In this example, Peg would pay:

Cost Sharing	
Deductibles	$3,500
Copayments	$0
Coinsurance	$2,500
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	$6,640

Managing Joe's Type 2 Diabetes
(a year of routine in-network care of a well-controlled condition)

The plan's overall deductible	$3,500
Specialist *[cost sharing]*	40%
Hospital (facility) *[cost sharing]*	40%
Other *[cost sharing]*	40%

This EXAMPLE event includes services like:
Primary care physician office visits *(including disease education)*
Diagnostic tests *(blood work)*
Prescription drugs
Durable medical equipment *(glucose meter)*

Total Example Cost	$5,600

In this example, Joe would pay:

Cost Sharing	
Deductibles	$3,500
Copayments	$0
Coinsurance	$500
What isn't covered	
Limits or exclusions	$20
The total Joe would pay is	$4,020

Mia's Simple Fracture
(in-network emergency room visit and follow up care)

The plan's overall deductible	$3,500
Specialist *[cost sharing]*	40%
Hospital (facility) *[cost sharing]*	40%
Other *[cost sharing]*	40%

This EXAMPLE event includes services like:
Emergency room care *(including medical supplies)*
Diagnostic test *(x-ray)*
Durable medical equipment *(crutches)*
Rehabilitation services *(physical therapy)*

Total Example Cost	$2,800

In this example, Mia would pay:

Cost Sharing	
Deductibles	$2,800
Copayments	$0
Coinsurance	$0
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	$2,800

The plan would be responsible for the other costs of these EXAMPLE covered services.

The Summary of Benefits and Coverage (SBC) document will help you choose a health plan. The SBC shows you how you and the plan would share the cost for covered health care services. NOTE: Information about the cost of this plan (called the contribution or premium) will be provided separately.
This is only a summary. For more information about your coverage, or to get a copy of the complete terms of coverage, visit www.cpg.org/mtdocs or call (800) 480-9967.
For general definitions of common terms, such as allowed amount, balance billing, coinsurance, copayment, deductible, provider, or other underlined terms see the Glossary. You can view the Glossary at www.cpg.org/uniform-glossary or call (800) 480-9967 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	**$ 500**/Individual or **$1,000** Family	Generally, you must pay all of the costs from **providers** up to the **deductible** amount before this **plan** begins to pay. If you have other family members on the **plan**, each family member must meet their own individual **deductible** until the total amount of **deductible** expenses paid by all family members meets the overall family deductible.
Are there services covered before you meet your deductible?	Yes, for example certain preventive services, COVID-19 expenses, and office visits.	This **plan** covers some items and services even if you haven't yet met the **deductible** amount. But a **copayment** or **coinsurance** may apply. See a list of preventive services at **healthcare.gov/coverage/preventive-care-benefits.****
Are there other deductibles for specific services?	No.	You don't have to meet **deductibles** for specific services.
What is the out-of-pocket limit for this plan?	**$3,500** individual / **$7,000** family	The **out-of-pocket limit** is the most you could pay in a year for covered services. If you have other family members in this **plan**, they have to meet their own **out-of-pocket limits** until the overall family **out-of-pocket limit** has been met.
What is not included in the out-of-pocket limit?	Contributions **(premiums**, **balance-billing** charges, penalties, and healthcare this **plan** doesn't cover	Even though you pay these expenses, they don't count toward the **out-of-pocket limit**.
Will you pay less if you use a network provider?	Yes. See www.kp.org or call (866) 213-3062 for a list of **network providers**.	This **plan** uses a provider **network**. You will pay less if you use a **provider** in the plan's **network**. You will pay the most if you use an **out-of-network provider**, and you might receive a bill from a **provider** for the difference between the provider's charge and what your **plan** pays (**balance billing**). Be aware, your **network provider** might use an **out-of-network provider** for some services (such as lab work). Check with your **provider** before you get services.
Do you need a referral to see a specialist?	Yes.	The Plan will pay some or all of the costs to see a **specialist** for covered services but only if you have the plan's permission before you see the **specialist**.

Questions: Call 1-866-213-3062 or visit http://my.kp.org/ecmt**.** If you aren't clear about any of the bolded terms used in this form, see the Glossary. You can view the Glossary at **www.cpg.org/uniform-glossary** or call 1-800-480-9967 to request a copy.

** See Page 5 for important information about evaluation, testing, and treatment for COVID-19, and telehealth services.

All **copayment** and **coinsurance** costs shown in this chart are after your **deductible** has been met, if a **deductible** applies.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information *
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	$25 copay/visit	Not covered.	**
	Specialist visit	$35 copay/visit	Not covered.	**
	Preventive care/screening/ immunization	No charge.	Not covered.	You may have to pay for services that aren't preventive. Ask your **provider** if the services needed are preventive. Then check what your **plan** will pay for. See a list of preventive services at **healthcare.gov/coverage/ preventive-care-benefits.**
If you have a test	Diagnostic test (x-ray, blood work)	20% coinsurance	Not covered.	**
	Imaging (CT/PET scans, MRIs)	20% coinsurance	Not covered.	**
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	20% coinsurance	Not covered.	None.
	Physician/surgeon fees			
If you need immediate medical attention	Emergency room care	20% coinsurance	20% coinsurance	
	Emergency medical transportation	20% coinsurance	20% coinsurance	If provided through the 911 emergency response system, ambulance services are covered if you reasonably believed that a medical emergency existed even if you are not transported to a hospital. **
	Urgent care	$50 copay/visit	Not covered.	**
If you have a hospital stay	Facility fee (e.g., hospital room)	20% coinsurance	Not covered.	Prior authorization is required. **
	Physician/surgeon fees			

* For more information about limitations and exceptions, see the plan or policy document at www.cpg.org.

** See Page 5 for important information about the evaluation, testing, and treatment of COVID-19 and telehealth services.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information *
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you need mental health, behavioral health, or substance abuse services.	Outpatient services	$25 copay/day individual / $12 copay/day group	Not covered.	There is 20% coinsurance for partial hospitalization for which prior authorization is required.
	Inpatient services	20% coinsurance	Not covered.	Prior authorization is required.
	Colleague Group	30% coinsurance	30% coinsurance	The **plan** will reimburse 70% up to a maximum reimbursable fee of $40. The member is responsible for all costs above that amount.
If you are pregnant	Office visits	$25 copay/PCP / $35 copay specialist	Not covered.	**Copay** applies only to the visit to confirm pregnancy.
	Childbirth/delivery professional services	20% coinsurance	Not covered.	Well-newborn care is covered.
	Childbirth/delivery facility services			
If you need help recovering or have other special health needs	Home health care	No charge.	Not covered.	Includes nurse visits (2 hours), aide visits (4 hours), therapy visits, and supplies. Limited to 210 visits per plan year.
	Rehabilitation services	$25 copay/visit	Not covered.	Benefits include hearing/speech, physical, and occupational therapy. Limited to 60 visits per plan year, combined facility and office, per each of the three therapies.
	Habilitation services	$25 copay/visit	Not covered.	
	Skilled nursing care	20% coinsurance	Not covered.	Limited to 60 days per plan year, combined with acute rehabilitation.
	Durable medical equipment	20% coinsurance	Not covered.	None.
	Hospice services	No charge.	Not covered.	None.
If your child needs dental or eye care	Children's eye exam	Not covered.	Not covered.	Vision benefits are available through EyeMed Vision Care.
	Children's glasses	Not covered.	Not covered.	
	Children's dental check-up	Not covered.	Not covered.	

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information *
		Retail	Mail Order	
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at www.kp.org.	Generic drugs	$10 copay	$10 for up to a 30-day supply, $20 for up to a 90-day supply	You may get up to a 30-day supply when using a retail pharmacy, and up to a 90-day supply when using the mail order pharmacy.
	Preferred brand drugs	$30 copay	$30 for up to a 30-day supply, $60 for up to a 90-day supply	
	Specialty drugs	$30 copay	$30 for up to a 30-day supply, $60 for up to a 90-day supply	

Excluded Services & Other Covered Services:

Services Your Plan Generally Does NOT Cover (Check your policy or plan document for more information and a list of any other excluded services.)

- Cosmetic Surgery
- Dental care (Adult)
- Long-term care
- Non-emergency care when traveling outside the U.S.
- Routine eye care (Adult)
- Routine foot care
- Weight loss programs

Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your plan document.)

- Acupuncture
- Bariatric surgery
- Chiropractic care
- Hearing aids
- Infertility treatment
- Private-duty nursing

* For more information about limitations and exceptions, see the plan or policy document at www.cpg.org.

** See Page 5 for important information about the evaluation, testing, and treatment of COVID-19 and telehealth services.

COVID-19 Evaluation, Testing, and Treatment and Telehealth Services: The Medical Trust will waive all copays, deductibles, and coinsurance for its members for healthcare services relating to the evaluation and testing for COVID-19. In addition, the Medical Trust will waive all copays, deductibles, and in-network coinsurance for its active members for healthcare services relating to the treatment of COVID-19. The Medical Trust will also waive all copays, deductibles, and coinsurance for all telehealth services with a Kaiser provider.

Your Rights to Continue Coverage: The Plan's Extension of Benefits program is similar, but not identical, to the healthcare continuation coverage provided under Federal law (known as COBRA) for non-church plans. Because the Plan is a church plan as described under Section 3(33) of ERISA, the Plan is exempt from COBRA requirements[1]. Nonetheless, subscribers and/or their enrolled dependents will have the opportunity to continue benefits for a limited time in certain instances when coverage through the health plan would otherwise cease. Individuals who elect to continue coverage must pay for the coverage. Call (800) 480-9967 for more information.

Your Grievance and Appeals Rights: There are agencies that can help if you have a complaint against your plan for a denial of a claim. This complaint is called a grievance or appeal. For more information about your rights, look at the explanation of benefits you will receive for that medical claim. Your plan documents also provide complete information to submit a claim, appeal, or a grievance for any reason to your plan. For more information about your rights, this notice, or assistance, contact Kaiser Permanente.

Does this plan provide Minimum Essential Coverage? Yes
Minimum Essential Coverage generally includes plans, health insurance available through the Marketplace or other individual market policies, Medicare, Medicaid, CHIP, TRICARE, and certain other coverage. If you are eligible for certain types of Minimum Essential Coverage, you may not be eligible for the premium tax credit.

Does this plan meet the Minimum Value Standards? Yes
If your plan doesn't meet the Minimum Value Standards, you may be eligible for a premium tax credit to help you pay for a plan through the Marketplace.

Language Access Services:
[Spanish (Español): Para obtener asistencia en Español, llame al (800) 480-9967.
[Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa (800) 480-9967.
[Chinese (中文): 如果需要中文的帮助， 请拨打这个号码 (800) 480-9967.
[Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' (800) 480-9967.

To see examples of how this plan might cover costs for a sample medical situation, see the next section.

[1] Under Section 4980B(d) of the Code and Treasury Regulation Section 54.4980 B-2, Q. and A. No. 4.

About these Coverage Examples:

This is not a cost estimator. Treatments shown are just examples of how this plan might cover medical care. Your actual costs will be different depending on the actual care you receive, the prices your providers charge, and many other factors. Focus on the cost sharing amounts (deductibles, copayments and coinsurance) and excluded services under the plan. Use this information to compare the portion of costs you might pay under different health plans. Please note these coverage examples are based on self-only coverage.

Peg is Having a Baby
(9 months of in-network pre-natal care and a hospital delivery)

The plan's overall deductible	$500
Specialist *[cost sharing]*	$35
Hospital (facility) *[cost sharing]*	20%
Other *[cost sharing]*	20%

This EXAMPLE event includes services like:
Specialist office visits (*prenatal care*)
Childbirth/Delivery Professional Services
Childbirth/Delivery Facility Services
Diagnostic tests (*ultrasounds and blood work*)
Specialist visit (*anesthesia*)

Total Example Cost	**$12,739**

In this example, Peg would pay:

Cost Sharing	
Deductibles	$500
Copayments	$90
Coinsurance	$2,001
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	**$2,651**

Managing Joe's type 2 Diabetes
(a year of routine in-network care of a well-controlled condition)

The plan's overall deductible	$500
Specialist *[cost sharing]*	$35
Hospital (facility) *[cost sharing]*	20%
Other *[cost sharing]*	20%

This EXAMPLE event includes services like:
Primary care physician office visits (*including disease education)*
Diagnostic tests (*blood work)*
Prescription drugs
Durable medical equipment (*glucose meter)*

Total Example Cost	**$7,400**

In this example, Joe would pay:

Cost Sharing	
Deductibles	$500
Copayments	$970
Coinsurance	$372
What isn't covered	
Limits or exclusions	$55
The total Joe would pay is	**$1,898**

Mia's Simple Fracture
(in-network emergency room visit and follow up care)

The plan's overall deductible	$500
Specialist *[cost sharing]*	$35
Hospital (facility) *[cost sharing]*	20%
Other *[cost sharing]*	20%

This EXAMPLE event includes services like:
Emergency room care *(including medical supplies)*
Diagnostic test *(x-ray)*
Durable medical equipment *(crutches)*
Rehabilitation services *(physical therapy)*

Total Example Cost	**$1,925**

In this example, Mia would pay:

Cost Sharing	
Deductibles	$500
Copayments	$205
Coinsurance	$172
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$877**

The plan would be responsible for the other costs of these EXAMPLE covered services.

The Summary of Benefits and Coverage (SBC) document will help you choose a health plan. The SBC shows you how you and the plan would share the cost for covered health care services. NOTE: Information about the cost of this plan (called the contribution or premium) will be provided separately.
This is only a summary. For more information about your coverage, or to get a copy of the complete terms of coverage, visit www.cpg.org/mtdocs or call (800) 480-9967.
For general definitions of common terms, such as allowed amount, balance billing, coinsurance, copayment, deductible, provider, or other underlined terms see the Glossary. You can view the Glossary at www.cpg.org/uniform-glossary or call (800) 480-9967 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	**$ 0**	See the chart starting on page 2 for your costs for services this plan covers.
Are there services covered before you meet your deductible?	Not applicable.	**
Are there other deductibles for specific services?	No.	You don't have to meet **deductibles** for specific services.
What is the out-of-pocket limit for this plan?	For network providers, **$1,750** individual / **$3,500** family	The **out-of-pocket limit** is the most you could pay in a year for covered services. If you have other family members in this **plan**, they have to meet their own **out-of-pocket limits** until the overall family **out-of-pocket limit** has been met.
What is not included in the out-of-pocket limit?	Contributions **(premiums**, **balance-billing** charges, penalties, and healthcare this **plan** doesn't cover	Even though you pay these expenses, they don't count toward the **out-of-pocket limit**.
Will you pay less if you use a network provider?	Yes. See www.kp.org or call (866) 213-3062 for a list of **network providers**.	This **plan** uses a provider **network**. You will pay less if you use a **provider** in the plan's **network**. You will pay the most if you use an **out-of-network provider**, and you might receive a bill from a **provider** for the difference between the provider's charge and what your **plan** pays (**balance billing**). Be aware, your **network provider** might use an **out-of-network provider** for some services (such as lab work). Check with your **provider** before you get services.
Do you need a referral to see a specialist?	Yes.	The Plan will pay some or all of the costs to see a **specialist** for covered services but only if you have the plan's permission before you see the **specialist**.

Questions: Call 1-866-213-3062 or visit http://my.kp.org/ecmt**.** If you aren't clear about any of the bolded terms used in this form, see the Glossary. You can view the Glossary at **www.cpg.org/uniform-glossary** or call 1-800-480-9967 to request a copy.

** See Page 5 for important information about evaluation, testing, and treatment for COVID-19, and telehealth services.

All **copayment** and **coinsurance** costs shown in this chart are after your **deductible** has been met, if a **deductible** applies.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information *
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	$25 copay/visit	Not covered.	**
	Specialist visit	$25 copay/visit	Not covered.	**
	Preventive care/screening/ immunization	No charge.	Not covered.	You may have to pay for services that aren't preventive. Ask your **provider** if the services needed are preventive. Then check what your **plan** will pay for. See a list of preventive services at **healthcare.gov/coverage/ preventive-care-benefits.**
If you have a test	Diagnostic test (x-ray, blood work)	$50 copay	Not covered.	**
	Imaging (CT/PET scans, MRIs)	$50 copay	Not covered.	**
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	$100 copay	Not covered.	None.
	Physician/surgeon fees			
If you need immediate medical attention	Emergency room care	$100 copay/visit	$100 copay/visit	**
	Emergency medical transportation	$0 copay	$0 copay	If provided through the 911 emergency response system, ambulance services are covered if you reasonably believed that a medical emergency existed even if you are not transported to a hospital. **
	Urgent care	$50 copay/visit	Not covered.	**
If you have a hospital stay	Facility fee (e.g., hospital room)	$100 copay per day to maximum of $600	Not covered.	Prior authorization is required. **
	Physician/surgeon fees			

* For more information about limitations and exceptions, see the plan or policy document at www.cpg.org.

** See Page 5 for important information about the evaluation, testing, and treatment of COVID-19 and telehealth services.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information *
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you need mental health, behavioral health, or substance abuse services.	Outpatient services	$25 copay/day individual / $12 copay/day group	Not covered.	None.
	Inpatient services	$100 copay per day to maximum of $600	Not covered.	Prior authorization is required.
	Colleague Group	30% coinsurance	30% coinsurance	The **plan** will reimburse 70% up to a maximum reimbursable fee of $40. The member is responsible for all costs above that amount.
If you are pregnant	Office visits	$25 copay	Not covered.	**Copay** applies only to the visit to confirm pregnancy.
	Childbirth/delivery professional services	$100 copay per day to maximum of $600	Not covered.	Well-newborn care is covered.
	Childbirth/delivery facility services			
If you need help recovering or have other special health needs	Home health care	No charge.	Not covered.	Includes nurse visits (2 hours), aide visits (4 hours), therapy visits, and supplies. Limited to 210 visits per plan year.
	Rehabilitation services	$25 copay/visit	Not covered.	Benefits include hearing/speech, physical, and occupational therapy. Limited to 60 visits per plan year, combined facility and office, per each of the three therapies.
	Habilitation services	$25 copay/visit	Not covered.	
	Skilled nursing care	No charge.	Not covered.	Limited to 60 days per plan year, combined with acute rehabilitation.
	Durable medical equipment	No charge.	Not covered.	None.
	Hospice services	No charge.	Not covered.	Prior authorization is required.
If your child needs dental or eye care	Children's eye exam	Not covered.	Not covered.	Additional vision benefits are available through EyeMed Vision Care.
	Children's glasses	Not covered.	Not covered.	
	Children's dental check-up	Not covered.	Not covered.	

* For more information about limitations and exceptions, see the plan or policy document at www.cpg.org.

** See Page 5 for important information about the evaluation, testing, and treatment of COVID-19 and telehealth services.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Retail	Mail Order	
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at www.kp.org.	Generic drugs	$10 copay	$10 for up to a 30-day supply, $20 for up to a 90-day supply	You may get up to a 30-day supply when using a retail pharmacy, and up to a 90-day supply when using the mail order pharmacy.
	Preferred brand drugs	$25 copay	$25 for up to a 30-day supply, $50 for up to a 90-day supply	
	Specialty drugs	$25 copay	$25 for up to a 30-day supply, $50 for up to a 90-day supply	

Excluded Services & Other Covered Services:

Services Your Plan Generally Does NOT Cover (Check your policy or plan document for more information and a list of any other excluded services.)

- Cosmetic Surgery
- Dental care (Adult)
- Long-term care
- Non-emergency care when traveling outside the U.S.
- Routine eye care (Adult)
- Routine foot care
- Weight loss programs

Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your plan document.)

- Acupuncture
- Bariatric surgery
- Chiropractic care
- Hearing aids
- Infertility treatment
- Private-duty nursing

* For more information about limitations and exceptions, see the plan or policy document at www.cpg.org.

** See Page 5 for important information about the evaluation, testing, and treatment of COVID-19 and telehealth services.

COVID-19 Evaluation, Testing, and Treatment and Telehealth Services: The Medical Trust will waive all copays, deductibles, and coinsurance for its members for healthcare services relating to the evaluation and testing for COVID-19. In addition, the Medical Trust will waive all copays, deductibles, and in-network coinsurance for its active members for healthcare services relating to the treatment of COVID-19. The Medical Trust will also waive all copays, deductibles, and coinsurance for all telehealth services with a Kaiser provider.

Your Rights to Continue Coverage: The Plan's Extension of Benefits program is similar, but not identical, to the healthcare continuation coverage provided under Federal law (known as COBRA) for non-church plans. Because the Plan is a church plan as described under Section 3(33) of ERISA, the Plan is exempt from COBRA requirements[1]. Nonetheless, subscribers and/or their enrolled dependents will have the opportunity to continue benefits for a limited time in certain instances when coverage through the health plan would otherwise cease. Individuals who elect to continue coverage must pay for the coverage. Call (800) 480-9967 for more information.

Your Grievance and Appeals Rights: There are agencies that can help if you have a complaint against your plan for a denial of a claim. This complaint is called a grievance or appeal. For more information about your rights, look at the explanation of benefits you will receive for that medical claim. Your plan documents also provide complete information to submit a claim, appeal, or a grievance for any reason to your plan. For more information about your rights, this notice, or assistance, contact Kaiser Permanente.

Does this plan provide Minimum Essential Coverage? Yes
Minimum Essential Coverage generally includes plans, health insurance available through the Marketplace or other individual market policies, Medicare, Medicaid, CHIP, TRICARE, and certain other coverage. If you are eligible for certain types of Minimum Essential Coverage, you may not be eligible for the premium tax credit.

Does this plan meet the Minimum Value Standards? Yes
If your plan doesn't meet the Minimum Value Standards, you may be eligible for a premium tax credit to help you pay for a plan through the Marketplace.

Language Access Services:
[Spanish (Español): Para obtener asistencia en Español, llame al (800) 480-9967.
[Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa (800) 480-9967.
[Chinese (中文): 如果需要中文的帮助， 请拨打这个号码 (800) 480-9967.
[Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' (800) 480-9967.

To see examples of how this plan might cover costs for a sample medical situation, see the next section.

[1] Under Section 4980B(d) of the Code and Treasury Regulation Section 54.4980 B-2, Q. and A. No. 4.

About these Coverage Examples:

This is not a cost estimator. Treatments shown are just examples of how this plan might cover medical care. Your actual costs will be different depending on the actual care you receive, the prices your providers charge, and many other factors. Focus on the cost sharing amounts (deductibles, copayments and coinsurance) and excluded services under the plan. Use this information to compare the portion of costs you might pay under different health plans. Please note these coverage examples are based on self-only coverage.

Peg is Having a Baby
(9 months of in-network pre-natal care and a hospital delivery)

The plan's overall deductible	$0
Specialist *[cost sharing]*	$25
Hospital (facility) *[cost sharing]*	0%
Other *[cost sharing]*	$25

This EXAMPLE event includes services like:
Specialist office visits (*prenatal care)*
Childbirth/Delivery Professional Services
Childbirth/Delivery Facility Services
Diagnostic tests (*ultrasounds and blood work)*
Specialist visit *(anesthesia)*

Total Example Cost	**$12,739**

In this example, Peg would pay:

Cost Sharing	
Deductibles	$0
Copayments	$1,290
Coinsurance	$0
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	**$1,350**

Managing Joe's type 2 Diabetes
(a year of routine in-network care of a well-controlled condition)

The plan's overall deductible	$0
Specialist *[cost sharing]*	$25
Hospital (facility) *[cost sharing]*	0%
Other *[cost sharing]*	$25

This EXAMPLE event includes services like:
Primary care physician office visits (*including disease education)*
Diagnostic tests *(blood work)*
Prescription drugs
Durable medical equipment *(glucose meter)*

Total Example Cost	**$7,400**

In this example, Joe would pay:

Cost Sharing	
Deductibles	$0
Copayments	$1,685
Coinsurance	$0
What isn't covered	
Limits or exclusions	$55
The total Joe would pay is	**$1,740**

Mia's Simple Fracture
(in-network emergency room visit and follow up care)

The plan's overall deductible	$0
Specialist *[cost sharing]*	$25
Hospital (facility) *[cost sharing]*	0%
Other *[cost sharing]*	$25

This EXAMPLE event includes services like:
Emergency room care *(including medical supplies)*
Diagnostic test *(x-ray)*
Durable medical equipment *(crutches)*
Rehabilitation services *(physical therapy)*

Total Example Cost	**$1,925**

In this example, Mia would pay:

Cost Sharing	
Deductibles	$0
Copayments	$325
Coinsurance	$0
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$325**

The plan would be responsible for the other costs of these EXAMPLE covered services.

The Summary of Benefits and Coverage (SBC) document will help you choose a health plan. The SBC shows you how you and the plan would share the cost for covered health care services. NOTE: Information about the cost of this plan (called the contribution or premium) will be provided separately.
This is only a summary. For more information about your coverage, or to get a copy of the complete terms of coverage, visit www.cpg.org/mtdocs or call (800) 480-9967.
For general definitions of common terms, such as allowed amount, balance billing, coinsurance, copayment, deductible, provider, or other underlined terms see the Glossary. You can view the Glossary at www.cpg.org/uniform-glossary or call (800) 480-9967 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	**$ 2,800**/Individual or **$5,450** Family	Generally, you must pay all of the costs from **providers** up to the **deductible** amount before this **plan** begins to pay. If you have other family members on the **plan**, each family member must meet their own individual **deductible** until the total amount of **deductible** expenses paid by all family members meets the overall family deductible.
Are there services covered before you meet your deductible?	Yes, for example certain preventive services and COVID-19 expenses	This **plan** covers some items and services even if you haven't yet met the **deductible** amount. But a **copayment** or **coinsurance** may apply. See a list of preventive services at **healthcare.gov/coverage/preventive-care-benefits.****
Are there other deductibles for specific services?	No.	
What is the out-of-pocket limit for this plan?	**$4,200** individual / **$8,450** family	The **out-of-pocket limit** is the most you could pay in a year for covered services. If you have other family members in this **plan**, they have to meet their own **out-of-pocket limits** until the overall family **out-of-pocket limit** has been met.
What is not included in the out-of-pocket limit?	Contributions **(premiums)**, **balance-billing** charges, penalties, and healthcare this **plan** doesn't cover	Even though you pay these expenses, they don't count toward the **out-of-pocket limit**.
Will you pay less if you use a network provider?	Yes. See www.kp.org or call (866) 213-3062 for a list of **network providers**.	This **plan** uses a provider **network**. You will pay less if you use a **provider** in the plan's **network**. You will pay the most if you use an **out-of-network provider**, and you might receive a bill from a **provider** for the difference between the provider's charge and what your **plan** pays (**balance billing**). Be aware, your **network provider** might use an **out-of-network provider** for some services (such as lab work). Check with your **provider** before you get services.
Do you need a referral to see a specialist?	Yes.	The Plan will pay some or all of the costs to see a **specialist** for covered services but only if you have the plan's permission before you see the **specialist**.

Questions: Call 1-866-213-3062 or visit http://my.kp.org/ecmt. If you aren't clear about any of the bolded terms used in this form, see the Glossary. You can view the Glossary at www.cpg.org/uniform-glossary or call 1-800-480-9967 to request a copy.

** See Page 5 for important information about evaluation, testing, and treatment for COVID-19, and telehealth services.

All **copayment** and **coinsurance** costs shown in this chart are after your **deductible** has been met, if a **deductible** applies.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information *
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	20% coinsurance	Not covered.	**
	Specialist visit	20% coinsurance	Not covered.	**
	Preventive care/screening/ immunization	No charge.	Not covered.	You may have to pay for services that aren't preventive. Ask your **provider** if the services needed are preventive. Then check what your **plan** will pay for. See a list of preventive services at **healthcare.gov/coverage/ preventive-care-benefits.**
If you have a test	Diagnostic test (x-ray, blood work)	20% coinsurance	Not covered.	**
	Imaging (CT/PET scans, MRIs)	20% coinsurance	Not covered.	**
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	20% coinsurance	Not covered.	None.
	Physician/surgeon fees			
If you need immediate medical attention	Emergency room care	20% coinsurance	20% coinsurance	**
	Emergency medical transportation	20% coinsurance	20% coinsurance	If provided through the 911 emergency response system, ambulance services are covered if you reasonably believed that a medical emergency existed even if you are not transported to a hospital. **
	Urgent care	20% coinsurance	Not covered.	**
If you have a hospital stay	Facility fee (e.g., hospital room)	20% coinsurance	Not covered.	Prior authorization is required. **
	Physician/surgeon fees			

* For more information about limitations and exceptions, see the plan or policy document at www.cpg.org.

** See Page 5 for important information about the evaluation, testing, and treatment of COVID-19 and telehealth services.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information *
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you need mental health, behavioral health, or substance abuse services.	Outpatient services	20% coinsurance	Not covered.	None.
	Inpatient services	20% coinsurance	Not covered.	Prior authorization is required.
If you are pregnant	Office visits	No charge.	Not covered.	None. **Deductible** does not apply to pre-natal and first post-partum visit.
	Childbirth/delivery professional services	20% coinsurance	Not covered.	Well-newborn care is covered.
	Childbirth/delivery facility services			
If you need help recovering or have other special health needs	Home health care	No charge.	Not covered.	Includes nurse visits (2 hours), aide visits (4 hours), therapy visits, and supplies. Limited to 210 visits per plan year.
	Rehabilitation services	20% coinsurance	Not covered.	Benefits include hearing/speech, physical, and occupational therapy. Limited to 60 visits per plan year, combined facility and office, per each of the three therapies.
	Habilitation services	20% coinsurance	Not covered.	
	Skilled nursing care	20% coinsurance	Not covered.	Limited to 60 days per plan year, combined with acute rehabilitation.
	Durable medical equipment	20% coinsurance	Not covered.	None.
	Hospice services	No charge.	Not covered.	Prior authorization is required.
If your child needs dental or eye care	Children's eye exam	Not covered.	Not covered.	Additional vision benefits are available through EyeMed Vision Care.
	Children's glasses	Not covered.	Not covered.	
	Children's dental check-up	Not covered.	Not covered.	

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information *
		Retail	Mail Order	
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at www.kp.org.	Generic drugs	15% coinsurance		You may get up to a 30-day supply when using a retail pharmacy, and up to a 90-day supply when using the mail order pharmacy. Your prescription deductible and out-of-pocket limit is combined with your medical deductible and out-of-pocket limit.
	Preferred brand drugs	25% coinsurance		
	Specialty drugs	25% coinsurance		

Excluded Services & Other Covered Services:

Services Your Plan Generally Does NOT Cover (Check your policy or plan document for more information and a list of any other excluded services.)		
• Cosmetic Surgery	• Dental care (Adult)	• Long-term care
• Non-emergency care when traveling outside the U.S.	• Routine eye care	• Routine foot care
• Weight loss programs		

Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your plan document.)		
• Acupuncture	• Bariatric surgery	• Chiropractic care
• Hearing aids	• Infertility treatment	• Private-duty nursing

COVID-19 Evaluation, Testing, and Treatment and Telehealth Services: The Medical Trust will waive all copays, deductibles, and coinsurance for its members for healthcare services relating to the evaluation and testing for COVID-19. In addition, the Medical Trust will waive all copays, deductibles, and in-network coinsurance

* For more information about limitations and exceptions, see the plan or policy document at www.cpg.org.

** See Page 5 for important information about the evaluation, testing, and treatment of COVID-19 and telehealth services.

for its active members for healthcare services relating to the treatment of COVID-19. The Medical Trust will also waive all copays, deductibles, and coinsurance for all telehealth services with a Kaiser provider.

Your Rights to Continue Coverage: The Plan's Extension of Benefits program is similar, but not identical, to the healthcare continuation coverage provided under Federal law (known as COBRA) for non-church plans. Because the Plan is a church plan as described under Section 3(33) of ERISA, the Plan is exempt from COBRA requirements[1]. Nonetheless, subscribers and/or their enrolled dependents will have the opportunity to continue benefits for a limited time in certain instances when coverage through the health plan would otherwise cease. Individuals who elect to continue coverage must pay for the coverage. Call (800) 480-9967 for more information.

Your Grievance and Appeals Rights: There are agencies that can help if you have a complaint against your plan for a denial of a claim. This complaint is called a grievance or appeal. For more information about your rights, look at the explanation of benefits you will receive for that medical claim. Your plan documents also provide complete information to submit a claim, appeal, or a grievance for any reason to your plan. For more information about your rights, this notice, or assistance, contact Kaiser Permanente.

Does this plan provide Minimum Essential Coverage? Yes
Minimum Essential Coverage generally includes plans, health insurance available through the Marketplace or other individual market policies, Medicare, Medicaid, CHIP, TRICARE, and certain other coverage. If you are eligible for certain types of Minimum Essential Coverage, you may not be eligible for the premium tax credit.

Does this plan meet the Minimum Value Standards? Yes
If your plan doesn't meet the Minimum Value Standards, you may be eligible for a premium tax credit to help you pay for a plan through the Marketplace.

Language Access Services:
[Spanish (Español): Para obtener asistencia en Español, llame al (800) 480-9967.
[Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa (800) 480-9967.
[Chinese (中文): 如果需要中文的帮助，请拨打这个号码 (800) 480-9967.
[Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' (800) 480-9967.

To see examples of how this plan might cover costs for a sample medical situation, see the next section.

[1] Under Section 4980B(d) of the Code and Treasury Regulation Section 54.4980 B-2, Q. and A. No. 4.

About these Coverage Examples:

This is not a cost estimator. Treatments shown are just examples of how this plan might cover medical care. Your actual costs will be different depending on the actual care you receive, the prices your providers charge, and many other factors. Focus on the cost sharing amounts (deductibles, copayments and coinsurance) and excluded services under the plan. Use this information to compare the portion of costs you might pay under different health plans. Please note these coverage examples are based on self-only coverage.

Peg is Having a Baby
(9 months of in-network pre-natal care and a hospital delivery)

- **The plan's overall deductible** $2,700
- **Specialist *[cost sharing]*** *20%*
- **Hospital (facility) *[cost sharing]*** 20%
- **Other *[cost sharing]*** *20%*

This EXAMPLE event includes services like:
Specialist office visits (*prenatal care)*
Childbirth/Delivery Professional Services
Childbirth/Delivery Facility Services
Diagnostic tests (*ultrasounds and blood work)*
Specialist visit *(anesthesia)*

Total Example Cost	**$12,739**

In this example, Peg would pay:

Cost Sharing	
Deductibles	$2,700
Copayments	$0
Coinsurance	$2,525
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	**$4,260**

Managing Joe's type 2 Diabetes
(a year of routine in-network care of a well-controlled condition)

- **The plan's overall deductible** $2,700
- **Specialist *[cost sharing]*** *20%*
- **Hospital (facility) *[cost sharing]*** 20%
- **Other *[cost sharing]*** *20%*

This EXAMPLE event includes services like:
Primary care physician office visits (*including disease education)*
Diagnostic tests *(blood work)*
Prescription drugs
Durable medical equipment *(glucose meter)*

Total Example Cost	**$7,400**

In this example, Joe would pay:

Cost Sharing	
Deductibles	$950
Copayments	$1,135
Coinsurance	$465
What isn't covered	
Limits or exclusions	$55
The total Joe would pay is	**$2,605**

Mia's Simple Fracture
(in-network emergency room visit and follow up care)

- **The plan's overall deductible** $2,700
- **Specialist *[cost sharing]*** *20%*
- **Hospital (facility) *[cost sharing]*** 20%
- **Other *[cost sharing]*** *20%*

This EXAMPLE event includes services like:
Emergency room care *(including medical supplies)*
Diagnostic test *(x-ray)*
Durable medical equipment *(crutches)*
Rehabilitation services *(physical therapy)*

Total Example Cost	**$1,925**

In this example, Mia would pay:

Cost Sharing	
Deductibles	$150
Copayments	$275
Coinsurance	$215
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$640**

The **plan** would be responsible for the other costs of these EXAMPLE covered services.

LiveHealth Online: see a doctor 24/7

It's easier and faster than going to urgent care

The next time you or someone in your family needs to see a doctor, use LiveHealth Online. See a doctor with a smartphone or tablet using our free app, or a computer with a webcam.[1]

With LiveHealth Online, you get:

- Immediate, 24/7 access to board-certified doctors.
- Secure and private video chats with your choice of doctor.
- Prescriptions that can be sent to your pharmacy, if needed.[2]

The cost of a LiveHealth Online visit is $49 or less depending on your health plan.

Sign up for LiveHealth Online today!
It's quick and easy to sign up — just go to **livehealthonline.com** or download the mobile app.

Download on the App Store
apple.com

ANDROID APP ON Google play
play.google.com/store

Anthem BlueCross BlueShield

LiveHealth ONLINE

1 LiveHealth Online is offered in most states and is expected to grow more in the near future. Visit the home page at livehealthonline.com to see the latest map showing where service is available.

2 As legally permitted in certain states.

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Anthem BlueCross BlueShield

LiveHealth® ONLINE

Frequently asked questions

What is LiveHealth Online®?

With LiveHealth Online, you have a doctor by your side 24/7. LiveHealth Online lets you talk face-to-face with a doctor through your mobile device or a computer with a webcam. No appointments, no driving and no waiting at an urgent care center.

Use LiveHealth Online for common health concerns like colds, the flu, fevers, rashes, infections, allergies and more! It's faster, easier and more convenient than a visit to an urgent care center.

Why would I use LiveHealth Online instead of going to visit my doctor in person?

LiveHealth Online is not meant to replace your primary care physician. However, it is a convenient option for care if your physician is not available, or if you need care for common problems like a cold or the flu. LiveHealth Online connects you with a board-certified doctor in just a couple of minutes. Plus, you can get a LiveHealth Online visit summary from the *MyHealth* tab to print, email or fax to your primary doctor.

LiveHealth Online should not be used for emergency care. If you experience a medical emergency, call **911** immediately.

When is LiveHealth Online available?

Doctors are available on LiveHealth Online 24/7, 365 days a year.

How do I access the LiveHealth Online mobile app?

You can download the LiveHealth Online mobile app for free on your mobile device by visiting the App Store℠ or Google Play™.

Do doctors have access to my health information?

LiveHealth Online doctors can only access your health information and review previous treatment recommendations and information from prior LiveHealth Online visits.

If you are using LiveHealth Online for the first time, you will be asked to answer a brief questionnaire about your health before you speak with a doctor. Then the information from your first online visit will be available for future LiveHealth Online visits.

How does LiveHealth Online work?

When you need to see a doctor, simply go to **livehealthonline.com** or access the LiveHealth Online mobile app. Select the state you are located in and answer a few questions. Best of all, LiveHealth Online is a part of your health plan. So, the cost of a LiveHealth Online visit is the same or less than a primary care office visit.

Establishing an account allows you to securely store your personal and health information. Plus, you can easily connect with doctors in the future, share your health history and schedule online visits at times that fit your schedule.

Once connected, you can talk and interact with the doctor as if you were in a private exam room.

How long does a LiveHealth Online session with a doctor usually last?

A typical LiveHealth Online session lasts about 10 minutes.

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How much does it cost to use LiveHealth Online?

LiveHealth Online is a part of your health plan. So, the cost of a LiveHealth Online visit is the same or less than a primary care office visit. To find out how much your visit will cost, enter your member ID on LiveHealth Online and the cost will be shown before you visit with a doctor.

Your family and friends also can use LiveHealth Online by paying the full cost of the visit, $49.

Will I be charged more if I use LiveHealth Online on weekends, holidays or at night?

No. The cost is the same.

How do I pay for a LiveHealth Online session?

LiveHealth Online accepts Visa, MasterCard and Discover cards as payment for an online visit with a doctor. Please keep in mind that charges for prescriptions aren't included in the cost of your doctor's visit.

Can I get online care from a doctor if I'm traveling or in another state?

As long as you are located in a state where LiveHealth Online is available, you can get online care. To determine if online visits with a doctor are available in your state, please visit **livehealthonline.com** and view the state map at the bottom of the home page.

Why do some states offer prescriptions after my visit and other states don't?

Some state laws require a face-to-face visit before allowing prescriptions. Every state is different and these laws change often. Please visit **livehealthonline.com** regularly to see if online visits with a doctor are available in your state. Please note that doctors using LiveHealth Online are not able to prescribe controlled substances or lifestyle drugs.

Do I have what I need to access doctors through LiveHealth Online?

To find out how to use LiveHealth Online on your computer or mobile device, go to **livehealthonline.com** and select the **About** tab. Then scroll down to the *More Information* section on the left side of the page.

Who do I get in touch with if I still have questions?

You can email, customersupport@livehealthonline.com or call toll free at 1-855-603-7985.

If you send us an email, please be sure to include:

- Your name
- Your email
- A phone number where you can be reached

Anthem BlueCross BlueShield

LiveHealth ONLINE

EPISCOPAL CHURCH MEDICAL TRUST

2021-2022 Consumer-Directed Health Plan/Health Savings Account Fact Sheet for Members

Your Consumer-Directed Health Plan

A Consumer-Directed Health Plan (CDHP),[1] coupled with a Health Savings Account (HSA), is a health plan that works a little differently from what you might be accustomed to.

Understanding how a CDHP/HSA works will help you get the most from your benefits. This fact sheet provides CDHP/HSA basics, including how to get started after you enroll and how to use your CDHP/HSA benefits.

How a CDHP Works

The Episcopal Church Medical Trust (Medical Trust) offers seven CDHPs: three through Anthem Blue Cross and Blue Shield (Anthem BCBS), three through Cigna, and one through Kaiser Permanente (Kaiser). See details below about the plans.

A CDHP is a high deductible health plan that allows you to set up an HSA to help pay for eligible healthcare expenses. It has many similarities to other types of health plans:

- Most preventive care services, such as age-appropriate annual preventive exams, well-child visits, and OB/GYN annual exams, are covered at 100% with no member cost-sharing when using network providers. Depending on your age and family history, other preventive care services may also be covered.
- You pay out of pocket until you reach the annual deductible,[2] then the plan begins to pay benefits. Your deductible is an integrated medical (including behavioral) and pharmacy deductible. This means both your medical and pharmacy expenses count toward your deductible.
- You will generally pay less when you use a network provider.[3]
- The plan has an out-of-pocket limit,[4] which is the most you will have to pay for eligible healthcare expenses each plan year. Once you reach this limit, the plan will begin to pay 100% of eligible expenses for the remainder of the plan year.

There are also important differences:

- CDHPs have higher annual deductibles, which include medical and prescription drug costs. That means you pay the full cost of medical and prescription drug costs until you reach the plan's annual deductible.
- Once you meet your annual deductible, you will pay coinsurance, which is a percentage of the cost for eligible services. This is different from other plans, which often use copayments in addition to or instead of coinsurance.
- You may set up an HSA to help pay for eligible expenses, including your annual deductible and coinsurance, with tax-free money. You can also choose to save your HSA money for future healthcare expenses.

[1] *Unless otherwise explicitly stated, Consumer-Directed Health Plan/Health Savings Account (CDHP/HSA) is used throughout to refer to the Anthem BCBS, Cigna, and Kaiser HDHPs, where they are alike.*

[2] *Your network and out-of-network deductibles accumulate separately, meaning one does not apply to the other. Members enrolled in a CDHP-15 with covered dependents must meet the family deductible before the plan pays for any other covered member.*

[3] *The Kaiser CDHPs do not cover out-of-network providers.*

[4] *Your network and out-of-network out-of-pocket limits accumulate separately, meaning one does not apply to the other. Members enrolled in a CDHP-15 with covered dependents must reach the family out-of-pocket limit before the plan begins to pay 100% of covered services for any covered member.*

How a HSA Works

An HSA is like a savings account for eligible healthcare expenses. When you enroll in the CDHP, you can contribute tax-free to an HSA. Here's how it works:

- You decide if you want to contribute and how much, up to IRS maximums. You can change or stop your contributions any time during the year.
- You can use the money in your HSA to pay for eligible healthcare expenses, including your annual deductible and medical, prescription, dental, and vision costs.
- You may also save the money in your HSA for future medical costs—including healthcare expenses in retirement.
- Your HSA is portable and will always belong to you, even if you change employers or retire.

Tax Advantages

There are three tax advantages that come with your HSA:

1. You do not pay taxes on your contributions.
2. Withdrawals from your HSA are tax-free as long as they are used to pay for qualified medical expenses.
3. Your earnings on investments are tax-free, (note that certain restrictions, such as minimum balance requirements, may apply to investment options).

If you withdraw money for any reason other than to pay for qualified medical expenses, you will pay taxes and an IRS penalty (currently 20%) on the amount of the withdrawal. The IRS penalty does not apply if you are age 65 or older, disabled, or if you have died and your HSA is being used by your spouse who is age 65 or older. (Spouses under age 65 must use HSA funds for eligible expenses or pay a penalty.) If you have died and your beneficiary is not your spouse, the account ceases to be an HSA and accumulated funds will be fully taxable to the beneficiary.

HSA Eligibility

To Contribute to an HSA

You must be enrolled in a qualifying Consumer-Directed Health Plan (CDHP) and cannot:

- be covered by Medicare, TRICARE, or other medical insurance,
- be claimed as a dependent on someone's tax return, or
- contribute to a Flexible Spending Account

To open an HSA, you must be enrolled in a qualifying CDHP. Generally, you are not permitted to be covered by other, disqualifying types of health plans, with these exceptions: certain limited forms of supplemental health coverage (described in IRS Publication 969), separate dental and vision coverage, and disability coverage. Disqualifying health coverage includes Medicare, TRICARE, non-CDHP coverage under a plan of your spouse's or domestic partner's employer, or healthcare flexible spending account (FSA) coverage. However, you are permitted coverage under a limited-purpose flexible spending account (LPFSA) or limited-purpose health reimbursement account (HRA). LPFSAs and limited-purpose HRAs are designed to work with HSAs. Contact your employer to see if an LPFSA or limited-purpose HRA is offered.

Also note that you may not be claimed as a dependent on another individual's tax return.

Network = Savings

You will usually pay less for services from network providers than you will from out-of-network providers for two reasons. First, your network coinsurance is lower than your out-of-network coinsurance.[5] Second, network providers can bill you based only on a certain amount, the "allowed amount."

The allowed amount is what our health plan carriers—Anthem BCBS, Cigna, and Kaiser—have negotiated with service providers on behalf of the Medical Trust. These discounted rates for medical services from network providers can save you money.

Using Network Providers

Remember, going to a network provider may have significant cost-saving advantages.

1. Provide your health plan membership information when you call to make the appointment.
2. If you see a network provider, you are not required to make payment at the time of service.[6] Your network provider will code the visit and bill it to your plan.
3. If you choose to pay out-of-pocket at the time of service, be sure that the service and your related payment are run through the health plan carrier claims system so that any network discount will apply and your payment will be credited toward your network deductible.
4. Anthem BCBS, Cigna, or Kaiser will send you an Explanation of Benefits (EOB) informing you of the cost share you will pay for the services based on the negotiated rates and plan coverage.
5. You may make payment by using your HSA debit card,[7] or you can use another bank card and either reimburse yourself with funds from your HSA or let your health savings remain in the HSA for future use.
6. Many preventive care services are paid at 100% when you use a network provider; all other services are subject to the annual deductible and, if applicable, coinsurance.

Using Out-of-Network Providers

It is important to note that if you see an out-of-network provider, you may be required to make payment at the time of service.[5]

1. Provide your health plan membership information when you call to make the appointment.
2. You may make payment by using your HSA debit card, or you can use another bank card and either reimburse yourself with funds from your HSA[7] or let your health savings remain in the HSA for future use.
3. Be sure that the service and your related payment are run through the health plan carrier claims system by reviewing your Explanation of Benefits so that your payment will be credited toward your out-of-network deductible and coinsurance maximum as applicable.

Prescription Benefits

Prescriptions must be paid for at the time of service at a retail pharmacy or through a mail-order pharmacy.

1. Provide the pharmacy with your Express Scripts card to ensure purchases are applied toward your annual deductible and coinsurance maximum, as applicable.
2. You will pay the negotiated rate. (Coinsurance begins once you have met your annual deductible.)
3. You may make payment by using your HSA debit card,[7] or you can use another bank card and either reimburse yourself with funds from your HSA or let your health savings remain in the HSA for future use.

Using Your HSA Contributions

Making regular contributions to your Health Savings Account is a simple and convenient way to build up your HSA balance, creating tax-favored savings for future qualified medical expenses.

[5] *The Kaiser CDHPs do not cover out-of-network providers.*

[6] *We encourage you to wait for your Explanation of Benefits from Anthem BCBS, Cigna, or Kaiser before making payment to ensure that the negotiated rate for service is applied.*

[7] *Note that some banks have fees associated with reimbursing yourself through your debit card. Check with your financial institution.*

Keep Your Receipts

The IRS requires that you keep records to show that HSA withdrawals were used to pay for or reimburse qualified medical expenses that had not been previously paid or reimbursed from another source.

Note that you may cover dependents under a Medical Trust CDHP even if they are not your federal tax code dependents for HSA purposes. For example, your 25-year-old child may not be a tax dependent, but they would still be eligible for coverage under the CDHP. Because your child is not a tax dependent, however, they will not be eligible to have expenses reimbursed from the HSA even though the child is covered under the CDHP. Remember: CDHP coverage depends on the Medical Trust's plan eligibility rules, but using HSA funds on a tax-free basis depends on the Federal tax code.

Any unused HSA funds will remain in your HSA for use in future years—there is no "use it or lose it" rule. If you change medical plans or retire, the HSA is still yours and can be used for qualified medical expenses.

Setting up an HSA

HealthEquity—If you enroll in a Medical Trust CDHP, you will automatically have an HSA set up by HealthEquity, who will send you a welcome kit. If you use HealthEquity, there are no setup fees for the HSA and your maintenance fees are waived. If your employment ends or you are no longer enrolled in a CDHP through the Medical Trust, you will be responsible for all fees.

HealthEquity also offers many other advantages, including access to web-based tools that can assist you in tracking and monitoring your HSA activity.

Local bank chosen by your employer—In some cases, your employer may choose an institution other than HealthEquity for HSA funding. If so, you will receive information from your employer concerning the HSA funding process.

Financial institution of your choice—If you do not wish to use HealthEquity, you may, after consulting with your employer, establish an HSA with any qualified financial institution., but You will be responsible for all fees.

If you do so, please keep in mind that you may not be able to direct contributions by your employer (if any) or pre-tax contributions to that financial institution. Please check with your employer and the institution. Consequently, you may lose valuable employer contributions and the ability to make contributions through convenient payroll deduction. (You will still be able to make after-tax contributions up to the contribution limits and claim a deduction on your federal income tax return.)

If you establish an HSA with HealthEquity (to receive employer contributions and your pre-tax contributions), you may then transfer funds to an HSA with another qualified financial institution.

Annual HSA Employer and Employee Combined Contribution Limits

The IRS sets the maximum amount that can be contributed to an HSA each year.

2021		2022	
Individual	$3,600	Individual	$3,650
Family	$7,200	Family	$7,300

If you are age 55 or older, you may make additional catch-up contributions of up to $1,000 per year.

These limits include your contributions plus any employer contributions, so keep that in mind when choosing how much to set aside in your HSA.

Timing of HSA Contributions

Contributions to an HSA cannot occur until after the first of the month in which the CDHP becomes effective, and your HSA has been opened. What that means is if your plan becomes effective on January 1, contributions cannot be made until after that date. If you have medical expenses on January 1 before your account is funded, you can pay out-of-pocket and reimburse yourself from your HSA once the funds are deposited. No reimbursement is permitted for expenses incurred before you open your HSA. So, for example, if you delay and do not complete the requisite paperwork to open the account until February 1, expenses incurred in January cannot be reimbursed.

Employer HSA Contributions

Each employer (diocese, parish, school, or other Episcopal organization) establishes its HSA contribution policy in line with IRS requirements.

Your employer's HSA contribution policy will define the amount of funds, if any, your employer will contribute to your HSA, the frequency with which these contributions will be made (bi-weekly, monthly, quarterly, or annually), and who will be eligible for such contributions.

Your employer is responsible for communicating its contribution policy to you.

Employee HSA Contributions

If you set up an HSA with HealthEquity or a financial institution chosen by your employer, you can make pre-tax contributions through automatic payroll deductions (if available). If you use a different financial institution, you can mail in an after-tax contribution, for which you can take a corresponding tax deduction at the end of the tax year. HSA contributions for a given calendar year must be made by the tax filing deadline for that year (generally, the following April 15).

Be mindful that your own contributions and any funding you will receive from your employer do not exceed the annual limits for HSA contributions.

Qualified Medical Expenses

Qualified medical expenses include, but are not limited to, deductibles and coinsurance, prescription drugs, mental health and substance use disorder treatment, as well as dental and vision services. HSA distributions can be used for qualified medical expenses for you, your spouse, and your federal tax code dependents. A list of qualified medical expenses can be found on the IRS website.

If Your Qualified Expenses Exceed the Amount in Your HSA

If your HSA funds do not cover your healthcare expenses, you can pay the difference out-of-pocket and reimburse yourself as funds are added to your account. For example, if you have $1,000 in your HSA in March and you incur $1,500 in medical expenses, you can use the $1,000 from your HSA and pay the additional $500 out-of-pocket. Throughout the year, you may reimburse yourself the remaining $500 from the HSA, as contributions are added to your account. You are responsible for keeping documentation to prove that the HSA funds being reimbursed were used for qualified medical expenses.

Domestic Partners and Same-Gender Spouses

If your group allows domestic partners to be covered as dependents on your health plan, you may enroll your domestic partner in the CDHP. However, the IRS only permits an employee's HSA funds to be used to cover the healthcare expenses of a domestic partner if that domestic partner otherwise qualifies as your federal tax code dependent.

Your domestic partner can open their own HSA, which your employer may or may not choose to fund. Note, however, that an employer contribution to an HSA of a non-employee domestic partner would be included in the employee's taxable income.

Same-gender couples who are legally married can use the account in the same way as different-gender married couples.

Additional Benefits

If you enroll in the CDHP, you will have access to the Medical Trust's value-added benefits, such as vision care through EyeMed, the Cigna Employee Assistance Program (EAP), Health Advocate, Amplifon Hearing Health Care discounts, and UnitedHealthcare Global Travel Assistance. For more information about these value-added benefits, please visit our website at *cpg.org*.

You may use your HSA funds, if available, to cover any applicable coinsurance amounts under these benefits.

U.S. Treasury Department HSA Information

The HSA section of the IRS website has links to informational brochures, up-to-date regulations, FAQs, IRS forms, and publications, including these:

Publication 502—A list of qualified medical expenses

Publication 969—A detailed explanation of HSAs and how the IRS treats them

Tax Information

Your HSA custodian will provide the following forms to both you and the IRS annually:

Form 5498-SA—This form details HSA contributions made by you and your employer for the year.

Form 1099-SA—This form reports all HSA distributions made during the year.

Your employer must report to you on your Form W-2, in box 12 with code W, all employer HSA contributions as well as any HSA amounts contributed by you (from your paycheck) on a pre-tax basis through an Internal Revenue Code section 125 cafeteria plan. You will be responsible for completing Form 8889, which details HSA contributions, when you file your Form 1040. Also, please note that any additional amounts contributed to your HSA must be reported on Form 8889 and may be eligible to be claimed as a tax deduction, which could lower your taxable income.

Questions?

If you have an HSA through HealthEquity and have questions or need assistance with HSA procedures and account questions, you may contact their Member Services team 24/7 at (866) 346-5800 or email *memberservices@healthequity.com*. Otherwise, please contact our Client Services team at (800) 480-9967, Monday to Friday, 8:30 AM to 8:00 PM ET, or email *mtcustserv@cpg.org*.

HealthEquity®

HSA INVESTMENT GUIDE

Use your HSA to build the ultimate retirement nest egg

Connecting Health and Wealth

PLANNING FOR HEALTHCARE COSTS IN RETIREMENT

Picture your retirement. What comes to mind? Maybe you envision lazy afternoons with your grandkids or lots of traveling, boating, golfing, RVing, and all the other fun stuff.

But think beyond the day to day: Retirement will also entail significant healthcare expenses. In fact, recent estimates show the average couple will need between $301,000[1] and $390,000[2] to cover out-of-pocket medical expenses in retirement.

Medicare isn't free. It has premiums just like your health insurance today. Prescriptions tend to cost more in retirement too. The irony is that healthy couples will need to absorb even more costs, as longer life expectancy translates into more healthcare spending.

Bottom line: You can't plan for retirement without also planning for your healthcare. That's why more Americans than ever are investing in their Health Savings Account (HSA) to build long-term retirement and healthcare savings.

Only an HSA delivers a triple-tax advantage[3]

- Make pre-tax contributions
- Grow tax-free earnings
- Enjoy tax-free distribution for qualified medical expenses

Taken together, this is a recipe for potential long-term growth and significant tax savings compared to other retirement account options.

[1] Based on median prescription drug expenses. Source: Employee Benefit Research Institute 2019: https://www.ebri.org/content/savings-medicare-beneficiaries-need-for-health-expenses-in-2019

[2] CNBC: https://www.cnbc.com/2019/07/18/retiring-this-year-how-much-youll-need-for-health-care-costs.html

[3] HSAs are never taxed at a federal income tax level when used appropriately for qualified medical expenses. Also, most states recognize HSA funds as tax-deductible with very few exceptions. Please consult a tax advisor regarding your state's specific rules.

COMPARE HSA TO 401(k)

When it comes to retirement, everyone talks about the 401(k). But your HSA is one of the best retirement accounts available. Not only can you invest your HSA[4] and potentially capitalize on tax-free growth, but your HSA also delivers powerful tax advantages you can't find anywhere else.

Table 1. HSA vs 401(k)

	HSA	401(k)
Assets	✔ Investable	✔ Investable
Contributions	✔ Not taxed	✘ FICA taxed
Earnings	✔ Not taxed	✔ Not taxed
Distribution for qualified medical expenses	✔ Not taxed	✘ Taxed (as ordinary income)
Distribution for non-qualified medical expenses	✘ Taxed (as ordinary income after age 65)	✘ Taxed (as ordinary income after age 59-1/2)
Required minimum distribution	✔ Never	✘ Yes (Age 72)

As you can see, your HSA brings all the tax efficiency of a 401(k) along with several extra bonuses. For example, 401(k) contributions are subject to 7.65% FICA payroll taxes, while HSA contributions are not. So, HSA contributions go further than 401(k) contributions and can help you save faster. In addition, HSAs do not have required minimum distributions. Plus, members age 65 and older can take taxable HSA distributions for any expense —just like a 401(k). And, of course, distributions are always tax-free when used for qualified medical expenses.

Considering how much you're likely to spend on healthcare in retirement, those advantages can translate into huge savings. Here's an example based on a modest 22 percent effective tax rate.

Table 2. Spending Power in Retirement

	HSA	401(k)
Balance (at age 60)	**$300,000**	**$300,000**
Spending power (distributions are not taxed)	**$300,000** (distributions are not taxed)	**$234,000** (distributions are taxed)

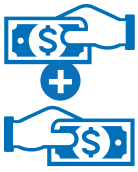
HSA SAVINGS (versus 401k) = $66,000

[4] Investments are subject to risk, including the possible loss of the principal invested, and are not FDIC or NCUA insured, or guaranteed by HealthEquity, Inc. Investing through the HealthEquity investment platform is subject to the terms and conditions of the Health Savings Account Custodial Agreement and any applicable investment supplement. Investing may not be suitable for everyone and before making any investments, review the fund's prospectus.

[5] After age 65, if you withdraw funds for any purpose other than qualified medical expenses, you will be subject to income taxes. Funds withdrawn for qualified medical expenses will remain tax-free.

OPTIMIZE YOUR RETIREMENT SAVINGS STRATEGY

Given that a significant portion of retirement spending will go toward healthcare costs, it is not ideal to use a 401(k) as your sole retirement savings vehicle. An HSA offers much more flexibility and empowers you to pay for qualified medical expenses in retirement—in many instances, tax-free. Therefore, in most cases, it is prudent to use a 401(k) in conjunction with an HSA. For many people, an effective contribution strategy could follow these steps.

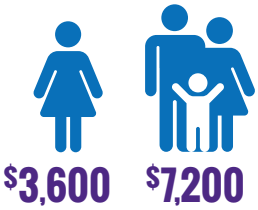


1 MAX OUT THE EMPLOYER HSA MATCH

Many organizations offer an annual seed contribution. Other organizations offer an ongoing HSA contribution match. Usually the match is dollar-for-dollar up to a specified limit. Given the short- and long-term flexibility associated with your HSA, it's important to capture this match first. Don't leave free HSA money on the table!

2 MAX OUT THE EMPLOYER 401(k) MATCH

Commonly, employers match fifty cents on the dollar up to six percent of employee income. Other match plans go dollar for dollar up to three percent. Regardless of the approach, an employer 401(k) match represents real income that should also be captured if available.



3 CONTRIBUTE THE HSA MAX

The HSA contribution limits for 2021 are $3,600 for individuals and $7,200 for families. Members 55+ can contribute an additional $1000 beyond these limits. In most cases, it may be advantageous to maximize contributions to your HSA before maxing out your 401(k). FICA savings alone often justify prioritizing the HSA.

4 MAX OUT YOUR401(k)

After maxing HSA contributions, then contribute additional money to a 401(k). Maxing contributions to both your HSA and retirement accounts should help you build a nest egg your future self will appreciate.

There are some members, however, for whom this strategy may not be ideal. Consider that HSA dollars cover myriad over-the-counter medicines, including cough syrup, pain relievers and even menstrual care products. If inclined to regularly use the HSA for such routine purchases, then a different long-term savings strategy should be considered. It's difficult to save for retirement if you're regularly dipping into your HSA for routine spending. For some people, the 401(k) early distribution penalty serves to create the necessary savings discipline.

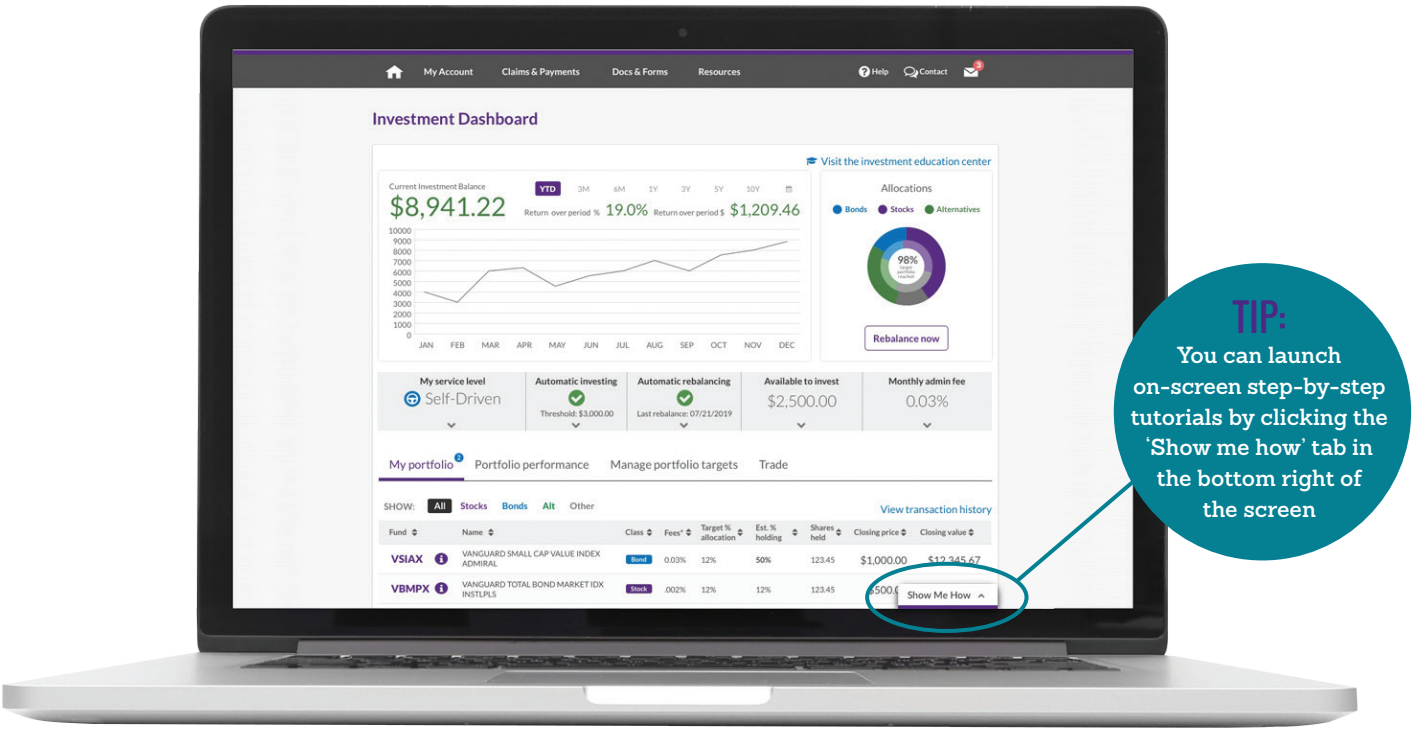
GETTING STARTED: HSA INVESTMENT DESKTOP

HealthEquity makes it easy to invest your HSA dollars. Here's how to access the HSA Investment Desktop:

1. Log into your HealthEquity member account
2. Hover over 'My Account' in the navigation bar
3. Select 'Investments' from the dropdown menu

Once inside, you have several options to choose and manage your investments.

- View portfolio performance and allocation
- Set portfolio targets
- Research fund options and historical performance
- Buy, sell and trade funds
- Automatically reinvest earnings and rebalance investments



TIP:
You can launch on-screen step-by-step tutorials by clicking the 'Show me how' tab in the bottom right of the screen

INVEST IN OUR LINEUP OF 24 LOW-COST VANGUARD FUNDS

Vanguard is the largest provider of mutual funds in the world and has more than 6 trillion dollars in assets under management.[7] Each of the funds we offer carries a comparatively low expense ratio (an expense ratio expresses the percentage of assets deducted each fiscal year for fund expenses). In addition, most of the funds we offer are rated 4- and 5-star by Morningstar,[8] an industry-leading research and advisory firm. Be confident that no matter your selection, you'll be in investing in high-quality funds.

Vanguard fund	Symbol	Morningstar (Mstar) category	Mstar rating	Expense ratio
Bonds				
Short Term Idx Adm	VBIRX	Intermediate - Term Bond	★★★	0.07
Total Bond Market Idx InstPls	VBMPX	Intermediate - Term Bond	★★★	0.03
Total Intl Bond Idx Adm	VTABX	World Bond	★★★	0.11
Inflation-Protected Secs I	VIPIX	TIPS	★★★★	0.07
Short-Term Infl-Prot Sec Idx Adm	VTAPX	TIPS	★★	0.06
Stocks				
Growth Index I	VIGIX	Large Growth	★★★★	0.04
Institutional Index Instl P1	VIIIX	Large Growth	★★★★★	0.02
Value Idx Adm	VVIAX	Large Blend	★★★★	0.05
Extended Market Idx InstlPlus	VEMPX	Mid-Cap Value	★★★	0.04
Mid-Cap Value Idx Adm	VMVAX	Mid-Cap Blend	★★★★	0.07
Small Cap Index Adm	VSMAX	Small Blend	★★★★★	0.05
Small Cap Value Idx Adm	VSIAX	Small Blend	★★★★	0.07
Total Intl Stock Indx InstlPls	VTPSX	Foreign Large Blend	★★★★	0.07
Emerging Markets Stock Idx I	VEMIX	Diversified Emerging Mkts	★★★	0.10
FTSE Social Index Adm	VFTAX	Large Blend	★★★★★	0.14
Other				
REIT Index I	VGSNX	Real Estate	★★★★	0.10
Materials Index Adm	VMIAX	Natural Resources	★★★★	0.10
Wellesley® Income Admiral™	VWIAX	Balanced Allocation	★★★★★	0.16
Target Date Funds				
Target Retirement 2020 Inv	VTWNX	Target Date 2016 - 2020	★★★★	0.13
Target Retirement 2030 Inv	VTHRX	Target Date 2026 - 2030	★★★★	0.14
Target Retirement 2040 Inv	VFORX	Target Date 2036 - 2040	★★★★	0.14
Target Retirement 2050 Inv	VFIFX	Target Date 2046 - 2050	★★★★	0.15
Target Retirement 2060 Inv	VTTSX	Target Date 2051 -	★★★	0.15
Retirement Income Inv	VTINX	Retiremnent Income	★★★★	0.12

[7] Investments made available to HSA holders are subject to risk, including the possible loss of the principal invested, and are not FDIC or NCUA insured, or guaranteed by HealthEquity, Inc. Investing through the HealthEquity investment platform is subject to the terms and conditions of the Health Savings Account Custodial Agreement and any applicable investment supplement. You should carefully consider the investment objectives, risks, charges and expenses of any mutual fund before investing. A prospectus and, if available, a summary prospectus containing this and other important information can be obtained by visiting the Vanguard website at vanguard.com. Please read the prospectus carefully before investing. Consult your advisor or the IRS with any questions regarding investments or on filing your tax return.

[8] As of Q3 2020

TAKE ADVANTAGE OF WEB-BASED AUTOMATED INVESTING ADVICE AND RECOMMENDATIONS

Investing can be confusing and somewhat time consuming. We understand. If you're not ready to manage you own portfolio, Advisor™ powered by **HealthEquity Advisors, LLC**[9] can help. The integrated Advisor™ platform offers two configurations, enabling you to adjust your level of control.

GPS

Tap into algorithm-based guidance and recommendations

GPS recommends investment options based on age, investment objectives, investment experience and more. This option gives members the opportunity to ultimately select their own investments based on targeted advice.

AUTOPILOT

Let intelligent technologies manage your entire portfolio

Member inputs create a risk profile, then **AutoPilot** will automatically select investments and rebalance member portfolios based on specified factors. **AutoPilot** empowers even the most inexperienced members to invest confidently.

[9] Investments are subject to risk, including the possible loss of the principal invested and are not FDIC or NCUA insured, or guaranteed by HealthEquity, Inc. HSA holders may select Vanguard funds for investment through the HealthEquity investment platform but HealthEquity, Inc. does not provide investment advice. HealthEquity Advisors, LLC™, a wholly owned subsidiary of HealthEquity, Inc. and an SEC-registered investment adviser, provides web-based investment advice to HSA holders that subscribe for its services (minimum thresholds and additional fees apply). Registration does not imply endorsement by any state or agency and does not imply a level of skill, education, or training. Investing may not be suitable for everyone. You should carefully consider the investment objectives, risks, charges and expenses of any mutual fund before investing. A prospectus and, if available, a summary prospectus containing this and other important information can be obtained by visiting the Vanguard website at vanguard.com. Please read the prospectus carefully before investing.

HealthEquity®

CONNECTING HEALTH AND WEALTH

Get support 24/7

Call us day or night. Our US-based service team measures success by problems solved. We'll do whatever it takes.

Say goodbye to hassle

Log in and manage everything via our simple mobile app.[10] Want to submit a claim? Easy. Just snap a photo and you're on your way.

Stay informed

Check out our vast library of webinars, tutorials, videos, calculators, and more. You'll find tips and tricks to make the most of your HSA.

Questions? We're here for you 24/7

866.735.8195 | HealthEquity.com/Learn

[10]Accounts must be activated via the HealthEquity website in order to use the mobile app.

Cigna Dental Benefit Summary
Episcopal Church Medical Trust
01/01/2023 (DDPV: Preventive Dental)

Administered by: Cigna Health and Life Insurance Company

This material is for informational purposes only and is designed to highlight some of the benefits available under this plan. Consult the plan documents to determine specific terms of coverage relating to your plan. Terms include covered procedures, applicable waiting periods, exclusions and limitations. **Your DPPO plan allows you to see any licensed dentist, but using an in-network dentist may minimize your out-of-pocket expenses.**

Cigna Dental PPO				
Network Options	***In-Network:*** **Total Cigna DPPO Network**		***Non-Network:*** **See Non-Network Reimbursement**	
Reimbursement Levels	Based on Contracted Fees		Maximum Reimbursable Charge	
Calendar Year Benefits Maximum Applies to: Class II & III expenses	$1,500		$1,500	
Calendar Year Deductible Individual Family	$0 $0		$0 $0	
Benefit Highlights	***Plan Pays***	***You Pay***	***Plan Pays***	***You Pay***
Class I: Diagnostic & Preventive Oral Evaluations Prophylaxis: routine cleanings X-rays: routine X-rays: non-routine Fluoride Application Sealants: per tooth Space Maintainers: non-orthodontic Emergency Care to Relieve Pain	100% No Deductible	No Charge	100% No Deductible	No Charge
Class II: Basic Restorative Restorative: fillings Endodontics: minor and major Periodontics: minor and major Oral Surgery: minor and major Anesthesia: general and IV sedation Anesthesia: Exparel Repairs: bridges, crowns and inlays Repairs: dentures Denture Relines, Rebases and Adjustments Osseous Surgery	80% No Deductible	20% No Deductible	80% No Deductible	20% No Deductible
Class III: Major Restorative Inlays and Onlays Prosthesis Over Implant Crowns: prefabricated stainless steel / resin Crowns: permanent cast and porcelain Bridges and Dentures	1% No Deductible	99% No Deductible	1% No Deductible	99% No Deductible
Benefit Plan Provisions:				

In-Network Reimbursement	For services provided by a Cigna Dental PPO network dentist, Cigna Dental will reimburse the dentist according to a Fee Schedule or Discount Schedule.
Non-Network Reimbursement	For services provided by a non-network dentist, Cigna Dental will reimburse according to the Maximum Reimbursable Charge. The MRC is calculated at the 80th percentile of all provider amounts in the geographic area. The dentist may balance bill up to their usual fees.
Cross Accumulation	All deductibles, plan maximums, and service specific maximums cross accumulate between in and out of network. Benefit frequency limitations are based on the date of service and cross accumulate between in and out of network.
Calendar Year Benefits Maximum	The plan will only pay for covered charges up to the yearly Benefits Maximum, when applicable. Benefit-specific Maximums may also apply.
Calendar Year Deductible	This is the amount you must pay before the plan begins to pay for covered charges, when applicable. Benefit-specific deductibles may also apply.
Pretreatment Review	Pretreatment review is available on a voluntary basis when dental work in excess of $200 is proposed.
Alternate Benefit Provision	When more than one covered Dental Service could provide suitable treatment based on common dental standards, Cigna will determine the covered Dental Service on which payment will be based and the expenses that will be included as Covered Expenses.
Oral Health Integration Program (OHIP)	Cigna Dental Oral Health Integration Program offers enhanced dental coverage for customers with the following medical conditions: diabetes, heart disease, stroke, maternity, head and neck cancer radiation, organ transplants and chronic kidney disease. There's no additional charge for the program, and those who qualify are eligible to receive reimbursement of their coinsurance for certain related dental procedures. Eligible customers can also receive guidance on behavioral issues related to oral health. Reimbursements under this program are not subject to the annual deductible, but will be applied to and are subject to the plan annual maximum. For more information including how to enroll in this program and a complete list of program terms and eligible medical conditions, go to www.mycigna.com or call customer service 24/7 at 1.800.CIGNA24.
Timely Filing	Out of network claims submitted to Cigna after 365 days from date of service will be denied.
Benefit Limitations*: Benefit frequency limitations are based on date of service and cross accumulate between in and out of network.*	
Oral Evaluations/Exams	3 per calendar year
X-rays (routine)	Bitewings: 2 per calendar year
X-rays (non-routine)	Complete series of radiographic images and panoramic radiographic images: Limited to a combined total of 1 per 36 months.
Cleanings	3 per calendar year, including periodontal maintenance procedures following active therapy.
Fluoride Application	2 per calendar year for children under age 19.
Sealants (per tooth)	Limited to posterior tooth. 1 treatment per tooth every 36 months for children under age 14.
Space Maintainers	Limited to non-orthodontic treatment for children under age 19.
Inlays, Crowns, Bridges, Dentures and Partials	Replacement every 60 months if unserviceable and cannot be repaired. Benefits are based on the amount payable for non-precious metals. No porcelain or white/tooth-colored material on molar crowns or bridges.
Denture and Bridge Repairs	Reviewed if more than once.
Denture Relines, Rebases and Adjustments	Covered if more than 6 months after installation. 1 per 36 months.
Prosthesis Over Implant	Replacement every 60 months if unserviceable and cannot be repaired. Benefits are based on the amount payable for non-precious metals. No porcelain or white/tooth-colored material on molar crowns or bridges.

Benefit Exclusions:
Covered Expenses will not include, and no payment will be made for the following:

- Procedures and services not included in the list of covered dental expenses;
- Diagnostic: cone beam imaging;
- Preventive Services: instruction for plaque control, oral hygiene and diet;
- Restorative: ceramic, resin, or acrylic materials on crowns or bridges on or replacing the upper and or lower first, second and/or third molars;
- Periodontics: bite registrations; splinting;
- Prosthodontic: precision or semi-precision attachments;
- Implants: implants or implant related services;
- Orthodontics: orthodontic treatment;
- Procedures, appliances or restorations, except full dentures, whose main purpose is to change vertical dimension, diagnose or treat conditions of dysfunction of the temporomandibular joint (TMJ), stabilize periodontally involved teeth or restore occlusion;
- Athletic mouth guards;

- Services performed primarily for cosmetic reasons;
- Personalization or decoration of any dental device or dental work;
- Replacement of an appliance per benefit guidelines;
- Services that are deemed to be medical in nature;
- Services and supplies received from a hospital;
- Drugs: prescription drugs;
- Charges in excess of the Maximum Reimbursable Charge

This document provides a summary only. It is not a contract. If there are any differences between this summary and the official plan documents, the terms of the official plan documents will prevail.

Product availability may vary by location and plan type and is subject to change. All group dental insurance policies and dental benefit plans contain exclusions and limitations. For costs and details of coverage, review your plan documents or contact a Cigna representative.

All Cigna products and services are provided exclusively by or through operating subsidiaries of Cigna Corporation, including Cigna Health and Life Insurance Company (CHLIC), Connecticut General Life Insurance Company, and Cigna Dental Health, Inc.

Cigna Dental Benefit Summary
Episcopal Church Medical Trust
01/01/2023 (DD50: Basic Dental)

Administered by: Cigna Health and Life Insurance Company

This material is for informational purposes only and is designed to highlight some of the benefits available under this plan. Consult the plan documents to determine specific terms of coverage relating to your plan. Terms include covered procedures, applicable waiting periods, exclusions and limitations. **Your DPPO plan allows you to see any licensed dentist, but using an in-network dentist may minimize your out-of-pocket expenses.**

Benefit Plan Features	***Total Cigna DPPO Network***		***Non-Network***
Network Options	Cigna DPPO Advantage	Cigna DPPO	See Non-Network Reimbursement
Reimbursement Levels	Fee Schedule	Discount on Fees	Maximum Reimbursable Charge
Calendar Year Benefits Maximum Applies to: Class II, III & IX expenses	$2,000	$2000	$2000
Calendar Year Deductible Individual Family	 $0 $0	 $50 $150	 $50 $150
Benefit Highlights	***Plan Pays***	***Plan Pays***	***Plan Pays***
Class I: Diagnostic & Preventive Oral Evaluations Prophylaxis: routine cleanings X-rays: routine X-rays: non-routine Fluoride Application Sealants: per tooth Space Maintainers: non-orthodontic Emergency Care to Relieve Pain	100% No Deductible	100% No Deductible	100% No Deductible
Class II: Basic Restorative Restorative: fillings Endodontics: minor and major Periodontics: minor and major Oral Surgery: minor and major Repairs: bridges, crowns and inlays Repairs: dentures Denture Relines, Rebases and Adjustments Osseous Surgery	85% No Deductible	85% After Deductible	85% After Deductible
Class III: Major Restorative Inlays and Onlays Prosthesis Over Implant Crowns: prefabricated stainless steel / resin Crowns: permanent cast and porcelain Bridges and Dentures Anesthesia: general and IV sedation Anesthesia: Exparel	50% No Deductible	50% After Deductible	50% After Deductible
Class IX: Implants	50% No Deductible	50% After Deductible	50% After Deductible
Benefit Plan Provisions:			
In-Network Reimbursement	For services provided by a Cigna Dental PPO network dentist, Cigna Dental will reimburse the dentist according to a Fee Schedule or Discount Schedule.		
Non-Network Reimbursement	For services provided by a non-network dentist, Cigna Dental will reimburse according to the Maximum Reimbursable Charge. The MRC is calculated at the 80th percentile of all provider amounts in the geographic area. The dentist may balance bill up to their usual fees.		

Cross Accumulation	All deductibles, plan maximums, and service specific maximums cross accumulate between in and out of network. Benefit frequency limitations are based on the date of service and cross accumulate between in and out of network.
Calendar Year Benefits Maximum	The plan will only pay for covered charges up to the yearly Benefits Maximum, when applicable. Benefit-specific Maximums may also apply.
Calendar Year Deductible	This is the amount you must pay before the plan begins to pay for covered charges, when applicable. Benefit-specific deductibles may also apply.
Carryover Provision	Certain Dental Expenses incurred and applied toward the Individual or Family Deductible during the last 3 months of the calendar year will be applied toward the next year's Deductible.
Pretreatment Review	Pretreatment review is available on a voluntary basis when dental work in excess of $200 is proposed.
Alternate Benefit Provision	When more than one covered Dental Service could provide suitable treatment based on common dental standards, Cigna will determine the covered Dental Service on which payment will be based and the expenses that will be included as Covered Expenses.
Oral Health Integration Program (OHIP)	Cigna Dental Oral Health Integration Program offers enhanced dental coverage for customers with the following medical conditions: diabetes, heart disease, stroke, maternity, head and neck cancer radiation, organ transplants and chronic kidney disease. There's no additional charge for the program, and those who qualify are eligible to receive reimbursement of their coinsurance for certain related dental procedures. Eligible customers can also receive guidance on behavioral issues related to oral health. Reimbursements under this program are not subject to the annual deductible, but will be applied to and are subject to the plan annual maximum. For more information including how to enroll in this program and a complete list of program terms and eligible medical conditions, go to www.mycigna.com or call customer service 24/7 at 1.800.CIGNA24.
Timely Filing	Out of network claims submitted to Cigna after 365 days from date of service will be denied.
Benefit Limitations: *Benefit frequency limitations are based on date of service and cross accumulate between in and out of network.*	
Oral Evaluations/Exams	3 per calendar year
X-rays (routine)	Bitewings: 2 per calendar year
X-rays (non-routine)	Complete series of radiographic images and panoramic radiographic images: Limited to a combined total of 1 per 36 months.
Diagnostic Casts	Payable only in conjunction with orthodontic workup.
Cleanings	3 per calendar year, including periodontal maintenance procedures following active therapy.
Fluoride Application	2 per calendar year for children under age 19.
Sealants (per tooth)	Limited to posterior tooth. 1 treatment per tooth every 36 months for children under age 14.
Space Maintainers	Limited to non-orthodontic treatment for children under age 19.
Inlays, Crowns, Bridges, Dentures and Partials	Replacement every 60 months if unserviceable and cannot be repaired. Benefits are based on the amount payable for non-precious metals. No porcelain or white/tooth-colored material on molar crowns or bridges.
Denture and Bridge Repairs	Reviewed if more than once.
Denture Relines, Rebases and Adjustments	Covered if more than 6 months after installation. 1 per 36 months.
Prosthesis Over Implant	1 every 60 months if unserviceable and cannot be repaired. Benefits are based on the amount payable for non-precious metals. No porcelain or white/tooth colored material on molar crowns or

Benefit Exclusions:
Covered Expenses will not include, and no payment will be made for the following:

- Procedures and services not included in the list of covered dental expenses;
- Diagnostic: cone beam imaging; covered only in conjunction with Class IX Implant coverage
- Preventive Services: instruction for plaque control, oral hygiene and diet;
- Restorative: ceramic, resin, or acrylic materials on crowns or bridges on or replacing the upper and or lower first, second and/or third molars;
- Periodontics: bite registrations; splinting;
- Prosthodontic: precision or semi-precision attachments;
- Orthodontics: orthodontic treatment;
- Procedures, appliances or restorations, except full dentures, whose main purpose is to change vertical dimension, diagnose or treat conditions of dysfunction of the temporomandibular joint (TMJ), stabilize periodontally involved teeth or restore occlusion;
- Athletic mouth guards;
- Services performed primarily for cosmetic reasons;
- Personalization or decoration of any dental device or dental work;
- Replacement of an appliance per benefit guidelines;
- Services that are deemed to be medical in nature;

- Services and supplies received from a hospital;
- Drugs: prescription drugs;
- Charges in excess of the Maximum Reimbursable Charge

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Cigna Dental Benefit Summary
Episcopal Church Medical Trust
01/01/2023 (DD25: Dental & Orthodontia)

Administered by: Cigna Health and Life Insurance Company

This material is for informational purposes only and is designed to highlight some of the benefits available under this plan. Consult the plan documents to determine specific terms of coverage relating to your plan. Terms include covered procedures, applicable waiting periods, exclusions and limitations. **Your DPPO plan allows you to see any licensed dentist, but using an in-network dentist may minimize your out-of-pocket expenses.**

Benefit Plan Features	***Total Cigna DPPO Network***		***Non-Network***
Network Options	Cigna DPPO Advantage	Cigna DPPO	See Non-Network Reimbursement
Reimbursement Levels	Fee Schedule	Discount on Fees	Maximum Reimbursable Charge
Calendar Year Benefits Maximum Applies to: Class II, III & IX expenses	$2,000	$2000	$2000
Calendar Year Deductible Individual Family	 $0 $0	 $25 $75	 $25 $75
Benefit Highlights	***Plan Pays***	***Plan Pays***	***Plan Pays***
Class I: Diagnostic & Preventive Oral Evaluations Prophylaxis: routine cleanings X-rays: routine X-rays: non-routine Fluoride Application Sealants: per tooth Space Maintainers: non-orthodontic Emergency Care to Relieve Pain	100% No Deductible	100% No Deductible	100% No Deductible
Class II: Basic Restorative Restorative: fillings Endodontics: minor and major Periodontics: minor and major Oral Surgery: minor and major Repairs: bridges, crowns and inlays Repairs: dentures Denture Relines, Rebases and Adjustments Osseous Surgery	85% No Deductible	85% After Deductible	85% After Deductible
Class III: Major Restorative Inlays and Onlays Prosthesis Over Implant Crowns: prefabricated stainless steel / resin Crowns: permanent cast and porcelain Bridges and Dentures Anesthesia: general and IV sedation Anesthesia: Exparel	85% No Deductible	85% After Deductible	85% After Deductible
Class IV: Orthodontia Coverage for Subscriber and All Dependents Lifetime Benefits Maximum: $1,500	50% No Deductible	50% After Deductible	50% After Deductible
Class IX: Implants	85% No Deductible	85% After Deductible	85% After Deductible
Benefit Plan Provisions:			
In-Network Reimbursement	For services provided by a Cigna Dental PPO network dentist, Cigna Dental will reimburse the dentist according to a Fee Schedule or Discount Schedule.		

Non-Network Reimbursement	For services provided by a non-network dentist, Cigna Dental will reimburse according to the Maximum Reimbursable Charge. The MRC is calculated at the 80th percentile of all provider amounts in the geographic area. The dentist may balance bill up to their usual fees.
Cross Accumulation	All deductibles, plan maximums, and service specific maximums cross accumulate between in and out of network. Benefit frequency limitations are based on the date of service and cross accumulate between in and out of network.
Calendar Year Benefits Maximum	The plan will only pay for covered charges up to the yearly Benefits Maximum, when applicable. Benefit-specific Maximums may also apply.
Calendar Year Deductible	This is the amount you must pay before the plan begins to pay for covered charges, when applicable. Benefit-specific deductibles may also apply.
Carryover Provision	Certain Dental Expenses incurred and applied toward the Individual or Family Deductible during the last 3 months of the calendar year will be applied toward the next year's Deductible.
Pretreatment Review	Pretreatment review is available on a voluntary basis when dental work in excess of $200 is proposed.
Alternate Benefit Provision	When more than one covered Dental Service could provide suitable treatment based on common dental standards, Cigna will determine the covered Dental Service on which payment will be based and the expenses that will be included as Covered Expenses.
Oral Health Integration Program (OHIP)	Cigna Dental Oral Health Integration Program offers enhanced dental coverage for customers with the following medical conditions: diabetes, heart disease, stroke, maternity, head and neck cancer radiation, organ transplants and chronic kidney disease. There's no additional charge for the program, and those who qualify are eligible to receive reimbursement of their coinsurance for certain related dental procedures. Eligible customers can also receive guidance on behavioral issues related to oral health. Reimbursements under this program are not subject to the annual deductible, but will be applied to and are subject to the plan annual maximum. For more information including how to enroll in this program and a complete list of program terms and eligible medical conditions, go to www.mycigna.com or call customer service 24/7 at 1.800.CIGNA24.
Timely Filing	Out of network claims submitted to Cigna after 365 days from date of service will be denied.
Benefit Limitations: *Benefit frequency limitations are based on date of service and cross accumulate between in and out of network.*	
Oral Evaluations/Exams	3 per calendar year
X-rays (routine)	Bitewings: 2 per calendar year
X-rays (non-routine)	Complete series of radiographic images and panoramic radiographic images: Limited to a combined total of 1 per 36 months.
Diagnostic Casts	Payable only in conjunction with orthodontic workup.
Cleanings	3 per calendar year, including periodontal maintenance procedures following active therapy.
Fluoride Application	2 per calendar year for children under age 19.
Sealants (per tooth)	Limited to posterior tooth. 1 treatment per tooth every 36 months for children under age 14.
Space Maintainers	Limited to non-orthodontic treatment for children under age 19.
Inlays, Crowns, Bridges, Dentures and Partials	Replacement every 60 months if unserviceable and cannot be repaired. Benefits are based on the amount payable for non-precious metals. No porcelain or white/tooth-colored material on molar crowns or bridges.
Denture and Bridge Repairs	Reviewed if more than once.
Denture Relines, Rebases and Adjustments	Covered if more than 6 months after installation. 1 per 36 months
Prosthesis Over Implant	1 every 60 months if unserviceable and cannot be repaired. Benefits are based on the amount payable for non-precious metals. No porcelain or white/tooth colored material on molar crowns or

Benefit Exclusions:
Covered Expenses will not include, and no payment will be made for the following:

- Procedures and services not included in the list of covered dental expenses;
- Diagnostic: cone beam imaging; covered only in conjunction with Class IX Implant coverage
- Preventive Services: instruction for plaque control, oral hygiene and diet;
- Restorative: ceramic, resin, or acrylic materials on crowns or bridges on or replacing the upper and or lower first, second and/or third molars;
- Periodontics: bite registrations; splinting;
- Prosthodontic: precision or semi-precision attachments;
- Procedures, appliances or restorations, except full dentures, whose main purpose is to change vertical dimension, diagnose or treat conditions of dysfunction of the temporomandibular joint (TMJ), stabilize periodontally involved teeth or restore occlusion;
- Athletic mouth guards;
- Services performed primarily for cosmetic reasons;
- Personalization or decoration of any dental device or dental work;
- Replacement of an appliance per benefit guidelines;

- Services that are deemed to be medical in nature;
- Services and supplies received from a hospital;
- Drugs: prescription drugs;
- Charges in excess of the Maximum Reimbursable Charge

This document provides a summary only. It is not a contract. If there are any differences between this summary and the official plan documents, the terms of the official plan documents will prevail.

Product availability may vary by location and plan type and is subject to change. All group dental insurance policies and dental benefit plans contain exclusions and limitations. For costs and details of coverage, review your plan documents or contact a Cigna representative

All Cigna products and services are provided exclusively by or through operating subsidiaries of Cigna Corporation, including Cigna Health and Life Insurance Company (CHLIC), Connecticut General Life Insurance Company, and Cigna Dental Health, Inc.

ECMT

40% OFF
additional complete pair of prescription eyeglasses

20% OFF
non-covered items, including non-prescription sunglasses

Find an eye doctor
(Insight Network)

- 866.804.0982
- eyemed.com
- EyeMed Members App
- For LASIK, call 1.800.988.4221

Heads Up
You may have additional benefits. Log into **eyemed.com/member** to see all plans included with your benefits.

SUMMARY OF BENEFITS

VISION CARE SERVICES	IN-NETWORK MEMBER COST	OUT-OF-NETWORK MEMBER REIMBURSEMENT
EXAM SERVICES		
Exam	$0 copay	Up to $30
Retinal Imaging	Up to $39	Not covered
CONTACT LENS FIT AND FOLLOW-UP		
Fit and Follow-up - Standard	Up to $40; contact lens fit and two follow-up visits	Not covered
Fit and Follow-up - Premium	10% off retail price	Not covered
FRAME		
Frame	$0 copay; 20% off balance over $150 allowance	Up to $47
STANDARD PLASTIC LENSES		
Single Vision	$10 copay	Up to $32
Bifocal	$10 copay	Up to $46
Trifocal	$10 copay	Up to $57
Progressive - Standard	$75 copay	Up to $46
Progressive - Premium Tier 1 - 3	$95 - 120 copay	Up to $46
Progressive - Premium Tier 4	$75 copay; 20% off retail price less $120 allowance	Up to $46
LENS OPTIONS		
Anti Reflective Coating - Standard	$45	Not covered
Anti Reflective Coating - Premium Tier 1 - 2	$57 - 68	Not covered
Anti Reflective Coating - Premium Tier 3	20% off retail price	Not covered
Photochromic - Non-Glass	$75	Not covered
Polycarbonate - Standard	$0 copay	Up to $28
Polycarbonate - Standard < 19 years of age	$0 copay	Up to $28
Scratch Coating - Standard Plastic	$15	Not covered
Tint - Solid and Gradient	$15	Not covered
UV Treatment	$15	Not covered
All Other Lens Options	20% off retail price	Not covered
CONTACT LENSES		
Contacts - Conventional	$0 copay; 15% off balance over $150 allowance	Up to $100
Contacts - Disposable	$0 copay; 100% of balance over $150 allowance	Up to $100
Contacts - Medically Necessary	$0 copay; paid in full	Up to $210
OTHER		
Hearing Care from Amplifon Network	Up to 64% off hearing aids; call 1.877.203.0675	Not covered
LASIK or PRK from U.S. Laser Network	15% off retail or 5% off promo price; call 1.800.988.4221	Not covered

FREQUENCY	ALLOWED FREQUENCY - ADULTS	ALLOWED FREQUENCY - KIDS
Exam	Once every 12 months	Once every 12 months
Frame	Once every 12 months	Once every 12 months
Lenses	Once every 12 months	Once every 12 months
Contact Lenses	Once every 12 months	Once every 12 months

(Plan allows member to receive either contacts and frame, or frames and lens services)

EyeMed reserves the right to make changes to the products available on each tier. All providers are not required to carry all brands on all tiers. For current listing of brands by tier, call 866.939.3633. No benefits will be paid for services or materials connected with or charges arising from: medical or surgical treatment, services or supplies for the treatment of the eye, eyes or supporting structures; Refraction, when not provided as part of a Comprehensive Eye Examination; services provided as a result of any Workers' Compensation law, or similar legislation, or required by any governmental agency or program whether federal, state or subdivisions thereof; orthoptic or vision training, subnormal vision aids and any associated supplemental testing; Aniseikonic lenses; any Vision Examination or any corrective Vision Materials required by a Policyholder as a condition of employment; safety eyewear; solutions, cleaning products or frame cases; non-prescription sunglasses; plano (non-prescription) lenses; plano (non-prescription) contact lenses; two pair of glasses in lieu of bifocals; electronic vision devices; services rendered after the date an Insured Person ceases to be covered under the Policy, except when Vision Materials ordered before coverage ended are delivered, and the services rendered to the Insured Person are within 31 days from the date of such order; or lost or broken lenses, frames, glasses, or contact lenses that are replaced before the next Benefit Frequency when Vision Materials would next become available. Fees charged by a Provider for services other than a covered benefit and any local, state or Federal taxes must be paid in full by the Insured Person to the Provider. Such fees, taxes or materials are not covered under the Policy. Allowances provide no remaining balance for future use within the same Benefit Frequency. Some provisions, benefits, exclusions or limitations listed herein may vary by state. Plan discounts cannot be combined with any other discounts or promotional offers. In certain states members may be required to pay the full retail rate and not the negotiated discount rate with certain participating providers. Please see online provider locator to determine which participating providers have agreed to the discounted rate.

Ready to live your best EyeMed life?

There's so much more to your vision benefits than copays and coverage. Get ready to see the good stuff for yourself.

Your network is the place to start

See who you want, when you want. You have thousands of providers to choose from – independent eye doctors, your favorite retail stores, even online options.

Keep your eyes open for extra discounts

Members already save an average 71% off retail using their EyeMed benefits,[1] but our long list of special offers takes benefits even further.

Remember, you're never alone

We're always here to help you use your benefits like a pro. Stay in-the-know with text alerts or healthy vision resources from the experts. If it can make benefits easier for you, we do it.

[1] Based on weighted average of sample transactions; EyeMed Insight network/$10 exam copay/$10 materials copay/$120 frame or contact lens allowance.

Create a member account at eyemed.com

Everything is right there in one spot. Check claims and benefits, see special offers and find an eye doctor – search for one with the hours, location and brands you want. For maximum mobility, try the EyeMed Members App (Google Play or App Store).

INDEPENDENT PROVIDER NETWORK + LENSCRAFTERS PEARLE VISION EST. 1961 TARGET OPTICAL

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Employee Assistance Program (EAP)
24/7

Employee Assistance Program (EAP)
24/7

Support for your mind and body.

EAP National Wellness Seminars: Take part in monthly seminars year-round on topics that apply to real-life concerns. Watch live or on demand from a computer, smartphone or tablet at: **Cigna.com/EAPWebCasts**.

Behavioral Awareness Series: Cigna offers free monthly behavioral health awareness seminars on autism, eating disorders, substance use and children's behavioral health issues. For more information, visit: **Cigna.com/individuals-families/health-wellness**.

Suicide Awareness and Prevention: Find crisis resources and information at **Cigna.com/individuals-families/health-wellness**.

Take advantage of your Healthy Rewards® discount program* for savings on many health and wellness products and services.

Call anytime for questions or support.

1.866.395.7794
myCigna.com
Employer ID:
episcopal
(for initial registration)
TTY/TDD users
call 711

Employee assistance program (EAP) services are in addition to, not instead of, your health plan benefits. These services are separate from your health plan benefits and do not provide reimbursement for financial losses. Program availability may vary by plan type and location, and are not available where prohibited by law.

* **Healthy Rewards programs are NOT insurance.** Rather, these programs give a discount on the cost of certain goods and services. The customer must pay the entire discounted cost. Some Healthy Rewards programs are not available in all states and programs may be discontinued at any time. Participating providers are solely responsible for their goods and services.

Some work/life services offered under the Cigna Employee Assistance Program may be provided by a Cigna-contracted third-party vendor.

For the members of Episcopal Church Medical Trust and their household members.

EPISCOPAL CHURCH MEDICAL TRUST

REAL SUPPORT FOR REAL LIFE

Get to know the Employee Assistance Program (EAP)

Cigna

Together, all the way.®

937484 a 02/21 SR #

HERE TO HELP. AND SUPPORT. AND PROBLEM-SOLVE.

With the Cigna Employee Assistance Program (EAP), you can get support for everyday issues and life challenges. The Employee Assistance Program (EAP) is here to connect you with real people who can help you find real solutions to life's challenges.

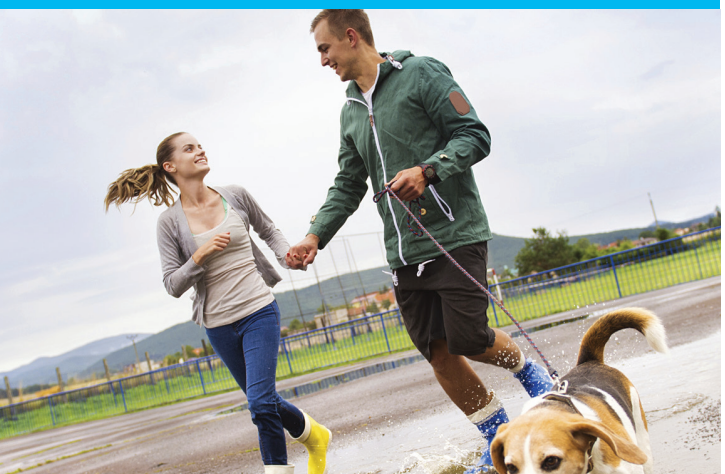
These services are all confidential and available at no additional cost to you and anyone living in your household.

Learn more about EAP at **Cigna.com/realsupport**.

To access mindfulness exercises and discover stress management techniques, explore our Managing Stress Toolkit at **Cigna.com/ManagingStress**.

Coping with disasters

It can be difficult to manage the impact of disasters such as flooding, hurricanes, wildfires or the tragedy of violence affecting your community. For online resources to help you and household members cope, visit the Disaster Resource Center at **Cigna.com/DisasterResourceCenter**.



Emotional Health

Get 1-10 sessions per issue per year with a dedicated, licensed counselor at no cost to you.

Start by calling or using live chat to get a referral. Through face-to-face or virtual sessions, get support on a range of topics, such as:

- Relationships and parenting
- Behavioral health and substance use
- Stress management

Confidential phone consultations are available to you and anyone living in your household at no cost. Work with a licensed EAP clinician for 20–30 minutes per phone session. There are no limits to how often you can call for various concerns; you can expect up to two phone sessions per issue.

Home Life Referrals

Get assistance with referrals to community resources and services.

- Adoption: Learn more about your options and the agencies that can help.
- Child Care: We'll help you find a place, program or person that's right for your family.
- Children with Special Needs: Let us help you better understand and care for your unique family needs.
- Education Guidance: We'll help you make the best decisions for your family for college searches and more.
- Parenting: Find guidance on everything from toilet training to sibling rivalry.
- Pet Care: From veterinarians to dog walkers, we'll help you ensure your pets are well taken care of.
- Prenatal Care: Find guidance through every pregnancy stage.
- Senior Care: Learn about solutions related to caring for an aging loved one.

Financial and Legal Assistance

- Financial Services Referral: Free 30-minute financial consultations by phone per topic and 25% off tax preparation.†
- Identity Theft: Get a free 60-minute expert consultation by phone for prevention or if you are victimized.
- Legal Consulting: Get a free 30-minute consultation with a network attorney and 25% off select fees.†

†Customers are required to pay the entire discounted charge for any discounted legal and/or financial services. Legal consultations related to employment matters are excluded. Additional restrictions may apply.

Employee Assistance Program (EAP) 24/7

CONNECT ANYTIME

Call 1.866.395.7794.
TTY/TDD users call 711.

Connect through **myCigna.com**

Employer ID:
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Employee Assistance & Work/Life Support Program

24/7

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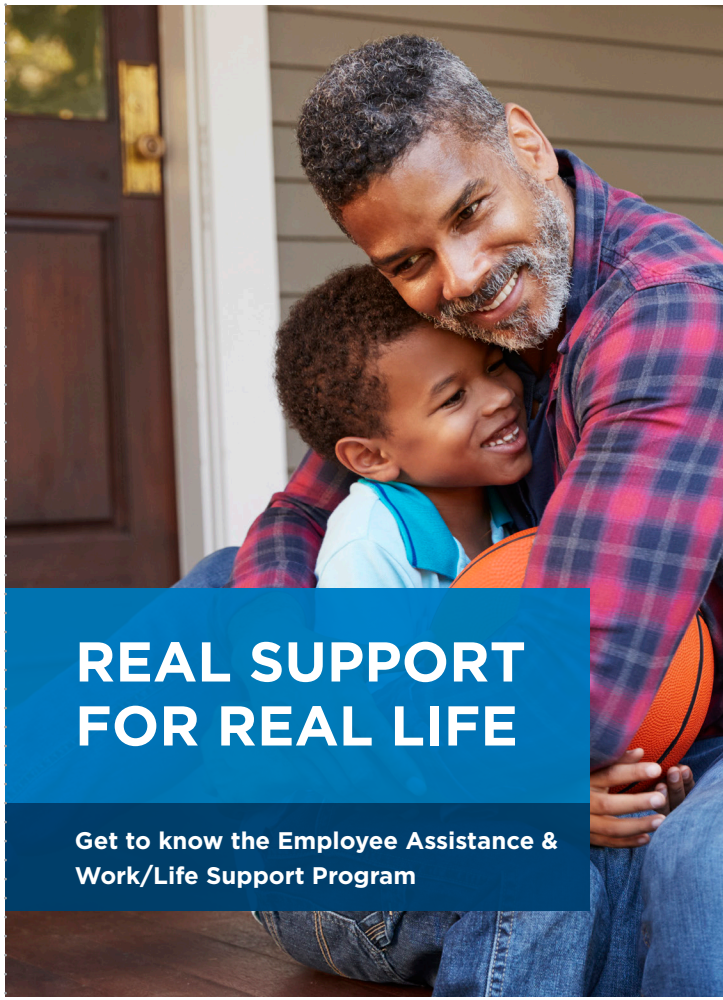
For the employees of Episcopal Church Medical Trust - Pastoral Support Network and their household members.

EPISCOPAL CHURCH MEDICAL TRUST



REAL SUPPORT FOR REAL LIFE

Get to know the Employee Assistance & Work/Life Support Program

Pastoral Support Network

Cigna

Together, all the way.®

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HERE TO HELP. AND SUPPORT. AND PROBLEM-SOLVE.

With the Employee Assistance & Work/Life Support Program, you can get support for everyday issues and life challenges. The Employee Assistance & Work/Life Support Program is here to connect you with real people who can help you find real solutions to life's challenges.

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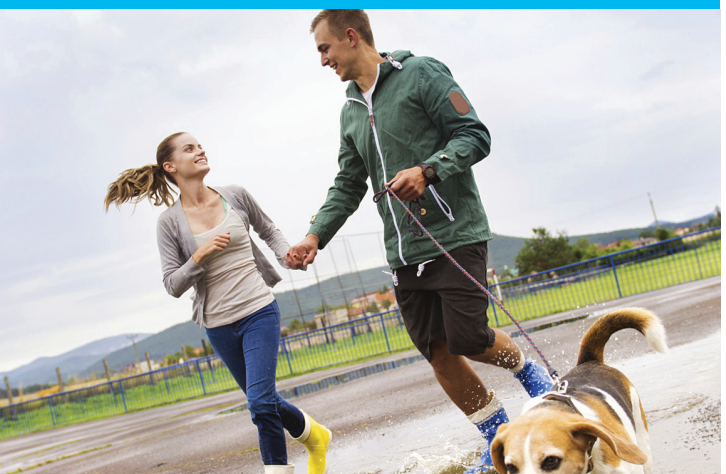

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- Legal Consulting: Get a free 30-minute consultation with a network attorney and 25% off select fees.†

Pastoral Support Network: The Pastoral Support Network (PSN) offers counseling and support services with a particular sensitivity to the unique issues priests and their families may experience. If there's an issue for which you'd like assistance, you can talk with a PSN counselor over the phone or get a referral for a counseling professional in your area.

The Pastoral Support Network is part of your EAP benefit, and is completely confidential. Neither your congregation/employer nor the Episcopal Church Medical Trust will be notified when you use the services.

†Customers are required to pay the entire discounted charge for any discounted legal and/or financial services. Legal consultations related to employment matters are excluded. Additional restrictions may apply.

Employee Assistance & Work/Life Support Program

24/7

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Cigna®

Getting started with counseling

Welcome to Talkspace

Talkspace is a digital space for private and convenient mental health support. With Talkspace, you can choose your therapist from a list of recommended, licensed providers and receive support day and night from the convenience of your device (iOS, Android, and Web).

How it works

Our members can begin to exchange unlimited messages (text, voice, and video) with their personal therapist immediately after registration. Therapists engage daily, five days per week, which often includes weekends. Every Talkspace member is granted a complimentary, 10-minute video session to get to know their new therapist. Additional video sessions can also be scheduled.

You will continue to work with the same therapist throughout your journey. However, you're always welcome to switch providers so you can find the perfect fit. Talkspace's clinical network features thousands of licensed, insured, and verified clinical professionals with specialties ranging from behavioral to emotional and wellness needs, including:

- ✓ **Stress**
- ✓ **Anxiety**
- ✓ **Depression**
- ✓ **Relationships**
- ✓ **Healthy living**
- ✓ **Trauma & grief**
- ✓ **Eating disorders**
- ✓ **Substance use**
- ✓ **Sleep**
- ✓ **Identity struggles**
- ✓ **Chronic issues**
- ✓ **And more**

Talkspace can work for you. In a study of 10,000 member participants, 70% experienced significant symptom improvement and 50% fully recovered after 12 weeks of regular engagement with their Talkspace therapist.

Ready to get started

→ Visit talkspace.com/EAPCigna

→ Complete our QuickMatch™ survey

→ Review your best matches and choose your personal therapist

To access counseling through Talkspace at no cost for your available EAP sessions per issue during the year, you'll need an EAP Code from Cigna EAP. Simply call Cigna at 877.622.4327 or go to your EAP Coverage Page on myCigna.com for live chat or self service.

La aplicación Talkspace no se encuentra disponible actualmente en español. Si necesita ayuda para encontrar un proveedor bilingüe, envíe un correo electrónico a cigna-support@talkspace.com.

Real People, **Real Stories**

“They took the pressure off a serious situation.”

Don called Health Advocate after his son suffered a broken leg in a serious fall.

His Personal Health Advocate worked with the health plan and hospital to coordinate rehab services that could accommodate his son as soon as he was discharged. She also scheduled the initial follow-up appointment with the orthopedic specialist.

Turn to us—we can help.

866.695.8622
Email: answers@HealthAdvocate.com
Web: HealthAdvocate.com/members

Download the app today!
Download on the App Store · GET IT ON Google Play

We’re here when you need us most

Your Health Advocate benefit can be accessed 24/7. Normal business hours are Monday - Friday, from 8 am to 10 pm, Eastern Time (ET). Staff is available for assistance after hours and on weekends.

There is no cost to use our service

Your employer or plan sponsor offers your Health Advocate benefit at no cost to you.

We’re not an insurance company

Health Advocate is not affiliated with any insurance or third party provider, and does not replace health insurance coverage, provide medical care or recommend treatment.

Your privacy is protected

Our staff carefully follows protocols and complies with all government privacy standards. Your medical and personal information is kept strictly confidential.

Welcome to Health Advocate

Personal health and well-being support anytime, anywhere

Our experts make healthcare easier, by supporting you and your eligible family members with a wide range of health and insurance-related issues through a single toll-free number.

HealthAdvocate℠

Welcome to Health Advocate!

This guide contains an overview of Health Advocate and the many ways we can help. Call the toll-free number anytime for **one-on-one, confidential support.**

Expert help at your side

Nothing is more important than your health and the health of your loved ones.

Our Personal Health Advocates are healthcare experts with extensive experience supporting people with important medical issues and decisions, no matter how common or complex. Typically registered nurses supported by medical directors and benefits experts, we'll work on your behalf to get you and your family the answers and peace of mind you need.

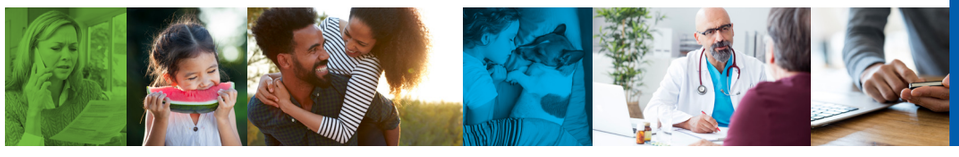
We support the whole family

Our services are available to employees, spouses, dependents, parents and parents-in-law.

Quickly reach us any time you like — by phone, email and secure messaging.

Easy access to your customized website and mobile app for articles, tips, tools and more!

Download on the App Store | GET IT ON Google Play



How We Can Help

Have you recently been diagnosed with a medical issue?
Count on us to:

- **Answer questions** about health conditions, diagnoses and treatments, no matter how complex
- **Research and explore** the latest treatment options
- **Coordinate services** relating to all aspects of your care

Need to find a doctor?
We can:

- **Use our Perfect Match℠ physician locator** to match you with the right quality doctors for your condition
- **Make an appointment** at a time that works for your schedule!

Considering a second opinion?
We'll do the work to:

- **Research and identify top experts** and Centers of Excellence nationwide
- **Arrange for the transfer of medical records,** test and lab results and X-rays
- **Set up face-to-face appointments**

Baffled by medical bills, claims denials or benefit questions?
Our experts can:

- **Explain how your benefits work,** including copays and deductibles
- **Review medical bills** to uncover possible duplicate charges or other errors
- **Do the research** and make the calls to resolve claims and billing issues

We make healthcare **easier**

- Expert healthcare help
- Healthcare decision support
- Research treatments
- Resolve claims issues

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

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EPISCOPAL CHURCH MEDICAL TRUST

Your Rights and Protections Against Surprise Medical Bills

WHEN YOU GET EMERGENCY CARE OR GET TREATED BY AN OUT-OF-NETWORK PROVIDER AT AN IN-NETWORK HOSPITAL OR AMBULATORY SURGICAL CENTER, YOU ARE PROTECTED FROM SURPRISE BILLING OR BALANCE BILLING.

What is "balance billing" (sometimes called "surprise billing")?

When you see a doctor or other health care provider, you may owe certain out-of-pocket costs, such as a copayment, coinsurance, and/or a deductible. You may have other costs or have to pay the entire bill if you see a provider or visit a health care facility that isn't in your health plan's network.

"Out-of-network" describes providers and facilities that haven't signed a contract with your health plan. Out-of-network providers may be permitted to bill you for the difference between what your plan agreed to pay and the full amount charged for a service. This is called "**balance billing**." This amount is likely more than in-network costs for the same service and might not count toward your annual out-of-pocket limit.

"Surprise billing" is an unexpected balance bill. This can happen when you can't control who is involved in your care—like when you have an emergency or when you schedule a visit at an in-network facility but are unexpectedly treated by an out-of-network provider.

You are protected from balance billing for:

Emergency services
If you have an emergency medical condition and get emergency services from an out-of-network provider or facility, the most the provider or facility may bill you is your plan's in-network cost-sharing amount (such as copayments and coinsurance). You **can't** be balance billed for these emergency services. This includes services you may get after you're in stable condition, unless you give written consent and give up your protections not to be balanced billed for these post-stabilization services.

Certain services at an in-network hospital or ambulatory surgical center
When you get services from an in-network hospital or ambulatory surgical center, certain providers there may be out-of-network. In these cases, the most those providers may bill you is your plan's in-network cost-sharing amount. This applies to emergency medicine, anesthesia, pathology, radiology, laboratory, neonatology, assistant surgeon, hospitalist, or intensivist services. These providers **can't** balance bill you and may **not** ask you to give up your protections not to be balance billed.

If you get other services at these in-network facilities, out-of-network providers **can't** balance bill you, unless you give written consent and give up your protections.

You're never required to give up your protections from balance billing. You also aren't required to get care out-of-network. You can choose a provider or facility in your plan's network.

When balance billing isn't allowed, you also have the following protections:

- You are only responsible for paying your share of the cost (like the copayments, coinsurance, and deductibles that you would pay if the provider or facility was in-network). Your health plan will pay out-of-network providers and facilities directly.

- Your health plan generally must:

    - Cover emergency services without requiring you to get approval for services in advance (prior authorization).

    - Cover emergency services by out-of-network providers.

    - Base what you owe the provider or facility (cost-sharing) on what it would pay an in-network provider or facility and show that amount in your explanation of benefits.

    - Count any amount you pay for emergency services or out-of-network services toward your deductible and out-of-pocket limit.

If you believe you've been wrongly billed, you may contact the federal No Surprises Help Desk at 1-800-985-3059.

Visit www.cms.gov/nosurprises/consumers for more information about your rights under federal law.

Premium Assistance Under Medicaid and the Children's Health Insurance Program (CHIP)

If you or your children are eligible for Medicaid or CHIP and you're eligible for health coverage from your employer, your state may have a premium assistance program that can help pay for coverage, using funds from their Medicaid or CHIP programs. If you or your children aren't eligible for Medicaid or CHIP, you won't be eligible for these premium assistance programs but you may be able to buy individual insurance coverage through the Health Insurance Marketplace. For more information, visit **www.healthcare.gov**.

If you or your dependents are already enrolled in Medicaid or CHIP and you live in a State listed below, contact your State Medicaid or CHIP office to find out if premium assistance is available.

If you or your dependents are NOT currently enrolled in Medicaid or CHIP, and you think you or any of your dependents might be eligible for either of these programs, contact your State Medicaid or CHIP office or dial **1-877-KIDS NOW** or **www.insurekidsnow.gov** to find out how to apply. If you qualify, ask your state if it has a program that might help you pay the premiums for an employer-sponsored plan.

If you or your dependents are eligible for premium assistance under Medicaid or CHIP, as well as eligible under your employer plan, your employer must allow you to enroll in your employer plan if you aren't already enrolled. This is called a "special enrollment" opportunity, and **you must request coverage within 60 days of being determined eligible for premium assistance**. If you have questions about enrolling in your employer plan, contact the Department of Labor at **www.askebsa.dol.gov** or call **1-866-444-EBSA (3272)**.

If you live in one of the following states, you may be eligible for assistance paying your employer health plan premiums. The following list of states is current as of July 31, 2022. Contact your State for more information on eligibility –

ALABAMA-Medicaid	CALIFORNIA-Medicaid
Website: http://myalhipp.com/ Phone: 1-855-692-5447	Website: Health Insurance Premium Payment (HIPP) Program http://dhcs.ca.gov/hipp Phone: 916-445-8322 Fax: 916-440-5676 Email: hipp@dhcs.ca.gov
ALASKA-Medicaid	**COLORADO-Health First Colorado (Colorado's Medicaid Program) & Child Health Plan Plus (CHP+)**
The AK Health Insurance Premium Payment Program Website: http://myakhipp.com/ Phone: 1-866-251-4861 Email: CustomerService@MyAKHIPP.com Medicaid Eligibility: https://health.alaska.gov/dpa/Pages/default.aspx	Health First Colorado Website: https://www.healthfirstcolorado.com/ Health First Colorado Member Contact Center: 1-800-221-3943/ State Relay 711 CHP+: https://www.colorado.gov/pacific/hcpf/child-health-plan-plus CHP+ Customer Service: 1-800-359-1991/ State Relay 711 Health Insurance Buy-In Program (HIBI): https://www.colorado.gov/pacific/hcpf/health-insurance-buy-program HIBI Customer Service: 1-855-692-6442
ARKANSAS-Medicaid	**FLORIDA-Medicaid**
Website: http://myarhipp.com/ Phone: 1-855-MyARHIPP (855-692-7447)	Website: https://www.flmedicaidtplrecovery.com/flmedicaidtplrecovery.com/hipp/index.html Phone: 1-877-357-3268

GEORGIA-Medicaid	MASSACHUSETTS-Medicaid and CHIP
GA HIPP Website: https://medicaid.georgia.gov/health-insurance-premium-payment-program-hipp Phone: 678-564-1162, Press 1 GA CHIPRA Website: https://medicaid.georgia.gov/programs/third-party-liability/childrens-health-insurance-program- reauthorization-act-2009-chipra Phone: (678) 564-1162, Press 2	Website: https://www.mass.gov/masshealth/pa Phone: 1-800-862-4840 TTY: (617) 886-8102
INDIANA-Medicaid	**MINNESOTA-Medicaid**
Healthy Indiana Plan for low-income adults 19-64 Website: http://www.in.gov/fssa/hip/ Phone: 1-877-438-4479 All other Medicaid Website: https://www.in.gov/medicaid/ Phone 1-800-457-4584	Website: https://mn.gov/dhs/people-we-serve/children-and-families/health-care/health-care-programs/programs-and-services/other-insurance.jsp Phone: 1-800-657-3739
IOWA-Medicaid and CHIP (Hawki)	**MISSOURI-Medicaid**
Medicaid Website: https://dhs.iowa.gov/ime/members Medicaid Phone: 1-800-338-8366 Hawki Website: http://dhs.iowa.gov/Hawki Hawki Phone: 1-800-257-8563 HIPP Website: https://dhs.iowa.gov/ime/members/medicaid-a-to-z/hipp HIPP Phone: 1-888-346-9562	Website: http://www.dss.mo.gov/mhd/participants/pages/hipp.htm Phone: 573-751-2005
KANSAS-Medicaid	**MONTANA-Medicaid**
Website: https://www.kancare.ks.gov/ Phone: 1-800-792-4884	Website: http://dphhs.mt.gov/MontanaHealthcarePrograms/HIPP Phone: 1-800-694-3084 Email: HHSHIPPProgram@mt.gov
KENTUCKY-Medicaid	**NEBRASKA-Medicaid**
Kentucky Integrated Health Insurance Premium Payment Program (KI-HIPP) Website: https://chfs.ky.gov/agencies/dms/member/Pages/kihipp.aspx Phone: 1-855-459-6328 Email: KIHIPP.PROGRAM@ky.gov KCHIP Website: https://kidshealth.ky.gov/Pages/ index.aspx Phone: 1-877-524-4718 Kentucky Medicaid Website: https://chfs.ky.gov	Website: http://www.ACCESSNebraska.ne.gov Phone: 1-855-632-7633 Lincoln: 402-473-7000 Omaha: 402-595-1178
LOUISIANA-Medicaid	**NEVADA-Medicaid**
Website: www.medicaid.la.gov or www.ldh.la.gov/lahipp Phone: 1-888-342-6207 (Medicaid hotline) or 1-855-618-5488 (LaHIPP)	Medicaid Website: http://dhcfp.nv.gov Medicaid Phone: 1-800-992-0900

MAINE-Medicaid	NEW HAMPSHIRE-Medicaid
Enrollment Website: https://www.maine.gov/dhhs/ofi/applications-forms Phone: 1-800-442-6003 TTY: Maine relay 711 Private Health Insurance Premium Webpage: https://www.maine.gov/dhhs/ofi/applications-forms Phone: -800-977-6740. TTY: Maine relay 711	Website: https://www.dhhs.nh.gov/programs-services/medicaid/health-insurance-premium-program Phone: 603-271-5218 Toll free number for the HIPP program: 1-800-852-3345, ext 5218
NEW JERSEY-Medicaid and CHIP	**SOUTH DAKOTA-Medicaid**
Medicaid Website: http://www.state.nj.us/humanservices/dmahs/clients/medicaid/ Medicaid Phone: 609-631-2392 CHIP Website: http://www.njfamilycare.org/index.html CHIP Phone: 1-800-701-0710	Website: http://dss.sd.gov Phone: 1-888-828-0059
NEW YORK-Medicaid	**TEXAS-Medicaid**
Website: https://www.health.ny.gov/health_care/medicaid/ Phone: 1-800-541-2831	Website: http://gethipptexas.com/ Phone: 1-800-440-0493
NORTH CAROLINA-Medicaid	**UTAH-Medicaid and CHIP**
Website: https://medicaid.ncdhhs.gov/ Phone: 919-855-4100	Medicaid Website: https://medicaid.utah.gov/ CHIP Website: http://health.utah.gov/chip Phone: 1-877-543-7669
NORTH DAKOTA-Medicaid	**VERMONT-Medicaid**
Website: http://www.nd.gov/dhs/services/medicalserv/medicaid/ Phone: 1-844-854-4825	Website: http://www.greenmountaincare.org/ Phone: 1-800-250-8427
OKLAHOMA-Medicaid and CHIP	**VIRGINIA-Medicaid and CHIP**
Website: http://www.insureoklahoma.org Phone: 1-888-365-3742	Website: https://www.coverva.org/en/famis-select https://www.coverva.org/en/hipp Medicaid Phone: 1-800-432-5924 CHIP Phone: 1-800-432-5924
OREGON-Medicaid	**WASHINGTON-Medicaid**
Website: http://healthcare.oregon.gov/Pages/index.aspx http://www.oregonhealthcare.gov/index-es.html Phone: 1-800-699-9075	Website: https://www.hca.wa.gov/ Phone: 1-800-562-3022
PENNSYLVANIA-Medicaid	**WEST VIRGINIA-Medicaid and CHIP**
Website: https://www.dhs.pa.gov/Services/Assistance/Pages/HIPP-Program.aspx Phone: 1-800-692-7462	Website: https://dhhr.wv.gov/bms/ http://mywvhipp.com/ Medicaid Phone: 304-558-1700 CHIP Toll-free phone: 1-855-MyWVHIPP (1-855-699-8447)
RHODE ISLAND-Medicaid and CHIP	**WISCONSIN-Medicaid and CHIP**
Website: http://www.eohhs.ri.gov/ Phone: 1-855-697-4347, or 401-462-0311 (Direct RIte Share Line)	Website: https://www.dhs.wisconsin.gov/badgercareplus/p-10095.htm Phone: 1-800-362-3002
SOUTH CAROLINA-Medicaid	**WYOMING-Medicaid**
Website: https://www.scdhhs.gov Phone: 1-888-549-0820	Website: https://health.wyo.gov/healthcarefin/medicaid/programs-and- eligibility/ Phone: 1-800-251-1269

To see if any other states have added a premium assistance program since July 31, 2022, or for more information on special enrollment rights, contact either:

U.S. Department of Labor
Employee Benefits Security Administration
www.dol.gov/agencies/ebsa
1-866-444-EBSA (3272)

U.S. Department of Health and Human Services
Centers for Medicare & Medicaid Services
www.cms.hhs.gov
1-877-267-2323, Menu Option 4, Ext. 61565

EPISCOPAL CHURCH MEDICAL TRUST

HIPAA Notice of Special Enrollment Rights

This notice informs you of your right to enroll in a group health plan sponsored by The Episcopal Church Medical Trust (a "Medical Trust Plan") under the special enrollment provisions of the Health Insurance Portability and Accountability Act (HIPAA).

If you are declining enrollment for yourself or your dependents (including your spouse) because of other health insurance or group health plan coverage, you may be able to enroll yourself and your dependents in a Medical Trust Plan if you or your dependents lose eligibility for that other coverage (or if the employer stops contributing toward your or your dependents' other coverage). However, you must request enrollment within 30* days after your or your dependents' other coverage ends (or after the employer stops contributing toward the other coverage).

In addition, if you have a new dependent as a result of marriage, birth, adoption, or placement for adoption, you may be able to enroll yourself and your dependents. However, you must request enrollment within 30* days after the marriage, birth, adoption, or placement for adoption.

Also, if you or any of your dependents loses eligibility for coverage under Medicaid or the Children's Health Insurance Plan (CHIP) or if you or any of your dependents becomes eligible for premium assistance under Medicaid or CHIP, you may be able to enroll yourself and your dependents in a Medical Trust Plan. However, you must request enrollment within 60* days after this change.

To request special enrollment or obtain more information, contact The Episcopal Church Medical Trust at the following address and phone number:

The Episcopal Church Medical Trust
19 East 34th Street
New York, NY 10016
(800) 480-9967

You may also review the applicable Medical Trust Plan Document Handbook available at *www.cpg.org/mtdocs*.

*Note: These deadlines have been temporarily extended as a result of the COVID-19 pandemic. Guidance was issued on April 28, 2020, directing plan sponsors to disregard the "Outbreak Period" when calculating these deadlines. The Outbreak Period is the period from March 1, 2020 until sixty (60) days after the announced end of the COVID-19 National Emergency (or other date announced through future guidance). If there are different Outbreak Periods in different parts of the country, additional guidance will be issued.

EXAMPLE: For purposes of this example, assume the National Emergency ends on April 30, 2023, and accordingly the Outbreak Period ends on June 29, 2023 (i.e., the 60th day after the end of National Emergency). The Outbreak Period must be disregarded for purposes of determining the special enrollment period described above.

If a plan member gives birth on March 31, 2023, the member has until July 29, 2023 (30 days after June 29, 2023, the end of the Outbreak Period) to enroll herself and her newborn in the group health plan.

EPISCOPAL CHURCH MEDICAL TRUST

Joint Notice of Privacy Practices

This notice describes how medical information about you may be used and disclosed and how you can get access to this information. Please review it carefully.

Introduction

Church Pension Group Services Corporation, doing business as The Episcopal Church Medical Trust (Medical Trust), is the plan sponsor of certain group health plans (each a Plan and together the Plans) that are subject to the Health Insurance Portability and Accountability Act of 1996 and the regulations enacted thereunder (HIPAA).

HIPAA places certain restrictions on the use and disclosure of Protected Health Information (PHI) and requires the Medical Trust to provide this Joint Notice of Privacy Practices (the "Notice") to you. PHI is your individually identifiable health information that is created, received, transmitted or maintained by the Plans or its business associates, regardless of the form of the information. It does not include employment records held by your employer in its role as an employer. This Notice describes how your PHI may be used and disclosed by the Plans and by employees of the Medical Trust that are responsible for internal administration of the Plans.

It also describes your rights regarding the use and disclosure of such PHI and how you can gain access to it.

What This Notice Applies To

This Notice applies only to health benefits offered under the Plans. The health benefits offered under the Plans include, but may not be limited to, medical benefits, prescription drug benefits, dental benefits, the health care flexible spending account, and any health care or medical services offered under the employee assistance program benefit. This Notice does not apply to benefits offered under the Plans that are not health benefits. Some of the Plans provide benefits through the purchase of insurance. If you are enrolled in an insured Plan, you will also receive a separate notice from that Plan, which applies to your rights under that Plan.

Duties and Obligations of the Plans

The privacy of your PHI is protected by HIPAA. The Plans are required by law to:

- Maintain the privacy of your PHI
- Provide you with a notice of the Plans' legal duties and privacy practices with respect to your PHI
- Abide by the terms of the Notice currently in effect

When the Plans May Use and Disclose Your PHI

The following categories describe the ways the Plans are required to use and disclose your PHI without obtaining your written authorization:

Disclosures to You. The Plans will disclose your PHI to you or your personal representative within the legally specified period following a request.

Government Audit. The Plans will make your PHI available to the U.S. Department of Health and Human Services when it requests information relating to the privacy of PHI.

As Required By Law. The Plans will disclose your PHI when required to do so by federal, state or local law. For example, the Plans may disclose your PHI when required by national security laws or public health disclosure laws.

The following categories describe the ways that the Plans *may* use and disclose your PHI **without obtaining your written authorization**:

- **Treatment.** The Plans may disclose your PHI to your providers for treatment, including the provision of care or the management of that care. For example, the Plans might disclose PHI to assist in diagnosing a medical condition or for pre-certification activities.
- **Payment.** The Plans may use and disclose your PHI to pay benefits. For example, the Plans might use or disclose PHI when processing payments, sending explanations of benefits (EOBs) to you, reviewing the medical necessity of services rendered, conducting claims appeals and coordinating the payment of benefits between multiple medical plans.
- **Health Care Operations.** The Plans may use and disclose your PHI for Plan operational purposes. For example, the Plans may use or disclose PHI for quality assessment and claim audits.
- **Public Health Risks.** The Plans may disclose your PHI for certain required public health activities (such as reporting disease outbreaks) or to prevent serious harm to you or other potential victims where abuse, neglect or domestic violence is involved.
- **National Security and Intelligence Activities.** The Plans may disclose your PHI for specialized government functions (such as national security and intelligence activities).
- **Health Oversight Activities.** The Plans may disclose your PHI to health oversight agencies for activities authorized by law (such as audits, inspections, investigations and licensure).
- **Lawsuits and Disputes.** The Plans may disclose your PHI in the course of any judicial or administrative proceeding in response to a court's or administrative tribunal's order, subpoena, discovery request or other lawful process.
- **Law Enforcement.** The Plans may disclose your PHI for a law enforcement purpose to a law enforcement official, if certain legal conditions are met (such as providing limited information to locate a missing person).
- **Research.** The Plans may disclose your PHI for research studies that meet all privacy law requirements (such as research related to the prevention of disease or disability).
- **To Avert a Serious Threat to Health or Safety.** The Plans may disclose your PHI to avert a serious threat to the health or safety of you or any other person.
- **Workers' Compensation.** The Plans may disclose your PHI to the extent necessary to comply with laws and regulations related to workers' compensation or similar programs.
- **Coroners, Medical Examiners and Funeral Directors.** The Plans may disclose your PHI to coroners, medical examiners or funeral directors for purposes of identifying a decedent, determining a cause of death or carrying out their respective duties with respect to a decedent.
- **Organ and Tissue Donation.** If you are an organ donor, the Plans may release your PHI to organizations that handle organ procurement or organ, eye or tissue transplantation or to an organ donation bank, as necessary to facilitate organ or tissue donation and transplantation.
- **Military and Veterans.** If you are a member of the armed forces, the Plans may release your PHI as required by military command authorities.
- **Inmates.** If you are an inmate of a correctional institution or under the custody of a law enforcement official, the Plans may release your PHI to the correctional institution or law enforcement official. This release would be necessary (1) for the institution to provide you with health care; (2) to protect your health and safety or the health and safety of others; or (3) for the safety and security of the correctional institution.
- **Business Associates.** The Plans may contract with other businesses for certain plan administrative services. The Plans may release your PHI to one or more of their business associates for plan administration if the business associate agrees in writing to protect the privacy of your information.

- **Plan Sponsor.** ECMT, as sponsor of the Plans, will have access to your PHI for plan administration purposes. Unless you authorize the Plans otherwise in writing (or your individual identifying data is deleted from the information), your PHI will be available only to the individuals who need this information to conduct these plan administration activities, but this release of your PHI will be limited to the minimum disclosure required, unless otherwise permitted or required by law.

The following categories describe the ways that the Plans *may* use and disclose your PHI **upon obtaining your written authorization**:

- Most uses and disclosures of psychotherapy notes;
- Uses and disclosures of PHI for marketing purposes; and
- Uses and disclosures that constitute a sale of PHI.

Any other use or disclosure of your PHI not identified in this section will be made only with your written authorization.

Authorizing Release of Your PHI

To authorize release of your PHI, you must complete a medical information authorization form. An authorization form is available at ***www.cpg.org*** or by calling (800) 480-9967. You have the right to limit the type of information that you authorize the Plans to disclose and the persons to whom it should be disclosed.

You may revoke your written authorization at any time. The revocation will be followed to the extent action on the authorization has not yet been taken.

Interaction with State Privacy Laws

If the state in which you reside provides more stringent privacy protections than HIPAA, the more stringent state law will still apply to protect your rights. If you have a question about your rights under any particular federal or state law, please contact the Church Pension Group Privacy Officer. Contact information is included at the end of this Notice.

Fundraising

The Plans may contact you to support their fundraising activities. You have the right to opt out of receiving such communications.

Underwriting

The Plans are prohibited from using or disclosing PHI that is genetic information for underwriting purposes.

Your Rights With Respect to Your PHI

You have the following rights regarding PHI the Plans maintain about you:

Right to Request Restrictions. You have the right to request that the Plans restrict their uses and disclosures of your PHI. You will be required to provide specific information as to the disclosures that you wish to restrict and the reasons for your request. The Plans are not required to agree to a requested restriction, but may in certain circumstances. To request a restriction, please write to the Church Pension Group Privacy Officer and provide specific information as to the disclosures that you wish to restrict and the reasons for your request.

Right to Request Confidential Communications. You have the right to request that the Plans' confidential communications of your PHI be sent to another location or by alternative means. For example, you may ask that all EOBs be sent to your office rather than your home address. The Plans are not required to accommodate your request unless your request is reasonable and you state that the ordinary communication process could endanger you. To request confidential communications, please submit a written request to the Church Pension Group Privacy Officer.

Right to Inspect and Copy. You have the right to inspect and obtain a copy of the PHI held by the Plans. However, access to psychotherapy notes, information compiled in reasonable anticipation of or for use in legal proceedings, and under certain other, relatively unusual circumstances, may be denied. Your request should be

made in writing to the Church Pension Group Privacy Officer. A reasonable fee may be imposed for copying and mailing the requested information. You may contact the Medical Trust Plan Administration at *jservais@cpg.org* for a full explanation of ECMT's fee structure.

Right to Amend. You have the right to request that the Plans amend your PHI or record if you believe the information is incorrect or incomplete. To request an amendment, you must submit a written request to the Medical Trust Plan Administration at *jservais@cpg.org.* Your request must list the specific PHI you want amended and explain why it is incorrect or incomplete and be signed by you or your authorized representative. All amendment requests will be considered carefully. However, your request may be denied if the PHI or record that is subject to the request:

- Is not part of the medical information kept by or for the Plans;
- Was not created by or on behalf of the Plans or its third party administrators, unless the person or entity that created the information is no longer available to make the amendment;
- Is not part of the information that you are permitted to inspect and copy; or
- Is accurate and complete.

Right to an Accounting of Disclosures. You have the right to receive information about when your PHI has been disclosed to others. Certain exceptions apply to this rule. For example, a Plan does not need to account for disclosures made to you or with your written authorization, or for disclosures that occurred more than six years before your request. To request an accounting of disclosures, you must submit your request in writing to the Medical Trust-Plan Administration at *jservais@cpg.org* and indicate in what form you want the accounting (*e.g.,* paper or electronic). Your request must state a time period of no longer than six years and may not include dates before your coverage became effective. The Medical Trust Plan Administrator will then notify you of any additional information required for the accounting request. A Plan will provide you with the date on which a disclosure was made, the name of the person or entity to whom PHI was disclosed, a description of the PHI that was disclosed, the reason for the disclosure and certain other information. If you request this accounting more than once in a 12-month period, you may be charged a reasonable, cost-based fee for responding to these additional requests. You may contact Medical Trust Plan Administration at *jservais@cpg.org* for a full explanation of the Medical Trust's fee structure.

Breach Notification. You have the right to receive a notification from the Plans if there is a breach of your unsecured PHI.

Right to a Paper Copy of This Notice. You are entitled to get a paper copy of this Notice at any time, even if you have agreed to receive it electronically. To obtain a paper copy of this Notice, please contact the Church Pension Group Privacy Officer.

If You Are a Person in the European Union, the Following Provisions Will Also Be Applicable to You:
For the purposes of the General Data Protection Regulation 2016/679 (the "GDPR"), the Data Controller is Church Pension Group Services Corporation registered in the State of Delaware in the United States with a registered address at 19 East 34th Street, New York, NY 10016.

You can request further information from our Privacy Officer at *Privacy@cpg.org*.

In addition to your rights with respect to your PHI addressed above, you may have additional or overlapping rights under the GDPR. GDPR rights regarding your PHI include the following:

- You may access and export a copy of PHI;
- You may request deletion of, and update to PHI;
- You have the right to be informed about any automated decision-making of PHI including the significance and consequences of such processing for you;
- You may also object to or restrict the Plans' use of PHI. For example, you can object at any time to

the Plans' use of PHI for direct marketing purposes.
- Where you believe that the Plans have not complied with its obligations under this Privacy Policy or the applicable law, you have the right to make a complaint to an EU Data Protection Authority;
- If the Plans' obtained your consent to use your PHI, you may withdraw that consent at any time.

Data Retention

We only retain PHI collected for a limited time period as long as we need it to fulfill the purposes for which have initially collected it, unless otherwise required by law.

Data Transfers

We maintain servers in United States and Canada and your information may be processed on servers located in the United States and Canada. Data protection laws vary among countries, with some providing more protection than others. Regardless of where your information is processed, we apply the same protections described in this policy.

If You Believe Your Privacy Rights Have Been Violated

If you believe your privacy rights have been violated by any Plan, you may file a complaint with the Church Pension Group Privacy Officer and with the Secretary of the U.S. Department of Health and Human Services. All complaints must be filed in writing. You will not be retaliated against for filing a complaint.

To contact the Church Pension Group Privacy Officer:

Privacy Officer
The Church Pension Group
19 East 34th Street
New York, NY 10016
(212) 592-8365
privacy@cpg.org

To contact the Secretary of the U.S. Department of Health and Human Services:
U.S. Department of Health and Human Services

Office of Civil Rights
200 Independence Avenue, SW
Washington, DC 20201
(202) 619-0257 | (877) 696-6775 (toll-free)
www.hhs.gov/contactus.html

Effective Date

This Notice is effective as of August 29, 2018.

Changes

Each Plan sponsored by the Medical Trust reserves the right to change the terms of this Notice and information practices and to make the new provisions effective for all PHI it maintains, including any PHI it currently maintains as well as PHI it receives or holds in the future, as permitted by applicable law. Any material amendment to the terms of this Notice and these information practices will be provided to you via mail or electronically with your prior written consent.

EPISCOPAL CHURCH MEDICAL TRUST

Notice of Nondiscrimination

Church Pension Group Services Corporation ("CPGSC") complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. CPGSC does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex. CPGSC:

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

If you need these services, contact Alicia McKinney, Civil Rights Coordinator.

If you believe that CPGSC has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can obtain a copy of the grievance procedures or file a grievance with: Alicia McKinney, Civil Rights Coordinator, Church Pension Group, 19 East 34th Street, New York, NY 10016, Phone: 212-592-6307, Fax: 212-592-9487, Email: amckinney@cpg.org. You can file a grievance by mail, fax, or email. If you need help filing a grievance, Alicia McKinney, Civil Rights Coordinator, is available to help you.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

EPISCOPAL CHURCH MEDICAL TRUST

Women's Health and Cancer Rights Act (WHCRA) Notice

If you have had or are going to have a mastectomy, you may be entitled to certain benefits under the Women's Health and Cancer Rights Acts of 1998 (WHCRA). For individuals receiving mastectomy-related benefits, coverage will be provided in a manner determined in consultation with the attending physician and the patient, for:

- All stages of reconstruction of the breast on which the mastectomy was performed;
- Surgery and reconstruction of the other breast to produce a symmetrical appearance;
- Prosthetics; and
- Treatment of physical complications of the mastectomy, including lymphedema.

These benefits will be provided subject to the same deductible and coinsurance applicable to other medical and surgical benefits provided under this plan.

If you would like more information on WHCRA benefits, call your Plan Administrator or The Episcopal Church Medical Trust at (800) 480-9967.