

The Episcopal Church Medical Trust Enrollment Guide



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

The Medical Trust exclusively serves ecclesiastic societies, dioceses, missionary districts, and other bodies subject to the authority of the church.

Should you need confirmation of your eligibility, please refer to your plan handbook or group administrator for eligibility details.

It's Easy to Enroll in Your 2008 Benefits

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

With annual open enrollment quickly approaching, it's time for you to start thinking about the coverages you would like to enroll in for next year. There are several important steps you should take to make your benefit selections and this guide is provided to assist you:

- **Read this Enrollment Guide carefully**, to understand the Plans the Medical Trust offers and the action steps required for you to enroll for 2008.
- **Access your personalized enrollment form** using the user name and password in your enrollment welcome letter to enroll online.

Please refer to page 19 for more detailed information on how to enroll.

What's Inside

The Episcopal Church Medical Trust ("the Medical Trust") provides this Enrollment Guide to help you make informed decisions about health care for yourself and your family.

In this guide you will find important highlights of:

- Medical Plan options;
- Prescription drug benefits;
- Mental health coverage;
- Vision benefits;
- Dental benefits; and
- Travel assistance services.

Please read through this entire Guide carefully, and share the information with your family. You'll also want to review the Medical Plan Schedules of Benefits available online or from your benefits administrator. The schedules provide more detailed information about the available benefits under each of the medical Plan options for which you're eligible.

Please note that you may not be eligible for all of the Plans described in this Guide as some options discussed may not be available in all locations or to all groups. Please access your online enrollment form for the Plans that are available to you. In addition, regional and local medical Plan options that your group or diocese may offer are not described in this Guide.

Contents

- Your Role in the Value of Your Health Care2
- Medical Plan Options3
 - About the Plans3
 - Understanding the Plan Designs4
 - Coverage Tiers and Costs5
 - Comparing Your Medical Plan Options6
 - Prescription Drug Benefits10
 - Vision Benefits13
 - Mental Health and Substance Abuse Benefits14
 - Health Advocate16
 - Dental Benefits17
 - Travel Assistance Services18
- Taking Action19
 - Have You Thought About19
 - Enrolling Online19
 - If You Do Not Enroll19
- Network Access Directions20
- For More Information Back Cover

Your Role in the Value of Your Health Care

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

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

- **Partner with your doctor.** Finding a doctor you trust and feel comfortable with is the first step toward ensuring good health. But once you've found that person, how can you work together to get the best care? Prepare for your office visits, listen and ask questions, learn all you can about your medical issues, and learn about wellness and preventive care.
- **Understand your treatment options.** Research shows that millions of people receive medical treatments or surgeries that are unnecessary and even harmful to their health. At the same time, many people don't get the treatment or surgery they need. When your doctor makes a recommendation, be sure you voice your questions, concerns, and preferences.
- **Learn more about your condition.** If you use the Internet to find health information, start by searching specialized sites connected with certain diseases. For example, if you're interested researching heart disease, visit the American Heart Association website at www.americanheart.org; asthma and allergies, visit the American Academy of Allergy, Asthma and Immunology website at www.aaaai.org; or cancer, visit the American Cancer Society website at www.cancer.org.
- **Get the most value from your prescription drug benefit.** While many factors that drive prescription drug increases are out of your control, there are steps you can take to save money. For an occasional minor ailment such as joint pain, heartburn, or allergies, ask your doctor if you can try an over-the-counter treatment first. Request generic or preferred drugs when possible. Use a participating retail pharmacy, or better yet, use the mail-order program to reduce your costs even more.
- **Stay well.** If you want to stay healthy and live a longer, healthier life, it is helpful to know your health risks and how to manage them. Get regular checkups, monitor your blood pressure, tell your doctor about all of the medications you're taking, and get the recommended screenings for your age and gender. Also consider exercising regularly and quitting smoking.

By taking care of your health today, you will be preparing for your health later in life and in retirement. By actively taking a role in managing your own health, together we can find the balance between individual and institutional wellness.

Medical Plan Options

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

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

About the Plans

All of the Medical Trust Plans provide care through a network of doctors, dentists, hospitals, pharmacies, laboratories, and other providers who have contracted to offer services at reduced rates. Each Plan works a bit differently.

In the following pages you will learn about how the different types of Plans are designed, how they work, and what you will need to think about in order to make the best decisions regarding your health coverage.

You will also learn that within each type of Plan, you may have options that allow you to determine which way you would like to approach the costs of your coverage.

Comparing Alternate Plan Options

When evaluating the Plan options available to you, it is important to understand the trade-offs that differentiate the Plans. Monthly premiums and out-of-pocket costs (when services are received) have an inverse relationship. For example, certain Plans may have low out-of-pocket costs with high monthly premiums and vice versa. Using in-network providers can benefit you by lowering your out-of-pocket costs. However, you may have instances where you need or prefer to seek care from an out-of-network provider. This freedom to choose (unavailable to HMO and EPO participants) may result in higher out-of-pocket costs than that of an in-network provider.

Understanding the Plan Designs

- **Under a PPO**, you can receive services from any provider, without coordinating your care through a primary care physician (PCP). A PPO gives you the flexibility to visit the providers you choose—inside or outside of the Plan’s network. However, the Plan pays greater benefits if you receive care from an in-network provider or facility. It’s important to note that when you participate in a PPO, you are responsible for ensuring that the services and care you receive are covered by your Plan. If you use an out-of-network provider, you’ll often be responsible for submitting your own claims.
- **Under an EPO**, you agree to use only the Plan’s network of professionals and facilities. It’s important to note that when you participate in an EPO, you are responsible for ensuring that the services and care you receive are covered by your Plan. The EPO works a lot like an HMO—for example, the EPO does not cover the cost of services received from nonparticipating providers, except in emergency situations. However, unlike most local HMOs, the EPO uses a national network. You are not required to select a PCP.
- **Under an HMO**, you agree to use the health care professionals and facilities associated with that HMO. Except in emergencies, HMOs don’t cover the cost of services you receive from doctors or other providers outside of the HMO’s network. With an HMO, there are no deductibles or claim forms. After a copayment for each office visit, most medical expenses are covered at 100%. You must select a PCP to coordinate your care.
- **Under a POS Plan**, you will receive benefits similar to an HMO, but with an out-of-network option. Some POS Plans are open-access, meaning you aren’t required to choose a PCP. If your POS Plan is not open-access, you will need to select a PCP to coordinate your care and help you receive the highest level of benefits. Your PCP provides routine care and oversees all aspects of your medical care, including referring you to specialists and hospitals as needed. Most in-network services are covered after a copayment. You can choose a different PCP for each covered family member and change PCPs at any time.

continued

Pay Now or Pay Later

It might help to think of the Plan options in terms of “pay now” or “pay later.” For example, your monthly premiums are going to be higher for 90/70 designs than 80/60 designs. However, your out-of-pocket costs when receiving services are higher in the 80/60 plans. It is important to think about your personal health care needs. Determine whether it makes sense to pay for more coverage with higher monthly payments or pay less from month to month with the risk of paying more only when you need services.

The Importance of the Network

Another factor to consider when choosing a Plan is access to providers. Often times participation in an exclusive or limited network Plan means that your out-of-pocket costs are lower if you see a doctor in the network but higher if you see a doctor who is not in the network. HMOs and EPOs, for example, will not pay for any non-emergency services that you receive out of the network. When choosing your plan, evaluate the importance of freedom when it comes to choosing your doctor.

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

In order to understand the HDHP/HSA combination, it is important to see how its two components work:

- The **HDHP** works much like a PPO. You can receive services from any provider, and you do not have to coordinate your care through a PCP. While the HDHP covers services in and outside of the network, like the PPO, the HDHP provides very strong financial incentives for you to use network providers. Despite the high deductible requirements, an HDHP provides first-dollar coverage for certain preventive care services.
- The **HSA** is a savings account funded by you and/or your employer with a “tax-favored” status. You can only open an HSA if you are enrolled in a qualified high deductible health plan. When you incur a medical expense, you can pay for it with your HSA funds or you can choose to pay for it out-of-pocket. If you do not use the money in your HSA, the balance continues to grow with tax-free earnings to use for future medical expenses. It is also important to note that the account is portable and can be used for medical expenses in retirement.

Once money is deposited in your HSA account, it’s yours until you spend it. Unused dollars earn interest tax-free with certain restrictions. If you change employers or retire, you can take your HSA with you. Withdrawals from your HSA are tax-free as long as they are used to pay for qualified medical expenses. Therefore, it is important that you maintain records for tax-reporting purposes.

The HDHP/HSA combination allows you to take control of your day-to-day health care costs through a savings/reimbursement account with the protection of a traditional health plan that promotes preventive care.

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

***The HDHP deductible is a combination of the medical and pharmacy deductible requirements. Therefore, to begin receiving benefits from your medical and prescription drug plans, you must meet one combined deductible.*

Coverage Tiers and Costs

If you elect coverage under one of the Plans, the coverage tiers available to you will depend on what is offered by your group or diocese. Coverage tiers range from single coverage for you only to family coverage for you and all of your dependents. Please see your online enrollment form for the specific coverage tiers available to you.

The cost of coverage will vary based on the Plan option you select and the number of dependents you choose to cover. The rates indicated on your online enrollment form may not necessarily be what your employer requires you to pay.

Comparing Your Medical Plan Options

You can use this chart which compares the different types of medical Plan designs to help you decide which type of Plan may work best for you:

Your Plan options will vary depending on which are being offered by your diocese or group. Please refer to your online enrollment form for further information.

Plan Feature	PPO	EPO	HMO	POS	HDHP/HSA
How the Plan Works	A PPO Plan works like an indemnity Plan, the primary difference being that you will pay less out-of-pocket when care is obtained from a network provider.	Comprehensive health care services are available to members for coinsurance or a copayment only when a network provider is used, except in emergency situations.	Comprehensive health care services are available to members for a small copayment only when a network provider is used, except in emergency situations.	A POS Plan works like a PPO Plan—the choice to use a network provider is yours to make. You decide at the “point of service” which physician you would like to visit.	The HDHP/HSA combination protects you like a PPO Plan with a high deductible. The HSA is a “tax-favored” savings account that can be funded to pay for current and future health care services (or other services, subject to tax and penalties). The HSA is portable and the unused savings carry over from year to year.
Using the Plan Network	When you use network providers, you pay a copayment for office visits, and the Plan pays higher benefits after a deductible for other in-network care. The coverage level is lower outside of the network, and you must meet a higher non-network deductible before benefits begin.	The Medical Trust EPO Plans use the same network as our national PPO Plans. However, an EPO generally does not pay benefits for non-emergency services you receive outside of the Plan’s network.	An HMO generally does not pay benefits for services you receive outside of the HMO’s network. Also, you must follow the HMO’s procedures for referrals in order to have your services covered. You also must elect a PCP when you enroll in an HMO.	In an open-access Plan, you do not need to have a PCP coordinate your care. However, some POS plans are not open-access and require a PCP. The coinsurance you pay is higher outside of the network.	For in-network care, a large percentage of your preventive care is covered. You can use your HSA to pay for other qualified services up to the HSA balance available. The coinsurance you pay is higher outside of the network.

Medical Plan Coverage Provisions

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

Plan Type	PPO				
Plan Design	PPO 90/70	PPO 80/60	PPO 75/50	High Option	Choice Plus PPO
Plan Partner(s)	Coventry, Empire BCBS	Coventry, Empire BCBS	Empire BCBS	Empire BCBS	United Healthcare
PCP Selection Required?	No	No	No	No	No
Referral Required for Specialty Care?	No	No	No	No	No
Network Individual/Family Deductible	\$250/\$500	\$350/\$700	\$900/\$1,800	\$100/\$250	\$0/\$0
Network Individual/Family Out-of-Pocket (OOP) Maximum (Excluding Deductibles)	\$1,000/\$2,000	\$1,500/\$3,000	\$2,700/\$5,400	\$0/\$0	\$0/\$0
Network Medical Member Coinsurance	10%	20%	25%	0%	0%
Network Lab & X-Ray Coinsurance/Copayment	20%	20%	25%	\$30	\$25
Routine Physical Copayment	\$25	\$25	\$35 PCP \$45 Specialist	\$30	\$25
Office Visit Copayment (PCP)	\$25	\$25	\$35	\$30	\$25
Office Visit Copayment (Specialist)	\$25	\$25	\$45	\$30	\$25
Non-Network Hospital Benefits Available?	Yes	Yes	Yes	Yes	Yes
Network Inpatient Admission Subject to Annual Deductible?	No	No	No	No	No
Network Inpatient Admission Deductible	\$100/\$600 per day/ maximum	\$100/\$600 per day/ maximum	\$100/\$600 per day/ maximum	\$150 per admission	\$100/\$600 per day/ maximum
Network Inpatient Admission Member Coinsurance After Deductible	10%	20%	25%	0%	0%
Network Outpatient Surgery Copayment/Member Coinsurance	10%	20%	25%	\$150	\$200
Non-Network Individual/Family Deductible	\$500/\$1,000	\$700/\$1,400	\$1,800/\$3,600	\$500/\$1,000	\$500/\$1,500
Non-Network Individual/Family OOP Maximum (Excludes Deductibles)	\$3,000/\$6,000	\$4,500/\$9,000	\$5,400/\$10,800	\$3,000/\$6,000	\$2,100/\$6,300
Non-Network Member Coinsurance	30%	40%	50%	30%	30%
Mental Health Benefit	CIGNA Behavioral Health	CIGNA Behavioral Health	CIGNA Behavioral Health	CIGNA Behavioral Health	CIGNA Behavioral Health

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

Plan Type	EPO			HMO	
Plan Design	EPO 90	EPO 80	Choice EPO	National HMO	Network
Plan Partner(s)	Coventry, BCBS, Aetna Select EPO	Coventry, Empire BCBS	United Healthcare	Aetna	CIGNA
PCP Selection Required?	No	No	No	Yes	Yes
Referral Required for Specialty Care?	No	No	No	Yes	Yes
Network Individual/Family Deductible	\$100/\$250	\$200/\$500	\$0/\$0	\$0/\$0	\$0/\$0
Network Individual/Family Out-of-Pocket (OOP) Maximum (Excluding Deductibles)	\$1,000/\$2,000	\$1,500/\$3,000	\$0/\$0	\$0/\$0	\$0/\$0
Network Medical Member Coinsurance	10%	20%	0%	0%	0%
Network Lab & X-Ray Coinsurance/Copayment	20%	20%	\$20	\$20	\$0
Routine Physical Copayment	\$25	\$25	\$20	\$20	\$20
Office Visit Copayment (PCP)	\$25	\$25	\$20	\$20	\$20
Office Visit Copayment (Specialist)	\$25	\$25	\$20	\$20	\$20
Non-Network Hospital Benefits Available?	No	No	No	No	No
Network Inpatient Admission Subject to Annual Deductible?	Yes	Yes	N/A	N/A	N/A
Network Inpatient Admission Deductible	\$0	\$0	\$100/\$600 per day maximum	\$150/\$600 per day maximum	\$350 per admission
Network Inpatient Admission Member Coinsurance After Deductible	10%	20%	0%	0%	0%
Network Outpatient Surgery Copayment/Member Coinsurance	10%	20%	\$150	\$250	\$250
Non-Network Individual/Family Deductible	N/A	N/A	N/A	N/A	N/A
Non-Network Individual/Family OOP Maximum (Excludes Deductibles)	N/A	N/A	N/A	N/A	N/A
Non-Network Member Coinsurance	N/A	N/A	N/A	N/A	N/A
Mental Health Benefit	CIGNA Behavioral Health	CIGNA Behavioral Health	CIGNA Behavioral Health	Aetna Medical Plan	CIGNA Behavioral Health

Plan Type	POS			HDHP/HSA
	QPOS	Choice POS II	Open Access Plus	HDHP/HSA
Plan Partner(s)	Aetna	Aetna	CIGNA	Empire BCBS II CIGNA
PCP Selection Required?	Yes	No	No	No
Referral Required for Specialty Care?	Yes	No	No	No
Network Individual/ Family Deductible	\$0/\$0	\$250/\$500	\$0/\$0	\$2,700/\$5,450 (medical and prescription drugs)
Network Individual/ Family Out-of-Pocket (OOP) Maximum (Excluding Deductibles)	\$0/\$0	\$1,000/\$2,000	\$0/\$0	\$1,500/\$3,000 (medical and prescription drugs)
Network Medical Member Coinsurance	0%	10%	0%	20% after deductible
Network Lab & X-Ray Coinsurance/Copayment	\$25	20%	0%	20% after deductible
Routine Physical Copayment	\$25	\$25	\$20	\$0
Office Visit Copayment (PCP)	\$25	\$25	\$20	20% after deductible
Office Visit Copayment (Specialist)	\$25	\$25	\$20	20% after deductible
Non-Network Hospital Benefits Available?	Yes	Yes	Yes	Yes
Network Inpatient Admission Subject to Annual Deductible?	No	No	No	Yes
Network Inpatient Admission Deductible	\$100 per day/\$600 maximum	\$100 per day/\$600 maximum	\$250 per admission	Part of network deductible
Network Inpatient Admission Member Coinsurance After Deductible	0%	10%	0%	20% after deductible
Network Outpatient Surgery Copayment/ Member Coinsurance	\$200	10%	0%	20% after deductible
Non-Network Individual/ Family Deductible	\$500/\$1,500	\$500/\$1,000	\$500/\$1,500	\$3,000/\$6,000
Non-Network Individual/ Family OOP Maximum (Excludes Deductibles)	\$2,100/\$6,300	\$3,000/\$6,000	\$3,500/\$10,500	\$4,000/\$7,000
Non-Network Member Coinsurance	30%	30%	20%	45%
Mental Health Benefit	Aetna Medical Plan	CIGNA Behavioral Health	CIGNA Behavioral Health	Empire BCBS/ CIGNA

Prescription Drug Benefits

When you enroll in one of our medical Plan options, you'll automatically have coverage for prescription drugs through the Medco Prescription Drug Program. This program includes a Formulary Management Program, which uses a "three-tier" copayment approach to covered drugs and is designed to control costs for you and the Plan. The formulary includes all FDA-approved drugs that have been placed in tiers based on their clinical effectiveness, safety, and cost. Tier 1 includes primarily generic drugs (smallest copayment); Tier 2 includes preferred drugs (middle copayment); and Tier 3 includes non-preferred drugs and all non-sedating antihistamines (highest copayment).

For 2008, there are two prescription drug benefit plans: the Standard Plan and the Premium Plan. Additionally, the HDHP/HSA Plan has its own prescription drug plan. [See your personalized open enrollment page for your predetermined* plan option.](#)

Standard

	RETAIL PRESCRIPTION DRUGS	MAIL-ORDER PRESCRIPTION DRUGS
Annual Prescription Deductible	\$50 per individual	N/A
Tier 1: Generic	You pay up to \$10.	You pay up to \$25.
Tier 2: Formulary Brand-Name	You pay up to \$30.	You pay up to \$70.
Tier 3: Non-Formulary Brand-Name and Brand Non-Sedating Antihistamines	You pay up to \$50.	You pay up to \$120.
Dispensing Limits Per Copayment	Up to a 30-day supply.	Up to a 90-day supply
Prescription Smoking Cessation Drugs Annual Maximum	1 cycle of therapy per individual.	

Premium

	RETAIL PRESCRIPTION DRUGS	MAIL-ORDER PRESCRIPTION DRUGS
Annual Prescription Deductible	\$50 individual	N/A
Tier 1: Generic	You pay up to \$5.	You pay up to \$12.
Tier 2: Formulary Brand-Name	You pay up to \$20.	You pay up to \$50.
Tier 3: Non-Formulary Brand-Name and Brand Non-Sedating Antihistamines	You pay up to \$35.	You pay up to \$80.
Dispensing Limits Per Copayment	Up to a 30-day supply.	Up to a 90-day supply
Prescription Smoking Cessation Drugs Annual Maximum	1 cycle of therapy per individual.	

The HDHP/HSA Plans

RETAIL AND MAIL-ORDER PRESCRIPTION DRUGS	
Network Prescription Deductible (combined with Medical Deductible)	\$2,700/\$5,450 (BCBS II and CIGNA)
Tier 1: Generic Drugs	15% after deductible
Tier 2: Brand-Name Drugs Included on the Medco Formulary	25% after deductible
Tier 3: Brand-Name Drugs Not Included on the Medco Formulary and All Non-Sedating Antihistamines	50% after deductible

*By your diocese or group.

Coverage of Non-Sedating Antihistamines

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

Prescription Deductible

The Prescription Drug Program has a *separate* annual deductible of \$50 per individual for retail prescriptions. (Please note, this does not apply to the HSA/High Deductible Health Plan.) **This annual Prescription Drug Program retail deductible does not apply to mail-order prescriptions, so you can begin receiving full mail-order program benefits without first meeting the annual retail deductible.** You may want to keep this in mind if you or a covered dependent will be receiving any maintenance medications during the coming calendar year.

Retail Refill Limit

To help manage overall program costs and limit dramatic increases to prescription drug copayments, the Prescription Drug Program will maintain a retail refill limit. The Retail Refill Limit requires that you participate in the mail-order program if you are prescribed a maintenance medication, rather than refilling multiple prescriptions for the same drug at a retail pharmacy.

Keep in mind, the retail pharmacy program allows for a total of three fills of a maintenance medication at a retail pharmacy (one original fill and two refills). Additional fills will not be covered by the program. Each fill can be for no more than a 30-day supply. Note that you are allowed a total of three fills, even if each is for less than 30 days.

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

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

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

Generic Medications

Generic medications and their brand-name counterparts have the same active ingredients and are manufactured according to the same strict federal regulations.

Generic drugs may differ in color, size, or shape, but the U.S. Food and Drug Administration (FDA) requires that the active ingredients have the same strength, purity, and quality as their brand-name counterparts.

For this reason, the Plans will cover the cost of the generic equivalent if you purchase a brand-name medication when there is a generic available. You will be charged the generic copayment and the cost difference between the brand-name and the generic medication.

If you have questions or concerns about generic medication, speak to your physician or your pharmacist, and he or she will be able to help you.

Your Plan May Have Coverage Limits

Your Plan may have certain coverage limits. For example, prescription drugs used for cosmetic purposes may not be covered, or a medication might be limited to a certain amount (such as the number of pills or total dosage) within a specific time period.

If you submit a prescription for a drug that has coverage limits, your pharmacist will tell you that approval is needed before the prescription can be filled. The pharmacist will give you or your doctor a toll-free number to call. If you use *Medco By Mail*, your doctor will be contacted directly.

When a coverage limit is triggered, more information is needed to determine whether your use of the medication meets your Plan's coverage conditions. We will notify you and your doctor of the decision in writing. If coverage is approved, the letter will indicate the amount of time for which coverage is valid. If coverage is denied, an explanation will be provided, along with instructions on how to submit an appeal.

Additional Information

It is always up to you and your doctor to decide which prescriptions are best for you. You are never required to use generic drugs or drugs that are on the Medco formulary list. If you prefer, you can use non-formulary brand-name drugs and pay a higher copayment.

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

Paper Claims Reimbursement

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

Vision Benefits

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

The chart below is for descriptive purposes only. For more complete information regarding your vision coverage, please refer to the official Plan Document Handbook.

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

Benefit Description	Network	Out-of-Network
Eye Examinations	You pay \$10	Plan pays up to \$30 for ophthalmologists or optometrists
Lenses*	You pay \$10 for single, bifocal or trifocal	Plan pays up to: \$32—single vision \$46—bifocal \$57—trifocal
Lens Options UV Coating Tint (Solid and Gradient) Standard Scratch Resistance Standard Polycarbonate Standard Anti-Reflective Coating Standard Progressive (Add-On to Bifocal) Other Add-Ons and Services	You pay up to \$15 You pay up to \$15 You pay up to \$15 You pay \$0 You pay up to \$45 You pay up to \$65 20% off retail price	You are responsible for the cost of any lens options that you elect from out-of-network providers
Frames*	\$130 allowance, 20% off balance over \$130	Plan pays up to \$47
Contact Lenses*		
Conventional	\$130 allowance, 15% off balance over \$130	Plan pays up to \$100
Disposable	\$130 allowance, then you pay balance over \$130	Plan pays up to \$100

** You are eligible to receive lenses and frames or contact lenses once every 12 months.*

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

Please keep in mind that many HMO and POS Plans may offer limited vision coverage through their networks. Check with your Plan for details.

For More Information

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

Mental Health Benefits

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

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

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

*except members enrolled in the HDHP/HSA plans, the Aetna HMO, and the Aetna QPOS Plans.

Employee Assistance Program (EAP)

The Employee Assistance Program (EAP), which is managed by CIGNA Behavioral Health, is available to all members enrolled in any active medical plan* and covers a vast array of family and personal services. The program is designed to assist our members with information, educational materials, resources, referrals, and ongoing support.

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

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

**Does not apply to fully-insured plans.*

The following schedule summarizes Mental Health/Substance Abuse Benefits for all members enrolled in Medical Trust Medical Plans except the HDHP/HSA Plans and Aetna HMO or QPOS Plans.

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

CIGNA Behavioral Health Member Services toll-free number: (800) 926-2273

CIGNA Behavioral Health Website: www.CIGNABehavioral.com

The following schedule summarizes Mental Health/Substance Abuse Benefits for members enrolled in the following Plans: Empire BCBS HDHP/HSA and CIGNA HDHP/HSA, where mental health/substance abuse benefits are administered by the medical plan.

COVERED SERVICE	COPAYMENT/COINSURANCE	ADDITIONAL LIMITATIONS AND EXPLANATIONS
Outpatient Visits	Network 20% after in-network deductible	Limited to 50 visits per calendar year. Authorization is not required.
	Non-Network 45% after out-of-network deductible	
Inpatient	Network 20% after in-network deductible	Authorization is required.
	Non-Network 45% after out-of-network deductible	

Empire BCBS: (800) 352-3152
CIGNA: (800) 244-6224

The following schedule summarizes Mental Health/Substance Abuse Benefits for members enrolled in the Aetna HMO.

COVERED SERVICE	COPAYMENT/COINSURANCE	ADDITIONAL LIMITATIONS AND EXPLANATIONS
Outpatient Visits	Network \$25 per visit	Aetna may require precertification after a certain number of visits. Call the number on the back of your Aetna ID card for more information. Out-of-network services are provided through the Medical Trust's Mental Health/Substance Abuse Supplement. All sessions must be preauthorized. Contact the Episcopal Church Medical Trust Mental Health Line before beginning treatment with a non-network provider.
	Non-Network 30%	
Inpatient	Network \$150 per day (\$600 maximum per admission)	You must contact Aetna prior to any inpatient hospitalization or other inpatient services for authorization. There is no out-of-network benefit for inpatient services.

Aetna Behavioral Health: (800) 755-2422
Episcopal Church Medical Trust Mental Health Line: (800) 806-0478

The following schedule summarizes Mental Health/Substance Abuse Benefits for members enrolled in the Aetna QPOS.

COVERED SERVICE	YOUR COPAYMENT AMOUNT	ADDITIONAL LIMITATIONS AND EXPLANATIONS
Outpatient Visits	Network \$25 per visit	Aetna may require precertification after a certain number of visits. Call the number on the back of your Aetna ID card for more information. For out-of-network services, all sessions must be preauthorized. Contact Aetna before beginning treatment with a non-network provider.
	Non-Network 30%	
Inpatient	Network \$100 per day (\$600 maximum per admission)	You must contact Aetna prior to any inpatient hospitalization or other inpatient services for authorization.
	Non-Network 30%	

Aetna Behavioral Health: (800) 755-2422

Health Advocate

Health Advocate is a program that helps members navigate and facilitate medical and administrative issues in the health care system.

Eligible employees and their spouses and dependent children are covered by this service. Additionally, the parents and parents-in-law of the employee are also eligible to use Health Advocate if the need should arise.

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

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

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

Dental Benefits

The dental Plans available to you are administered by CIGNA. You may choose from the three dental Plans described below during open enrollment. Please refer to the chart to compare the coverage levels available in each Plan.

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

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

Dental Plan Comparison Chart*

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

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

Travel Assistance Services

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

MEDEX Assistance Corporation provides a comprehensive emergency medical assistance program 24 hours a day, 7 days a week. Their highly trained, multi-lingual coordinators work with an extensive information and communication system to provide you with assistance you may need while traveling. With MEDEX's assistance, you will have access to worldwide medical and dental referrals, replacement of prescription medication and corrective lenses, and various other travel-related medical services.

This service is provided to you alongside your medical benefits. You do not need to enroll, and there is no additional premium charge for this service. ***Please note, MEDEX is not responsible for your medical costs while you are traveling.*** If costs are incurred, and depending upon where you travel, you may be required to pay for your health care services. If the services are covered under your medical Plan, you can submit them as medical Plan claims for reimbursement. Your Medical Plan Handbook and Schedule of Benefits will determine what's covered by your Plan and how to submit a claim.

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

Additional Information

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

Taking Action

Have You Thought About...

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

- **Choice of providers.** Do you like to see any doctor you choose, or are you comfortable using a defined network of doctors in exchange for increased benefits? Are there enough of the kinds of doctors you want to see in the network?
- **Coverage under another plan.** Are you or your family members covered under another medical plan? If so, what are the plan benefits, and how much do they cost? What are the coordination of benefits provisions? Which plan is the primary plan?
- **Covered benefits.** What benefits are limited or not covered? Is there a good match between what is provided and what you think you will need? For example, if you have a chronic disease, is there a special program for that illness? Will the Plan provide the medicines and equipment you may need? Find out what types of care or procedures the Plan won't pay for.
- **Provider availability.** Where will you go for care? Are these places near where you work or live? How does the Plan handle care when you are away from home?
- **Costs.** To get a true idea of what your costs will be under each Plan, look at how much you will pay for your premium and other costs. Are there deductibles you must pay before the Plan begins to help cover your costs? After you have met your deductible, how much of the costs will the Plan pay? Does this amount vary by the type of service, doctor, or health facility used? Are there copayments you must pay for certain services, such as doctor visits? If you use doctors outside a Plan's network, how much more will you pay to get care? If a Plan does not cover certain services or care that you think you will need, how much will you have to pay?

Enrolling Online

Now that you have read about your benefit options, you are ready to enroll online.

- Use the instructions and personal user name and password you received in the mail. When you enroll, you'll want to include your plan and coverage tier selections, as well as your dependent information.

NOTE: Only those plans listed on your online form are available to you.

- YOU CAN PRINT THE PLAN CONFIRMATION STATEMENT FOR YOUR RECORDS AFTER YOU MAKE YOUR COVERAGE SELECTIONS.

If You Do Not Enroll

Only you know which benefit decisions are right for you. If you do not enroll by the deadline and your current Plan is not offered in 2008, your medical benefits may be terminated. If your current Plan is still available for 2008, you will continue in the same Plan with the same coverage tier.

Network Access Directions

Plans administered by Aetna

1. Go to: <http://www.aetna.com/docfind>
2. Click on "I Accept"
3. Follow the steps on the website
4. For step 3, Select a Plan, use the following grid to check network access for a specific plan:

For Plan.....	Select a plan Category.....	Select plan
HMO.....	Aetna Standard Plans.....	HMO
QPOS.....	Aetna Standard Plans.....	QPOS
Choice POS II	Aetna Open Access® Plans.....	Aetna Choice® POS II
Select EPO.....	Aetna Open Access® Plans.....	Elect Choice EPO

Plans Administered by CIGNA (Medical and Dental)

1. Go to: <http://www.cigna.com>
2. Click on Provider Directory on the left hand side of the screen
3. Select the type of provider you are looking for (including dental plans)
4. Enter your zip code or city/state and indicate how far you are willing to travel
5. If searching for medical providers:
 - a. Choose Network for HMO (you will have to select a network after this step)
 - b. Choose Open Access Plus Only for HDP/HSA or OAPOr, if searching for dental providers:
 - c. Choose Managed care plan with open access to dentists – CIGNA Dental PPO

Plans administered by Empire BCBS

1. Go to: <http://www.empireblue.com/medicaltrust>
2. Click on: To Enter site, click here
3. Click on: Find a Doctor on left side of page
4. Select the: PPO/EPO Network and continue with the directions on the screen.

Plans administered by Coventry

1. Go to: <http://www.mycoventryhealth.com>
2. Enter LOGIN: ECM01
3. Follow the directions in the Take Control section under Choose a Provider

Plans administered by UnitedHealthcare

1. Go to: http://www.uhc.com/find_physician
2. Select: Find a Physician
3. Enter the city/state/zip information for your search
4. Under Select Plan, choose:
 - a. UnitedHealthcare Choice (which is the EPO) or
 - b. UnitedHealthcare Choice Plus (which is the PPO)

The Plans described in this document (collectively, the "Plans") are sponsored and administered by the Church Pension Group Services Corporation ("CPGSC"), also known as the Episcopal Church Medical Trust (the "Medical Trust"). The Plans that are self-funded are funded by the Episcopal Church Clergy and Employees' Benefit Trust ("ECCEBT"), which is a voluntary employees' beneficiary association within the meaning of section 501(c)(9) of the Internal Revenue Code.

This document contains only a partial, general description of the Plans. It is provided for informational purposes only and should not be viewed as a contract, an offer of coverage, 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 (schedule of benefits, summary Plan description, booklet, booklet-certificate), the official Plan documents will govern. The Church Pension Fund and CPGSC (collectively, "CPG"), retain the right to amend, terminate, or modify the terms of the Plans, as well as any post-retirement health subsidy, at any time, without notice and for any reason.

The Plans are church Plans within the meaning of section 3(33) of the Employee Retirement Income Security Act and section 414(e) of the Internal Revenue Code. Not all Plans are available in all areas of the United States, and not all Plans are available on both a self-funded and fully insured basis. The Plans do not cover all health care expenses, and Plan participants should read the official Plan documents carefully to determine which benefits are covered, as well as any applicable exclusions, limitations, and procedures.

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

CPG does not provide any health care services and therefore cannot guarantee any results or outcomes. Health care providers and vendors are independent contractors in private practice and are neither employees nor agents of CPG. The availability of any particular provider cannot be guaranteed, and provider network composition is subject to change.

If you are a Plan participant, call the number on your ID card for more information about the Plan in which you are enrolled. All other individuals should call (800) 480-9967.

For More Information

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

For Questions About...	You Should Contact...
The Episcopal Church Medical Trust	www.cpg.org (800) 480-9967 (Monday through Friday, 8:30 a.m. — 5:30 p.m. EST)
Coventry	www.MyCoventryHealth.com Access ID: ECM01 (800) 410-7989 (24 hours a day, 7 days a week)
Aetna	www.aetna.com HMO/POS: (877) 380-8584 Choice POSII/Select EPO/Health Fund: (877) 235-4005 (Monday through Friday, 8:00 a.m. — 6:00 p.m. EST)
Empire BlueCross BlueShield	www.empireblue.com (800) 352-3152 (Monday through Friday, 9:00 a.m. — 8:00 p.m. EST)
United Healthcare	www.myuhc.com (866) 204-8533 (Monday through Friday, 8:00 a.m. — 8:00 p.m. EST)
CIGNA (Medical)	www.cigna.com (800) 244-6224 (Monday through Friday, 9:00 a.m. — 5:00 p.m. EST)
Medco Prescription Drug Benefits	www.medco.com (800) 841-3361 (24 hours a day, 7 days a week)
CIGNA Behavioral Health (& EAP)	www.CignaBehavioral.com (800) 926-2273 (24 hours a day, 7 days a week)
Mental Health Supplement	www.cpg.org (800) 806-0478 (Monday through Friday, 8:30 a.m. — 5:00 p.m.)
EyeMed Vision Care	www.enrollwiththeyemed.com/access (866) 723-0596 Monday through Saturday, 8:00 a.m. — 11:00 p.m. Sunday 11:00 a.m. — 8:00 p.m.
CIGNA (Dental)	www.cigna.com (800) 244-6224 Monday through Friday, (9:00 a.m. — 5:00 p.m.)
MEDEX Assistance Corporation	www.medexassist.com (800) 527-0218 (from U.S., Canada, Puerto Rico, Virgin Islands, and Bermuda) (410) 453-6330 (call collect) (24 hours a day, 7 days a week)
Health Advocate	www.HealthAdvocate.com (866) 695-8622 (24 hours a day, 7 days a week)



**THE EPISCOPAL CHURCH
MEDICAL TRUST**

445 Fifth Avenue
New York, NY 10016