CHURCH PENSION GROUP
Passionate About Our Purpose

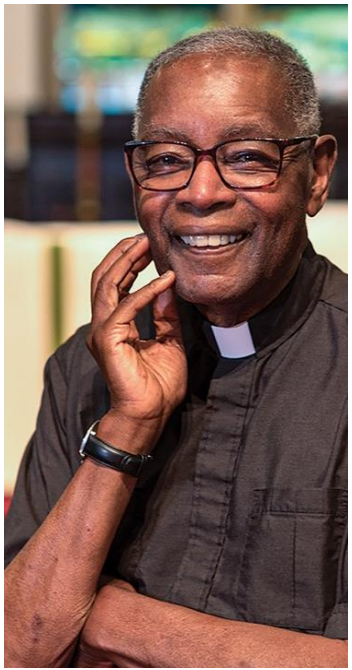
Diocese of West Missouri

Rev. Chris Hamby
Senior Relationship Manager

October 2025
2026 Annual Enrollment


BENEFITS

About the Church Pension Group



CPG's Lines of Business Support Clergy and Lay Employees

Benefits • Publishing • Property & Casualty Insurance

Journey to Well-being

- Preparing for Your Journey
- Core Medical Plan Benefits
- Dental Benefits
- Annual Enrollment
- Additional Resources
- Financial Wellness
- Medicare Secondary Payer Small Employer Exception (MSP-SEE)

Journey to Well-Being

Preparing for Your Journey

Your Checklist

- ☑ Learn how your healthcare benefits work
- ☑ Enroll in the benefits that suit you best:
  - ☑ Consider your healthcare needs and those of your family for 2026
  - ☑ Compare options and costs
  - ☑ Enroll by the deadline
- ☑ Review and update your information and that of your dependent(s)

First Stop

Core Medical Plan Benefits

Core Medical Plan Benefits

The Travel Guide to Well-being

Your health plans and the many benefits offered

- Types of Medical Plans
- Medical Plan Details
- Quantum Health
- Behavioral Health
- Cigna Employee Assistance Program (EAP)
- Pharmacy
- Vision
- Hearing
- Hinge Health
- Active & Fit
- Telehealth and Virtual Visits
- Care Management Programs
- UnitedHealthcare Global Assistance

Types of Medical Plans

Types of Medical Plans

Preferred Provider Organization (PPO)

Anthem BCBS

- Includes network and out-of-network benefits
- Does not require referrals
- Generally, has a lower out-of-pocket cost when you use a network provider or facility

Anthem BlueCross BlueShield

cigna healthcare

Consumer-Directed Health Plan (CDHP)

Anthem BCBS

- Higher deductibles – you pay most medical and prescription expenses until you meet the plan's deductibles
- Works with a Health Savings Account (HSA) to help you pay for eligible healthcare expenses now and in the future

A Closer Look at the Health Savings Account (HSA)

An account you use to pay your share of qualified medical expenses

Must be enrolled in a Consumer-Directed Health Plan

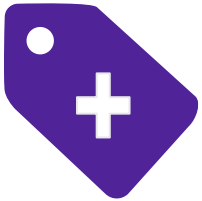
+

- Not covered by Medicare, TRICARE, or other medical insurance
- Cannot be claimed as a dependent on anyone's tax return
- Cannot contribute to a Healthcare Flexible Spending Account (FSA)

How the Health Savings Account Works

An account you use to pay your share of qualified medical expenses

- Tax-free* contributions
- Tax-free* interest
- Opportunity for tax-free investment earnings (subject to a minimum balance requirement)
- No taxes* on money used for qualified medical expenses

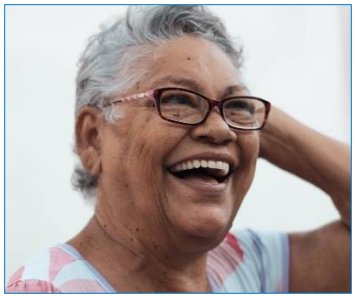


- Can save for future qualified medical expenses
- Is portable – you can take it with you

*With respect to federal income tax. Certain states may tax HSA contributions or withdrawals; please consult your personal tax advisor.

Health Savings Account Contributions

How much can you contribute in 2026?



Individual

$4,400

Total combined (employee/employer) contribution allowed

Family

$8,750

Total combined (employee/employer) contribution allowed

Catch-up (≥ age 55)

$1,000

Additional amount allowed for those 55 and older

Health Savings Account Setup

Setup with HealthEquity is automatic with CDHP enrollment

- Activate by calling HealthEquity at 877-713-7712
- Setup and monthly maintenance fees are paid by the Medical Trust*
- HealthEquity HSA Guidebook is available online

- You, your spouse and your eligible dependents can use Visa HSA debit cards
- Designate a beneficiary for your account

Use your own bank or a qualified financial institution

- You pay setup and maintenance fees
- Pre-tax salary contributions may not be possible

*The Medical Trust will not pay the maintenance fees if you are either no longer employed or enrolled in a Medical Trust CDHP.

Medical Plan Details

Medical Benefits

Certain terms you need to understand to be able to compare plans are on the left, and their definitions are on the right.

Deductible	A fixed amount you pay for a covered healthcare service, usually when you receive the service
Out-of-Pocket Limit	You pay the full cost of healthcare until you reach this amount. Then the plan begins to pay benefits
Copay	The most you will pay for covered healthcare expenses for the calendar year
Coinsurance	The percentage you pay for the allowed amount of a covered service after meeting your deductible

Medical Benefits

Term	Definition
Deductible	You pay the full cost of healthcare until you reach this amount. Then the plan begins to pay benefits
Out-of-Pocket Limit	The most you will pay for covered healthcare expenses for the calendar year
Copay	A fixed amount you pay for a covered healthcare service, usually when you receive the service
Coinsurance	The percentage you pay for the allowed amount of a covered service after meeting your deductible

Medical Benefits

Anthem PPO 100 | Cigna PPO 100

	Network	Out-of-Network
Deductible	$0 individual / $0 family	$500 individual / $1,000 family
Out-of-Pocket Limit	$2,000 individual / $4,000 family	$4,000 individual / $8,000 family
Office Visit	$30 copay (primary care) $45 copay (specialist) $0 (preventive care)	50% coinsurance
Diagnostic Tests	$0 copay	50% coinsurance
Urgent Care	$50 copay	$50 copay
Emergency Care	$250 copay	$250 copay
Outpatient Surgery	$200 copay	50% coinsurance
Hospital Stay	$250 copay	50% coinsurance
Behavioral Health (outpatient)	$0 copay	30% coinsurance

Medical Benefits

Anthem PPO 90 | Cigna PPO 90

	Network	Out-of-Network
Deductible	$500 individual / $1,000 family	$1,000 individual / $2,000 family
Out-of-Pocket Limit	$2,500 individual / $5,000 family	$5,000 individual / $10,000 family
Office Visit	$30 copay (primary care) $45 copay (specialist) $0 (preventive care)	50% coinsurance
Diagnostic Tests	$0 copay	50% coinsurance
Urgent Care	$50 copay	$50 copay
Emergency Care	$250 copay	$250 copay
Outpatient Surgery	10% coinsurance	50% coinsurance
Hospital Stay	10% coinsurance	50% coinsurance
Behavioral Health (outpatient)	$30 copay	30% coinsurance

Medical Benefits

Anthem PPO 80 | Cigna PPO 80

	Network	Out-of-Network
Deductible	$1,000 individual / $2,000 family	$2,000 individual / $4,000 family
Out-of-Pocket Limit	$3,500 individual / $7,000 family	$7,000 individual / $14,000 family
Office Visit	$30 copay (primary care) $45 copay (specialist) $0 (preventive care)	50% coinsurance
Diagnostic Tests	20% coinsurance	50% coinsurance
Urgent Care	$50 copay	$50 copay
Emergency Care	$250 copay	$250 copay
Outpatient Surgery	20% coinsurance	50% coinsurance
Hospital Stay	20% coinsurance	50% coinsurance
Behavioral Health (outpatient)	$30 copay	30% coinsurance

Medical Benefits

Anthem CDHP-15* | Cigna CDHP-15*

	Network	Out-of-Network
Deductible	$1,700 individual / $3,400 family	$3,400 individual / $6,800 family
Out-of-Pocket Limit	$2,400 individual / $4,800 family	$4,800 individual / $9,600 family
Office Visit	15% coinsurance (primary care / specialist)	40% coinsurance
	$0 (preventive care)	40% coinsurance
Diagnostic Tests	15% coinsurance	40% coinsurance
Urgent Care	15% coinsurance	40% coinsurance (Anthem) 15% coinsurance (Cigna)
Emergency Care	15% coinsurance	15% coinsurance
Outpatient Surgery	15% coinsurance	40% coinsurance
Hospital Stay	15% coinsurance	40% coinsurance
Behavioral Health (outpatient)	15% coinsurance	40% coinsurance

*If you have family members enrolled in the plan, the family deductible must be met before the plan begins to pay for any covered member, and the family out-of-pocket limit must be met before the plan begins to pay 100% of eligible services.

Medical Benefits

Anthem CDHP-20 | Cigna CDHP-20

	Network	Out-of-Network
Deductible	$3,400 individual / $6,800 family	$3,400 individual / $6,800 family
Out-of-Pocket Limit	$4,200 individual / $8,450 family	$7,000 individual / $13,000 family
Office Visit	20% coinsurance (primary care / specialist) $0 (preventive care)	45% coinsurance 45% coinsurance
Diagnostic Tests	20% coinsurance	20% coinsurance
Urgent Care	20% coinsurance	20% coinsurance (Cigna) 45% coinsurance (Anthem)
Emergency Care	20% coinsurance	45% coinsurance
Outpatient Surgery	20% coinsurance	45% coinsurance
Hospital Stay	20% coinsurance	45% coinsurance
Behavioral Health (outpatient)	20% coinsurance	45% coinsurance

Details About Your Medical Coverage

Summaries of Benefits and Coverage

EPISCOPAL CHURCH MEDICAL TRUST

Anthem BlueCard PPO 100

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

Coverage Period: 01/01/2026 – 12/31/2026

Coverage for: All tiers | Plan Type: PPO

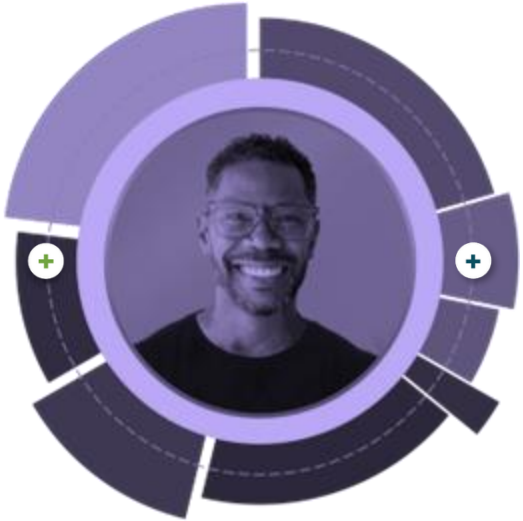
The Summary of Benefits and Coverage (SBC) document will help you choose a health plan. The SBC shows you how you and the plan would share the cost for covered health care services. NOTE: Information about the cost of this plan (called the premium) will be provided separately. This is only a summary. 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: **$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.

Quantum Health

Members whose plans use the Anthem and Cigna networks can contact Quantum's nurses, benefit experts, and claim specialists whenever they need help.

- Preparing for a hospital stay
- Reviewing care options
- Learning about a health condition
- Resolving claims, billing, and benefits questions—and lots more!



- Finding in-network providers
- Comparing provider cost and quality ratings
- Confirming coverage and obtaining precertifications
- Contacting doctors to coordinate treatment

Members can still contact their medical providers directly for services.

Quantum Health

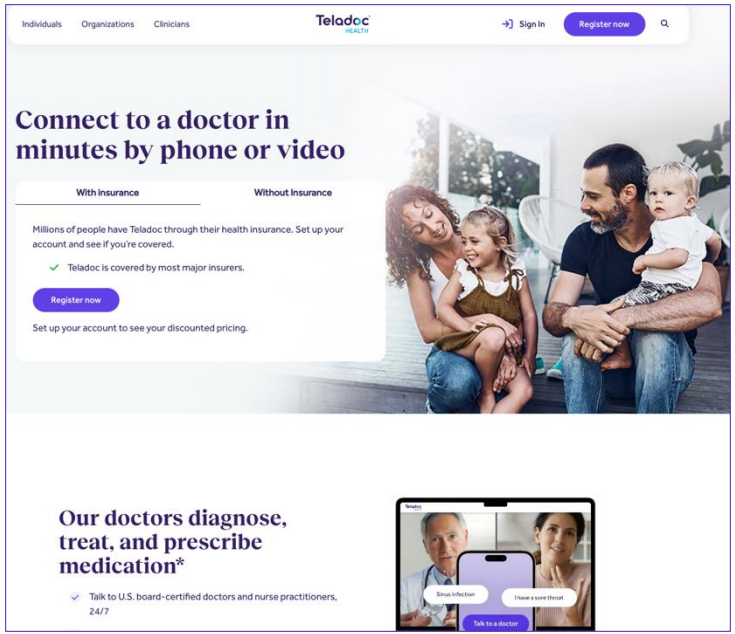
Quantum Care coordinators may call members if:

- They can save on out-of-pocket costs
- They qualify for a coaching program
- There is a concern about their prescriptions
- A procedure or discharge follow-up is required

Remember to share your ID card with your pharmacy, physicians, and medical facilities.

Additional Services

Members whose plans use the Anthem and Cigna networks have access to Quantum Health's telehealth platform



Teladoc Health offers

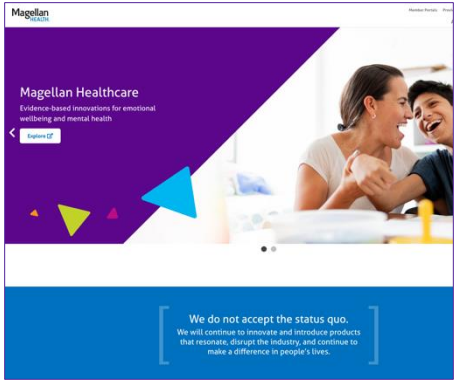
- 24/7/365 services via phone, website, or app
- Access to board-certified doctors and nurse practitioners
- Treatment for a wide range of medical and behavioral health conditions

To access Teladoc

- Call Quantum at 866-871-0629, 8:30 AM to 10:00 PM ET, Monday through Friday
- Outside those hours, call Teladoc directly at 1-800-835-2362

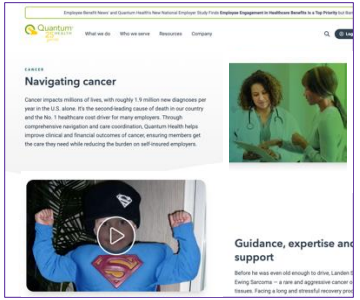
Additional Services (continued)

Magellan Healthcare



- Outreach to members undergoing inpatient/ intensive outpatient treatment
- Continuing care plans
- Health education, including coping strategies and relapse prevention
- Emotional support and community resources

Expert Cancer Review



Reviews by oncology experts at NCI-designated cancer centers include:

- Evaluation of proposed care plans
- Clinical recommendations
- Access to cutting-edge research and clinical trials

One Place to Go, One Team to Help

Members who have questions about claims, benefits, medications, or care coordination should contact Quantum.

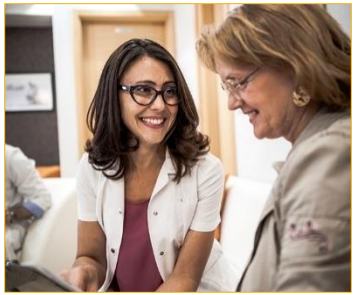
Call 866-871-0629, Monday to Friday, 8:30 AM to 10:00 PM EST

Visit *MyQuantumCare.org*

Use the Quantum app, Quantum Health, available from the Apple Store® and Google Play™

For Help with Mental Health or Substance Use Disorder

Contact Quantum.



Benefit highlights

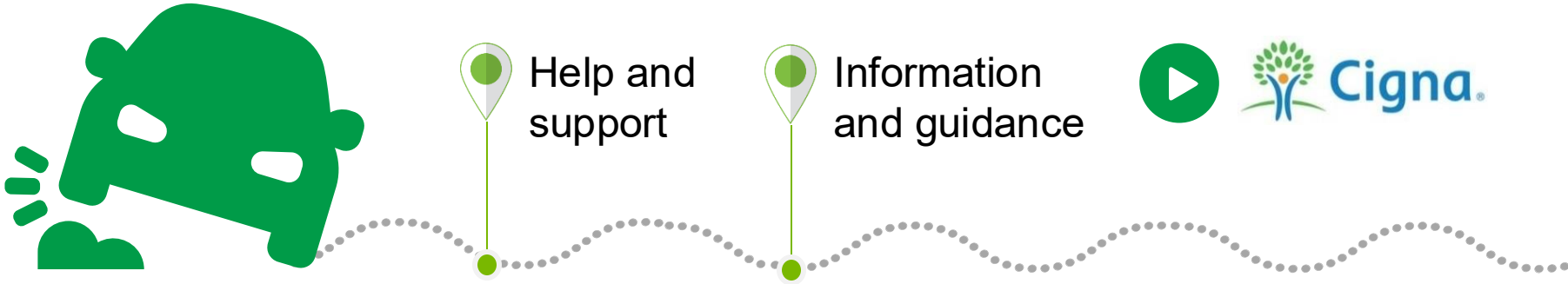
- Office visits
- Medication management
- Outpatient services
- Inpatient services

Please note

- Prior authorization may be required for certain services.

For the Bumps in the Road

The Employee Assistance Program is here for you



EAP Overview

The EAP offers

- Up to 10 face-to-face, strictly confidential sessions with a Cigna EAP provider
- Unlimited 60-minute, in-the-moment telephonic consultations
- Referrals to community services
- Referrals to financial and legal professionals

Getting in touch

866-871-0629
8:30 AM to 10 PM
Monday to Friday
(via Quantum)

All other times & EAP-only: 866-395-7794
or *myCigna.com*

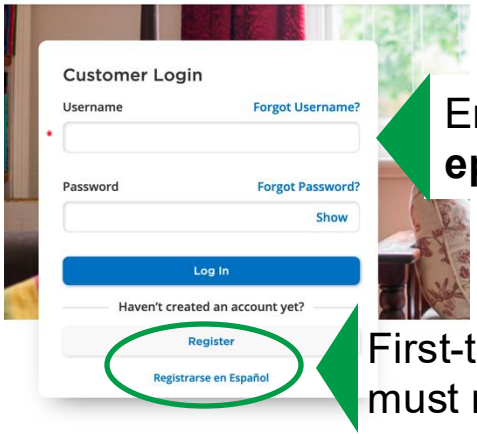
Additional features

- $0 cost
- Available 24/7/365 to everyone in your household

Accessing Cigna EAP Resources Online

Under “Coverage” menu, select “Employee Assistance Program (EAP)”

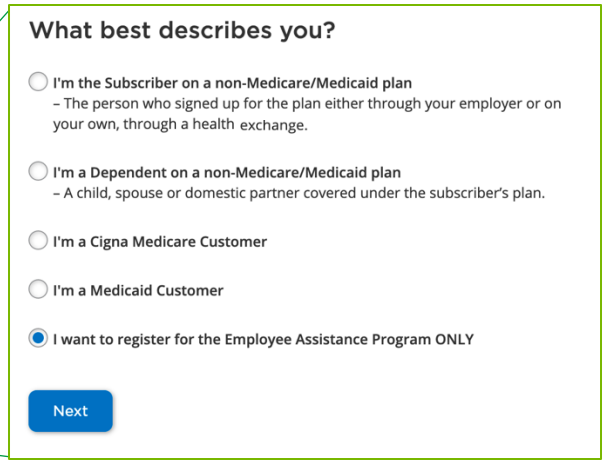
myCigna.com



Employer Name or ID:
episcopal

First-time visitors must register

Webpage detail



Talkspace Online Therapy Service

- Behavioral health services now more accessible to employees and their household members.
- EAP members can use EAP benefits to connect with Talkspace therapists via live video or private messaging.
- Requires an EAP code* and is subject to the same session limits as other EAP counseling.
- There is no additional cost.

*An EAP code can be obtained by calling your EAP toll-free program number or through the Emotional Health tile, under “Visit an EAP counselor” on the EAP Coverage Page on *myCigna.com*.

Pharmacy

Things to Know About Your Pharmacy Benefits

Types of Prescription Drugs

- Generic
- Preferred brand
- Non-preferred brand
- Specialty

How to Obtain

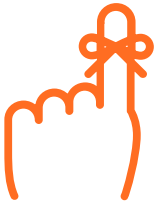
- Retail pharmacy
- Home delivery

Prescription Drug Benefits

Managed by Express Scripts

Benefit highlights

- Generic and brand-name medications
- Accredo Specialty Pharmacy
  - SaveOnSP
- Broad national retail pharmacy network
- Home delivery



Things to remember

- Preauthorization may be required
- Generic or pay the difference
- Retail refill limit
- Home delivery required for maintenance medications

To learn more

- Plan Document Handbook
- Summary of Benefits and Coverage
- Call Quantum at 866-871-0629

EXPRESS SCRIPTS®

Quantum® HEALTH

Prescription Drug Benefits

2026 Express Scripts–Premium Plan

	Retail	Home Delivery
Deductible	None	None
Generic	Up to $5 copay	Up to $12 copay
Preferred Brand-name	Up to $35 copay	Up to $87 copay
Non-preferred Brand-name	Up to $70 copay	Up to $175 copay
Specialty Rx	Up to $90 copay	Up to $225 copay
Dispensing Limits	Up to 30-day supply*	Up to 90-day supply

*30-day supply is allowed for only the first three refills at retail before it goes to maintenance at Home Delivery.

Prescription Drug Benefits

2026 Express Scripts–CDHP-15

	Retail and Home Delivery
Deductible (combined with medical deductible)	$1,700 individual / $3,400 family
Generic	15% coinsurance after deductible
Preferred Brand-name	25% coinsurance after deductible
Non-preferred Brand-name	50% coinsurance after deductible
Specialty Rx	50% coinsurance after deductible
Dispensing Limits	Up to 30-day supply* (retail) or 90-day supply (home delivery)

*30-day supply is allowed for only the first three refills at retail before it goes to maintenance at Home Delivery.

Prescription Drug Benefits

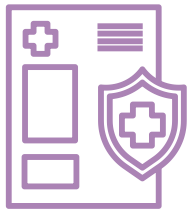
2026 Express Scripts–CDHP-20

	Retail and Home Delivery
Deductible (combined with medical deductible)	$3,400 individual / $6,800 family
Generic	15% coinsurance after deductible
Preferred Brand-name	25% coinsurance after deductible
Non-preferred Brand-name	50% coinsurance after deductible
Specialty Rx	50% coinsurance after deductible
Dispensing Limits	Up to 30-day supply* (retail) or 90-day supply (home delivery)

*30-day supply is allowed for only the first three refills at retail before it goes to maintenance at Home Delivery.

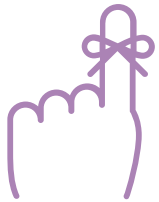
Benefits Overview

EyeMed Insight Network



Benefit highlights

- $0 copay for annual visit
- $200 allowance for frames or contact lenses
- Discounts on products/services



Things to remember

- Benefit through EyeMed Vision Care's Insight Network
- Broad provider network

To learn more

- Anthem/Cigna: call Quantum at 866-871-0629
- Kaiser: call EyeMed at 866-723-0513 OR
- visit *eyemedvisioncare.com/ecmt* OR
- use EyeMed app

Plan Benefits

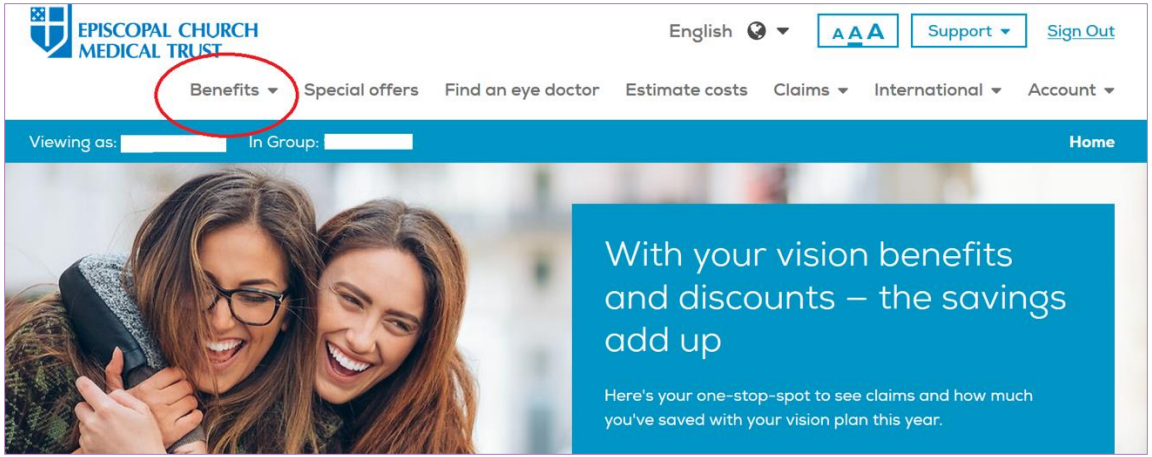
See Summary of Benefits at *cpg.org/mtdocs*

	In-Network Member cost	Out-of-Network Member Reimbursement
Exam (once every 12 months)	$0 copay	Up to $30
Frames (once every 12 months)	$0 copay; $200 allowance; 20% off balances over $200	Up to $63
Standard plastic lenses	$10 to $120 copay	Up to $32 to $57
Contact lenses		
Conventional and disposable	$0 copay; $200 allowance plus discounts on balances over $200 (conventional), $200 allowance (disposable)	Up to $133
Medically necessary	$0 copay; paid in full	Up to $210
Laser vision correction	15% off retail price or 5% off promotional price	N/A

Accessing EyeMed Resources Online

From the homepage, select the “Benefits” menu

eyemedvisioncare.com/ecmt



Or use EyeMed mobile app (download from Apple Store® or Google Play™)

Hearing Aid Benefits

Benefit allowance and hearing aid device discounts

- All active plans
- Maximum benefit of $3,000 every three years

Hinge Health

Hinge Health and Expert Medical Second Opinion

- Virtual musculoskeletal wellness program
- Second opinion from musculoskeletal expert for Anthem and Cigna members
- Learn more at *hingehealth.com/ecmt*

Active & Fit

Health and Wellness

- Discounted memberships to gyms and fitness centers
- Flexible contracts
- Exercise video library
- To access Active & Fit
  - Call 866-871-0629
  - Visit *MyQuantumCare.org* (click on Plans/Health and Wellness)

Care from the Safety and Convenience of Your Home

24/7/365 access to board-certified physicians

Anthem and Cigna
Access Teladoc through Quantum at MyQuantumCare.org

Kaiser
kp.org

- Access medical and behavioral health professionals.
- Connect via computer or mobile device with the type of doctor you select.
- Chat securely and privately by phone or video in minutes.
- Obtain prescriptions for certain medications.

Quantum HEALTH

KAISER PERMANENTE®

Care from the Safety and Convenience of Your Home

Talk to your healthcare provider

- Have an online appointment with your personal healthcare provider.
- Chat securely and privately through the electronic medium of your provider's choice (Zoom, Skype, phone).
- Obtain prescriptions for certain medications.

Quantum Health

Access help with one call, click, or tap

Call Quantum at 866-871-0629

Visit *myQuantumCare.org*

Use the *Quantum Health* mobile app (available from the Apple Store® and Google Play™)

The right care at the right time and the right cost*

- Coordinate care among doctors
- Confirm coverage of services
- Understand prior authorizations required for certain treatments
- Get answers to other questions

Quantum® HEALTH

*For those using Anthem and Cigna networks

Coverage Review and Prior Authorization

For plan payments to be made, approval is required before certain services are rendered

Coverage review – helps determine whether certain services meet clinical policies as Medically Necessary or if they are Experimental/ Investigational/Unproven.

Prior authorization – when you use a network provider, Quantum will complete any required prior authorization on your behalf.

Out-of-Network Providers – when you use an out-of-network provider, it is your responsibility to ensure that the required prior authorization is completed.

Plan Document Handbook – Review the Plan Document Handbook or call Quantum Health if you have questions about prior authorization.

Benefit Overview

24-hour assistance while traveling

What it includes

- 24/7 assistance when more than 100 miles from home or outside the US
- Referrals and scheduling of treatment
- Help replacing Rx and stolen or lost travel documents
- Emergency travel resources

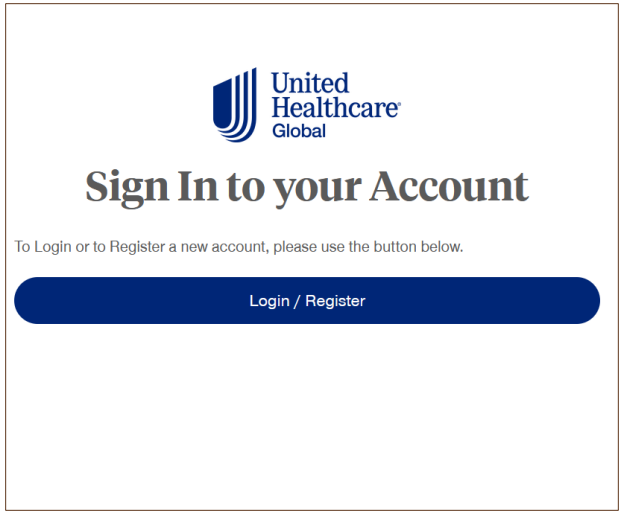
Getting in touch

- In US, call 800-527-0218
  Outside US, call collect: 410-453-6330
- Email *assistance@uhcglobal.com*
- Visit *uhcglobal.com*

Accessing Resources Online

Follow the on-screen instructions to complete your account setup

worldwatch.uhcglobal.com

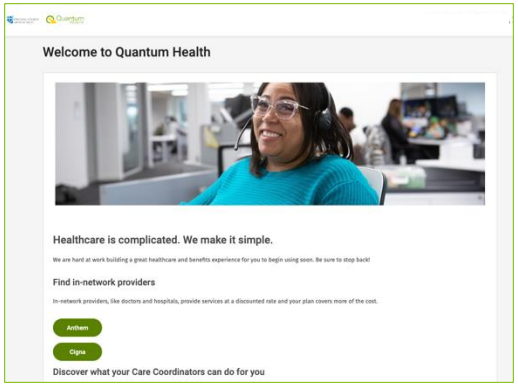


Log in to your account and discover all the ways UnitedHealthcare Global Assistance can help you.

Connecting with Your Benefits

Quantum Health

MyQuantumCare.org



Call Quantum at 866-871-0629

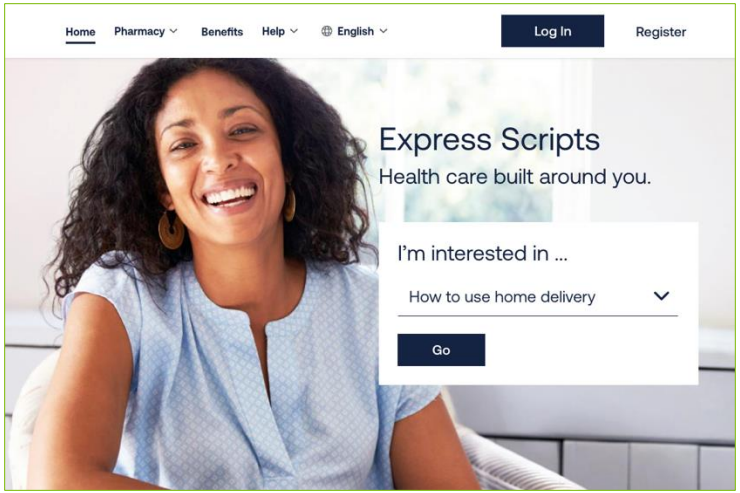
Use the *Quantum Health* mobile app (download from the Apple Store® or Google Play™)

- Find network providers.
- Review care options.
- Get answer to claims, billing, and benefits questions.
- Verify coverage and, if needed, obtain prior approval.
- Replace an ID card.
- And more!

Quantum® HEALTH

Connecting with Your Benefits

Express Scripts

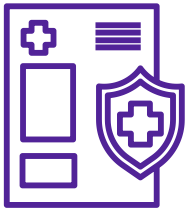


- Call Quantum at 866-871-0629.
- Locate participating retail pharmacies.
- Find benefits, coverage, and formulary information.
- Order prescriptions through Express Scripts Home Delivery.
- And more!

Next Stop

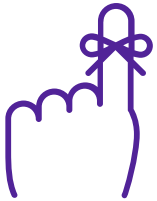
Dental Benefits

Delta Dental Benefits



Benefit Highlights

- Three routine cleanings a year (four under certain circumstances)
- Diagnostic/preventive care at no cost
- Nationwide network



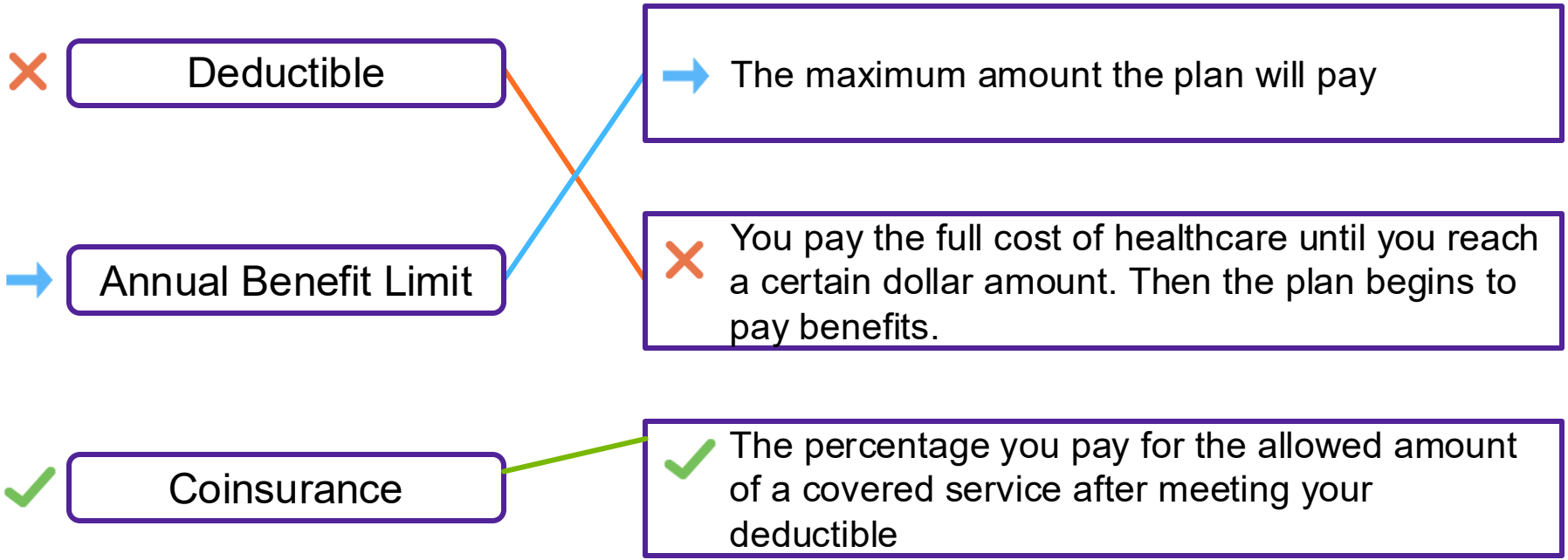
Things to Remember

- Balance billing: difference between dentist charge and Delta Dental amount or any dentist charge over Delta Dental allowance
- Two networks: Delta Dental PPO and Premier

Additional Information

- Delta Dental Plan Document Handbook and benefit highlights sheets
- “Maximize Your Savings” brochure and more
- *cpg.org/deltadental*

Dental Plan Definitions



Dental Plan Comparison–Premium Plan

	Delta Dental Premium Plan (2026)		
	PPO Network	**Premier Network**	**Out-of-Network**
Deductible	$0/$0	$0/$0	$50/$150
Annual Benefit Limit*	$3,000	$2,500	$2,000
Preventive and Diagnostic	No charge	No charge	No charge
Basic Restorative	85% coinsurance**	85% coinsurance	75% coinsurance
Major Restorative	85% coinsurance	85% coinsurance	75% coinsurance
Orthodontic Services	50% Coinsurance	50% coinsurance	40% coinsurance
Orthodontia Lifetime Maximum**	$2,000	$2,000	$1,500

*Plan payments apply toward maximums across all networks.
**What the plan pays

Dental Plan Comparison–Comprehensive

	Delta Dental Comprehensive (2026)		
	PPO Network	**Premier Network**	**Out-of-Network**
Deductible	$0/$0	$0/$0	$100/$300
Annual Benefit Limit*	$2,500	$2,000	$1,500
Preventive and Diagnostic	No charge	No charge	No charge
Basic Restorative	85% coinsurance**	85% coinsurance	75% coinsurance
Major Restorative	50% coinsurance	50% coinsurance	40% coinsurance
Orthodontic Services	50% coinsurance	50% coinsurance	40% coinsurance
Orthodontia Lifetime Maximum**	$1,500	$1,500	$1,000

*Plan payments apply toward maximums across all networks.
**What the plan pays

Example

You can save the most with PPO

Claims example	Most claims savings	Some claims savings	No claims savings
	Delta Dental PPO	**Delta Dental Premier**	**Non–Delta Dental dentist**
Dentist charge for a crown	$2,100	$2,100	$2,100
Plan allowance	$1,050	$1,500	$2,100
Percentage paid by plan	85%*	85%*	75%*
Plan payment	$893	$1,275	$1,575
Patient payment	**$157 ($1,050-$893)**	**$225 ($1,500-$1,275)**	**$525 ($2,100-$1,575)**
Balance-billing	**NO**	**NO**	**YES****

* This example assumes no deductible or maximum applied toward the service and is based on the Premium Plan design.
** Non-contracted dentists can charge the difference between their submitted charge for a service and the Plan Allowance. In this example, it's $2,100 minus $1,575, or $525.

Delta Dental SmileWay® Wellness Benefits[1]

Expanded dental coverage

Available to members with any of the following diagnoses:

- Amyotrophic lateral sclerosis (ALS)
- Cancer
- Chronic kidney disease
- Diabetes
- Heart disease
- HIV/AIDS
- Huntington’s disease
- Joint replacement
- Lupus
- Opioid misuse and addiction
- Parkinson’s disease
- Rheumatoid arthritis
- Sjögren’s syndrome
- Stroke

[1]Known as SmileWay Enhanced Benefits in Texas.

Delta Dental SmileWay® Wellness Benefits*

Expanded coverage

SmileWay® Wellness Benefits*

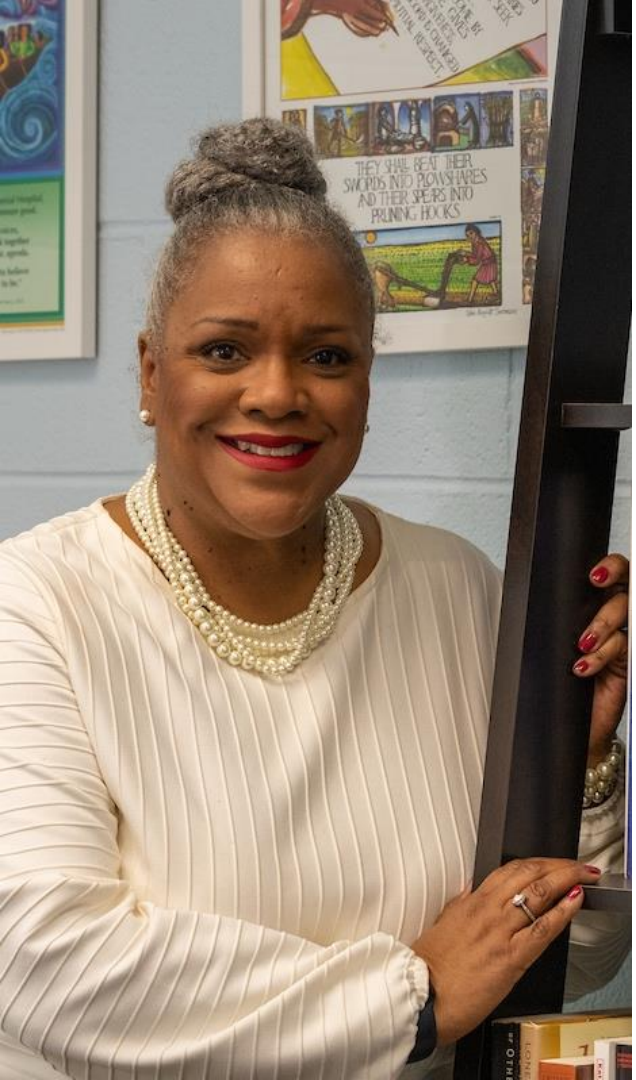
100% coverage	One periodontal scaling and root planning procedure per quadrant (D4341 or D4342) per calendar or contract year**
Four of the following (any combination) per calendar or contract year:**	
100% coverage	Prophylaxis (teeth cleaning) (D1110 or D1120)
	Periodontal maintenance procedure (D4910)
	Scaling in presence of moderate or severe gingival inflammation (D4346)

If eligible, opt in by visiting *deltadentalins.com/smileway* or by calling Delta Dental Customer Service at 888-894-7059, Monday to Friday.

[1]Known as SmileWay Enhanced Benefits in Texas.
[2]This coverage is subject to applicable maximums and deductibles under the terms and conditions outlined in your plan's Evidence of Coverage.

Next Stop: Health Plan Options for Active Employees Age 65 and Over

Medicare Secondary Payer Small Employer Exception (MSP-SEE)



Medicare Secondary Payer Small Employer Exception (MSP-SEE)

What is it?

An exception granted by the Centers for Medicare & Medicaid Services to small employers and their eligible employees age 65 and older (and/or certain eligible dependents age 65 and older) so that they may enroll in a medical plan under which Medicare is the primary payer of claims, and The Episcopal Church Medical Trust (Medical Trust) plan is the secondary payer.

Active Employees Age 65 and Over

Under the Age Discrimination in Employment Act…

An employer that offers Medical Trust health plans to active employees under age 65 (and their spouses)

- Must offer the same health plans to its active employees who are 65 and older (and their spouses)
- This requirement applies irrespective of employees' Medicare eligibility, and
- Employees must meet the eligibility requirements of the Episcopal Health Plan

Active Employees Age 65 and Over

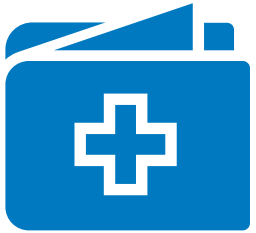
Medicare beneficiaries can choose to decline employer coverage.

- Retain Medicare as primary coverage
- Can also choose to purchase secondary coverage BUT not from the employer group plan (i.e., cannot continue to be enrolled in the Medical Trust Group Medicare Advantage Plan or receive a post-retirement health subsidy)
- Receiving financial incentives from employer to choose Medicare as primary coverage is not allowed

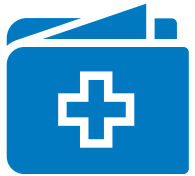
Medicare Secondary Payer Small Employer Exception Plans (MSP-SEE Plans)

- Employer group health plans are usually the primary payer for Medicare-eligible members*
- MSP rules provide an exception for small employers (Small Employer Exception or SEE)
- MSP-SEE plans are less expensive than corresponding standard plans because they coordinate claims with Medicare

Under the MSP-SEE, Medicare becomes the primary payer and the Medical Trust the secondary payer.



Medicare:
Primary Payer



Medical Trust:
Secondary Payer

*Comparable to private insurance “coordination of benefits.”

Eligibility Requirements

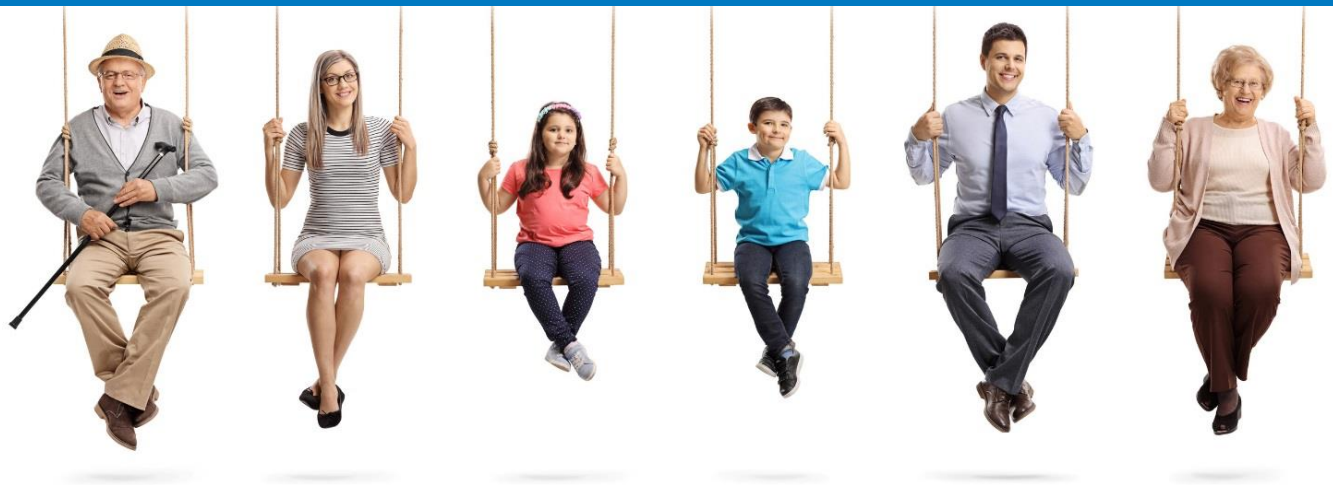
Employees and their eligible dependents are eligible for the MSP-SEE Plan if they and their employer meet **all** these conditions:

- Employer has 19 or fewer employees in the current and preceding year.
- Employer offers MSP-SEE plan to employees.
- Employee meets standard Medical Trust eligibility criteria.
- Employee (and/or eligible dependent) is 65 or older.
- Employee (and/or eligible dependent) is enrolled in Medicare Part A (or both Parts A and B) based on age only.

Eligibility Requirements

How does the family plan work if not everyone is 65 and older?

Any member of the family under age 65 who meets the Medical Trust's standard eligibility requirements for coverage under an active employment-based plan will be enrolled in the MSP-SEE Plan along with the eligible 65+ member, but their benefits will not be coordinated with Medicare.



MSP-SEE Enrollment and Disenrollment Process

Employee/ Employer

Submits Eligibility Certification and copy of Medicare ID card to…

Diocesan/Group Administrator

Signs Eligibility Certification and completes Online Enrollment. Forwards Certification and copy of Medicare ID card to…

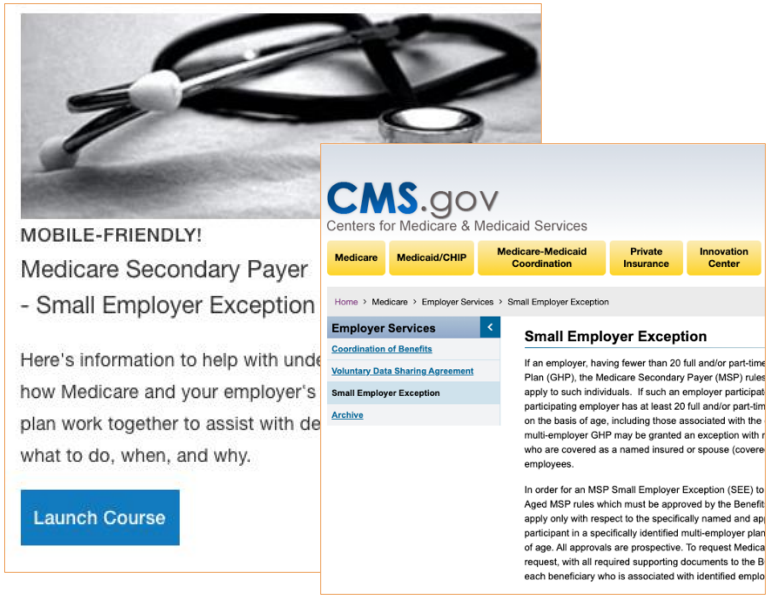
CPG Client Services

Receives Eligibility Certification, Online Enrollment Transaction, and copy of Medicare ID card. Verifies eligibility and submits to…

Centers for Medicare & Medicaid Services (CMS)

Resources

cpg.org/elearning | cms.gov



cpg.org

- MSP-SEE Eligibility Certification Form
- Administrative Policy Manual
- Letter Template for Active Employees Turning Age 65

cms.gov

- Small Employer Exception

Next Stop

Annual Enrollment

Annual Enrollment

- Three Steps to Annual Enrollment: Learn, Evaluate, Decide
- Annual Enrollment Timeline
- Top Considerations

Annual Enrollment

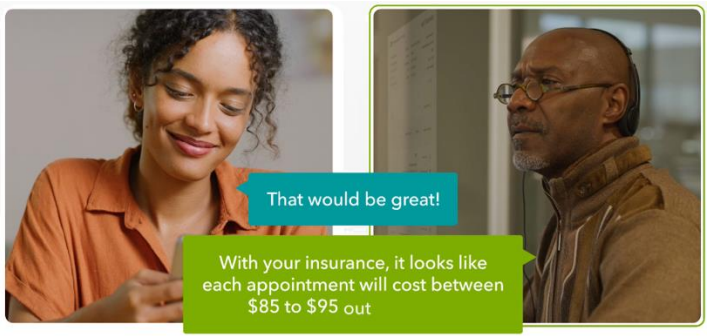
Three Steps to Annual Enrollment: Learn, Evaluate, Decide

Annual Enrollment

- A chance to consider your healthcare needs for the coming year
- An opportunity to review your choices regarding medical and dental benefits
- A reminder to review your information and that of your dependent(s)

Annual Enrollment Support

For members whose plans use Anthem and Cigna networks



During the 2026 Annual Enrollment period, **Quantum Care Coordinators** will be available to help members understand plan options and choose the right plans for themselves and their families.

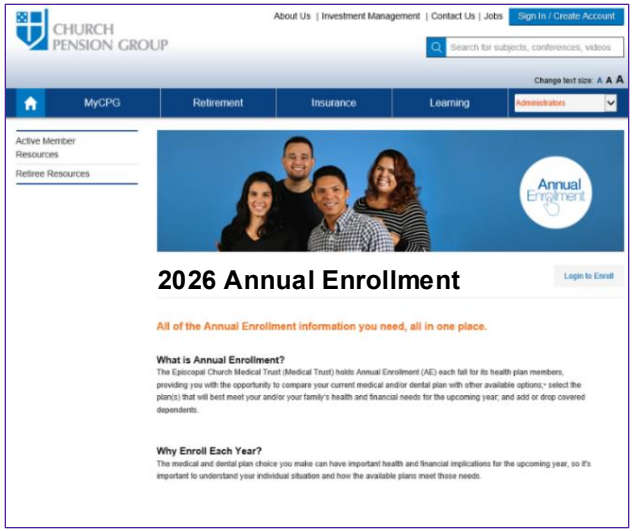
- Compare plan options
- Understand out-of-pocket costs for services
- Understand coverages

Call Quantum Health at 866-871-0629

Step 1: Learn

Learn about your 2026 options

cpg.org/annualenrollment



Customized content

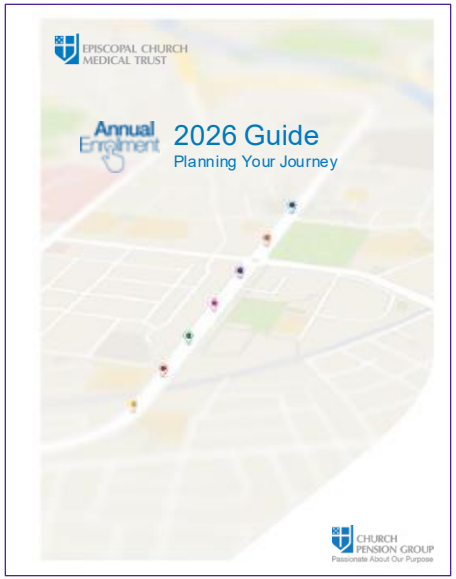
- Active members
- Pre-65 former employees
- Post-65 former employees

Annual Enrollment

Step 1: Learn

View and download plan-specific materials from the CPG Benefits Library

cpg.org/mtdocs



- Annual Enrollment Guide*
- Plan Document Handbooks
- Summary of Benefits and Coverage for each plan
- Claim Forms
- Glossary of Medical Terms
- Regulatory Notices

*You can also access the *Annual Enrollment Guide* at *cpg.org/AEGuide*.

Step 2: Evaluate

Do your benefits still align with your needs?

Factors to consider

- Use of healthcare
- Provider choice

Out-of-pocket costs

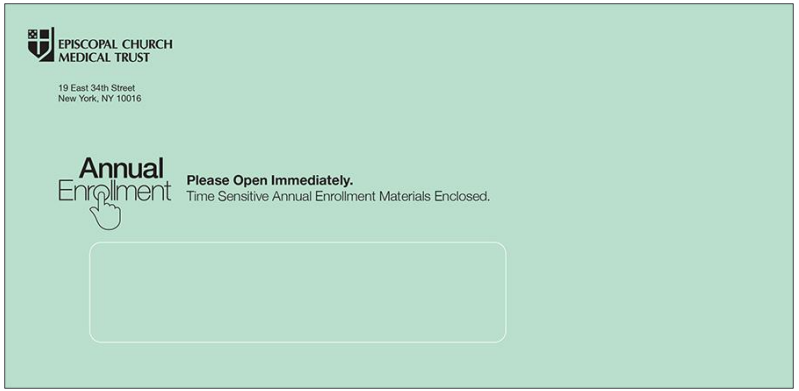
- Individual and family deductibles
- Copays and coinsurance
- Out-of-pocket limits
- Expenses above annual or lifetime maximums for certain benefits

Annual Enrollment

Step 3: Decide

2026 Annual Enrollment will take place between mid-October and late November 2025

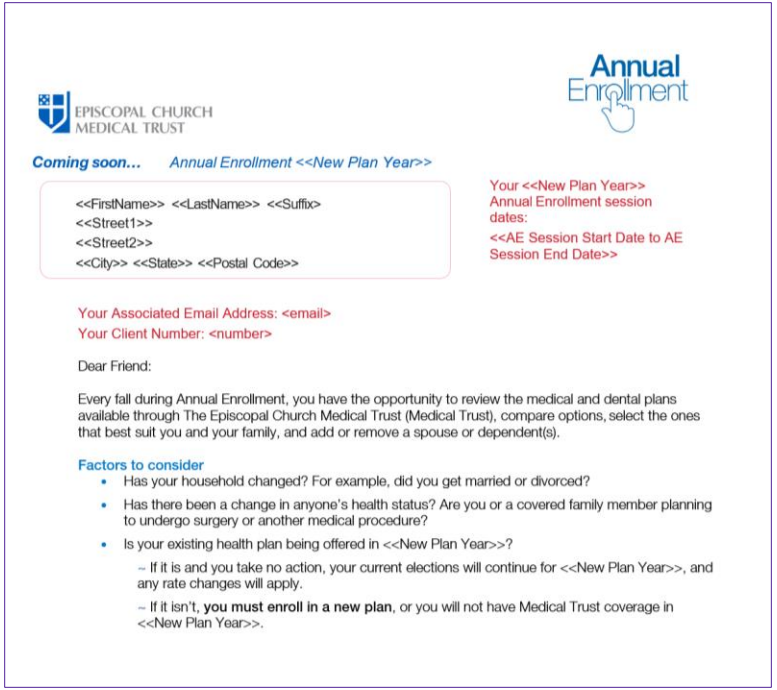
Look for a letter in the mail with your group's enrollment dates and the email address associated with your MyCPG Account.


EPISCOPAL CHURCH MEDICAL TRUST

19 East 34th Street
New York, NY 10016

Annual Enrollment

Please Open Immediately.
Time Sensitive Annual Enrollment Materials Enclosed.


EPISCOPAL CHURCH MEDICAL TRUST

Annual Enrollment

Coming soon... *Annual Enrollment <<New Plan Year>>*

<<FirstName>> <<LastName>> <<Suffix>>
<<Street1>>
<<Street2>>
<<City>> <<State>> <<Postal Code>>

Your <<New Plan Year>> Annual Enrollment session dates:
<<AE Session Start Date to AE Session End Date>>

Your Associated Email Address: <email>
Your Client Number: <number>

Dear Friend:

Every fall during Annual Enrollment, you have the opportunity to review the medical and dental plans available through The Episcopal Church Medical Trust (Medical Trust), compare options, select the ones that best suit you and your family, and add or remove a spouse or dependent(s).

Factors to consider

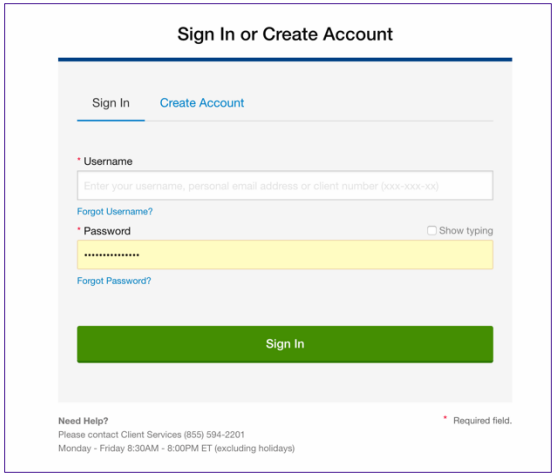
- Has your household changed? For example, did you get married or divorced?
- Has there been a change in anyone's health status? Are you or a covered family member planning to undergo surgery or another medical procedure?
- Is your existing health plan being offered in <<New Plan Year>>?
  - If it is and you take no action, your current elections will continue for <<New Plan Year>>, and any rate changes will apply.
  - If it isn't, **you must enroll in a new plan**, or you will not have Medical Trust coverage in <<New Plan Year>>.

Annual Enrollment

Step 3: Decide

Use the Decision Guides on the Annual Enrollment page, *cpg.org/annualenrollment*, to learn about health plan benefits

cpg.org/mycpg



Log in to MyCPG Accounts using the email address associated with your account. Don't have one? Select "Create Account."

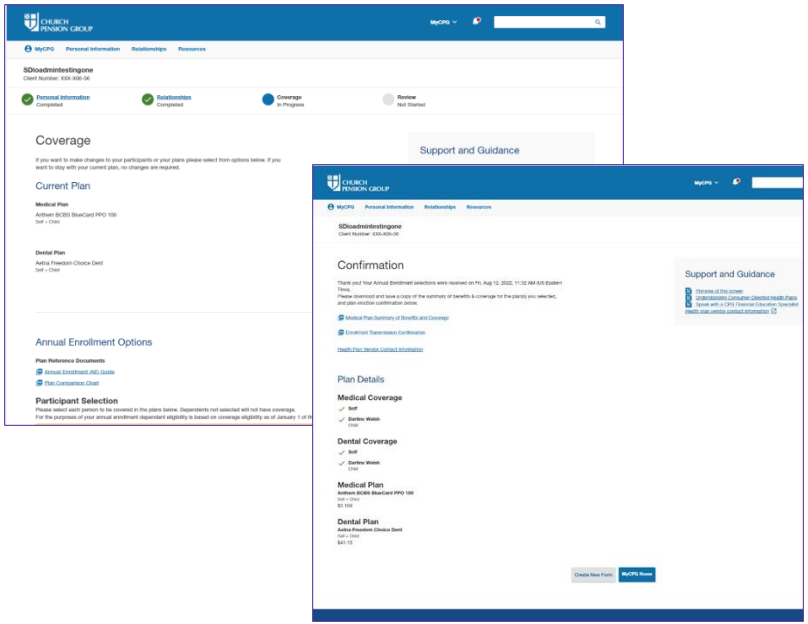
Then you can review

- Your and your dependents' personal details
- Your plan options
- Your group's plan comparison table
- Your beneficiaries' information

Annual Enrollment

Step 3: Decide

Make your health plan selections



Be sure to confirm or update information about eligible dependent(s). Then submit your selections and save or print your confirmation.

- Medical
- Dental (if offered by your group)

Annual Enrollment

Annual Enrollment Timeline

Key Annual Enrollment Dates

Late September 2025

Your Mailing Sent

October 15, 2025

Annual Enrollment Begins

November 21, 2025

Annual Enrollment Ends

January 1, 2026

New Plan Year Begins

Annual Enrollment

Top Considerations

Three Steps to Annual Enrollment

Learn, Evaluate, Decide

Take action!

1. Consider your healthcare needs and those of your family for 2026.
2. Compare your plan options: *Summaries of Benefits and Coverage* at *cpg.org/mtdocs* and Delta Dental plans at *cpg.org/deltadental*.
3. Refer to your group timeline for enrollment deadline.
4. Enroll using the Annual Enrollment website: *cpg.org/annualenrollment.*
5. **If your current medical options are being offered for 2026** and you don't want to make changes, you don't need to re-enroll.
6. **If your current plan is not being offered for 2026**, you must choose a new plan, or you will not have coverage in 2026.

During Annual Enrollment, Quantum Health can help you review existing benefits, understand plan options, and choose the right plan for yourself and your family.

Three Steps to Annual Enrollment

Learn, Evaluate, Decide

Remember!

1. Review your information and that of your dependent(s) and note any changes.
2. Look for the “Beneficiaries” tab on *MyCPG Accounts* and review the information therein.
3. Contact your HR administrator if you need assistance or didn’t receive an Annual Enrollment letter.
4. If you have coverage under a spouse’s plan, consider your options carefully.
5. Plan changes take effect January 1, 2026.
6. You can decline coverage for 2026, subject to Denominational Health Plan requirements.

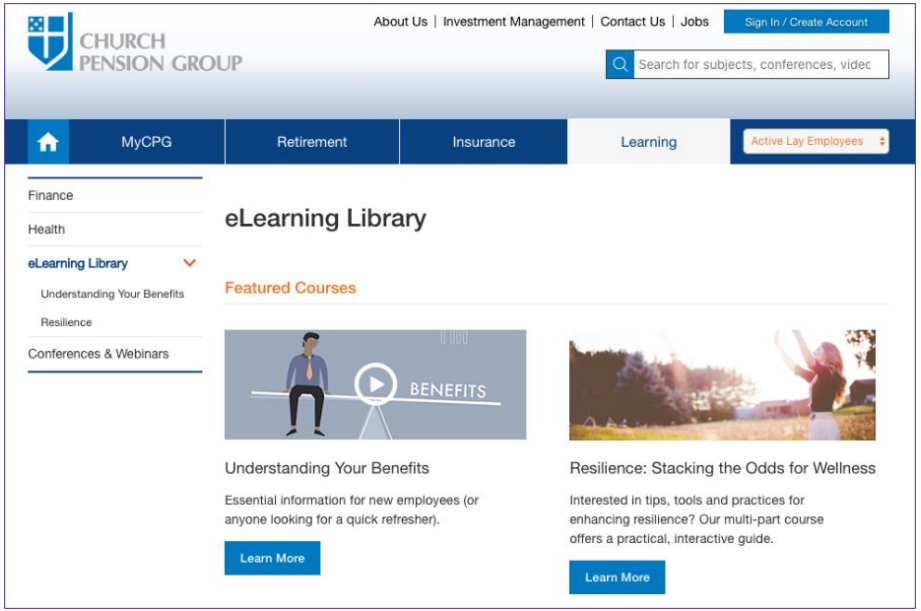
Annual Enrollment

Connecting with Your Benefits

Learning Center and eLearning Library

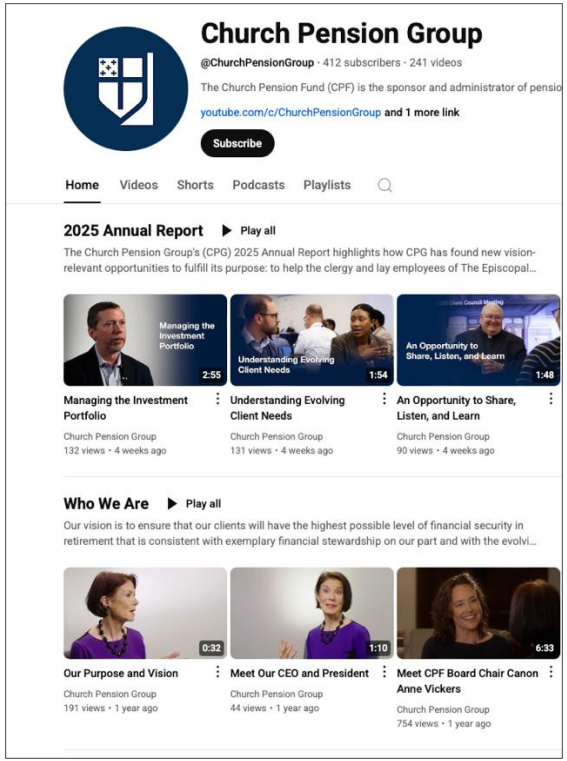
Learning in one place with easy-to-access courses:

- Understanding Your Benefits
- Visioning: See Your Way to Wellness
- Bite-Sized Nutrition
- Resilience: Stacking the Odds for Wellness
- Facing Dementia



Connecting with CPG

Information at your fingertips

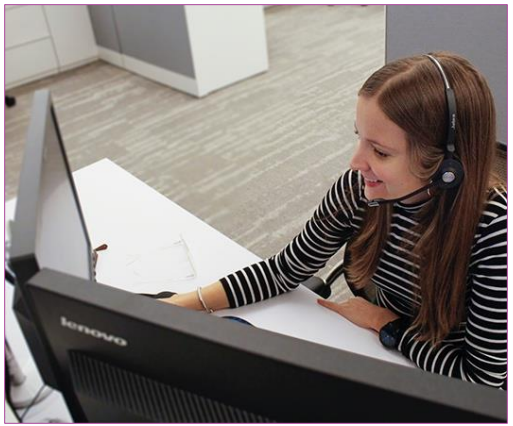


- Timely posts about benefits, Annual Enrollment, and more
- Additional social media content on health and well-being from CPG and websites of plan providers

Follow Us! @ChurchPension

At Your Service

Resources to guide you to your destination



CPG Client Services

Member Services

- 800-480-9967
  Monday to Friday
  8:30 AM to 8:00 PM ET
- Email *mtcustserv@cpg.org*

Disclaimers

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CPF currently offers a post-retirement health subsidy to eligible clergy and spouses. However, CPF is required to maintain sufficient liquidity and assets to pay its pension and other benefit plan obligations. Given uncertain financial markets and their impact on assets, CPF has reserved the right, at its discretion, to modify or discontinue the post-retirement health subsidy at any time.

Investing involves risk, including risk of loss. Fees and other terms and restrictions may apply. The information presented here is not investment advice, and does not take into account the investment objectives, financial situation, or retirement needs of particular individuals. It is important that you consider this information in the context of your personal risk tolerance, investment objectives, and financial and retirement goals. You should not rely on this information in making any investment or other decision that will affect your personal financial, retirement, or tax situation. You should contact your own professional advisor prior to making any such decision.

Neither CPF's defined contribution plans, nor any company or account maintained to manage or hold plan assets and interests in such plans or accounts, are subject to registration, regulation, or reporting under the Investment Company Act of 1940, the Securities Act of 1933, the Securities Exchange Act of 1934, the Employee Retirement Income Security Act of 1974, as amended (ERISA), or state securities laws. Plan participants and beneficiaries therefore will not be afforded the protections of the provisions of those laws. In addition, as church plans, CPF's defined contribution plans are not subject to ERISA.

Short-term disability and long-term disability insurance products and services are offered by American Family Life Assurance Company of New York, NAIC No. 60526. The information provided here is a summary of the group disability income insurance coverage and is for illustrative purposes only. A certificate with more complete policy information is available upon request. Please refer to the certificate or the group policy for a complete description of coverage, terms, conditions, exclusions, and limitations. If any conflict exists between the certificate and/or policy and the information described here, the terms of the certificate and policy will govern. Other self-funded disability benefits may be provided by The Church Pension Fund.

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 of the Episcopal Church (the "Church") and their eligible dependents. 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.

This material is not a substitute for professional medical advice or treatment. CPG does not provide any healthcare services and, therefore, cannot guarantee any results or outcomes. Always seek the advice of a healthcare professional with any questions about your personal healthcare, including diet and exercise.

Church Life Insurance Corporation, NAIC No. 61875, a New York life insurance company, with its home office located at 19 East 34th Street, New York, New York 10016 ("Church Life"), offers group and, in certain circumstances, individual life insurance and annuities to clergy and lay employees, and their families, in the service of The Episcopal Church. Product availability and features may vary by state, and products may not be available in all states. Church Life is not licensed in all states. Any and all guarantees by Church Life are based on and expressly subject to the claims-paying ability of Church Life. The Church Pension Fund does not guarantee the payment of principal of or interest on any Church Life insurance policy or annuity contract. Information and descriptions of products and services are provided solely for general informational purposes and are not intended to be complete descriptions of, or to create a contract or an offer to provide, coverage. For complete details of coverage, including exclusions, limitations and restrictions, please see the actual life insurance policy or annuity contract. If any description of a Church Life product conflicts with the terms of the actual life insurance policy or annuity contract, then the terms of such life insurance policy or annuity contract will govern.

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Thank you for your participation.

CHURCH PENSION GROUP
Passionate About Our Purpose