



Diocese of West Missouri

Rev. Chris Hamby, CRPC
Senior Relationship Manager

October 14, 2026
2027 Annual Enrollment

Our Purpose

We exist to support the Church's clergy and lay employees in their calling to spread the gospel.



Support Our Purpose Through Three Lines of Business



Employee Benefits • Publishing • Property & Casualty Insurance

≡ Your 2027 Medical Plan Options ≡

Your employer offers these types of medical plans



**Preferred Provider
Organization (PPO)**



**Consumer-Directed
Health Plan (CDHP)**

Preferred Provider Organization (PPO) ≡

Anthem BCBS | Cigna

- 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



Types of Medical Plans

Consumer-Directed Health Plan (CDHP) ≡

Anthem BCBS | Cigna

- 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



Cannot be covered by Medicare,
TRICARE, or other medical insurance

Cannot be claimed as a dependent
on anyone's tax return

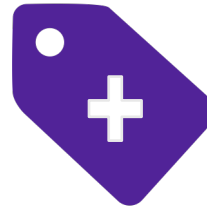
Cannot contribute to a Healthcare
Flexible Spending Account (FSA)

How the Health Savings Account (HSA) 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 withdrawals 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 (HSA) Contributions

How much can you contribute in 2027?



Individual

\$4,500

Total combined
(employee/employer)
contribution allowed



Family

\$9,000

Total combined
(employee/employer)
contribution allowed



Catch-up ($\geq$ age 55)

\$1,000

Additional amount
allowed for those
55 and older

Health Savings Account (HSA) Setup

Setup with HealthEquity is automatic with CDHP enrollment



- Activate by calling HealthEquity at [877-713-7712](tel: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



Can use your own bank or a qualified financial institution

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

Medical Benefits

Term	Definition
✓ 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

Anthem PPO 100 | Cigna PPO 100

	Network	Out-of-Network
Deductible	\$500 individual / \$1,000 family	\$1,000 individual / \$2,000 family
Out-of-Pocket Limit	\$3,500 individual / \$7,000 family	\$7,000 individual / \$14,000 family
Office Visit	\$35 copay (primary care) \$50 copay (specialist) \$0 (preventive care)	50% coinsurance
Diagnostic Tests	0% coinsurance	50% coinsurance
Urgent Care	\$60 copay	\$60 copay
Emergency Care	\$250 copay	\$250 copay
Outpatient Surgery	\$200 copay	50% coinsurance
Hospital Stay	\$250 copay	50% coinsurance
Behavioral Health (outpatient)	\$35 copay	30% coinsurance

Medical Benefits

Anthem PPO 90 | Cigna PPO 90

	Network	Out-of-Network
Deductible	\$1,000 individual / \$2,000 family	\$2,000 individual / \$4,000 family
Out-of-Pocket Limit	\$4,000 individual / \$8,000 family	\$8,000 individual / \$16,000 family
Office Visit	\$35 copay (primary care) \$50 copay (specialist) \$0 (preventive care)	50% coinsurance
Diagnostic Tests	10% coinsurance	50% coinsurance
Urgent Care	\$60 copay	\$60 copay
Emergency Care	\$250 copay	\$250 copay
Outpatient Surgery	10% coinsurance	50% coinsurance
Hospital Stay	10% coinsurance	50% coinsurance
Behavioral Health (outpatient)	\$35 copay	30% coinsurance

Medical Benefits

Anthem PPO 80 | Cigna PPO 80

	Network	Out-of-Network
Deductible	\$1,500 individual / \$3,000 family	\$3,000 individual / \$6,000 family
Out-of-Pocket Limit	\$5,000 individual / \$10,000 family	\$10,000 individual / \$20,000 family
Office Visit	\$35 copay (primary care) \$50 copay (specialist) \$0 (preventive care)	50% coinsurance
Diagnostic Tests	20% coinsurance	50% coinsurance
Urgent Care	\$60 copay	\$60 copay
Emergency Care	\$250 copay	\$250 copay
Outpatient Surgery	20% coinsurance	50% coinsurance
Hospital Stay	20% coinsurance	50% coinsurance
Behavioral Health (outpatient)	\$35 copay	30% coinsurance

Medical Benefits

Anthem CDHP-15* | Cigna CDHP-15*

	Network	Out-of-Network
Deductible	\$2,200 individual / \$4,400 family	\$4,400 individual / \$8,800 family
Out-of-Pocket Limit	\$3,900 individual / \$7,800 family	\$7,800 individual / \$15,600 family
Office Visit	15% coinsurance (primary care / specialist) \$0 (preventive care)	40% coinsurance 40% coinsurance
Diagnostic Tests	15% coinsurance	15% coinsurance (Anthem) 40% coinsurance (Cigna)
Urgent Care	15% coinsurance	15% coinsurance (Cigna) 40% coinsurance (Anthem)
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	\$3,600 individual / \$7,200 family	\$7,200 individual / \$14,400 family
Out-of-Pocket Limit	\$5,000 individual / \$10,000 family	\$10,000 individual / \$20,000 family
Office Visit	20% coinsurance (primary care / specialist) \$0 (preventive care)	45% coinsurance 45% coinsurance
Diagnostic Tests	20% coinsurance	20% coinsurance (Anthem) 45% coinsurance (Cigna)
Urgent Care	20% coinsurance	20% coinsurance (Cigna) 45% coinsurance (Anthem)
Emergency Care	20% coinsurance	20% coinsurance
Outpatient Surgery	20% coinsurance	45% coinsurance
Hospital Stay	20% coinsurance	45% coinsurance
Behavioral Health (outpatient)	20% coinsurance	45% coinsurance

Active Employees Age 65 and Over

Under the Age Discrimination in Employment Act...



Employers offering Medical Trust health plans to active employees under 65 & spouses must

- offer the same plans to active employees/spouses 65+ irrespective of employee Medicare eligibility

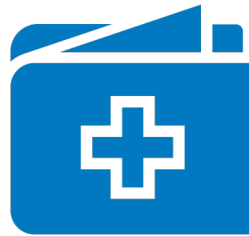
Employees must

- meet plan eligibility requirements

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

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

Under the MSP-SEE



Medicare =
Primary Payer



Medical Trust =
Secondary Payer

Eligibility Requirements

Employees/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 prior 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 A and B) based on age only

MSP-SEE Enrollment and Disenrollment Process



Resources

cpg.org/eLearning | cms.gov

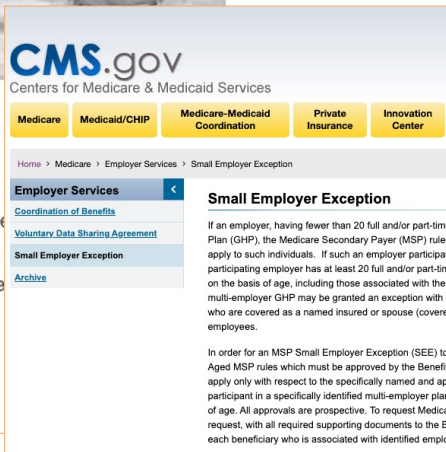


MOBILE-FRIENDLY!

Medicare Secondary Payer
- Small Employer Exception

Here's information to help with understanding how Medicare and your employer's plan work together to assist with decisions on what to do, when, and why.

[Launch Course](#)



cpg.org

- Medicare Secondary Payer SEE Member Fact Sheet
- Administrative Policy Manual
- Letter Template for Active Employees Turning Age 65

cms.gov

- Small Employer Exception

Details About Your Medical Coverage

Summaries of Benefits and Coverage



Anthem BlueCard PPO 80

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

Coverage Period: 01/01/20XX – 12/31/20XX

Coverage for: All tiers | Plan Type: PPO



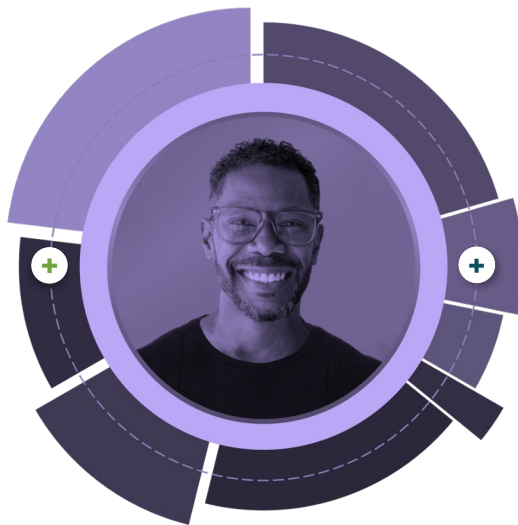
The Summary of Benefits and Coverage (SBC) document will help you choose a health [plan](#). The SBC shows you how you and the [plan](#) would share the cost for covered health care services. NOTE: Information about the cost of this [plan](#) (called the [premium](#)) will be provided separately. This 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/midocs 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: \$ ^{***} Individual / \$ ^{***} Family Out-of-Network: \$ ^{****} Individual / \$ ^{****} 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: \$ ^{****} Individual / \$ ^{****} Family Out-of-Network: \$ ^{****} Individual / \$ ^{****} 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
- Finding in-network providers
- Comparing provider cost and quality ratings



- Confirming coverage and obtaining precertifications
- Contacting doctors to coordinate treatment
- Resolving claims, billing, and benefits questions—and lots more!

Members can still contact their medical providers directly for services.



Quantum Health

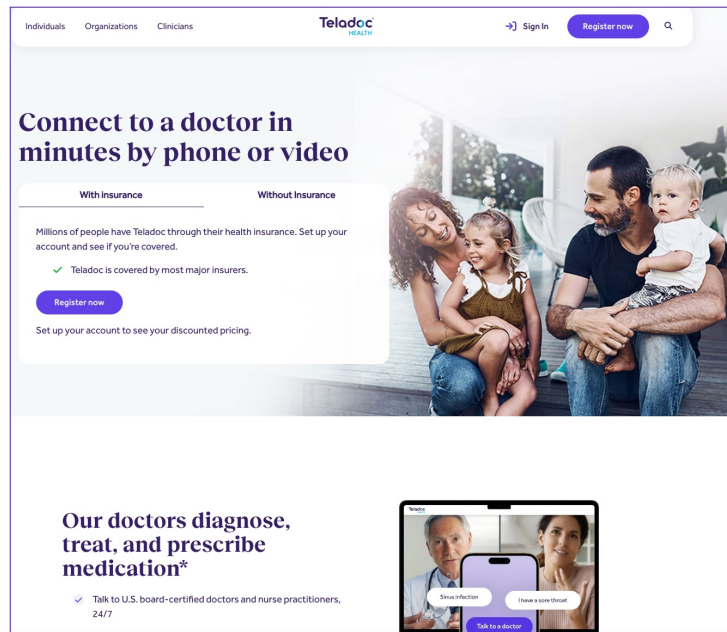
- They can save on out-of-pocket costs
- They qualify for a coaching program
- There is a concern about their prescriptions
- A procedure or discharge follow-up is required

**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 Teladoc Health



Teladoc Health offers

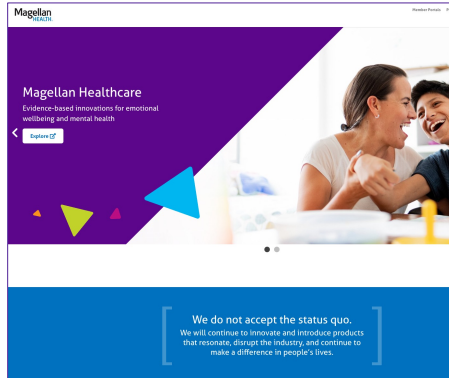
- 24/7/365 services via phone, website, or app
- Access to board-certified doctors and nurse practitioners
- Treatment for a wide range of medical and behavioral health conditions

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

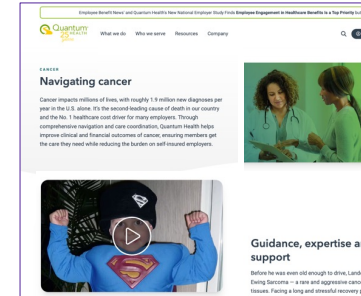
Additional Services (continued)

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

Coverage Review and Prior Authorization

For plan payments to be made, certain services require preapproval



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, you're responsible for ensuring 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.

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



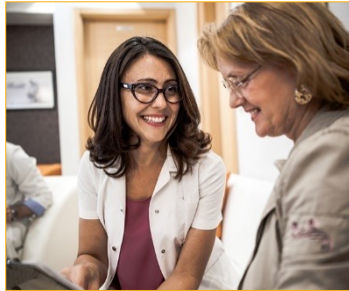
Visit MyQuantumCare.org



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

≡≡≡ For Help with Mental Health or Substance Use Disorder ≡≡≡

Anthem and Cigna members, contact Quantum



Benefit highlights

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



Please note

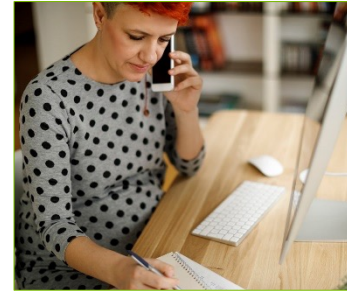
- Prior authorization may be required for certain services.

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](https://mycigna.com)

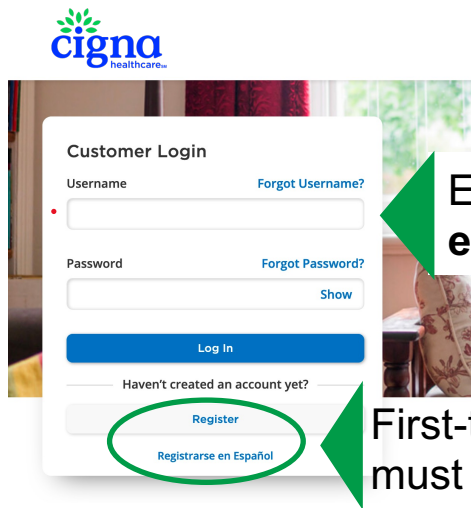
Additional features

- \$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



Customer Login

Username [Forgot Username?](#)

Password [Forgot Password?](#) [Show](#)

[Log In](#)

Haven't created an account yet?

[Register](#)

[Registrarse en Español](#)

Employer Name or ID:
episcopal

First-time visitors
must register

Webpage detail

What best describes you?

- ☐ I'm the Subscriber on a non-Medicare/Medicaid plan
– The person who signed up for the plan either through your employer or on your own, through a health exchange.
- ☐ I'm a Dependent on a non-Medicare/Medicaid plan
– A child, spouse or domestic partner covered under the subscriber's plan.
- ☐ I'm a Cigna Medicare Customer
- ☐ I'm a Medicaid Customer
- ☒ I want to register for the Employee Assistance Program ONLY

[Next](#)



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

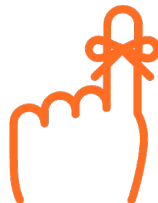
Prescription Drug Benefits

Managed by Express Scripts



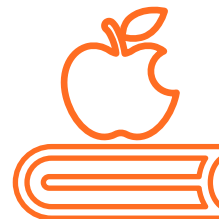
Benefit highlights

- Generic and brand-name drugs
- Accredo Specialty Pharmacy
 - SaveOnSP
- Broad national retail pharmacy network
- EncircleRx weight-management
- Home delivery



Things to remember

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



More information

- Plan Document Handbook
- Summary of Benefits and Coverage
- [Call Quantum at 866-871-0629](tel:866-871-0629)

New virtual care at no member cost

In 2027, The Episcopal Church Medical Trust will provide eligible employees and dependents whose plans use the Anthem and Cigna networks access to Digbi's tailored virtual care program

Personalized, science-based guidance

Digbi uses precision biology—including at-home gut microbiome and genetic testing—plus glucose tracking and expert coaching to help individuals

Support for multiple needs

Digbi can help manage weight (with or without GLP-1s), blood sugar, digestive issues, and more

≡ Digbi: New Weight-Management Vendor for 2027 ≡

ENDING

GLP-1 coverage

GLP-1s for weight loss, with or without co-morbidities, will not be covered by our medical plans.

GLP-1s will continue to be covered for diabetes treatment*



STARTING

Digbi

Personalized support for glucose health, digestive wellness, and weight reduction**

More information to come.

*Subject to applicable utilization management requirements, prior authorization requirements, and other plan terms.

**GLP-1s may be obtained outside Medical Trust plans from manufacturers at direct-to-consumer prices.

Prescription Drug Benefits

2027 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 \$90 copay for 30 day supply
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 via Home Delivery.

Prescription Drug Benefits

2027 Express Scripts—CDHP-15

	Retail and Home Delivery
Deductible (combined with medical deductible)	\$2,200 individual / \$4,400 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 up to 90-day supply (home delivery)

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

Prescription Drug Benefits

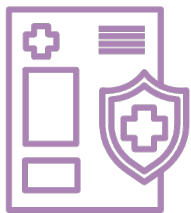
2027 Express Scripts—CDHP-20

	Retail and Home Delivery
Deductible (combined with medical deductible)	\$3,600 individual / \$7,200 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 up to 90-day supply (home delivery)

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

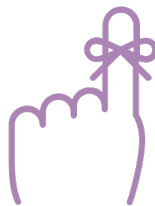
Benefits Overview

EyeMed Insight Network



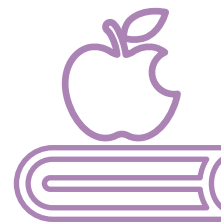
Benefit highlights

- \$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](tel:866-871-0629)
- Kaiser: call EyeMed at [866-723-0513](tel:866-723-0513)
- Visit eyemedvisioncare.com/ecmt
- Use EyeMed app

Plan Benefits

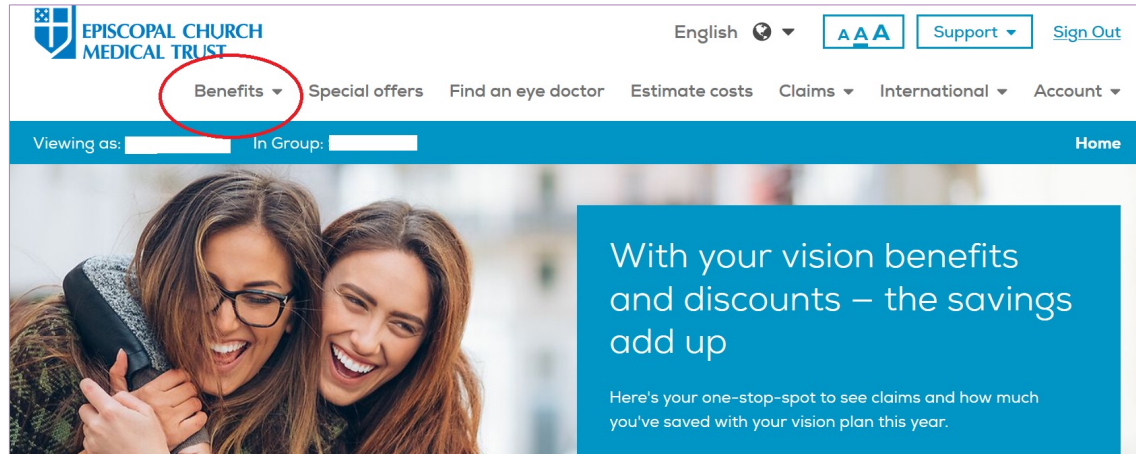
See Summary of Benefits at cpg.org/mtdocs

	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

Hearing Aid Benefits

Benefit allowance and hearing aid device discounts

- All active plans: Anthem, Cigna, Kaiser
- 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)

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



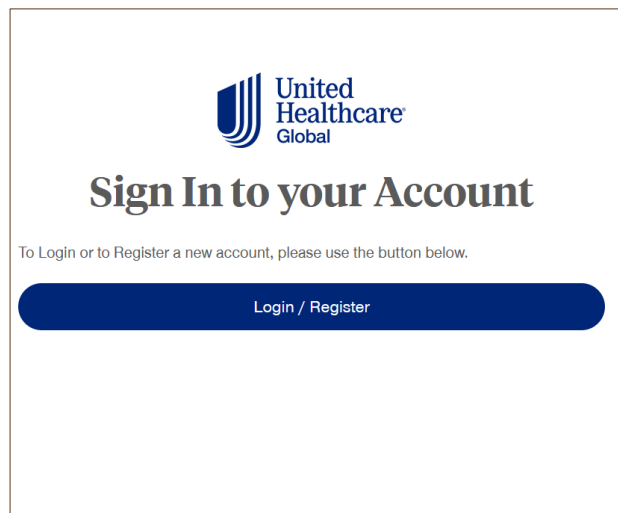
Getting in touch

- In US, call [800-527-0218](tel:800-527-0218)
Outside US, call collect: [410-453-6330](tel:410-453-6330)
- Email assistance@uhcglobal.com
- Visit uhcglobal.com

Accessing Resources Online

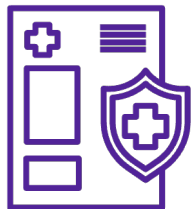
Follow the on-screen instructions to complete your account setup

worldwatch.uhcglobal.com

A screenshot of the UnitedHealthcare Global website's sign-in page. At the top is the UnitedHealthcare Global logo. Below it, the text "Sign In to your Account" is displayed in a large, bold font. Underneath this, a smaller line of text reads "To Login or to Register a new account, please use the button below." At the bottom of the section is a dark blue button with the text "Login / Register" in white.

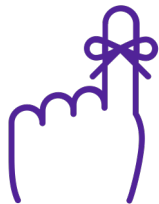
Log in to your account and discover all the ways UnitedHealthcare Global Assistance can help you.

Delta Dental Benefits



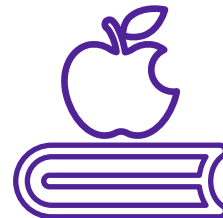
Benefit Highlights

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



Things to Remember

- Networks: Delta Dental PPO and Delta Dental Premier
- Balance billing: difference between dentist charge and Delta Dental allowance. Any dentist charge over Delta Dental allowance may be charged with out-of-network providers



Additional Information

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

Dental Plan Comparison–Premium Plan

Delta Dental Premium Plan (2027)

	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 (2027)

	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

Dental Plan Comparison–Basic

Delta Dental Basic (2027)

	PPO Network	Premier Network	Out-of-Network
Deductible	\$0/\$0	\$0/\$0	\$0/\$0
Annual Benefit Limit*	\$2,000	\$1,500	\$1,000
Preventive and Diagnostic	No charge	No charge	No charge
Basic Restorative	80% coinsurance**	80% coinsurance	70% coinsurance
Major Restorative	40% coinsurance	40% coinsurance	1% coinsurance
Orthodontic Services	Not covered	Not covered	Not covered
Orthodontia Lifetime Maximum**	N/A	N/A	N/A

*Plan payments apply toward maximums across all networks.

**What the plan pays

Delta Dental SmileWay® Wellness Benefits¹

Expanded dental coverage



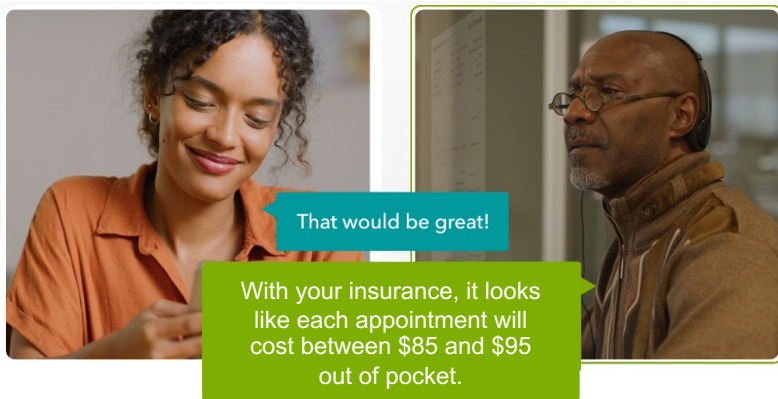
Available to members with any of the following diagnoses:

- 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

¹Known as SmileWay Enhanced Benefits in Texas.

Annual Enrollment Support

For members whose plans use Anthem and Cigna networks



During the 2027 Annual Enrollment period, **Quantum Care Coordinators** will be available to help members understand plan options and choose the right one for themselves and their dependents.

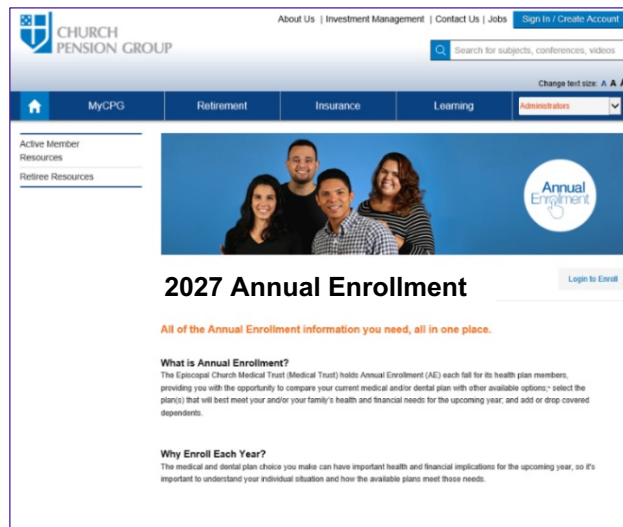
- Compare plan options
- Understand coverages
- Understand out-of-pocket costs

Call Quantum Health at 866-871-0629

Step 1: Learn

Learn about your 2027 options

cpg.org/annualenrollment



Customized content

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



Step 2: Evaluate

Do your benefits still align with your needs?



Factors to consider

- Use of healthcare
- Provider choice



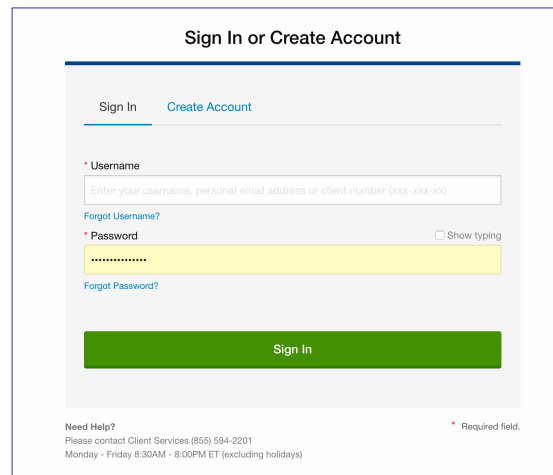
Out-of-pocket costs

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

Step 3: Decide

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

cpg.org/mycpg



The screenshot shows a web form titled "Sign In or Create Account". It has two tabs: "Sign In" (selected) and "Create Account". Under the "Sign In" tab, there is a field for "Username" with a placeholder "Enter your username, personal email address or client number (xxx-xxx-xx)". Below this is a link "Forgot Username?". There is also a field for "Password" with a placeholder "*****" and a "Show typing" checkbox. Below the password field is a link "Forgot Password?". At the bottom of the form is a green "Sign In" button. At the very bottom of the page, there is a "Need Help?" section with contact information: "Please contact Client Services (855) 594-2201 Monday - Friday 8:30AM - 8:00PM ET (excluding holidays)". A red asterisk indicates a "Required field."



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



Three Steps to Annual Enrollment: Learn, Evaluate, Decide



Step 3: Decide

Make your health plan selections



The screenshot displays the 'MyCPG' portal for user 'SDiosdrentestingone'. The 'Coverage' section shows 'Current Plan' details for 'Medical Plan' (Aetna BCBS BlueCard PPO 100) and 'Dental Plan' (Aetna Freedom Choice Dent). Below this, 'Annual Enrollment Options' are listed, including 'Plan Reference Documents' and 'Participant Selection'. The 'Confirmation' section shows a summary of selections, including 'Medical Plan' and 'Dental Plan', with checkboxes for 'Self' and 'Spouse/Dependent' under 'Medical Coverage' and 'Dental Coverage'. A 'Check New Plan' button is visible at the bottom.



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

- Medical
- Dental



Key Annual Enrollment Dates

Early October 2026

Your Email
Sent



October 14, 2026

Annual Enrollment
Begins



November 6, 2026

Annual Enrollment
Ends



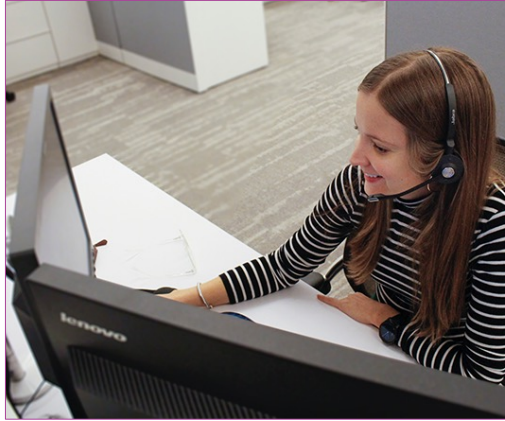
January 1, 2027

New Plan Year
Begins



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

Complimentary Financial Discussions

**Contact the Church Pension Group
Financial Education Specialists for
a confidential discussion.**

Call 888-735-7114,
Monday to Friday,
8:30 AM to 8:00 PM ET



Online scheduling tool
cpg.org/letschat



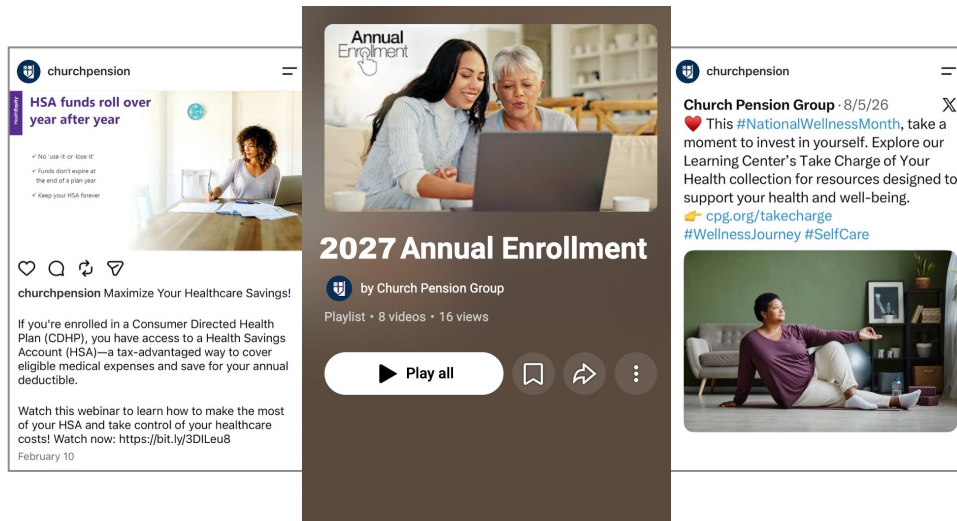
Larry Dresner
English



Toni Marie Sutliff
English and Spanish

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 plan provider websites

Follow Us! @ChurchPension



Questions & Answers



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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.

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