







Episcopal Church Medical Trust

Kate Baxley
Regional Account Specialist
Western Region, IBAMS

Debra Klinger
Human Resources Administrator, Episcopal Diocese of Texas

Diocese of Texas
2015 Medical and Dental Plans

CHURCH PENSION GROUP

About the Medical Trust

Introduction

A partnership in good health – why we are here today

- **Healthcare benefits overview**
  - About the Medical Trust
  - Healthcare Plans
  - Pharmacy Benefits
  - 2015 Benefits Update
  - Dental Plans
  - Beyond the Basics – Additional Benefits
  - Rollout of the Employee Roster
  - Resources

About the Medical Trust

- **Trust established in 1978**
- **Self-funded through a Voluntary Employees' Beneficiary Association (VEBA)**
- **Serves domestic Episcopal dioceses, parishes, missions, schools, and institutions**
- **Dedicated to serving The Episcopal Church**
  - 144 Participating Groups
  - 21,000+ households with medical coverage
  - 14,000+ households with dental coverage

Our Mission

Provide access to high-quality benefits and consistent service, balancing compassionate benefits with financial stewardship

The Medical Trust

Serving the Church

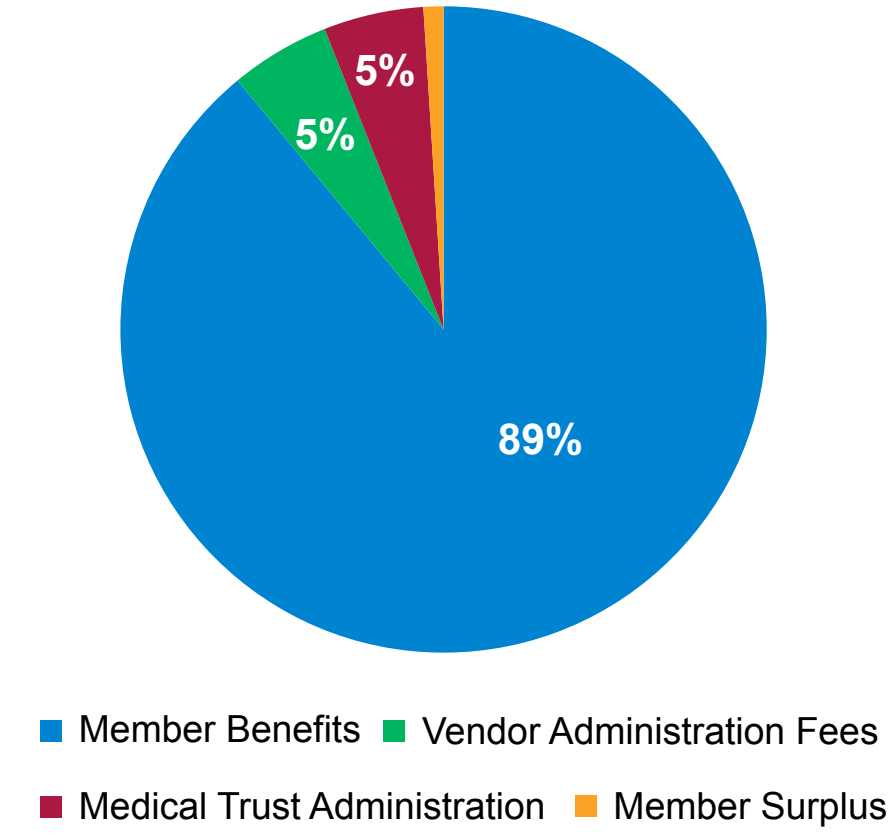
- High-quality health plans that provide robust benefits
- Advocacy for employers and employees
- Competitive rating and stability
- High levels of client service and satisfaction

Financial Sustainability

- Proactive case/risk management
- Cost reduction and mitigation
- Stable and adequate reserving

How Is Each Dollar Spent?

89% of each dollar goes to benefits and an additional percent to member surplus*



*Above ACA minimum requirement of 85% for large groups and 80% for small groups.

2015 Medical Plan Choices – Active Employees and Pre-65 Retirees

2015 Medical Plan Choices

Network-Only Plan

- Aetna HMO
- Anthem BCBS EPO 80

Network & Out-of-Network Plans

- Cigna Open Access Plus (OAP)
- Cigna HDHP / HSA
- Anthem BCBS PPO 75/50

All Plans: Preventive Care

Routine and Preventive Services

Benefits include covered services received in a physician's office such as:

- **Routine exams**
- **Well-Woman and Well-Man exams**
- **Routine exam X-rays and lab services**
- **Well-Child checkups**
- **Immunizations**
- **Other Routine Services**

Women's Preventive Care

In accordance with the Affordable Care Act women's preventive care services are available with no copay or coinsurance on a network basis:

- **Annual visit and recommended preventive services**
- **Breastfeeding counseling and equipment such as breast pumps**
- **FDA-approved contraceptive methods**
- **Domestic violence screening and counseling**
- **Gestational diabetes screening for pregnant and high-risk women**
- **HIV screening and counseling annually**
- **Sexually transmitted infections counseling annually**
- **Human papillomavirus (HPV) testing every 3 years**

Aetna National HMO — At a Glance

Plan Provision	Network
Annual deductible (person/family)	$0 / $0
Annual OOP max (person/family) (total = annual deductible + annual coinsurance max)	$2,000 / $4,000
Member coinsurance	0%
Office visit	**$0 Preventive** $25 (PCP or Specialist)
Urgent care	$50 copay
Emergency room	$100 (waived if admitted)
Inpatient hospital	$150 copay per day, $500 max per admission
Outpatient hospital	$250 copay

*Amounts shown are combined limits for both medical/behavioral and prescription costs.

Anthem BCBS EPO 80 — At a Glance

Plan Provision	Network
Annual deductible (person/family)	$350 / $700
Annual OOP max (person/family) (total = annual deductible + annual coinsurance max)	$2,350 / $4,700
Member coinsurance	20%
Office visit	**$0 Preventive** $25 (PCP or Specialist)
Urgent care	20%
Emergency room	$100
Inpatient hospital	20%
Outpatient hospital	20%

*Amounts shown are combined limits for both medical/behavioral and prescription costs.

Cigna OAP— At a Glance

Plan Provision	Network	Out-of-Network
Annual deductible	$500 / $1,000	$1,000 / $2,000
Annual OOP max* person/family (total = annual deductible + annual coinsurance max)	$2,500 / $5,000	$6,500 / $13,000
Member coinsurance	20%	40%
Office visit	**$0 Preventive** $25 (PCP/Specialist)	40%
Urgent care	$50 copay	$50
Emergency room	$100 copay	$100
Inpatient hospital	$250 copay per admission, then 20%	40%
Outpatient surgery	$250 copay	40%

*Amounts shown are combined limits for both medical/behavioral and prescription costs.

Anthem BCBS PPO 75/50 — At a Glance

Plan Provision	Network	Out-of-Network
Annual deductible	$900 / $1,800	$1,800 / $3,600
Annual OOP max* person/family (total = annual deductible + annual coinsurance max)	$4,100 / $8,200	$8,200 / $16,400
Member coinsurance	25%	50%
Office visit	**$0 Preventive** $35 PCP/ $45 Specialist	50%
Urgent care	25%	$50
Emergency room	$100	$100
Inpatient hospital	$100 copay per day, max $600 per admission, then 25%	50%
Outpatient hospital	25%	50%

*Amounts shown are combined limits for both medical/behavioral and prescription costs.

HDHPs / HSAs: The Basics

Medicare Supplement Plans

Who is Eligible to Enroll in a Medicare Supplement Plan?

- **Retirees of the Episcopal Church who are:**
- **Clergy or Lay retirees (Post 65 years old)**
  - Retired with at least 5 full years credited service (YCS)
  - Enrolled in Medicare Part A and Part B
  - Medicare-enrolled spouse or domestic partner of eligible retirees
  - Medicare-enrolled surviving spouse, surviving domestic partner or the surviving disabled dependent (disability must have begun before age 25) of eligible retirees

2014 Medicare Supplement Plans

Benefit Type	Medicare A&B	Compare the Plans: Comprehensive	Plus	Premium
Annual Out-of-Pocket Maximum (Medical Only)*	No Limit	$2,000	$1,750	$1,500
Medicare Inpatient Deductible per Benefit Period** (Days 1-60)	Member Pays $1,216	Member Pays $390	Member Pays $150	Plan Pays 100%
Inpatient Coinsurance** (Days 61-90)	Member Pays $304/Day	Plan Pays 100%		
Inpatient Coinsurance** (Days 91+)	Member Pays $608/Day	Plan Pays 100%		
Skilled Nursing Facility** (Days 21-100); Limit 100 Days per Benefit Period	Member Pays $152/Day	Plan Pays 100%		

* Pharmacy and Vision costs do NOT count toward annual out-of-pocket maximum.

** Benefit period begins at admission, ends when no inpatient care is received for 60 days; applies to Part A covered services.

2014 Medicare Supplement Plans (cont'd)

Compare the Plans

Benefit Type	Medicare A&B	Comprehensive	Plus	Premium
Durable Medical Equipment	Member Pays 20%	Plan Pays 100%		
Physician Office Visits	Member Pays "20%	Member Pays $20	Member Pays $15	Member Pays $15
Annual Routine Physical	Only "Welcome to Medicare" Covered	Plan Pays 100% (Limit $200 for office visit only)		
Outpatient Hospital/ Surgery	Member Pays Various Amounts	Member Pays $275	Member Pays $275	Member Pays $175
Outpatient Therapy**	Member Pays Various Amounts	Member Pays 30%*	Member Pays 20%*	Member Pays 0%***
Routine & Preventive Services	Member Pays Various Amounts	Plan Pays 100% (Includes some services not covered by Medicare)		
All Other Services	Member Pays Various Amounts	Member Pays 30%*	Member Pays 20%*	Member Pays 20%*

* You pay only this % of the amount remaining AFTER Medicare pays.
** Includes Speech, PT, OT, (see Plan Handbook for details).
*** Continues after Medicare Benefits are exhausted.

HDHP / HSA

- **High Deductible Health Plan**
  - Traditional PPO Plan
  - Designed to be partnered with a Health Savings Account
- **Health Savings Account**
  - Tax advantaged account for qualified healthcare expenses
- **HDHP / HSA Fact Sheet – www.cpg.org/mtdocs**

Cigna HDHP/HSA — At a Glance

Plan Provision	Network	Out-of-Network
Annual deductible	$2,700 / $5,450	$3,000 / $6,000
Annual coinsurance max (total = medical + Rx coinsurance)	$1,500 / $3,000	$4,000 / $7,000
Annual OOP max* (total = annual deductible + annual coinsurance max)	$4,200 / $8,450	$7,000 / $13,000
Member coinsurance	20%	45%
Office visit	**$0 Preventive** 20% (PCP or Specialist)	45%
Urgent care	20%	20%
Emergency room	20%	20%
Inpatient hospital	20%	45%
Outpatient surgery	20%	45%

*Amounts shown are combined limits for both medical/behavioral and prescription costs.

Pharmacy Benefits — Express Scripts

	Non-HDHP Plans – Premium Plan		Non-HDHP Plan – Standard Plan		Cigna HDHP/HSA
	Retail	**Mail Order**	**Retail**	**Mail Order**	**Retail & Mail Order**
Annual Prescription Deductible	$50 per person	None	$50 per person	None	$2,700 per person $5,450 per family (Combined with Medical)
Annual Out-of-Pocket Maximum	$2,500 individual / $5,000 family in-network $2,500 individual / $5,000 family out-of-network (accumulates separately from the medical benefit)				$4,200 individual / $8,450 family in-network $7,000 individual / $13,000 family out-of-network (combined with medical)
Copays Tier 1: Generic	Up to $5	Up to $12	Up to $10	Up to $25	You pay 15% after deductible
Copays Tier 2: Formulary	Up to $25	Up to $70	Up to $35	Up to $90	You pay 25% after deductible
Copays Tier 3: Non-formulary	Up to $45	Up to $110	Up to $60	Up to $150	You pay 50% after deductible
Dispensing Limits per Copayment	Up to a 30-day supply	Up to a 90-day supply	Up to a 30-day supply	Up to a 90-day supply	Up to a 30-day supply (retail) or 90-day supply (mail order)

Additional Benefits

- Employee Assistance Program (EAP)
- Health Advocate
- EyeMed Vision
- FrontierMEDEX
- HearPO

DHP Denominational Healthcare Plan

- **The Executive Board decided in 2013 that EDOT will achieve parity by offering single coverage to both lay and clergy staff hired after 1/1/15.**
- **The parity mandates that each parish pay for single coverage equal to Cigna High Deductible Plan plus 80% HSA contribution.**
- **For 2015 this is a monthly cost of: $472 plus $180 = $652.00 ***
- *** Lay employees can buy-up to other coverage**

HDHPs: The Stories Behind the Benefits

Richard is Single. How Does an HDHP Work for Him?

It's January 15, and Richard slips on the ice!

- His network doctor sends him for an MRI at a network facility. The doctor's visit and MRI would have cost Richard $5,000. Good thing he's in the Medical Trust's HDHP with negotiated rates! He pays $3,000
- Unfortunately, Richard broke his ankle during the fall and is in great pain. He needs lots of medicine, with a cost of $1,000. Good thing he's in the Express Scripts program, with a negotiated cost of $800
- How do these medical and prescription costs work with an HDHP?

Let's take a look!

Richard's Bucket List

Bucket #1:
The Annual Deductible

Richard must fill this bucket by paying 100% of the negotiated cost of services ($2,700 for a single person)

Richard's negotiated doctor and MRI costs = $3,000

$2,700

Bucket #2:
Maximum Annual Coinsurance

Richard must fill this bucket by paying the appropriate co-insurance ($1,500 for a single person)

Richard's co-insurance is 20% of the remaining $300 = $60

Richard's co-insurance for the $800 of formulary medication is 25% = $200

Richard's 2nd bucket is not yet full. He still has to pay $1,240 to fill his bucket

$60 + $200 = $260

Bucket #1 = $2,700 + Bucket #2 = $1,500 = $4,200 Out-of-Pocket Maximum (OOP)

Richard, Mary and their Two Children, Nan and Bert Have Family Coverage. How Does an HDHP Work for Them?

On January 2nd the family gets hit by a beer truck!

- While their injuries are minor, they all require medical care
- At the emergency room, they had X-rays, medications and Bert was treated for a broken arm. The cost for their care was $30,000! Good thing they are in the Medical Trust's HDHP with negotiated rates which are $22,000
- How do these costs work with an HDHP?

Let's take a look!

The Family's Bucket List

Bucket #1: Annual Deductible

The family must fill this bucket by paying 100% of the negotiated cost of services (up to the $5,450 network deductible for a family)

The family's negotiated cost of services = $22,000

$5,450

Bucket #2: The Family's Annual Coinsurance Maximum

The family must fill this bucket by paying the appropriate coinsurance (up to the $3,000 maximum for a family)

The family's coinsurance is 20% of the remaining $16,550 (which equals $3,310). However, they only have to pay $3,000

They have met their annual Out of Pocket Maximum (OOP). For the remainder of the year, all of their network medical, pharmacy and behavioral health is provided with no further cost share

$3,000

Bucket #1 = $5,450 + Bucket #2 = $3,000 = $8,450 OOP

Fenton, Laura and their two children, Joe and Frank Have Family Coverage. How Does an HDHP Work for Them?

On Spring break, the family goes skiing. Joe likes to hot dog and gets hurt!

- **Joe reluctantly goes to the emergency room. At the emergency room, he has X-rays and is diagnosed with a concussion. Joe has to stay overnight. The cost for his care was $9,000. Good thing they are in the Medical Trust's HDHP with negotiated rates which are $5,700**
- **How do these costs work with an HDHP?**

Let's take a look!

Joe's Bucket List (Which Counts Toward the Family's Bucket)

Bucket #1: Annual Deductible

While the family's total annual deductible is 100% of the negotiated cost of services to a maximum of $5,450, each individual never pays more than $2,700

Joe's negotiated cost of services = $5,700

Joe's Bucket: $2,700

Family's Bucket: $5,450

Bucket #1 remaining Annual Deductible for the family is $2,750

Bucket #2: The Family's Annual Coinsurance Maximum

While the family's Annual Coinsurance Maximum is $3,000, Joe's Annual Coinsurance is $1,500. He has an outstanding balance of $3,000 ($5,700 – $2,700) and will pay 20% of this cost = $600

Joe still has $900 left to fill bucket #2 before his health costs are provided with no further cost share.

Joe's Bucket: $600

Family's Bucket: $3,000

Bucket #2 remaining Annual Coinsurance for the family is $2,400

Fenton Gets the Flu!

Bucket #1:
Annual Deductible

While the family's total annual deductible is 100% of the negotiated cost of services to a maximum of $5,450, with Joe's injury, the balance of the family's deductible is $2,750.

Fenton's **network** doctor visit is $145 with a negotiated cost of $80. He also needs medication with a negotiated cost of $900 (the true cost was $1,400).

Fenton stays in bucket #1, until he reaches the Annual Deductible of $2,700. He still has $1,720 to fill his bucket!

Fenton's Bucket: $980

Balance of the Family's Bucket: $2,750

Bucket #1: Remaining Annual Deductible for the family is $1,770

HDHP / HSA — The Details

Who is Eligible to Have a Health Savings Account

- **Must be enrolled in a qualifying HDHP**
- **Cannot be covered by other medical insurance, including Medicare, with limited exceptions:**
  - Can have AFLAC-type coverage
  - Can have separate dental or vision coverage
  - Can have disability coverage
- **Cannot contribute to a Health Savings Account while using a regular Flexible Spending Account (FSA)**
  - Instead, enroll in a “limited purpose” FSA (if available)

Setting Up the Health Savings Account

- **The Medical Trust has a partnership with JP Morgan Chase***
  - You must set up the account
  - The Medical Trust will pay the set-up and monthly maintenance fees
  - Employer contributions go through our lock box
- **You can use any qualified financial institution (includes those that can set up IRAs)**
  - In this case, you are responsible for set up and maintenance fees

*For Cigna HSAs, HSA Bank will become the administrator beginning in the summer of 2015.

Setting Up the Health Savings Account (Cont'd.)

- **Account must be set up before contributions or distributions can be made**
  - January 1st is a holiday
  - It will take several days to establish the account on our lock box
- **Remember to designate a death beneficiary on the account**
  - If spouse, account balance not taxable on your death and your spouse can continue to use the funds as a tax-advantaged health savings account
  - If anyone else, or if you fail to designate a beneficiary, the account will be closed, the balance will be taxed, and the money distributed to your heirs

Contributing to the Account

Employer contributions →

Employee payroll deductions →

Direct deposits by employee or anyone →

- **IRS 2015 contribution maximums are $3,350 (individual) and $6,650 (family)***
  - Excess contributions are taxable to you and you pay a 10% penalty
- **You can make additional contributions, or withdraw excess contributions and associated interest, until April 15, 2016****

*These amounts are the total contribution allowed from *both* the employee and the employer. An additional $1,000 is allowed if the account holder is age 55+.

**The deadline is extended for any extensions to your tax return.

Contributing to the Account (Cont'd.)

Special Rules for Spouses / Families

- If all are enrolled in HDHPs, the maximum contribution is the family limit, which can be split evenly or as the parties decide
- Only the account holder can make the extra $1,000 contribution
- Each covered individual, except IRS dependents, is eligible for and can open a separate account

Partial / Last Month Rule

- You may make proportionate contributions only for the portion of the year you are eligible
- If you are not eligible for an HSA for the entire year, but are on the first day of December, you can make contributions as if you were eligible the entire year
- You must remain eligible for the entire next year

Distributions from the Account

- **You do not have to use the money in any particular year**
- **You can continue to use the money even when you are no longer eligible to contribute to the account**
  - Not enrolled in an HDHP
  - Enrolled in Medicare
- **You are not taxed on the amount distributed from the account IF you use it for qualifying healthcare expenses**
  - IRS Publication 502
  - Includes dental and vision out of pocket expenses
  - Includes prescription medications – no OTC products
- **If used for non-qualifying expense, you will pay federal income tax and a 20% excise tax as a penalty**
  - If you are age 65+, you don't pay the penalty

For Whom Can You Use the Account

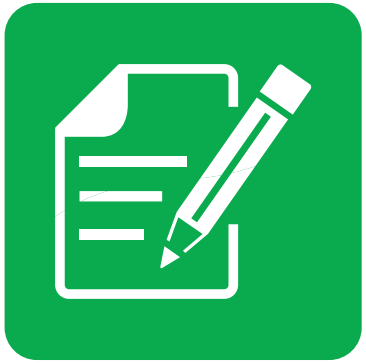
- **Yourself**
- **Your spouse (even if the spouse is not on your HDHP)**
- **Your dependents that you can claim on your tax return (even if not on your HDHP)**
  - If your age 27+ children are on your HDHP, they are eligible to set up separate HSAs and can use that money themselves
  - If your domestic partner is on your HDHP, he or she is eligible to set up a separate HSA and can use that money him or herself
  - Remember the family contribution limit

Using the Money in the Account

- **Remember that you do not have to use it!**
- **Prescriptions – you will pay at the time of filling the prescription**
  - Could be 100% of Express Scripts negotiated cost!
  - Consider getting prescriptions filled before the end of the year
- **Other services – you should NOT pay at the time of service**
  - The provider may not know whether you have met the deductible
  - The provider may not know whether you have met the out-of-pocket maximum
  - WAIT for the Explanation of Benefits before paying

Additional Paperwork

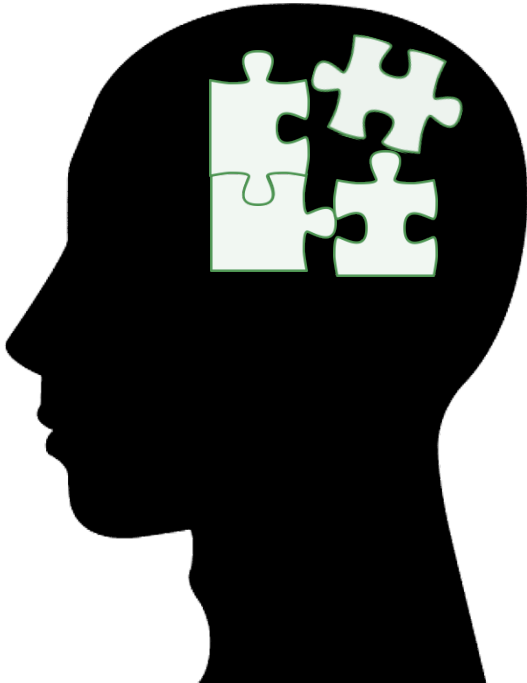
- **Remember to keep track of how much is contributed**
  - The trustee bank will send IRS Form 5498-SA to show the amount of contributions made to the account
  - Your employer will enter the amount it contributed, including your contributions made through payroll deduction, in Box 12 of your W-2
  - If over the maximum, you have until April 15 (or the date of any extension to your return) to withdraw the excess plus any interest earned on the excess
- **Remember to keep track of how each distribution is used**
  - The trustee will send IRS Form 1099-SA
  - Must have receipts to show used for qualifying healthcare expenses for audit purposes
- **Filing your tax return**
  - IRS Form 8889



Behavioral Health Benefits

- **Plan partners**
  - Cigna Behavioral Health
    - Plan partner for majority of plans
    - Thirty years experience
    - Extensive provider network for behavioral health and substance abuse

- **Robust benefits**
  - Mental Health Parity
  - Follow evidence based guidelines
  - Integrated in medical plans



Reminder: Resolution effective January 1, 2009

“ Any active clergy or Diocesan staff who no longer qualifies for the High Deductible Health Care Plan after January 1, 2009 will be limited to annual medical benefits payments for the amount of the annual premium for the Blue Cross Blue Shield EPO 80 Plan. Such individual will be offered any of the Diocese's plans that are under the Church Medical Trust umbrella for health care offered in that year, but any cost over and above the BCBS EPO 80 shall be the responsibility of that active employee. A billing statement will be sent to each employee who wishes to buy up their medical coverage."

HDHP/HSA – How the Pieces Work Together for 2015

High Deductible –Limits

If a clergy /staff employee or their spouse are turning 65 in 2015 they are no longer eligible for a High Deductible plan with the Health Savings Account

Due to Resolution-- those clergy and staff must elect one of the Blue Cross Blue Shield plans or buy-up to the Cigna Open Access Plan

2015 Buy-up costs for active clergy/staff

Level	BCBS EPO 80	BCBS 75/50	Cigna OE	Cigna Buy-Up
Single	$ 954.00	$ 868.00	$ 965.00	$ 11.00
EE + Sp	$ 1,908.00	$ 1,736.00	$ 1,930.00	$ 22.00
EE + children	$ 1,717.00	$ 1,562.00	$ 1,737.00	$ 20.00
Family	$ 2,862.00	$ 2,604.00	$ 2,895.00	$ 33.00

Your HSA Account after the Cigna High Deductible Plan

- **Your HSA account will no longer be connected to the Cigna website.**
- **If you have a balance-J P Morgan Chase will give you a new account and debit cards.**
- **All auto claim processing will discontinue.**
- **Continue to keep your receipts for all medical, dental and prescription tax qualified purchases!**
- **Once your balance is zero-you must close your account!**
- **You have the option to rollover your funds to another HSA account at your bank or credit union.**

2015 Medical Plan Choices – Retired Employees

Medicare Supplement Plans

Who is Eligible to Enroll in a Medicare Supplement Plan?

- **Retirees of the Episcopal Church who are:**
- **Clergy or Lay retirees (Post 65 years old)**
  - Retired with at least 5 full years credited service (YCS)
  - Enrolled in Medicare Part A and Part B
  - Medicare-enrolled spouse or domestic partner of eligible retirees
  - Medicare-enrolled surviving spouse, surviving domestic partner or the surviving disabled dependent (disability must have begun before age 25) of eligible retirees

Post-65 Retirement Healthcare

The Episcopal Church Medical Trust's Medicare Supplement Plans

- **Three Plan Choices administered by UnitedHealthcare**
  - Comprehensive Plan
  - Plus Plan
  - Premium Plan
- **Must be an eligible retiree or eligible spouse or surviving spouse and enrolled in Medicare Part A and B**
- **Available without Rx if enrolled in Part D**
  - With Rx better for most CPF retirees
- **Network is Medicare**
  - Does your provider accept Medicare?
- **Providers file with Medicare**
  - Medicare forwards claims to UHC
- **Supplement Plans augment Medicare covered services**
  - Additional benefits cover some services not covered by Medicare

2014 Medicare Supplement Plans

Benefit Type	Medicare A&B	Compare the Plans: Comprehensive	Plus	Premium
Annual Out-of-Pocket Maximum (Medical Only)*	No Limit	$2,000	$1,750	$1,500
Medicare Inpatient Deductible per Benefit Period** (Days 1-60)	Member Pays $1,216	Member Pays $390	Member Pays $150	Plan Pays 100%
Inpatient Coinsurance** (Days 61-90)	Member Pays $304/Day	Plan Pays 100%		
Inpatient Coinsurance** (Days 91+)	Member Pays $608/Day	Plan Pays 100%		
Skilled Nursing Facility** (Days 21-100); Limit 100 Days per Benefit Period	Member Pays $152/Day	Plan Pays 100%		

* Pharmacy and Vision costs do NOT count toward annual out-of-pocket maximum.

** Benefit period begins at admission, ends when no inpatient care is received for 60 days; applies to Part A covered services.

2014 Medicare Supplement Plans (cont'd)

Compare the Plans

Benefit Type	Medicare A&B	Comprehensive	Plus	Premium
Durable Medical Equipment	Member Pays 20%	Plan Pays 100%		
Physician Office Visits	Member Pays "20%	Member Pays $20	Member Pays $15	Member Pays $15
Annual Routine Physical	Only "Welcome to Medicare" Covered	Plan Pays 100% (Limit $200 for office visit only)		
Outpatient Hospital/ Surgery	Member Pays Various Amounts	Member Pays $275	Member Pays $275	Member Pays $175
Outpatient Therapy**	Member Pays Various Amounts	Member Pays 30%*	Member Pays 20%*	Member Pays 0%***
Routine & Preventive Services	Member Pays Various Amounts	Plan Pays 100% (Includes some services not covered by Medicare)		
All Other Services	Member Pays Various Amounts	Member Pays 30%*	Member Pays 20%*	Member Pays 20%*

* You pay only this % of the amount remaining AFTER Medicare pays.
** Includes Speech, PT, OT, (see Plan Handbook for details).
*** Continues after Medicare Benefits are exhausted.

What Is The Medicare Supplement Subsidy?

The Medicare Supplement Subsidy (Cost Assistance for the Medicare Supplement Plan)

- **CPF benefit for eligible retired clergy with 10 or more Years of Credited Service (YCS)**
- **Reviewed annually by CPF's Board of Trustees**
- **Available to eligible spouse or eligible surviving spouse**
  - Must be married on day of retirement or death and eligible cleric earned at least 3 YCS during the marriage

Costs (per month, per person with prescription drug benefit)*

Plan Type	No Subsidy	Full Subsidy
Comprehensive Plan	$310	$0
Plus Plan	$425	$155
Premium Plan	$485	$170.50

You must be enrolled in Medicare Part A and Part B and have at least 10 Years of Credited Service to be eligible.

*2014 The Episcopal Church Medical Trust Medicare Supplement Plan Costs

Disclaimer: Please note that The Church Pension Fund plans to continue to provide the Medicare Supplement subsidy. However, given the rising cost of medical care coupled with the uncertainty regarding the structure of Medicare in the future, this should not be viewed as a guarantee of the Medicare Supplement subsidy in perpetuity.

What Is The Medicare Supplement Subsidy?

Medicare Supplement Subsidy
Clergy eligible to retire before July 1, 2013?

20 YCS
- Covers full cost of Comprehensive Plan

10 to 20 YCS
- Monthly subsidy reduced $2 per year of CS under 20 years

Full subsidy cost to "buy up" in 2015 (per month/per person)
- Plus Plan with RX $115
- Premium Plan with RX $175

Subsidy can only be applied to Episcopal Church Medical Trust plans

Medicare Supplement Subsidy
Clergy NOT eligible to retire before July 1, 2013?

- Clergy receive a 50% subsidy toward cost of Comprehensive Plan with Rx at 10 YCS
- Subsidy increases 5% with each additional YCS, with full subsidy toward cost of Comprehensive Plan with Rx at 20 YCS

Examples of Medicare Supplement Subsidy Based on 2014 Monthly Rates for the Comprehensive Plan

YCS	CPF Subsidy	Member Pays
10	50%	$155.00
11	55%	$139.50
12	60%	$124.00
13	65%	$108.50
14	70%	$93.00
15	75%	$77.50
16	80%	$62.00
17	85%	$46.50
18	90%	$31.00
19	95%	$15.50
20	100%	$0

Disclaimer: Please note that The Church Pension Fund plans to continue to provide the Medicare Supplement Subsidy. However, given the rising cost of medical care coupled with the uncertainty regarding the structure of Medicare in the future, this should not be viewed as a guarantee of the Medicare Supplement Subsidy in perpetuity.

2015 Plan Contributions: Medicare Supplement with Rx

Effect of Clergy Subsidy on Contributions	No Subsidy	Full Subsidy
Comprehensive Plan with Rx	$310	$0
Plus Plan with Rx	$425	$115 *
Premium Plan with Rx	$485	$175 *

- Per person per month
- Retiree and spouse may choose different plans

* Buy-up for Plus Plan is paid for by Diocese of Texas

* Buy-up for Premium is $60.00 per month per person, $115 is paid for by Diocese of Texas

Pharmacy Benefits All Plans

Prescription Drug Benefits

- **Plan partner**
  - Express Scripts for majority of plans
- **Plan designs**
  - Standard
- **Coverage management programs**

Express Scripts Pharmacy Tiers

Generic:

- **Same active ingredients as the brand-name it replaces. Binder may differ.**

Formulary:

- **A list of brand-name drugs preferred by a plan based on clinical effectiveness and cost. *(Also called "Preferred Brand Name")***

Non-Formulary:

- **Brand-name drugs not on your plan's formulary. *(Also called "Non-Preferred Brand Name")***

Mail Order for Maintenance Meds

Mail Order required for most maintenance meds

- 3 fills covered at retail pharmacy
- After 3rd fill, Express Scripts mail order required for benefit

Mail Order is easy, convenient, accurate

- Member can mail prescription
- Doctor can fax or order online
- Email/mail reminder when refill is due
- Automatic refill available on request

Up to triple the supply for less than triple copay

- Controls costs for both member and plan

Pharmacy Benefits — Express Scripts

	Non-HDHP Plans – Premium Plan		Non-HDHP Plan – Standard Plan		Cigna HDHP/HSA
	Retail	**Mail Order**	**Retail**	**Mail Order**	**Retail & Mail Order**
Annual Prescription Deductible	$50 per person	None	$50 per person	None	$2,700 per person $5,450 per family (Combined with Medical)
Annual Out-of-Pocket Maximum	$2,500 individual / $5,000 family in-network $2,500 individual / $5,000 family out-of-network (accumulates separately from the medical benefit)				$4,200 individual / $8,450 family in-network $7,000 individual / $13,000 family out-of-network (combined with medical)
Copays Tier 1: Generic	Up to $5	Up to $12	Up to $10	Up to $25	You pay 15% after deductible
Copays Tier 2: Formulary	Up to $25	Up to $70	Up to $35	Up to $90	You pay 25% after deductible
Copays Tier 3: Non-formulary	Up to $45	Up to $110	Up to $60	Up to $150	You pay 50% after deductible
Dispensing Limits per Copayment	Up to a 30-day supply	Up to a 90-day supply	Up to a 30-day supply	Up to a 90-day supply	Up to a 30-day supply (retail) or 90-day supply (mail order)

Retired Clergy Pharmacy Benefits — Express Scripts

	Comprehensive Plan			Plus and Premium Plans		
	Retail	Retail	Mail order/ Home Delivery	Retail	Retail	Mail Order/ Home Delivery
Annual Prescription Deductible	None	None	None	None	None	None
Generic copayment	$10	$30	$25	$5	$15	$12
Formulary brand-name copayment	$30	$90	$70	$25	$75	$60
Non-formulary brand-name and all non-sedating antihistamines	$50	$150	$120	$40	$120	$100
Dispensing Limits per copayment	Up to a 31-day supply	63-90 day supply	Up to a 90-day supply	Up to a 31-day supply	63-90 day supply	Up to 90-day supply

"Generic or Pay the Difference"

Here's an example of what the member pays if a generic is available, but the brand name is specified:

Brand Name Cost = $90

Generic Cost = $30

Generic Copayment = $10

$90 Brand Name Cost - $30 Generic Cost = $60 Difference

$10 Copayment + $60 Difference

=

$70 Net Cost to the Member

If a generic medication cannot be used for a medical reason, call us to discuss.

Be Proactive!

Talk to your doctor about your plan

- Review the Express Scripts Formulary
- Ask for generic drugs when available

Look over / discuss your prescriptions

- Are paper prescriptions for Mail Order for 90 days?
- Does you doctor know to request “90 days supply”?
- Did your doctor specify that generics may be dispensed?

Rx Benefits Managed by Express Scripts

Behind-the-Scenes

- **Express Scripts review all prescriptions for:**
  - Possible drug interactions
  - Medical efficacy
  - Safety (dose, duration, etc.)
- **Prior authorization may be required based on need, quantity**
- **Express Scripts will call your doctor directly with questions**

What is Step Therapy?

- **Utilizes evidence-based medicine**
- **Certain medications will be dispensed/covered only after others have been tried and failed**

If you have already tried an alternative medication without success, call us to discuss.

2014/15 Benefits Update

2015 Plan Design Change Highlights

Prescription Drugs

- **Compounds Exclusion (9/15/2014 effective)**
- **Rx Out of Pocket Maximum**
  - $2,500 Single
  - $5,000 Family
- **Oral Contraceptives**
- **Formulary Changes**
- **Infertility**

2015 Plan Design Change Highlights

Medical/Behavioral Benefits

- **Autism Spectrum Disorder – ABA therapy**
- **Infertility**
- **Transgender**
- **High Performing Network Providers**
- **Medical Management**
- **Dialysis**

BCBS Platform Change

- **Effective January 1, 2015:**
  - Anthem BlueCross BlueShield (Anthem)
- **Highlights**
  - Same company
  - Same service quality
  - Same attention to what matters most – our members!
  - Same National PPO Network access
    - Largest network of physicians, specialists, and hospitals in the country

Quick Reference Guide to Changes

	Before January 1, 2015	After January 1, 2015
Plan Administrator Name/Brand	Empire BlueCross BlueShield	Anthem BlueCross BlueShield
Web site	www.empireblue.com/ medicaltrust	www.anthem.com
ID Card	Only use Empire ID Card for medical services rendered **prior to January 1, 2015**	Only use Anthem ID Card for medical services rendered **on or after January 1, 2015**
Member Services	1-800-352-3152	1-844-812-9207
Out-of-network Claim Filing	Empire BlueCross BlueShield PO Box 5009 Middletown, NY 10940	Anthem BlueCross BlueShield PO Box 105187 Atlanta, GA 30348

Dental

Cigna Dental — At a Glance

Plan Provision	Preventive	Basic	Dental & Orthodontia
Preventive Services (includes 3 cleanings per year)	0%	0%	0%
Basic Services	20%	15%	15%
Major Services	99%	50%	15%
Orthodontic Services	99%	Not covered	50% ($1,500 lifetime max)
Deductible (non-network only)	N/A	$50 / $150	$25 / $75
Non-Network Benefit (based on network-approved rates)	Same as In-Network	Same as In-Network	Same as In-Network
Annual Benefit Maximum (in addition to preventive care)	$1,500	$2,000	$2,000

Beyond the Basics

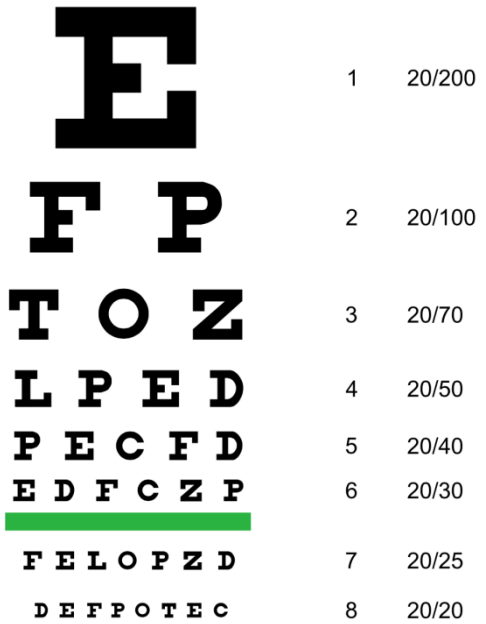
Additional Benefits

What other benefits come with Medical Trust health plans?

- **Medical Trust Plan members enjoy many "value-added" benefits, including**
  - EyeMed vision care
  - Employee Assistance Program (EAP)
  - Health Advocate
  - HearPO hearing care
  - FrontierMEDEX travel assistance
- **Vision, EAP and Health Advocate benefits are the same for Episcopal Health Plan and Medicare Supplement Health Plan members**
- **Hearing and travel benefits have differences**

EyeMed Vision Care

- **Annual eye exam with $0 copay when using network providers**
- **Annual allowance for contacts or frames; discounts on amounts in excess of allowance when using network provider. Additional eyewear purchases at 40% off**
- **Non-prescription sunglasses at 20% off**
- **20% off remaining balances beyond plan coverage limits**
  - Savings on prescription eyeglasses or contact lenses
- **Discounted pricing for LASIK or PRK surgical procedures**



Employee Assistance Program (EAP)

- Free, confidential resource for counseling, support, and life event assistance
- Administered by Cigna Behavioral Health
- Available to all members of the plan and their household members, regardless of medical coverage
- 24/7 access to EAP network clinicians nationwide
- Fast problem-solution

Employee Assistance Program (EAP)

- **Included with all medical trust plans with $0 member copay** (Tip: Use the EAP before using mental health/substance abuse benefits to save the mental health/substance abuse co-pay)
- **Up to 10 face-to-face sessions per issue at $0 copay**
- **Members can receive treatment for the same issue on multiple occasions each year**
- **Unlimited telephonic sessions**

Employee Assistance Program (EAP)

Life event resource and referral

- Child care, elder care, pet care
- Legal and financial services
- ID theft and fraud assistance

Extensive online resources

- Health and wellness
- Family and caregiving
- Daily living
- Relocation center
- Working smarter
- Savings center
- Interactive tools

Health Advocate

Private, confidential assistance for healthcare concerns

- Helps employees use benefits offered by employer
- Personalized, objective, independent assistance with clinical and administrative issues
- Service provided by experienced senior healthcare professionals
- Provides continuity of care via single point of contact

Health Advocate

A personal health advocate:

- Typically, a registered nurse with considerable experience – average 10 years – in the medical delivery system
- Chosen for medical expertise, commitment to service excellence, and strong problem-resolution skills
- Supported by physicians and specialists in claims management, behavioral health, social work, pharmacy, nutrition, wellness, lifestyle change counseling, and other specialties
- The member's single ongoing contact person

Health Advocate

Eligibility

- Active and retired members of the Medical Trust
- Members' spouses
- Members' dependent children
- Members' parents
- Members' parents-in-law

Health Advocate

Your Health Advocate can:

- Identify leading healthcare providers and institutions nationwide
- Schedule specialized treatment and tests
- Answer questions about test results, treatment recommendations, and medications recommended by your physician
- Work with insurers to obtain approvals for needed services
- Resolve insurance claims and help negotiate billing and payment arrangements
- Foster communication and benefits coordination between physicians and insurers

Health Advocate

Your Health Advocate can also:

- Arrange for transfers of medical records, X-rays and lab results
- Assist with eldercare and related healthcare issues
- Arrange for home care equipment after discharge from a hospital
- Locate and research the newest treatments for a medical condition
- Assist with finding qualified wellness programs, providers and services

FrontierMEDEX Travel Assistance

- **Provides 24/7 emergency medical advocacy**
- **Trained, multi-lingual coordinators can help you**
  - Obtain worldwide medical and dental referrals
  - Replace prescription medication and corrective lenses
  - Access various other travel-related medical services
- **FrontierMEDEX is not responsible for medical costs while you are traveling**
- **Plan Specifics**
  - Episcopal Health Plan members emergency care falls under their health plan coverage; FontierMEDEX is service assistance only
  - Medicare Supplement Health Plan members have a travel benefit under the United Healthcare plans

HearPO Hearing Care

- **Provides access to HearPO network discounts**
- **Applicable to hearing aids and supplies through more than 1,400 HearPO affiliates across the U.S.**
- **Eligibility includes extended family members**
- **Plan Specifics**
  - Episcopal Health Plan members have access to discounts only
  - Medicare Supplement Health Plan members have a hearing benefit under the United Healthcare plans

The Episcopal Church Medical Trust: Serving You

We are here to support you with:

- **Problem Resolution**
- **Education and Awareness**
- **Patient Advocacy**

Our Client Services team is available:

Monday through Friday

8:30 am to 8:00 pm EST

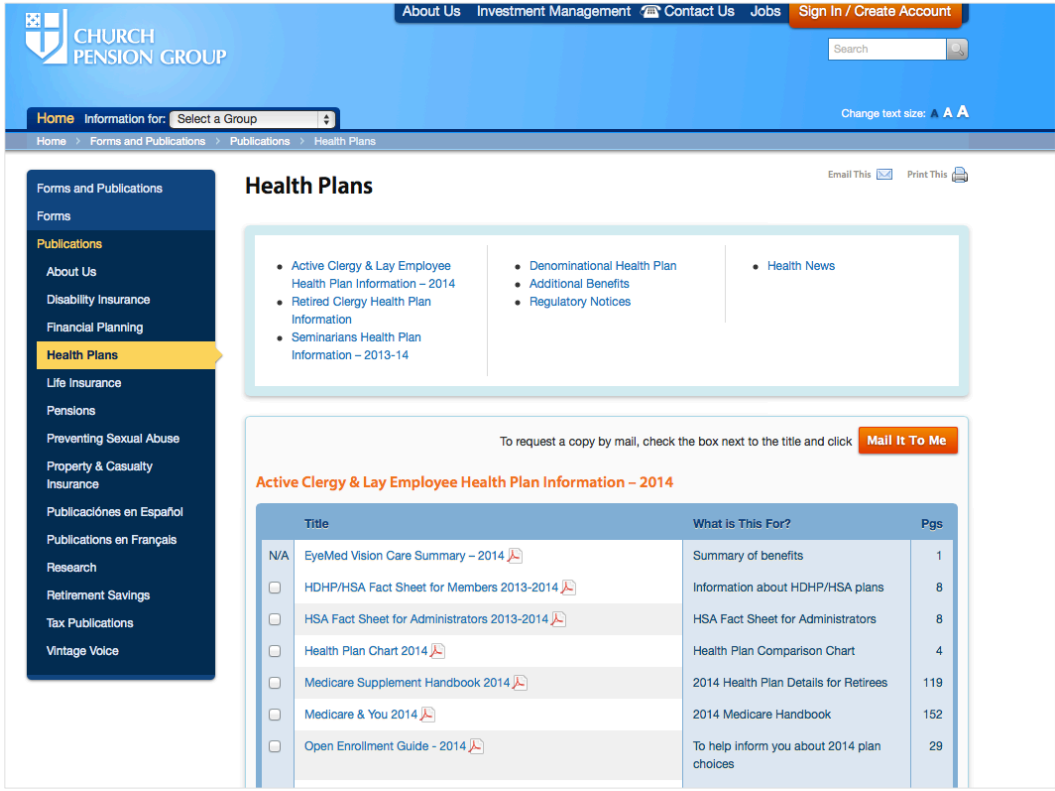
1-800-480-9967 / mtcustserv@cpg.org

The Medical Trust Website

www.cpg.org/mtdocs

Our website is open 24 / 7 / 365 for members to:

- **Access and print forms, handbooks, and other information and documents**
- **Access updated information relating to plans**
- **Access a wide variety of information and resources additional to healthcare-related**



Thank You!

Save the Date March 3-4, 2015
Lay Planning for Tomorrow
St Martin's Houston
March 5-6, 2015 Clergy Planning
for Tomorrow, Camp Allen

Important Notice

The Church Pension Fund and its affiliates do not provide, and none of the information in this presentation should be viewed as, financial, investment, tax, legal, or other advice. Your personal decisions should be based on the recommendations of your own professional advisors.

This presentation is provided for informational purposes only. Please consult the official plan document for additional details of coverage. In the event of a conflict between the information contained in this presentation and the official plan documents, the official plan documents will govern. The Church Pension Fund and its affiliates retain the right to amend, terminate, or modify the terms of any benefit plans described in this presentation, consistent with applicable law.