TO: Administrators, Vestry, Financial and Benefit Committee, Treasurers, Clergy
RE: 2020 Medical and Dental Benefits Annual Enrollment Information
DATE: October 11, 2019

Annual or Open Enrollment for the Medical and Dental Plans for parishes and Episcopal entities within the Diocese of Alabama is coming soon. It is especially important that you assist your employees in this process. As their employer you bear a responsibility to equally support your eligible employees in understanding and obtaining the benefits available through their employment. We will mail information to each of the current participants, but you may have other employees who should have access to benefits or who are hired after this information is distributed. The Annual Enrollment period for Medical Benefits is October 29 through November 16. Open Enrollment for Dental Benefits will be December 2 through December 20.

Canonical Compliance

In 2009 the General Convention of the Episcopal Church adopted two amendments to the Canons of the Episcopal Church. One amendment required parity in medical benefits between ordained and lay employees working 30 hours or more a week (1500 annually). A second amendment required that Episcopal entities obtain medical benefits through The Episcopal Medical Trust of The Church Pension Fund. A long grace period to allow parishes to slowly implement these requirements ended in January 2016. The provisions adopted also provided for each diocese to define parity (Note that parity is not optional, only its definition).

Parity defined: In the Diocese of Alabama medical benefits for clergy include: (1) Payment of the premium solely by the employer (the parish in most cases) for 3 of the plans and premium cost-sharing for the 4th plan offered. (2) Paid coverage for family or single plans at the employee’s discretion. This establishes the definition of “parity”. The intent of the Canons is that medical benefits of employees scheduled to work 30 or more hours per week (1500 annually) whether ordained or lay will include these provisions.

Premium Cost-Sharing: In 2017 the Diocesan Council amended the definition of parity by introducing premium cost-sharing on one of our plans. Any employee and all employees choosing the PPO 80 Plan should pay a portion of the premium through payroll deductions (see the enclosed Employee letter for amounts). Of the four plans being offered, this remains the only plan with premium cost-sharing. This rule applies equally to ordained and non-ordained employees. If your parish is still bearing the full cost of the premium we urge you to introduce the premium payroll deduction. We believe you will eventually find the cost, if not shared, to be prohibitive. We think it is better to ease into premium cost sharing over several years. By delaying you may find introduction of employee premium cost-sharing at a later date even more difficult on employee budgets.
Who is Eligible for Medical Benefits?

All employees of Episcopal Congregations, ancillary ministries which meet certain requirements (schools and pre-schools operating as separate employers from the congregation may be exempt), and the diocese are eligible to participate if they work a minimum of 20 hours per week. For employees scheduled to work fewer than 30 hours per week, but 20 or more, the premium may or may not be paid by the employer (in most cases the congregation) but the employee is eligible to participate at their own expense. In addition, eligible employees may include eligible dependents participating at their own expense if the employee works fewer than 30 hours per week but 20 or more.

Employees must enroll in coverage within 30 days of employment or a change in employment resulting in eligibility for mandatory paid benefits. The enrollment process begins with a call or email to Gallagher Benefit Services in Selma, Alabama (800.752.2569). Speak with Ms. Amy Jones. In addition, eligible employees may enroll during the annual enrollment period. Open Enrollment for the Diocese of Alabama Group will begin October 29 and end November 16. Please make sure your employees know these dates.

Note that employees scheduled to work 1500 hours or more annually (approx. 30 hours per week) must be offered paid medical benefits with some or all of the premium expense paid by the employer as determined by the Diocesan Policy on Parity and Plan choices.

Can Employees Decline the Medical Benefit?

Individual employees can decline the benefit. Their declination must be in writing and must be retained in the employee file. A parish cannot decline to offer the benefits, but an individual employee may decline in writing to participate. Note that all eligible employees must be offered participation in the medical benefits. Eligible employees are those scheduled to work 1000 hours or more annually. If they are scheduled to work fewer than 1500 hours annually but 1000 or more hours annually, their participation may be at their own expense.

Can We Reimburse an Employee for Premiums Paid for a Plan from Another Provider or Pay the Premiums Directly?

No. Federal regulations prohibit employers from paying the premium of an employee who is purchasing coverage from another provider if that employer (parish) offers a group health plan, which you do! If you need further information on this regulation contact Rob Morpeth in the Diocesan office.

Can Employees Switch to Medicare at Age 65 and Remain Employed?

Despite the numerous advertisements and messages to the contrary, there is not a penalty for enrolling in Medicare past age 65 if you have been employed by an employer offering an employee medical plan and you have retained proof provided by the benefit provider of credible coverage. An employee may decline the group health plan, but the employer (parish or school)
may not in any manner incent the employee’s declination nor contribute to their purchase of coverage through means other than the group plan offered.

Any Exceptions?

Yes. If the employer has fewer than 20 employees and applies for and receives from the government an exemption, an eligible employee can enroll in Medicare and choose the MSP PPO 80 Plan which is designed to work alongside Medicare. More information is available from The Episcopal Medical Trust (EMT). The EMT will assist the parish in applying for the exemption.

What are the Medical Plan Choices in 2020?

The three primary plans are not changing from 2019: Anthem PPO 80, Anthem PPO 70, and the Anthem CDHP 20. All plans are administered through Anthem Blue Cross Blue Shield and access the BCBS network of providers. A summary of the benefits in each plan is available on the CPG web site during annual enrollment and during the plan year: www.cpg.org. I am including a summary of the plan benefits with this letter and will also make them available on the diocesan web site: https://www.dioala.org. Click on the “Resources” and then on “Administration”.

A fourth plan is available for employees of employers who have received a “Medicare Exemption”. For information on applying for the government exemption contact the Church Pension Fund Episcopal Medical Trust or the Diocesan office.

Can a Parish (employer) Limit the Plan Choice for their Employees?

Note that under parity all eligible employees, lay and ordained, scheduled to work 30 or more hours weekly (1500 annually) must have the same choices. Because it is our policy to provide our eligible ordained employees with single or family coverage with all or a portion of the premium paid by the employer depending on the plan selection, non-ordained employees must be offered the same benefit according to the Church Canons. Further, individual employers within the diocesan medical benefits group may not alter the choice unilaterally, i.e. one parish cannot decide that all employees including clergy are permitted to select only the Anthem BCBS HD Plan. Note, however, that parity in medical benefits applies only to eligible employees scheduled to work 30 or more hours weekly (1500 annually). Employees scheduled to work 20 or more hours per week, but less than 30 hours may choose to participate but, in most parishes, at their own expense.

A Word on Premiums and Plan Choices.

Our premiums (the amount we pay The Episcopal Medical Trust for the Plans) will increase in 2020 by varying amounts. The percentage increase in 2020 for single coverage is higher than for family coverage to partially address an imbalance that has developed between the two pricing tiers. The average increase for the Diocesan Group in 2020 is 9.21%. This is higher than the Episcopal Medical Trust norm. It reflects the fact that our group has for many years cost the Medical Trust more than we have paid in premiums. Rather than a drastic increase to address
the difference in one year, the Episcopal Medical Trust does include an additional increase above the norm.

The diocesan medical benefits plan will continue to include differing premiums and, please note, that payment of a portion of the premium through payroll deductions is continued for one of the plans in 2020.

Frankly, we still encourage employees to select the CDHP Plan because we anticipate it being the only affordable option at some point for our congregations and the diocese. We want employees to learn how the plan works while we as employers are still able to make contributions to their Health Savings Accounts (HSA). We anticipate a day when the CDHP Plan will be the only plan available and we as employers will not be able to assist with funding of the HSA. Those employees who remain on the PPO Plan until that year may have a more difficult transition. At the same time, let me be clear, the choice of plan is an employee privilege and while incentives such as employer funding of the HSA are provided, the same choice and benefit must be made available to all, ordained and lay, under parity as provided in the Church Canons.

Medical Benefit Monthly Premiums & Plan Choices in 2020

Anthem BCBS CDHP-20/HSA
- $610 Single-Employer Portion
- $1,409 Family-Employer Portion

While this plan has higher Out of Pocket Maximums, these costs are partially offset by contributions from the employer and the diocese to an employee Health Savings Account (HSA). Once the Out of Pocket Maximum is met, the Plan works like a PPO Plan. The total contribution to the employee’s HSA in 2020, assuming receipt of a wellness bonus, will be $1,600 for single coverage and $4,000 for family coverage. This money belongs to the employee and can be used tax-free for approved medical purposes. Funds contributed to the Health Savings Account (HSA) by the employer belong to the employee even if they leave employment. Because the employee is already bearing more of the cost, employee deductions to further off-set the premium are not allowed.

Anthem PPO 80
- $658.50 Single-Employer Portion
- $78.00 Single-Employee Portion
- $736.50 TOTAL PREMIUM
- $1,509 Family-Employer Portion
- $180 Family-Employee Portion
- $1,689 TOTAL PREMIUM

Employees pay a portion of the premium through payroll deductions. This plan is more expensive than others since it offers lower co-pays and deductibles. To off-set the higher premium cost, employers

1 This includes an employer contribution to the employee Health Savings Account of $50/month for single and $125/month for family coverage. An additional “wellness” bonus HSA contribution is available from the diocese.
Medical Benefits in the Episcopal Diocese of Alabama in 2020

should implement payroll deductions for a portion of the billed premium as provided in the rate structure above this paragraph.

Anthem BCBS PPO 70  
$673.50  Single-Employer Portion  
$1,544.00  Family-Employer Portion

This plan is familiar in that you pay pre-set deductibles and co-insurance for doctor’s visits and procedures. However, the Out of Pocket Maximum is higher than the PPO 80 Plan lowering the premium by shifting cost to the employee. There is NO payroll deduction allowed to off-set the billed premium on this plan.

Anthem MSP PPO 80  
$592.50  Single-Employer Portion  
$1,358.00  Family-Employer Portion

This plan is available only to small employers (parishes with fewer than 20 employees) that have received a small employer exemption from Medicare and is available only to employees who are Medicare eligible, and scheduled to work more than 20 hours per week.

Are There Bonus HSA Contributions for CDHP Participants in 2020?

Yes. There are two different bonus contributions available in addition to the monthly contribution. These contributions go directly into employee Health Savings Accounts at a bank of their choice which handles HSA deposits (We recommend using HealthEquity, Inc.). The money belongs to the employee and is theirs to use for medical purposes tax-free even after they leave employment. The monthly employer contribution will remain at $50 monthly for single tier coverage and $125 a month for family coverage.

In addition to the monthly contribution, employees who switch to the CDHP 20 Plan in 2020 will receive a one time “Enrollment Bonus” contribution to their HSA account of $300 for single coverage and $500 for family coverage putting money at their disposal early in the year.

Everyone in the CDHP 20 Plan is also eligible for a “Wellness Bonus”. In 2020 a contribution of $1,000 for single coverage and $2,500 for family coverage will be made to the participant’s HSA once proof of an adult in the plan receiving a “wellness exam” is provided to the diocesan office. The exam itself is 100% covered under the plan and is important because it can help with early diagnosis. Again and again early diagnosis has proven to help reduce overall medical costs and, of course, improve the likelihood of successful treatment.

Together, the monthly employer contribution and the wellness bonus offset $1,600 of the out of pocket maximum for single coverage and $4,000 for family coverage (this does not include the Enrollment Bonus available to new CDHP enrollees). These are tax-free funds² which remain in the employee’s Health Savings Account (HSA) even if not used during 2020 and even when they leave employment. These funds are intended to assist the employee in covering the higher out of pocket expenses potentially associated with the CDHP.

² The funds are not subject to taxes when used for approved medical expenses.
Medical Benefits in the Episcopal Diocese of Alabama in 2020

To receive the “Wellness Bonus” contribution, the eligible employee must be enrolled in the Anthem CDHP and submit proof of an adult member in the plan having received a "wellness exam" (Please, NO medical information or social security numbers) to:

Staff Officer for Finance and Administration
ATTN Wellness Exam
Episcopal Diocese of Alabama
521 20th ST N
Birmingham AL 35203

A note on physician’s stationary simply stating the patient’s name; that a “wellness exam” was performed; and the date of the exam is sufficient. I would prefer NOT to receive anything with the employee’s social security number, birthdate, or medical information. The HSA bonus contribution will be deposited directly to the employee’s HSA account.

To receive the “Enrollment Bonus” an employee must choose to enroll in the CDHP 20 Plan for 2020 having not been enrolled previously in the CDHP 20 Plan. It will be helpful if we are alerted to the plan choice but we will also monitor enrollment and contribute the bonus in January.

NOTE: Both bonuses are extra benefits provided by the Diocese of Alabama and do not involve the Episcopal Medical Trust. All questions and requests for the bonuses should be directed to Rob Morpeth in the Diocesan office NOT to the Church Pension Group, the Episcopal Medical Trust or to Anthem Blue Cross Blue Shield.

How Does Annual Enrollment Work?

Current plan participants (employees) will receive information from the Church Pension Fund, Episcopal Medical Trust and from my office. The information will alert them to open enrollment and inform them of the procedures. Participants should have already created online accounts with the CPG. They will use this login information to access open enrollment. Everyone should login and, at the minimum, be sure their information is correct. Please, communicate all of this to your employees. Open Enrollment begins October 29 and closes November 16. Employees must weigh carefully their plan options and are encouraged to make informed choices. Eligible employees who are not currently enrolled who wish to enroll must go through the normal enrollment process during the Annual Enrollment Period.

What about Dental Coverage?

Our dental benefit is NOT OFFERED THROUGH THE EPISCOPAL MEDICAL TRUST (EMT). Please ignore any choices for dental coverage indicated when you log into your CPG account for open enrollment. Dental benefits in the Diocese of Alabama are completely separate from the benefits offered through the Church Pension Fund and the EMT.

All parishes must offer dental coverage, but the choice of handling premiums through payroll deduction or as a “paid benefit” is left to the parish (This is different from the Medical Benefit). Note that it must be handled the same way for all employees of the parish working 30 or more hours per week (1500 annually). Open Enrollment for Dental benefits will be 12/2/2019 through 12/20/2019. Amy Jones with Gallagher Benefits can assist you with
Medical Benefits in the Episcopal Diocese of Alabama in 2020

enrollment. **No action is required for those who wish to continue their existing dental benefits.** Monthly premium information on dental plans for 2020 is as follows:

- Employee Only (EE): $31.72
- Employee + Spouse (ES): $78.06
- Employee + Child (EC): $74.55
- Employee + Family (EF): $100.53

Plan benefits are on the diocesan web site (www.dioala.org, click on “Resources” and then “Administrative”). **Note that if you did not enroll within 30 days of employment and wish to enroll now, you must complete the application process during the open enrollment period in December.**

What Happens Next?

Watch for information from the Episcopal Medical Trust and the Church Pension Fund on open enrollment for the medical benefits. **If you have moved during the year and did not change your address in your CPG account, the notice will probably go to your old address!** This is why it is best for everyone to log in and have a look during medical open enrollment even if their plan selection is not changing.

Where do I go for help?

For **questions about current benefits or claims**, it is best to begin with a call to the client service center of the Episcopal Medical Trust or to Anthem Blue Cross Blue Shield. The number for the client service center is 1-800-480-9967. The number for Anthem BCBS is 1-844-812-9207 (on the back of your benefit card).

An important resource rarely used is the **Employee Assistance Program**. This service, available 24 hours a day, is included in all the medical plans. It provides assistance in accessing the resources available in your plan. EAP can help with referrals for in-person counseling, legal consultation, financial services and referrals, tips for balancing work and family, and assistance for finding child and senior care. Access EAP by calling 1-866-395-7794. Much more information is also available at https://www.cpg.org/active-clergy/insurance/health-and-wellness/additional-benefits/employee-assistance-program/. (Go to www.cpg.org and click through for the Employee Assistance Program – EAP).

If you need help in finding the best in-network doctors or hospitals, obtaining second opinions, resolving benefit claims and issues, correcting billing mistakes (other than those on invoices from Gallagher Benefit Services) call the **Health Advocate** at 1-866-8622. This free service is provided as a part of your medical plan benefits. You can also learn more at https://www.cpg.org/active-clergy/insurance/health-and-wellness/additional-benefits/health-advocate/?ref=tabbedBanner (Go to www.cpg.org and click through for the “Health Advocate”).
If your question is about the **Canonical Requirements for Parity in Medical Benefits**, please visit the Church Pension Fund website Go to [www.cpg.org](http://www.cpg.org) and click through for the Denomination Health Plan information or contact Rob Morpeth in the Diocesan office, especially if your question is about the local application of the Canons.

If you are seeking a **summary of medical benefits** in the various medical plans visit the Church Pension web site at the address provided in the Annual Enrollment information. No one should make a plan selection until they understand the plan benefits. Much of the information on current plans and benefits can be found at [www.cpg.org](http://www.cpg.org), click on “Active Lay Employees” then “Insurance” then “Health”. A summary chart is also included with this letter.

### For Even More Information

Rob Morpeth, Staff Officer for Finance and Administration of The Episcopal Diocese of Alabama, is the manager of the medical benefits program for employees of Episcopal entities in the Diocese of Alabama. You can reach him by email at rmorpeth@dioala.org (note: the address starts with an ‘r’), by USPS at Episcopal Diocese of Alabama, 521 20th Street North, Birmingham, Alabama 35203, or by phone at 205-358-9225 DD, or 205-715-2060 ext. 9225.

Ms. Makenzie Snyder assists in the administration of benefits and is also available to answer questions. She can be contacted at msnyder@cpg.org, 205-358-9221DD or 205-715-2060, extension 9221.

Ms. Amy Jones with Gallagher Benefits in Selma, Alabama assists us with medical and dental enrollment. For enrollment forms and to process first-time enrollment in either the dental or medical benefit programs contact Amy at Amy_Jones@ajg.com. Amy is available by phone at 800-752-2569.

The Church is enriched through the service of all of our employees, both ordained and non-ordained. The example the church sets as an employer can and should be an important part of our witness to the world. For these reasons, the Bishop and Diocesan Council commend this benefit program to the participating employers and employees within the Episcopal Diocese of Alabama.

Sincerely,

Rob Morpeth
Staff Officer for Finance and Administration
Episcopal Diocese of Alabama
<table>
<thead>
<tr>
<th>Plan</th>
<th>Anthem BCBS BlueCard PPO 80</th>
<th>Anthem BCBS BlueCard PPO 70</th>
<th>Anthem BCBS CDHP 20/HSA</th>
</tr>
</thead>
<tbody>
<tr>
<td>Annual Medical Deductible</td>
<td>$1,000 per person</td>
<td>$2,000 per person</td>
<td>$3,500 per person</td>
</tr>
<tr>
<td></td>
<td>$2,000 per family</td>
<td>$4,000 per family</td>
<td>$7,000 per family</td>
</tr>
<tr>
<td>Annual Out-of-Pocket Limit</td>
<td>$3,500 per person</td>
<td>$7,000 per person</td>
<td>$5,000 per person</td>
</tr>
<tr>
<td></td>
<td>$7,000 per family</td>
<td>$14,000 per family</td>
<td>$10,000 per family</td>
</tr>
<tr>
<td>Preventive Care</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Preventive Services &amp; Well-Child Care</td>
<td>$0 copay</td>
<td>50% coinsurance</td>
<td>$0 copay</td>
</tr>
<tr>
<td>Physician Services</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Office Visit</td>
<td>$30 copay</td>
<td>50% coinsurance</td>
<td>$30 copay</td>
</tr>
<tr>
<td>Diagnostic Services (outpatient)</td>
<td>20% coinsurance</td>
<td>30% coinsurance</td>
<td>20% coinsurance</td>
</tr>
<tr>
<td>Specialist Care</td>
<td>$45 copay</td>
<td>50% coinsurance</td>
<td>$45 copay</td>
</tr>
<tr>
<td>Hospital Services</td>
<td></td>
<td></td>
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</tr>
<tr>
<td>Inpatient Services (including inpatient maternity services)</td>
<td>20% coinsurance</td>
<td>50% coinsurance</td>
<td>30% coinsurance</td>
</tr>
<tr>
<td>Outpatient Surgery</td>
<td>20% coinsurance</td>
<td>50% coinsurance</td>
<td>30% coinsurance</td>
</tr>
<tr>
<td>Emergency Room Care</td>
<td>$250 copay</td>
<td>$250 copay</td>
<td>$250 copay</td>
</tr>
<tr>
<td>Ambulance Services</td>
<td>20% coinsurance</td>
<td>20% coinsurance</td>
<td>20% coinsurance</td>
</tr>
<tr>
<td>Mental Health/Substance Abuse</td>
<td></td>
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<tr>
<td>Outpatient Services</td>
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<tr>
<td>Inpatient Services</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Other Medical Services</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Durable Medical Equipment</td>
<td>20% coinsurance</td>
<td>50% coinsurance</td>
<td>30% coinsurance</td>
</tr>
<tr>
<td>Home Health Care</td>
<td>20% coinsurance</td>
<td>50% coinsurance</td>
<td>30% coinsurance</td>
</tr>
<tr>
<td>Outpatient Therapy</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Skilled Nursing / Acute Rehabilitation Facility</td>
<td>20% coinsurance</td>
<td>50% coinsurance</td>
<td>30% coinsurance</td>
</tr>
<tr>
<td>Urgent Care Services</td>
<td>$50 copay</td>
<td>$50 copay</td>
<td>$50 copay</td>
</tr>
</tbody>
</table>

This chart is a general description and is provided for informational purposes only. It should not be viewed as an offer of coverage. In the event of a conflict between this chart and the official Plan documents, the official Plan documents will govern.
## Prescription Drug Benefits

<table>
<thead>
<tr>
<th></th>
<th>Express Scripts</th>
<th>CDHP-20/HSA</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Retail</td>
<td>Home Delivery</td>
</tr>
<tr>
<td>Annual Prescription Deductible</td>
<td>None</td>
<td>None</td>
</tr>
<tr>
<td>(in-network)</td>
<td></td>
<td></td>
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<td></td>
<td></td>
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</tr>
<tr>
<td>Tier 1: Generic</td>
<td>Up to a $10 copay</td>
<td>Up to a $25 copay</td>
</tr>
<tr>
<td>Tier 2: Preferred Brand Name</td>
<td>Up to a $40 copay</td>
<td>Up to a $100 copay</td>
</tr>
<tr>
<td>Tier 3: Non-Preferred Brand Name</td>
<td>Up to a $50 copay</td>
<td>Up to a $200 copay</td>
</tr>
<tr>
<td>Dispensing Limits Per Copayment</td>
<td>Up to a 30-day supply</td>
<td>Up to a 90-day supply</td>
</tr>
</tbody>
</table>

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<table>
<thead>
<tr>
<th>Vision Benefits</th>
<th>EyeMed</th>
<th>Out-of-Network</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Eye Examinations</td>
<td>$0 copay</td>
<td>Plan pays up to $30 for ophthalmologists or optometrists</td>
</tr>
<tr>
<td>Lenses (eligible once every calendar year)</td>
<td>$10 copay</td>
<td>Plan pays up to: $32 for single vision, $46 for bifocal, $57 for trifocal</td>
</tr>
<tr>
<td></td>
<td></td>
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</tr>
<tr>
<td><strong>Lens Options</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Standard Progressive (add-on to bifocal)</td>
<td>Up to $75 copay</td>
<td>Play pays up to $46</td>
</tr>
<tr>
<td>UV Coating</td>
<td>up to $15 copay</td>
<td></td>
</tr>
<tr>
<td>Tint (solid and Gradient)</td>
<td>up to $15 copay</td>
<td></td>
</tr>
<tr>
<td>Standard Scratch Resistance</td>
<td>up to $15 copay</td>
<td>You are responsible for the cost of any lens options that you elect from out-of-network providers.</td>
</tr>
<tr>
<td>Standard Polycarbonate</td>
<td>$0 copay</td>
<td></td>
</tr>
<tr>
<td>Standard Anti-Reflective Coating</td>
<td>up to $45 copay</td>
<td></td>
</tr>
<tr>
<td>Disposable</td>
<td>20% off retail price</td>
<td></td>
</tr>
<tr>
<td>Frames (eligible once every calendar year)</td>
<td>$150 allowance, 20% off balance over $150</td>
<td>Plan pays up to $47</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Contact Lenses (eligible once every calendar year)</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Conventional</td>
<td>$150 allowance, 15% off balance over $150</td>
<td>Plan pays up to $100</td>
</tr>
<tr>
<td>Disposable</td>
<td>$150 allowance, then you pay balance over $150</td>
<td>Plan pays up to $100</td>
</tr>
</tbody>
</table>

This chart is a general description and is provided for informational purposes only. It should not be viewed as an offer of coverage. In the event of a conflict between this chart and the official Plan documents, the official Plan documents will govern.
The Plans described in this document (collectively, the Plans) are sponsored and administered by the Church Pension Group Services Corporation (CPGSC), also known as The Episcopal Church Medical Trust (the Medical Trust). The Plans that are self-funded are funded by The Episcopal Church Clergy and Employees' Benefit Trust (ECCEBT), which is a voluntary employees’ beneficiary association within the meaning of section 501(c)(9) of the Internal Revenue Code.

This document contains only a partial, general description of the Plans. It is provided for informational purposes only and should not be viewed as a contract, an offer of coverage, a confirmation of eligibility, or investment, tax, medical or other advice. In the event of a conflict between this document and the official Plan documents (summary of benefits and coverage, Plan Document Handbook), the official Plan documents will govern. The Church Pension Fund and CPGSC (collectively, CPG), retain the right to amend, terminate or modify the terms of the Plans, as well as any post-retirement health subsidy, at any time, for any reason and, unless required by law, without notice.

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

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

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

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

For all eligible employees of Episcopal Diocese of Alabama, Policy # 904211

All Eligible Employees

Effective date: January 1.

- Dental insurance can help lower your out-of-pocket expenses so you and your family can maintain healthy smiles—and better overall health, too
- It pays all or part of your dental expenses, depending on the type of procedure. Benefits will be paid after any applicable deductible has been met, up to the annual maximum
- Cover your spouse1 and your dependent children so you can help your whole family stay healthy
  - An eligible child is defined as a child to age 262
- Benefit from group rates that may be more affordable than buying dental insurance on your own

Compare the annual cost of your Dental insurance with paying your dental expenses yourself

National Average Retail charge3 for dental procedures:

<table>
<thead>
<tr>
<th>Service</th>
<th>Cost</th>
</tr>
</thead>
<tbody>
<tr>
<td>Adult cleaning</td>
<td>$89 twice yearly = $178</td>
</tr>
<tr>
<td>Oral examination</td>
<td>$49 twice yearly = $98</td>
</tr>
<tr>
<td>Bitewing x-rays</td>
<td>$60</td>
</tr>
<tr>
<td>Total annual cost for preventive care</td>
<td>$336</td>
</tr>
</tbody>
</table>

Other services you or a dependent may need:

<table>
<thead>
<tr>
<th>Service</th>
<th>Cost</th>
</tr>
</thead>
<tbody>
<tr>
<td>Fluoride Treatment</td>
<td>$35</td>
</tr>
<tr>
<td>One surface filling</td>
<td>$155</td>
</tr>
<tr>
<td>Root canal</td>
<td>$1,089</td>
</tr>
<tr>
<td>Crown</td>
<td>$1,108</td>
</tr>
</tbody>
</table>

Additional plan features

- Your plan includes our Lifetime of Smiles® program, with benefits many people prefer, such as brush biopsies for the early detection of oral cancer
- Sun Life Dental Network, the PPO network for your plan, includes 120,000+ unique dentists, offers you more options to help save on fees and can make your annual maximum go even further2

How Sun Life's Dental insurance can help

- Encourages routine cleanings and checkups at the dentist
- Cover your family’s dental bills and reduce dental care costs for you and your family
- Maintain oral health to prevent infections and tooth loss
# Dental Coverage Overview

<table>
<thead>
<tr>
<th>Calendar Year Maximum</th>
<th>In-Network</th>
<th>Out-of-Network</th>
</tr>
</thead>
<tbody>
<tr>
<td>Types I, II and III Preventive Basic and Major Services</td>
<td>$1,500 per person</td>
<td>$1,500 per person</td>
</tr>
<tr>
<td>Type IV Ortho Services</td>
<td>$1,500 lifetime per child under age 19</td>
<td>$1,500 lifetime per child under age 19</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Calendar Year Deductible</th>
<th>In-Network</th>
<th>Out-of-Network</th>
</tr>
</thead>
<tbody>
<tr>
<td>Procedure Type</td>
<td>N/A</td>
<td>N/A</td>
</tr>
<tr>
<td>Type I Preventive Services</td>
<td>N/A</td>
<td>N/A</td>
</tr>
<tr>
<td>Type II, III (Basic and Major Services)</td>
<td>$50 individual/$150 family</td>
<td>$50 individual/$150 family</td>
</tr>
<tr>
<td>Type IV Ortho Services</td>
<td>N/A</td>
<td>N/A</td>
</tr>
</tbody>
</table>

The plan pays the following percentage for procedures:

<table>
<thead>
<tr>
<th>Procedure Type</th>
<th>In-Network</th>
<th>Out-of-Network</th>
</tr>
</thead>
<tbody>
<tr>
<td>Type I Preventive Services</td>
<td>100%</td>
<td>100%</td>
</tr>
<tr>
<td>Type II Basic Services</td>
<td>50%</td>
<td>30%</td>
</tr>
<tr>
<td>Type III Major Services</td>
<td>50%</td>
<td>50%</td>
</tr>
<tr>
<td>Type IV Ortho Services</td>
<td>50%</td>
<td>50%</td>
</tr>
</tbody>
</table>

### Type I Preventive Dental Services, including:
- Oral evaluations – once in any 6 month period
- Routine dental cleanings – once in any 6 month period (frequency combined with periodontal maintenance)
- Fluoride treatment – once in any 6-month period. *Only for children under age 14*
- Sealants – no more than once per tooth in any 36-month period, only for permanent molar teeth. *Only for children under age 14*
- Genetic test for susceptibility to oral diseases
- Bitewing x-rays – once in any 12 month period
- Intraoral complete series x-rays – once in any 60-month period

### Type II Basic Dental Services, including:
- New fillings
- Simple extractions, incision and drainage
- Surgical extractions of erupted teeth, impacted teeth, or exposed root
- Biopsy (including brush biopsy)
- Endodontics (includes root canal therapy) – once per tooth in any 24 month period
- General anesthesia and IV sedation when medically required
- Minor gum disease treatment: (non-surgical periodontics)
- Scaling and root planing – once in any 24-month period per area
- Localized delivery of antimicrobial agents
  - Periodontal maintenance – once in any 6 consecutive months
  - Stainless steel crowns. *Only for children under age 19*

### Type III Major Dental Services, Including:
- Dentures and Bridges, subject to 10 year replacement limit
- Inlay, onlay, and crown restorations – once per tooth in any 10 year period.
- Major gum disease treatment: (surgical periodontics)

### Type IV Orthodontic Services, Including:
Orthodontic Treatment:
Orthodontic treatment is limited to the Dependent Children or student age listed above

### Waiting Periods
For a complete description of services and waiting periods, please review the certificate of insurance. If you were covered under your employer’s prior plan the wait will be waived for any type of service covered under the prior plan and this plan.
- No waiting period for preventive or basic services.
Important Plan Provisions

Limitations and exclusions
Exclusions may prevent expenses from being covered based on certain circumstances. The following expenses may not be covered:

- Procedures not performed by a licensed dentist
- Procedures not listed as covered dental expenses
- Dental care for injuries that are work related, self-inflicted, or not caused by an accident
- Orthognathic surgery
- Dental care resulting from active participation in a riot or commission of a felony
- Experimental treatment, oral hygiene, plaque control programs, and dietary instruction
- Dental care for injuries sustained as a result of war or act of war
- Charges for pulp caps
- Dental expenses incurred while coverage is not in force
- Charges for care, treatment, services, or supplies to the extent that any benefit is provided by Medicare
- Charges not customarily made when there is no insurance or charges for which there is no legal obligation to pay
- Charges for failure to keep appointments
- Replacement or repair of a lost, stolen, or damaged prosthetic or orthodontic appliance
- Additional services, such as orthodontia and/or surgical implants, are not covered unless specifically listed under covered services. Also not covered are charges for diagnostic services and treatment of jaw joint problems, such as temporomandibular joint disorders, by any method unless specifically covered under the Certificate

*Subject to state law variations.

Group insurance policies are underwritten by Sun Life Assurance Company of Canada (Wellesley Hills, MA) in all states, except New York, under Policy Form Series 15-GP-01 and 15-DEN-C-01. In New York, group insurance policies are underwritten by Sun Life and Health Insurance Company (U.S.) (Lansing, MI) under Policy Form Series 15-GP-01 and 15-DEN-C-01. Product offerings may not be available in all states and may vary depending on state laws and regulations.

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SLPC 28019 12/13 (exp. 12/18)
Dental Q&A

How does a PPO work?
PPO stands for Participating Provider Organization. With a dental PPO plan, dental providers agree to participate in a dental network by offering discounted fees on most dental procedures. When you visit a provider in the network, you could see lower out-of-pocket costs because providers in the network agree to these pre-negotiated discounted fees on eligible claims.

How do I find a dentist?
Simply visit www.sunlife.com/findadentist. Follow the prompts to find a dentist in your area who participates in the PPO network. You do not need to select a dentist in advance.

Do I have to choose a dentist in the PPO network?
No. You can visit any licensed dentist for services. However, you could see lower out-of-pocket costs when you visit a dentist in the network.

Where do I find my dental ID card?
Your personalized electronic dental ID card is available through Online Advantage. You can register at www.sunlife.com/onlineadvantage. Please present this card to your dentist at your next visit to show that you are covered by a Sun Life Dental plan.

What if I have already started dental work...like a root canal or braces...that requires several visits?
Your coverage with us and your prior plan may handle these procedures differently. To ensure a smooth transition for work in progress, call our dental claims experts before your next visit at 800-442-7742.

Is it necessary to request a pre-determination of benefits prior to receiving services?
A pre-determination of benefits allows Sun Life to review your provider's plan for treatment before the work is done. We can tell you ahead of time how much of the work will probably be covered by the plan, and how much you may need to cover. If the charge for any dental treatment is expected to exceed $300, it is recommended that a dental treatment plan be submitted for review before treatment begins.

Do I have to file the claim?
Dentists in the PPO network will file claims for you. Some non-network dentists will file claims for you as well. If a non-network dentist will not file your claim, simply ask your dentist to complete a standard American Dental Association (ADA) claim form and mail it to:

Sun Life Financial
P.O. Box 2940
Clinton, IA 52733

How can I get more information about my coverage?
After the effective date of your coverage, you can visit www.sunlife.com/onlineadvantage to create an account with Online Advantage. Once you're logged in, you'll be able to see your plan details, personalized dental ID card, and more. Or you can call Sun Life's Dental Customer Service at 800-442-7742. You can also call any time, day or night, to access our automated system and get answers to common questions when it's convenient for you.
Get benefits information on the go!

**Download our Benefit Tools app for quick access to:**

- An overview of your coverage details
- Your electronic dental ID card
- Find a dentist near you

### Dental plan provisions

**Benefit adjustments**

Benefits will be coordinated with any other dental coverage. Under the Alternative Treatment provision, benefits will be payable for the most economical services or supplies meeting broadly accepted standards of dental care.

**Late entrant**

If you apply for dental insurance more than 31 days after a covered person first becomes eligible, the person is a late entrant. The benefits for the first 12 months of coverage for late entrants will be limited as follows:

**Time Insured Continuously Under the Policy**

- Less than 6 months
- At least 6 months but less than 12 months
- At least 12 months

**Benefits Provided for Only These Services**

- Preventive Dental Services
- Preventive and Amalgam and Composite Fillings under Basic Dental Services
- Preventive, Basic, Major and Orthodontic Dental Services

We will not pay for any treatment that is started or completed during the late entrant limitation period.

This summary represents a general overview and is not a complete description of your plan. It is being provided before your certificate is issued. All of our dental policies include exclusions, limitations, and frequency requirements. The actual provisions of your dental policy will be used to determine coverage for any claims that you submit.

This plan does not provide coverage for pediatric oral health services that satisfies the requirements for “minimum essential coverage” as defined by The Patient Protection and Affordable Care Act (PPACA).

**Please read the Important Plan Provisions section located at the end of this document for Limitations and Exclusions.**

1. If permitted by the Employer's employee benefit plan and not prohibited by state law, the term “spouse” in this benefit includes any individual who is either recognized as a spouse, a registered domestic partner, or a partner in a civil union, or otherwise accorded the same rights as a spouse.
2. Please see your employer for more specific information.
3. Average Retail Costs were determined by our national claims analysis for the year 2017. The costs represent a mean average rounded to the nearest dollar representing what you may pay without plan services.
4. Classification of services varies by plan design.
5. Total number of combined prophylaxis cleaning and periodontal maintenance procedures cannot exceed 4 in a 12 month period.
6. There may be tax consequences to you and your employees.
7. Sun Life’s dental networks include dentists contracted with Dental Health Alliance, LLC® (D H.A.,®) and dentists under access arrangements with other dental networks.
8. You will need to register for Online Advantage to access these features.