

Plan Document Handbook

Cigna Dental Plans

Benefits effective as of January 2022

The Episcopal Church Medical Trust
Our Health, Our Members, Our Church



INTRODUCTION

ABOUT US

The Episcopal Church Medical Trust (the “Medical Trust”) maintains a series of benefit Plans (each a “Plan” and collectively, the “Plans”) for the eligible Employees (and their Eligible Dependents) of The Episcopal Church. Since 1978, the Plans sponsored by the Medical Trust have served the dioceses, parishes, schools, missionary districts, seminaries, and other institutions subject to the authority of the Episcopal Church. The Medical Trust serves thousands of active Employees, retirees, and their Eligible Dependents. The Plans are intended to qualify as “church plans” within the meaning of Section 414(e) of the Internal Revenue Code, and are exempt from the requirements of the Employee Retirement Income Security Act of 1974, as amended (ERISA).

The Medical Trust funds certain of its benefit Plans through a trust fund known as The Episcopal Church Clergy and Employees’ Benefit Trust (ECCEBT). The ECCEBT is intended to qualify as a Voluntary Employees’ Beneficiary Association (VEBA) under Section 501(c)(9) of the Internal Revenue Code. The purpose of the ECCEBT is to provide Benefits to eligible Employees, former Employees, and their Dependents in the event of illness or expenses for various types of medical care and treatment.

SERVING THE CHURCH

The mission of the Medical Trust is to “balance compassion and benefits with financial stewardship.” This is a unique mission in the world of healthcare benefits, and we believe that our experience and mission to serve The Episcopal Church offers a level of expertise that is unparalleled.

If you have questions about any of our Plans, please don’t hesitate to contact us. We’re looking forward to serving you.

For more information, please visit our website at www.cpg.org. Or you may call Client Services at (800) 480-9967.

Benefits described in this Plan Document Handbook are effective as of January 1, 2022.

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CHAPTER 1
SUMMARIES OF BENEFITS AND COVERAGE

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Cigna Dental Benefit Summary

Episcopal Church Medical Trust

01/01/2022 (DD50: Basic Dental)



Administered by: Cigna Health and Life Insurance Company

This material is for informational purposes only and is designed to highlight some of the benefits available under this plan. Consult the plan documents to determine specific terms of coverage relating to your plan. Terms include covered procedures, applicable waiting periods, exclusions and limitations. **Your DPPO plan allows you to see any licensed dentist, but using an in-network dentist may minimize your out-of-pocket expenses.**

Benefit Plan Features	Total Cigna DPPO Network		Non-Network
Network Options	Cigna DPPO Advantage	Cigna DPPO	See Non-Network Reimbursement
Reimbursement Levels	Fee Schedule	Discount on Fees	Maximum Reimbursable Charge
Calendar Year Benefits Maximum Applies to: Class II, III & IX expenses	\$2,000	\$2000	\$2000
Calendar Year Deductible			
Individual	\$0	\$50	\$50
Family	\$0	\$150	\$150
Benefit Highlights	Plan Pays	Plan Pays	Plan Pays
Class I: Diagnostic & Preventive Oral Evaluations Prophylaxis: routine cleanings X-rays: routine X-rays: non-routine Fluoride Application Sealants: per tooth Space Maintainers: non-orthodontic Emergency Care to Relieve Pain	100% No Deductible	100% No Deductible	100% No Deductible
Class II: Basic Restorative Restorative: fillings Endodontics: minor and major Periodontics: minor and major Oral Surgery: minor and major Repairs: bridges, crowns and inlays Repairs: dentures Denture Relines, Rebases and Adjustments Osseous Surgery	85% No Deductible	85% After Deductible	85% After Deductible
Class III: Major Restorative Inlays and Onlays Prosthesis Over Implant Crowns: prefabricated stainless steel / resin Crowns: permanent cast and porcelain Bridges and Dentures Anesthesia: general and IV sedation Anesthesia: Exparel	50% No Deductible	50% After Deductible	50% After Deductible
Class IX: Implants	50% No Deductible	50% After Deductible	50% After Deductible
Benefit Plan Provisions:			
In-Network Reimbursement	For services provided by a Cigna Dental PPO network dentist, Cigna Dental will reimburse the dentist according to a Fee Schedule or Discount Schedule.		
Non-Network Reimbursement	For services provided by a non-network dentist, Cigna Dental will reimburse according to the Maximum Reimbursable Charge. The MRC is calculated at the 80th percentile of all provider amounts in the geographic area. The dentist may balance bill up to their usual fees.		

Cross Accumulation	All deductibles, plan maximums, and service specific maximums cross accumulate between in and out of network. Benefit frequency limitations are based on the date of service and cross accumulate between in and out of network.
Calendar Year Benefits Maximum	The plan will only pay for covered charges up to the yearly Benefits Maximum, when applicable. Benefit-specific Maximums may also apply.
Calendar Year Deductible	This is the amount you must pay before the plan begins to pay for covered charges, when applicable. Benefit-specific deductibles may also apply.
Carryover Provision	Certain Dental Expenses incurred and applied toward the Individual or Family Deductible during the last 3 months of the calendar year will be applied toward the next year's Deductible.
Pretreatment Review	Pretreatment review is available on a voluntary basis when dental work in excess of \$200 is proposed.
Alternate Benefit Provision	When more than one covered Dental Service could provide suitable treatment based on common dental standards, Cigna will determine the covered Dental Service on which payment will be based and the expenses that will be included as Covered Expenses.
Oral Health Integration Program (OHIP)	Cigna Dental Oral Health Integration Program offers enhanced dental coverage for customers with the following medical conditions: diabetes, heart disease, stroke, maternity, head and neck cancer radiation, organ transplants and chronic kidney disease. There's no additional charge for the program, and those who qualify are eligible to receive reimbursement of their coinsurance for certain related dental procedures. Eligible customers can also receive guidance on behavioral issues related to oral health. Reimbursements under this program are not subject to the annual deductible, but will be applied to and are subject to the plan annual maximum. For more information including how to enroll in this program and a complete list of program terms and eligible medical conditions, go to www.mycigna.com or call customer service 24/7 at 1.800.CIGNA24.
Timely Filing	Out of network claims submitted to Cigna after 365 days from date of service will be denied.
Benefit Limitations: Benefit frequency limitations are based on date of service and cross accumulate between in and out of network.	
Oral Evaluations/Exams	3 per calendar year
X-rays (routine)	Bitewings: 2 per calendar year
X-rays (non-routine)	Complete series of radiographic images and panoramic radiographic images: Limited to a combined total of 1 per 36 months.
Diagnostic Casts	Payable only in conjunction with orthodontic workup.
Cleanings	3 per calendar year, including periodontal maintenance procedures following active therapy.
Fluoride Application	2 per calendar year for children under age 19.
Sealants (per tooth)	Limited to posterior tooth. 1 treatment per tooth every 36 months for children under age 14.
Space Maintainers	Limited to non-orthodontic treatment for children under age 19.
Inlays, Crowns, Bridges, Dentures and Partial	Replacement every 60 months if unserviceable and cannot be repaired. Benefits are based on the amount payable for non-precious metals. No porcelain or white/tooth-colored material on molar crowns or bridges.
Denture and Bridge Repairs	Reviewed if more than once.
Denture Relines, Rebases and Adjustments	Covered if more than 6 months after installation. 1 per 36 months.
Prosthesis Over Implant	1 every 60 months if unserviceable and cannot be repaired. Benefits are based on the amount payable for non-precious metals. No porcelain or white/tooth colored material on molar crowns or
Benefit Exclusions:	
Covered Expenses will not include, and no payment will be made for the following:	
<ul style="list-style-type: none"> • Procedures and services not included in the list of covered dental expenses; • Diagnostic: cone beam imaging; • Preventive Services: instruction for plaque control, oral hygiene and diet; • Restorative: ceramic, resin, or acrylic materials on crowns or bridges on or replacing the upper and or lower first, second and/or third molars; • Periodontics: bite registrations; splinting; • Prosthodontic: precision or semi-precision attachments; • Orthodontics: orthodontic treatment; • Procedures, appliances or restorations, except full dentures, whose main purpose is to change vertical dimension, diagnose or treat conditions of dysfunction of the temporomandibular joint (TMJ), stabilize periodontally involved teeth or restore occlusion; • Athletic mouth guards; • Services performed primarily for cosmetic reasons; • Personalization or decoration of any dental device or dental work; • Replacement of an appliance per benefit guidelines; • Services that are deemed to be medical in nature; • Services and supplies received from a hospital; 	

- Drugs: prescription drugs;
- Charges in excess of the Maximum Reimbursable Charge

This document provides a summary only. It is not a contract. If there are any differences between this summary and the official plan documents, the terms of the official plan documents will prevail.

Product availability may vary by location and plan type and is subject to change. All group dental insurance policies and dental benefit plans contain exclusions and limitations. For costs and details of coverage, review your plan documents or contact a Cigna representative

All Cigna products and services are provided exclusively by or through operating subsidiaries of Cigna Corporation, including Cigna Health and Life Insurance Company (CHLIC), Connecticut General Life Insurance Company, and Cigna Dental Health, Inc.

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Cigna Dental Benefit Summary

Episcopal Church Medical Trust

01/01/2022 (DD25: Dental & Orthodontia)



Administered by: Cigna Health and Life Insurance Company

This material is for informational purposes only and is designed to highlight some of the benefits available under this plan. Consult the plan documents to determine specific terms of coverage relating to your plan. Terms include covered procedures, applicable waiting periods, exclusions and limitations. **Your DPPO plan allows you to see any licensed dentist, but using an in-network dentist may minimize your out-of-pocket expenses.**

<i>Benefit Plan Features</i>	<i>Total Cigna DPPO Network</i>		<i>Non-Network</i>
<i>Network Options</i>	Cigna DPPO Advantage	Cigna DPPO	See Non-Network Reimbursement
<i>Reimbursement Levels</i>	Fee Schedule	Discount on Fees	Maximum Reimbursable Charge
<i>Calendar Year Benefits Maximum</i> Applies to: Class II, III & IX expenses	\$2,000	\$2000	\$2000
<i>Calendar Year Deductible</i> Individual Family	\$0 \$0	\$25 \$75	\$25 \$75
<i>Benefit Highlights</i>	<i>Plan Pays</i>	<i>Plan Pays</i>	<i>Plan Pays</i>
<i>Class I: Diagnostic & Preventive</i> Oral Evaluations Prophylaxis: routine cleanings X-rays: routine X-rays: non-routine Fluoride Application Sealants: per tooth Space Maintainers: non-orthodontic Emergency Care to Relieve Pain	100% No Deductible	100% No Deductible	100% No Deductible
<i>Class II: Basic Restorative</i> Restorative: fillings Endodontics: minor and major Periodontics: minor and major Oral Surgery: minor and major Repairs: bridges, crowns and inlays Repairs: dentures Denture Relines, Rebases and Adjustments Osseous Surgery	85% No Deductible	85% After Deductible	85% After Deductible
<i>Class III: Major Restorative</i> Inlays and Onlays Prosthesis Over Implant Crowns: prefabricated stainless steel / resin Crowns: permanent cast and porcelain Bridges and Dentures Anesthesia: general and IV sedation Anesthesia: Exparel	85% No Deductible	85% After Deductible	85% After Deductible
<i>Class IV: Orthodontia</i> Coverage for Subscriber and All Dependents Lifetime Benefits Maximum: \$1,500	50% No Deductible	50% After Deductible	50% After Deductible
<i>Class IX: Implants</i>	85% No Deductible	85% After Deductible	85% After Deductible
<i>Benefit Plan Provisions:</i>			
<i>In-Network Reimbursement</i>	For services provided by a Cigna Dental PPO network dentist, Cigna Dental will reimburse the dentist according to a Fee Schedule or Discount Schedule.		

Non-Network Reimbursement	For services provided by a non-network dentist, Cigna Dental will reimburse according to the Maximum Reimbursable Charge. The MRC is calculated at the 80th percentile of all provider amounts in the geographic area. The dentist may balance bill up to their usual fees.
Cross Accumulation	All deductibles, plan maximums, and service specific maximums cross accumulate between in and out of network. Benefit frequency limitations are based on the date of service and cross accumulate between in and out of network.
Calendar Year Benefits Maximum	The plan will only pay for covered charges up to the yearly Benefits Maximum, when applicable. Benefit-specific Maximums may also apply.
Calendar Year Deductible	This is the amount you must pay before the plan begins to pay for covered charges, when applicable. Benefit-specific deductibles may also apply.
Carryover Provision	Certain Dental Expenses incurred and applied toward the Individual or Family Deductible during the last 3 months of the calendar year will be applied toward the next year's Deductible.
Pretreatment Review	Pretreatment review is available on a voluntary basis when dental work in excess of \$200 is proposed.
Alternate Benefit Provision	When more than one covered Dental Service could provide suitable treatment based on common dental standards, Cigna will determine the covered Dental Service on which payment will be based and the expenses that will be included as Covered Expenses.
Oral Health Integration Program (OHIP)	Cigna Dental Oral Health Integration Program offers enhanced dental coverage for customers with the following medical conditions: diabetes, heart disease, stroke, maternity, head and neck cancer radiation, organ transplants and chronic kidney disease. There's no additional charge for the program, and those who qualify are eligible to receive reimbursement of their coinsurance for certain related dental procedures. Eligible customers can also receive guidance on behavioral issues related to oral health. Reimbursements under this program are not subject to the annual deductible, but will be applied to and are subject to the plan annual maximum. For more information including how to enroll in this program and a complete list of program terms and eligible medical conditions, go to www.mycigna.com or call customer service 24/7 at 1.800.CIGNA24.
Timely Filing	Out of network claims submitted to Cigna after 365 days from date of service will be denied.
Benefit Limitations: <i>Benefit frequency limitations are based on date of service and cross accumulate between in and out of network.</i>	
Oral Evaluations/Exams	3 per calendar year
X-rays (routine)	Bitewings: 2 per calendar year
X-rays (non-routine)	Complete series of radiographic images and panoramic radiographic images: Limited to a combined total of 1 per 36 months.
Diagnostic Casts	Payable only in conjunction with orthodontic workup.
Cleanings	3 per calendar year, including periodontal maintenance procedures following active therapy.
Fluoride Application	2 per calendar year for children under age 19.
Sealants (per tooth)	Limited to posterior tooth. 1 treatment per tooth every 36 months for children under age 14.
Space Maintainers	Limited to non-orthodontic treatment for children under age 19.
Inlays, Crowns, Bridges, Dentures and Partial	Replacement every 60 months if unserviceable and cannot be repaired. Benefits are based on the amount payable for non-precious metals. No porcelain or white/tooth-colored material on molar crowns or bridges.
Denture and Bridge Repairs	Reviewed if more than once.
Denture Relines, Rebases and Adjustments	Covered if more than 6 months after installation. 1 per 36 months
Prosthesis Over Implant	1 every 60 months if unserviceable and cannot be repaired. Benefits are based on the amount payable for non-precious metals. No porcelain or white/tooth colored material on molar crowns or
Benefit Exclusions: Covered Expenses will not include, and no payment will be made for the following:	
<ul style="list-style-type: none"> • Procedures and services not included in the list of covered dental expenses; • Diagnostic: cone beam imaging; • Preventive Services: instruction for plaque control, oral hygiene and diet; • Restorative: ceramic, resin, or acrylic materials on crowns or bridges on or replacing the upper and or lower first, second and/or third molars; • Periodontics: bite registrations; splinting; • Prosthodontic: precision or semi-precision attachments; • Procedures, appliances or restorations, except full dentures, whose main purpose is to change vertical dimension, diagnose or treat conditions of dysfunction of the temporomandibular joint (TMJ), stabilize periodontally involved teeth or restore occlusion; • Athletic mouth guards; • Services performed primarily for cosmetic reasons; • Personalization or decoration of any dental device or dental work; • Replacement of an appliance per benefit guidelines; • Services that are deemed to be medical in nature; 	

- Services and supplies received from a hospital;
- Drugs: prescription drugs;
- Charges in excess of the Maximum Reimbursable Charge

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Cigna Dental Benefit Summary
Episcopal Church Medical Trust
01/01/2022 (DDPV: Preventive Dental)



Administered by: Cigna Health and Life Insurance Company

This material is for informational purposes only and is designed to highlight some of the benefits available under this plan. Consult the plan documents to determine specific terms of coverage relating to your plan. Terms include covered procedures, applicable waiting periods, exclusions and limitations. **Your DPPO plan allows you to see any licensed dentist, but using an in-network dentist may minimize your out-of-pocket expenses.**

Cigna Dental PPO				
Network Options	In-Network: Total Cigna DPPO Network		Non-Network: See Non-Network Reimbursement	
Reimbursement Levels	Based on Contracted Fees		Maximum Reimbursable Charge	
Calendar Year Benefits Maximum Applies to: Class II, III & IX expenses	\$1,500		\$1,500	
Calendar Year Deductible Individual Family	\$0 \$0		\$0 \$0	
Benefit Highlights	Plan Pays	You Pay	Plan Pays	You Pay
Class I: Diagnostic & Preventive Oral Evaluations Prophylaxis: routine cleanings X-rays: routine X-rays: non-routine Fluoride Application Sealants: per tooth Space Maintainers: non-orthodontic Emergency Care to Relieve Pain	100% No Deductible	No Charge	100% No Deductible	No Charge
Class II: Basic Restorative Restorative: fillings Endodontics: minor and major Periodontics: minor and major Oral Surgery: minor and major Anesthesia: general and IV sedation Anesthesia: Exparel Repairs: bridges, crowns and inlays Repairs: dentures Denture Relines, Rebases and Adjustments Osseous Surgery	80% No Deductible	20% No Deductible	80% No Deductible	20% No Deductible
Class III: Major Restorative Inlays and Onlays Prosthesis Over Implant Crowns: prefabricated stainless steel / resin Crowns: permanent cast and porcelain Bridges and Dentures	1% No Deductible	99% No Deductible	1% No Deductible	99% No Deductible
Benefit Plan Provisions:				

<i>In-Network Reimbursement</i>	For services provided by a Cigna Dental PPO network dentist, Cigna Dental will reimburse the dentist according to a Fee Schedule or Discount Schedule.
<i>Non-Network Reimbursement</i>	For services provided by a non-network dentist, Cigna Dental will reimburse according to the Maximum Reimbursable Charge. The MRC is calculated at the 80th percentile of all provider amounts in the geographic area. The dentist may balance bill up to their usual fees.
<i>Cross Accumulation</i>	All deductibles, plan maximums, and service specific maximums cross accumulate between in and out of network. Benefit frequency limitations are based on the date of service and cross accumulate between in and out of network.
<i>Calendar Year Benefits Maximum</i>	The plan will only pay for covered charges up to the yearly Benefits Maximum, when applicable. Benefit-specific Maximums may also apply.
<i>Calendar Year Deductible</i>	This is the amount you must pay before the plan begins to pay for covered charges, when applicable. Benefit-specific deductibles may also apply.
<i>Pretreatment Review</i>	Pretreatment review is available on a voluntary basis when dental work in excess of \$200 is proposed.
<i>Alternate Benefit Provision</i>	When more than one covered Dental Service could provide suitable treatment based on common dental standards, Cigna will determine the covered Dental Service on which payment will be based and the expenses that will be included as Covered Expenses.
<i>Oral Health Integration Program (OHIP)</i>	Cigna Dental Oral Health Integration Program offers enhanced dental coverage for customers with the following medical conditions: diabetes, heart disease, stroke, maternity, head and neck cancer radiation, organ transplants and chronic kidney disease. There's no additional charge for the program, and those who qualify are eligible to receive reimbursement of their coinsurance for certain related dental procedures. Eligible customers can also receive guidance on behavioral issues related to oral health. Reimbursements under this program are not subject to the annual deductible, but will be applied to and are subject to the plan annual maximum. For more information including how to enroll in this program and a complete list of program terms and eligible medical conditions, go to www.mycigna.com or call customer service 24/7 at 1.800.CIGNA24.
<i>Timely Filing</i>	Out of network claims submitted to Cigna after 365 days from date of service will be denied.
<i>Benefit Limitations: Benefit frequency limitations are based on date of service and cross accumulate between in and out of network.</i>	
Oral Evaluations/Exams	3 per calendar year
X-rays (routine)	Bitewings: 2 per calendar year
X-rays (non-routine)	Complete series of radiographic images and panoramic radiographic images: Limited to a combined total of 1 per 36 months.
Cleanings	3 per calendar year, including periodontal maintenance procedures following active therapy.
Fluoride Application	2 per calendar year for children under age 19.
Sealants (per tooth)	Limited to posterior tooth. 1 treatment per tooth every 36 months for children under age 14.
Space Maintainers	Limited to non-orthodontic treatment for children under age 19.
Inlays, Crowns, Bridges, Dentures and Partial	Replacement every 60 months if unserviceable and cannot be repaired. Benefits are based on the amount payable for non-precious metals. No porcelain or white/tooth-colored material on molar crowns or bridges.
Denture and Bridge Repairs	Reviewed if more than once.
Denture Relines, Rebases and Adjustments	Covered if more than 6 months after installation. 1 per 36 months.
Prosthesis Over Implant	Replacement every 60 months if unserviceable and cannot be repaired. Benefits are based on the amount payable for non-precious metals. No porcelain or white/tooth-colored material on molar crowns or bridges.
<i>Benefit Exclusions:</i> Covered Expenses will not include, and no payment will be made for the following:	
<ul style="list-style-type: none"> • Procedures and services not included in the list of covered dental expenses; • Diagnostic: cone beam imaging; • Preventive Services: instruction for plaque control, oral hygiene and diet; • Restorative: ceramic, resin, or acrylic materials on crowns or bridges on or replacing the upper and or lower first, second and/or third molars; • Periodontics: bite registrations; splinting; • Prosthodontic: precision or semi-precision attachments; • Implants: implants or implant related services; • Orthodontics: orthodontic treatment; • Procedures, appliances or restorations, except full dentures, whose main purpose is to change vertical dimension, diagnose or treat conditions of dysfunction of the temporomandibular joint (TMJ), stabilize periodontally involved teeth or restore occlusion; • Athletic mouth guards; 	

- Services performed primarily for cosmetic reasons;
- Personalization or decoration of any dental device or dental work;
- Replacement of an appliance per benefit guidelines;
- Services that are deemed to be medical in nature;
- Services and supplies received from a hospital;
- Drugs: prescription drugs;
- Charges in excess of the Maximum Reimbursable Charge

This document provides a summary only. It is not a contract. If there are any differences between this summary and the official plan documents, the terms of the official plan documents will prevail.

Product availability may vary by location and plan type and is subject to change. All group dental insurance policies and dental benefit plans contain exclusions and limitations. For costs and details of coverage, review your plan documents or contact a Cigna representative.

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CHAPTER 2 ELIGIBILITY AND ENROLLMENT

Eligibility for the Episcopal Health Plan (EHP)

The Medical Trust determines the minimum eligibility for the Plans. The employer or Group Administrator is responsible for determining whether the Employee is eligible for any employer contributions towards coverage, confirming that Members meet the eligibility criteria described below and for maintaining documentation related to the Members' enrollment and elections. The Medical Trust may request a copy of required documentation at any time.

Eligible Individuals and their Eligible Dependents described below must be part of a Participating Group that is participating in the EHP.

Eligible Individuals

- An Employee normally scheduled to work 1,000 or more compensated hours per plan year or who is treated as a full-time Employee under the Employer Shared Responsibility Provisions under the Affordable Care Act (Pay or Play Rules), but only for the applicable stability period
- A Seminarian who is a full-time student enrolled at a participating seminary of the Association of Episcopal Seminaries
- A Member of a Religious Order
- A Pre-65 Former Employee, not eligible for Medicare, as long as their former employer is participating in the EHP
- A cleric eligible for benefits under The Church Pension Fund Clergy Short-Term Disability Plan, or The Church Pension Fund Clergy Long-Term Disability Plan who was eligible to participate in the EHP prior to their disability

Eligible Dependents

- A Spouse*
- A Domestic Partner, if Domestic Partner Benefits are elected by the Participating Group
- A Child who is 30¹ years of age or younger on December 31 of the current year**
- A Disabled Child, 30¹ years of age or older on December 31 of the current year, provided the disability began before the age of 25**
- A Pre-65 Dependent, not eligible for Medicare, of a Post-65 Former Employee enrolled in the Group Medicare Advantage Plan (GMAP)***
- A Pre-65 Surviving Dependent of a deceased Post-65 Former Employee or Pre-65 Former Employee***
- A Pre-65 Dependent, of a Pre-65 Former Employee enrolled in the GMAP****

**For information on the eligibility of a former Spouse refer to the Termination of Individual Coverage, under Divorce*

***The Dependent must be enrolled under the Subscriber's Plan.*

****The Dependent will be enrolled as a Subscriber; however, eligibility is based on the Post-65 Former Employee's status.*

*****The Dependent will be enrolled as a Subscriber; however, eligibility is based on the Pre-65 Former Employee's status.*

¹ Fully insured plans may not cover children up to age 30; as the eligibility rules of the regional or local plans vary and will apply, please confirm prior to enrollment.

Ineligible Individuals

Individuals described below are not eligible to enroll in the EHP.

- A part-time Employee who is scheduled to work and be compensated for less than 1,000 hours per Plan Year unless such Employee is required to be treated as a full-time Employee under the Pay or Play Rules
- A Temporary Employee unless such Employee is required to be treated as a full-time Employee under the Pay or Play Rules
- A Seasonal Employee unless such Employee is required to be treated as a full-time Employee under the Pay or Play Rules
- A Seminarian who is not a full-time student or not enrolled at a participating seminary of the Association of Episcopal Seminaries
- A parent or other relative of a Subscriber, including grandchildren and in-laws, not listed in the Eligible Dependents section above
- A Post-65 Former Employee or Pre-65 Former Employee (or Spouse/Domestic Partner) eligible to enroll in Medicare, regardless of whether they are actually enrolled in Medicare
- A volunteer
- An Employee whose working papers have expired and can no longer legally work
- An individual who refuses to provide a Social Security or Individual Taxpayer Identification Number
- A Dependent's dependent who is not a legal ward, foster child, legally adopted or who has not been placed with the Subscriber/Spouse/Domestic Partner for adoption
- An individual who is on long-term disability and eligible to enroll in Medicare Part A and Part B
- An individual who has been barred from enrolling because their eligibility has been terminated for cause (see page 27)

COVERAGE AND ELIGIBILITY EXCEPTIONS

There may be certain circumstances where an individual who does not meet the eligibility requirements listed above may choose to request a special eligibility determination from the Plan. The Bishop or Ecclesiastical Authority with authority over the Participating Group must submit the Coverage and Eligibility Exception Request Form to the Plan in these circumstances. The Plan will review the case presented and provide an individual eligibility determination within approximately 30 days after receipt of the form. If eligibility is granted, the effective date of coverage will be the first of the month following the receipt of the enrollment form. The Coverage and Eligibility Exception Request Form is available in the Appendix section of the Administrative Policy Manual.

IMPORTANT NOTES

Waiting Periods

The Plan may allow Participating Groups to require that an Eligible Individual be employed for a length of time before being allowed to participate in the Plan, subject to a maximum waiting period of 60 days. It should be noted that requiring a longer waiting period may result in a violation of the Affordable Care Act, which could result in significant penalties.

Additional information on new hires can be found in the Plan Election and Enrollment Guidelines section.

Medicare/Medicaid

Except as noted under Ineligible Individuals above, eligibility for Medicare/Medicaid or the receipt of Medicare/Medicaid benefits will not be taken into account in determining eligibility for participation in the EHP. For participation in the EHP for Qualified Small Employer Exception, eligibility for Medicare will be taken into account in determining eligibility.

Eligibility for the Episcopal Health Plan (EHP) for Qualified Small Employer Exception (SEE)

MEDICARE SECONDARY PAYER (MSP) — SMALL EMPLOYER EXCEPTION (SEE)

Some Employees and/or Dependents are eligible to participate in a Plan that qualifies for the Medicare Secondary Payer (MSP)—Small Employer Exception (SEE). Generally, Medicare is not responsible for paying primary (first) for someone who is actively working. However, Medicare allows an exception for some employers with fewer than 20 employees.

An Employee, who is 65 or over, or an Employee with a Dependent who is 65 or over, actively working for an employer who has fewer than 20 employees in the current year and had fewer than 20 employees in the previous year, may be eligible to choose a Plan that is offered under the SEE.

If the Member is approved and enrolled, Medicare would become the primary payer of claims covered under Medicare Part A only. Part A is hospitalization insurance that helps cover inpatient care in hospitals, skilled nursing facilities, hospices, and home health care situations. The EHP SEE will act as the secondary payer of claims. The Plan will coordinate benefit payments with Medicare so that any claims not paid by Medicare will be processed under the EHP.

If the Member is enrolled in Medicare Part B, which covers services such as doctor visits, outpatient procedures, and some prescription drugs, the Plan they are enrolled in will coordinate benefit payments with Medicare. If the Member is not enrolled in Medicare Part B, the EHP will remain the primary payer of benefits.

DETERMINING ELIGIBILITY FOR THE EHP SEE

The Medical Trust determines eligibility for the Plans. The employer or Group Administrator is responsible for determining whether the Employee is eligible for any employer contributions towards coverage, confirming that Members meet the eligibility criteria described below and for maintaining documentation related to the Members' enrollment and elections. The Medical Trust may request a copy of required documentation at any time. The employer or Group Administrator is responsible to notify The Medical Trust when they no longer meet the SEE criteria noted below.

Eligible Individuals and their Eligible Dependents described below must be part of a Participating Group that is participating in the EHP SEE.

The following criteria must be met first for eligibility to be allowed in the EHP SEE:

1. The Eligible Individual must work for an employer with fewer than 20 employees for each of the 20 or more calendar weeks in the current and preceding year and must be approved by CMS as a small employer.
2. The Eligible Individual or Eligible Dependent or both must be age 65 or over and enrolled in Medicare Part A on the basis of age only.

Note: When the above criteria have been met, the Eligible Individual's Dependents who are younger than age 65 and meet the eligibility requirements for the EHP will be enrolled in the same Plan; however, their Benefits will not coordinate with Medicare.

Eligible Individuals

- An Employee normally scheduled to work 1,000 or more compensated hours per Plan Year or who is treated as a full-time Employee under the Pay or Play Rules
- A Member of a Religious Order
- A cleric eligible for benefits under The Church Pension Fund Clergy Short-Term Disability Plan who is employed by the Participating Group and who was eligible to participate in the EHP prior to their disability

Eligible Dependents

- A Spouse*
- A Domestic Partner, if Domestic Partner benefits are elected by the Participating Group
- A Child who is 30² years of age or younger on December 31 of the current year
- A Disabled Child, 30² years of age or older on December 31 of the current year, provided the disability began before the age of 25**

**For information on the eligibility of a former Spouse refer to the Termination of Individual Coverage, under Divorce*

***The Dependent must be enrolled under the Subscriber's Plan.*

Ineligible Individuals

Individuals described below are not eligible to enroll in the EHP for SEE.

- Any Employee working for a Participating Group that does not meet the criteria for the SEE
- A part-time Employee who is scheduled to work and be compensated for less than 1,000 hours per year unless such Employee is required to be treated as a full-time Employee under the Pay or Play Rules
- A Temporary Employee unless such Employee is required to be treated as a full-time Employee under the Pay or Play Rules
- A Seasonal Employee unless such Employee is required to be treated as a full-time Employee under the Pay or Play Rules
- A Seminarian
- A parent or other relative of a Subscriber, including grandchildren and in-laws, not listed in the Eligible Dependents section above
- A volunteer
- An Employee whose working papers have expired and can no longer legally work
- An Eligible Individual or Eligible Dependent who refuses to provide a Social Security or Individual Taxpayer Identification Number
- A Dependent's dependent who is not a legal ward, foster child, legally adopted or who has not been placed with the Subscriber/Subscriber's Spouse/Domestic Partner for adoption
- An individual who has been barred from enrolling because their eligibility has been terminated for cause (see page 27)

² Fully insured plans may not cover children up to age 30; as the eligibility rules of the regional or local plans vary and will apply please confirm prior to enrollment.

Eligibility for the Group Medicare Advantage Plan (GMAP)

The Medical Trust determines eligibility for the Plans. The employer or Group Administrator is responsible for determining whether the Employee is eligible for any employer contributions towards coverage, confirming that Members meet the eligibility criteria described below and for maintaining documentation related to the Members' enrollment and elections. The Medical Trust may request a copy of required documentation at any time. In addition, separate eligibility rules apply for the subsidy under The Church Pension Fund Clergy Post-Retirement Medical Assistance Plan. Additional details can be found in *A Guide to Clergy Benefits* at cpg.org/clergyguide.

Generally, one becomes eligible for Medicare at age 65, although a person may become eligible sooner if they become disabled.

Eligible Individuals and Eligible Dependents must be enrolled in Medicare Parts A and B in order to enroll in the GMAP medical Plans, but not in the retiree dental Plans.

Eligible Individuals (must provide a Social Security or Individual Taxpayer Identification Number)

- A Post-65 Former Employee
- A Retired Member of a Religious Order
- A Pre-65 Former Employee who is enrolled in Medicare Parts A and B
- Cleric receiving benefits under The Church Pension Fund Clergy Long-Term Disability Plan who is enrolled in Medicare Parts A and B
- A pre-65 employee on long-term disability who is enrolled in Medicare Parts A and B

Eligible Dependents (must provide a Social Security or Individual Taxpayer Identification Number)

- A Spouse or Surviving Spouse*
- A Domestic Partner or Surviving Domestic Partner
- A Dependent Disabled Child or Surviving Dependent Disabled Child, provided the disability began before the age of 25

**For information on the eligibility of a former spouse refer to the Termination of Individual Coverage, under Divorce*

Important Notes

Medicare Secondary Payer (MSP)

The Plan must comply with the government's Medicare Secondary Payer (MSP) law, which outlines when Medicare is not responsible for paying first for health claims. The government designed Medicare to provide health coverage for retired individuals. Medicare requires employer group health plans to be the primary payer of health claims for individuals who are working and eligible for active group healthcare coverage. If an Employee who is 65 or older is eligible for coverage under an employer-provided health plan, as defined by the employer's policy, then Medicare will not be the primary payer for health claims.

Each employer must determine which Employees are eligible for employer-provided health benefits. The employer must comply with the Age Discrimination in Employment Act (ADEA), if applicable, which requires employers to offer to their over age 65 Employees and Spouses the same coverage that is offered to Employees and Spouses under age 65, regardless of their Medicare eligibility. In

addition, this equal benefit rule applies to coverage offered to full-time and part-time Employees. Those Employees over age 65 who are qualified for employer-provided health benefits and meet the Plan's eligibility rules described in this section must be offered the EHP or EHP SEE, if eligible.

Medicare beneficiaries are free to reject employer plan coverage and retain Medicare as their primary coverage. However, when Medicare is the primary payer, employers cannot offer such Employees (or their Spouses) secondary coverage for items and services covered by Medicare. Medicare states that an employer cannot sponsor or contribute to individual Medicare supplement health plans, Medicare HMOs, or Group Medicare Advantage plans for Medicare beneficiaries who are otherwise eligible for active group health coverage. Therefore, the Plan does not offer group Medicare supplement health plans, group Medicare HMOs, or Group Medicare Advantage plans to Employees and their Spouses over age 65 who are Medicare beneficiaries and the Employee and their eligible Spouse can no longer receive a subsidy under The Church Pension Fund Post-Retirement Medical Assistance Plan. Failure to comply with the MSP rules can result in penalties assessed against the employer. It is the employer's responsibility to comply with the MSP rules and by participating in the Plans the employer agrees to indemnify and hold the Medical Trust harmless from any claims resulting from the failure to comply with the MSP rules.

Small Employer Exception

Medicare provides an exception from this general rule for small employers, generally, those with fewer than 20 full- and/or part-time employees in the current and preceding years. A small employer may request Medicare to pay as primary for Medicare eligible beneficiaries by seeking a "small employer exception." This must be done through the Medical Trust as the employer's health plan.

The Centers for Medicare and Medicaid Services (CMS) does not aggregate religious organizations for MSP purposes. Incorporated parishes and churches that are part of a church-wide organization, such as a diocese or synod, are considered to be individual employers.

Eligible Small Employers must apply to CMS for approval to participate in the SEE by submitting an Employee Certification Form for each participant who may be eligible to the Medical Trust. (Eligible participants generally are those age 65 or older who are enrolled or eligible to enroll in Medicare Part A and, if applicable, Medicare Part B.) Once CMS has approved an employer and participants for the SEE, Medicare then becomes the primary payer of claims under Medicare Part A and, if applicable, Medicare Part B, for approved participants. The SEE Plan becomes the secondary payer and will coordinate benefit payments with Medicare for Medicare Part A claims and, if applicable, Medicare Part B claims.

Because Medicare will become the primary payer of claims covered under Medicare Part A, to participate in the EHP SEE, any members of the family who are eligible must be enrolled in Medicare Part A. Medicare Part A insurance helps cover the cost of inpatient care in hospitals, skilled nursing facilities, hospices, and home health care situations.

For all other coverage, such as doctor visits, outpatient procedures, and prescription drug coverage, the Medical Trust plan will remain the primary payer of Benefits. However, if an Employee or Eligible Dependent elects to enroll in Medicare Part B coverage, Medicare will become the primary payer of Part B claims and the Medical Trust plan will coordinate benefit payments with Medicare and become the secondary payer.

When Medicare becomes the primary payer for claims under Medicare Part A or Part B, the cost to employers of providing medical coverage may be reduced. Employees' hospitalization costs, including out-of-pocket expenses such as Deductibles and Coinsurance, will typically be lower as well. In

addition to the cost savings typically realized with Medicare as the primary payer of the claims, additional savings can be realized by using Network Providers. The Member will usually pay less for services from Network Providers than from Out-of-Network Providers.

Individuals who are enrolled in the EHP SEE will continue to have access to the value-added Benefits included in the Medical Trust plans, such as

- Vision care
- Employee Assistance Program (EAP)
- Health advocacy
- Travel assistance

Participation in the EHP SEE is not mandatory. Although the employer and the individual Employee may be approved to participate in the EHP SEE, the Employee has the option to elect a different plan offered by the employer.

Working for the Church after Retirement

Regardless of the retired Employee's status under The Church Pension Fund Clergy Pension Plan, if the Post-65 Former Employee is eligible for employer-provided health benefits such as coverage under the EHP, Medicare generally prohibits the Plan from offering the Post-65 Former Employee coverage under the GMAP.

If the Post-65 Former Employee who is working for The Episcopal Church after retirement does not qualify for coverage under the EHP or EHP SEE, then the Post-65 Former Employee may be eligible to enroll in the GMAP.

Failure to comply with the MSP rules can result in penalties assessed against the employer. It is the employer's responsibility to comply with the MSP rules and by participating in the Plans, the employer agrees to indemnify and hold the Medical Trust harmless from any claims resulting from the failure to comply with the MSP rules.

Plan Election and Enrollment Guidelines

This section addresses the Plan's rules and requirements related to enrollment and election changes. Topics include effective dates, termination procedures, Significant Life Events, Annual Enrollment, and other procedures.

Subscriber Responsibilities

The Plan and its administrators rely on information provided by Subscribers when evaluating the coverage and benefits under the Plan. Subscribers must provide all required information (including their and their enrolled Dependent's Social Security Number or individual taxpayer identification number) through a Medical Life Participant System (MLPS) submission or with an enrollment form to the Group Administrator.

All information provided must be accurate, truthful, and complete. Any fraudulent statement, omission or concealment of facts, misrepresentation or incorrect information will be considered an intentional misrepresentation of a material fact and may result in the denial of a claim, cancellation or rescission of coverage, or any other legal remedy available to the Plan.

Plan Elections and Changes

Eligible Individuals make their Plan elections and Coverage Tier elections upon first becoming eligible to participate in the Plan.

Plan elections generally remain in place for the entire Plan Year, provided the required contributions for coverage are received by the Plan. A Subscriber may not change their elected Plan or Coverage Tier except during Annual Enrollment, unless there is a Significant Life Event or a HIPAA Special Enrollment Event.

IMPORTANT NOTE: The Plan does not allow a Member to enroll in or terminate dental coverage mid-year without a Significant Life Event or HIPAA Special Enrollment Event.

Significant Life Events

A Significant Life Event gives a Subscriber the opportunity to make a change to enrollment. The enrollment change must be made within 30 days of the event and must be consistent with the event. Significant Life Events include:

- Marital status change (e.g., marriage, divorce, legal separation or annulment of marriage)
- Qualification or termination of a Domestic Partnership (in Participating Groups offering Domestic Partner coverage)
- Change in the number of Dependents (e.g., an increase through marriage, birth, adoption or placement for adoption, or a decrease through death or Dependent gaining own health Benefits)
- Change in Dependent status (e.g., becoming ineligible by reaching a limiting age)
- Change in employment status of a Subscriber or Dependent, that affects Plan eligibility (e.g. termination or commencement of employment, changing from full-time to part-time employment, significant change in the employer contribution or eligibility for contribution, commencement of or return from an unpaid leave of absence, changing from Employee to Pre-65 Former Employee or Post-65 Former Employee)
- Judgment, decree or order (e.g., a Qualified Medical Child Support Order (QMCSO))
- Change in residence or work site for a Subscriber or Dependent that affects network access to the current Plan
 - For example, if a Subscriber previously resided in an area in which only the PPO was available and then moved into an area where the HMO and PPO are available, the Subscriber may elect a new Plan. Conversely, if a Subscriber moved out of the HMO service area, and was therefore no longer eligible for the HMO, the Subscriber may elect a new Plan.
- Significant change in the cost of the Plan or a significant curtailment of medical coverage during a Plan Year for a Subscriber or Dependent
- Medicare or Medicaid entitlement (or loss of such entitlement)
- HIPAA Special Enrollment Event (see below)
- Enrollment in or termination of a Medicare Part D plan
- Change in employment or insurance status of Spouse
- Qualification change of a post-65 actively working Subscriber or Subscriber's Spouse to participate in the EHP SEE or GMAP
- Any other Significant Life Events provided under the applicable regulations and provided for under the employer's Section 125 Plan

IMPORTANT NOTE: A Provider's discontinuation of participation in a Plan network is not a Significant Life Event and does not permit an election change.

The effective date of coverage for an election change due to a Significant Life Event is the first day of the month following the Significant Life Event (except in the case of birth, adoption or placement for adoption of a Child). Election changes must be received by the Plan no later than 30 days after the Significant Life Event (60 days if the change relates to loss or eligibility for Medicaid plan or State child healthcare plan) and are valid for the remainder of the current Plan Year.

The employer is responsible for providing the Member a Summary of Benefits and Coverage (SBC) and a Notice of Special Enrollment for each applicable Plan within 90 days of enrollment resulting from a Significant Life Event.

HIPAA Special Enrollment Events

Certain Significant Life Events are considered to be HIPAA Special Enrollment Events that would allow an Eligible Individual who is not covered by the Plan to enroll themselves and their Eligible Dependents for coverage under the Plan outside of the Annual Enrollment period. HIPAA Special Enrollment Events include:

- Marriage
- Birth of a Child
- Adoption or placement for adoption of a Child
- Loss of coverage under another group health plan, including
 - The expiration of COBRA coverage if the other coverage was under a COBRA continuation provision, or
 - If the other coverage was not under COBRA,
 - Loss of eligibility for the other coverage or
 - Termination of employer contributions toward the Employee's other coverage
- Loss of eligibility for coverage in a Medicaid plan under Title XIX of the Social Security Act or a state child healthcare plan under Title XXI of the Social Security Act, and
- Eligibility for assistance with coverage under the Plan through a Medicaid plan under Title XIX of the Social Security Act or a state child healthcare Plan under Title XXI of the Social Security Act

Eligible Individuals will generally have 30 days to enroll in the Plan after a HIPAA Special Enrollment Event, but will have 60 days to enroll in the Plan as a result of a HIPAA Special Enrollment Event that is a loss of eligibility for coverage under a Medicaid plan or a state child healthcare plan or eligibility for assistance with coverage under the Plan through a Medicaid plan or state child healthcare plan. In the case of birth, adoption or placement for adoption of a Child, coverage will be effective retroactive to the date of the event. For all other HIPAA Special Enrollment Events, coverage will be effective as of the first day of the month following the month in which the request for coverage is processed.

The deadline to enroll in a group health plan sponsored by The Episcopal Church Medical Trust under the special enrollment provisions of the Health Insurance Portability and Accountability Act (HIPAA) has been temporarily extended as a result of the COVID-19 pandemic. Guidance was issued on April 28, 2020, directing plan sponsors to disregard the "Outbreak Period" when calculating these deadlines. The Outbreak Period is the period from March 1, 2020 until sixty (60) days after the announced end of the COVID-19 National Emergency (or other date announced through future guidance). If there are different Outbreak Periods in different parts of the country, additional guidance will be issued. Please see the example below and for complete details please review the HIPAA Special Enrollment Rights Notice.

Example: For purposes of this example, assume the National Emergency ends on April 30, 2022, and accordingly the Outbreak Period ends on June 29, 2022 (i.e., the 60th day

after the end of National Emergency). The Outbreak Period must be disregarded for purposes of determining the special enrollment period.

If a plan member gives birth on March 31, 2022, the member has until July 29, 2022 (30 days after June 29, 2022, the end of the Outbreak Period), to enroll herself and her newborn in the group health plan.

The employer is responsible for providing the Member an SBC for each applicable Plan and a Notice of Special Enrollment within 90 days of enrollment resulting from a HIPAA Special Enrollment Event.

Reporting Eligibility and Enrollment Changes

The Group Administrator must report all changes that affect Member Benefit coverage and Plan elections to the Plan when they occur, but no later than 30 days after the occurrence. Examples of what should be reported include:

- Demographic information change
- Dependent information change
- Employment status change
- Employer change (e.g. transfer to a new church or diocese)
- Change resulting from a Significant Life Event
- Change resulting from a HIPAA Special Enrollment Event
- Death of a Member or Dependent
- Retirement of an Employee
- Billing information change
- Disability of a Child
- Change of gender

The Subscriber or Eligible Individual must notify the Group Administrator when a Significant Life Event or other enrollment change occurs. The Group Administrator should request supporting documentation regarding Dependent eligibility.

The Group Administrator must then notify the Plan through an MLPS submission or with an enrollment form within 30 days after the event. Failure by the Group Administrator to perform this task could jeopardize the Subscriber's or Eligible Individual's enrollment.

The following additional requirements also apply:

- Health Plan choice may be restricted if a Subscriber or an Eligible Individual has Eligible Dependents living outside the service area of a particular Plan.
- If a local managed care Plan is elected, additional paper enrollment forms from the local Plan option must be submitted to the Plan.
- Pre-65 Former Employees and Post-65 Former Employees who do not receive any contribution assistance from the Participating Group may submit enrollment forms directly to the Plan.
- It should be noted that certain additional requirements may apply under the GMAP that should be taken into consideration in the processing of enrollment paperwork. Therefore, to ensure timely access to prescription drug coverage, the enrollment form and all required materials must be received at least 3 months prior to your desired coverage effective date.

Other changes such as a change of address or phone number can and should be reported to the

Plan when they occur.

Required Information and Documentation

All of the information requested on MLPS or the enrollment form (such as Social Security Number and date of birth) is required in order for a Plan election or other change to be processed.

The Participating Group is responsible for verifying a Member's personal data and may be required to provide the Plan with copies of the following documentation:

- Birth Certificate
- Social Security Card
- Individual Taxpayer Identification Number (ITIN) Card
- Marriage Certificate
- Divorce Decree
- Domestic Partnership Affidavit
- Statement of Dissolution of Domestic Partnership
- Child Affidavit
- Placement or Custody Order from social services, a welfare agency or court of competent jurisdiction
- Adoption Petition or Decree
- Medicare Card
- Driver's License

Annual Enrollment

Annual Enrollment is the annual period during which Subscribers of the EHP, the EHP SEE and GMAP and other Eligible Individuals may elect or change health Plans for the following Plan Year for themselves and their Eligible Dependents, or change Dependents covered by the Plan. Subscribers must complete the enrollment form or use the Annual Enrollment website, as appropriate. Generally, Annual Enrollment occurs during the fall with changes becoming effective on January 1 of the following Plan Year.

At the beginning of Annual Enrollment, Subscribers receive a letter outlining the steps required to make Plan election(s) or other changes for the upcoming Plan Year. The letter contains information about the Annual Enrollment website, instructions, and the dates the Annual Enrollment website will be available.

The Group Administrator should notify the Plan of other Eligible Individuals who would like to take part in Annual Enrollment prior to Annual Enrollment. To administer this, the Plan will request a mailing list and other information in advance in order to include them in Annual Enrollment.

The Annual Enrollment website contains:

- Current demographic and coverage information
- Available medical and/or dental Plans
- Full contribution rates for each Plan and Coverage Tier³³
- Options to add or remove Eligible Dependents
- The deadline for submitting Plan elections

³³ Employer/Employee cost share information is not provided.

- Links to Summary of Benefits and Coverage (SBCs)
- Reference material and other helpful resources

Newly Eligible Individuals Enrollment

Newly Eligible Individuals have a period of 30 days immediately following the date they become an Eligible Individual to elect a health Plan for the remainder of the current Plan Year. Plan elections, once made, cannot be changed for the remainder of the current Plan Year, unless the Member experiences a Significant Life Event or HIPAA Special Enrollment Event. The employer must provide the SBCs for all available Plans to the Employee no later than the first day the Employee is eligible to enroll in the Plan.

Seminarian Annual Enrollment

Annual Enrollment for Seminarians is held in conjunction with Annual Enrollment in the fall, with changes becoming effective January 1 of the following year.

New Plan elections for Seminarians who begin studying in the spring semester may be submitted before the commencement of classes. Plan elections must be submitted before the semester in which the Seminarian is enrolling commences. The Seminary Group Administrator must provide the SBCs for all available Plans to the Seminarian no later than the first day the Seminarian is eligible to enroll in coverage.

Specific Guidelines and Effective Dates of Coverage

Coverage is effective on the first day of the month following the date Eligible Individuals first become eligible to participate in the Plan or following the Significant Life Event, unless otherwise specified. Completed enrollment forms or MLPS submissions must be received by the Plan within 30 days of the event, (or 60 days if the change relates to loss or eligibility for Medicaid plan or State child healthcare plan).

New Eligible Individual

The effective date of coverage for a new Employee is the first day of the month following the Employee's date of hire, or date the Employee becomes eligible. For example, if the date of hire is Monday, June 2, then coverage is effective July 1.

However, if an Employee's date of hire is the first working day of the month and the first calendar day of the month (e.g., Sunday, June 1), coverage for the Employee will commence on the first day of that month (i.e., Sunday, June 1), provided that the Plan receives an enrollment form or MLPS submission within 30 days of that date.

In order to ensure compliance with the Affordable Care Act, in no event may the effective date of coverage for a new Employee be later than the first of the month following 60 days from the later of the date of hire or date the Employee becomes eligible.

If the Employee does not enroll (or is not automatically enrolled by the Participating Group, if applicable) within 30 days from the date when they becomes eligible, the Employee must wait for an applicable Significant Life Event or HIPAA Special Enrollment Event to occur, or wait until the next Annual Enrollment period.

Religious Orders

The effective date of coverage for a postulant, novice or professed member of a Religious Order is the first day of the month following the date in which they are received or accepted by the Religious Order.

However, if a postulant, novice or member is received or accepted by the Religious Order on the first working day of the month and the first calendar day of the month (e.g., Monday, June 1), coverage for the postulant, novice or member will commence on the first day of that month (i.e. Monday, June 1), provided that the Plan receives an enrollment form or MLPS submission within 30 days of that date.

Elections must be received by the Plan no later than 30 days after that date. If the postulant, novice or member does not enroll when initially eligible, then they must wait for an applicable Significant Life Event or HIPAA Special Enrollment Event to occur or until the next Annual Enrollment period.

Seminarians

The effective date of coverage for a Seminarian is the first day of the month in which the first semester or term in which they enroll as a full-time student begins.

Elections must be received by the Plan within 30 days of the seminary's published registration deadline for that semester.

If the Seminarian does not enroll within 30 days from the date they becomes eligible, then they must wait for an applicable Significant Life Event or HIPAA Special Enrollment Event to occur, or wait to enroll at the beginning of any subsequent semester and be covered starting with the first day of the month that semester begins. Enrollment will continue year-round for the duration of the time in seminary, until the Seminarian is no longer eligible (for example, because of graduation).

Pre-65 Former Employees

A Pre-65 Former Employee from a Participating Group who retires but is not Medicare-eligible, may continue coverage through the Episcopal Health Plan (EHP) with no change to the coverage effective date, provided an enrollment form or MLPS submission confirming continuation of coverage and change to Pre-65 Former Employee status is received by the Plan within 30 days of the retirement date.

If the Pre-65 Former Employee wants to make a plan election change as a result of retirement, then the coverage effective date of the new Plan will be the first day of the month following the retirement date. Elections must be received by the Plan no later than 30 days after the retirement date.

If the Pre-65 Former Employee does not make an election change within 30 days of the retirement date, then they must wait for an applicable Significant Life Event or HIPAA Special Enrollment Event to occur, or wait until the next Annual Enrollment period.

Once the Pre-65 Former Employee becomes Medicare-eligible, they must actively switch enrollment to the Group Medicare Advantage Plan (GMAP). If the enrolled Spouse/Domestic Partner is not Medicare-eligible at that time, then the enrolled Spouse/Domestic Partner may remain in the EHP until becoming Medicare-eligible, at which time they too must actively switch enrollment to the GMAP. The enrolled Children who are not Disabled Children may remain in the EHP until the end of the year in which they reach age 30⁴.

⁴ Fully insured plans may not cover children up to age 30; as the eligibility rules of the regional or local plans vary and

If the Pre-65 Former Employee has a spouse who becomes age 65 and is not actively working, the Post-65 Spouse of the Pre-65 Former Employee is allowed to enroll in the GMAP provided they are enrolled in Medicare Parts A and B. The Pre-65 Former Employee remains in the EHP. This reverse split is allowed because the Subscriber is a Pre-65 Former Employee.

IMPORTANT NOTE: An Employee who terminates their employment with a Participating Group prior to meeting the eligibility requirements for a Pre-65 Former Employee will be offered an Extension of Benefits (as described below).

Pre-65 Former Employee, not covered under the Episcopal Health Plan (EHP)

Enrollment in the EHP for Pre-65 Former Employees who are not currently enrolled in the EHP is limited to those who:

- a) Waived EHP coverage as a qualified opt out and have subsequently experienced a HIPAA Special Enrollment Event, or
- b) Join the EHP as part of a new Participating Group during their initial enrollment period, provided they were covered under that group's plan and included in the group census

For these limited circumstances, the Pre-65 Former Employee may enroll in the EHP at the time of a HIPAA Special Enrollment Event or Annual Enrollment, and remain in the EHP until such time as the individual becomes Medicare-eligible, at which time the Pre-65 Former Employee is no longer eligible for the EHP and must actively switch enrollment to the GMAP. If the enrolled Spouse/Domestic Partner is not Medicare-eligible at that time, then the enrolled Spouse /Domestic Partner may remain in the EHP until becoming Medicare-eligible, at which time the Spouse/Domestic Partner too is no longer eligible for the EHP and must actively switch enrollment to the GMAP.

The enrolled Children who are not a Disabled Child may also remain in the EHP until the end of the year in which they reach age 30.⁵

Health Plan elections must be received by the Plan no later than 30 days after a HIPAA Special Enrollment Event or Annual Enrollment. See pages 18-19 for information on HIPAA Special Enrollment extensions due to COVID-19.

Post-65 Former Employees

The effective date of coverage for the GMAP for a Post-65 Former Employee is the first day of the month in which they turn age 65, provided that they are enrolled in Medicare Parts A and B and meets the eligibility requirements of the Plan.

If the Post-65 Former Employee does not enroll when initially eligible, then they must wait for an applicable Significant Life Event or HIPAA Special Enrollment Event to occur, or wait until the next Annual Enrollment period.

Dependents

The effective date of coverage for an Eligible Dependent is the same date as the Subscriber's effective date. If the Subscriber does not enroll all Eligible Dependents within 30 days of a

will apply, please confirm prior to enrollment.

⁵ Fully insured plans may not cover children up to age 30; as the eligibility rules of the regional or local plans vary and will apply, please confirm prior to enrollment.

Significant Life Event or HIPAA Special Enrollment Event, then the Eligible Dependents may not enroll until the next Annual Enrollment period or until another Significant Life Event or HIPAA Special Enrollment Event occurs. See pages 18-19 for information on HIPAA Special Enrollment extensions due to COVID-19.

New Children

A Subscriber's newborn Child is covered under the Plan for the first 30 days immediately following birth only if the newborn Child is enrolled in the Plan. The Subscriber must enroll the new Child for coverage within 30 days of the birth to ensure claims incurred during the first 30 days are covered and for coverage to continue beyond the 30-day period. The coverage effective date will be the date of birth. If applicable, monthly contribution rates will change to reflect the new Coverage Tier on the first day of the month following the date of birth. If a properly completed enrollment form or MLPS submission is not received by the Plan within the 30-day period, the Child may not be enrolled in the Plan until the next Annual Enrollment period or the occurrence of a subsequent Significant Life Event or HIPAA Special Enrollment Event. Please see pages 18-19 for special enrollment provisions in effect as a result of the COVID-19 pandemic.

Note: The newborn child of a Dependent Child will not be covered by the Plan, even for the first 30 days, unless that child is placed for adoption, or is a legal ward or foster child of the Subscriber/Subscriber's Spouse/Domestic Partner.

Adopted Children

Upon timely notification, coverage for the Child will be effective on the date of adoption, or, if earlier, placement for adoption. The Plan will consider a Child placed for adoption as eligible for enrollment on the date when the Subscriber becomes legally obligated to support that Child prior to that Child's adoption. If the Subscriber does not enroll the Child within 30 days of that date, then the Child may not enroll until the next Annual Enrollment period or until a subsequent Significant Life Event or HIPAA Special Enrollment Event occurs. If a Child placed for adoption is not adopted, all health coverage ceases when the placement ends and will not be continued. The Plan will only cover expenses incurred by the birth mother, including the birth itself, if the birth mother is an enrolled Member on the date of birth.

Domestic Partners

A Subscriber may enroll their eligible Domestic Partner for coverage under the Plan if the Subscriber meets the Plan's eligibility requirements and is part of a Participating Group that offers Domestic Partner coverage. The Plan requires a signed affidavit attesting to the Domestic Partnership. If the Subscriber does not enroll their eligible Domestic Partner within 30 days after submission of a valid Domestic Partnership Affidavit, then the eligible Domestic Partner may not enroll until the next Annual Enrollment period or until a Significant Life Event or HIPAA Special Enrollment Event occurs.

Non-Medicare-eligible Dependents

A Post-65 Former Employee and the Employee's Eligible Dependents may split enrollment between the EHP and the GMAP in cases where the Post-65 Former Employee is eligible for Medicare and the Dependents are not eligible for Medicare and are under age 65. Eligibility in the EHP will end once the Spouse/Domestic Partner becomes Medicare-eligible and/or reaches age 65, at which time, the Spouse/Domestic Partner must actively switch enrollment to the GMAP. The Subscriber's enrolled

Children who are not a Disabled Child may continue to participate in the EHP until the end of the year in which they reach age 30.⁶

Disabled Child

If the Dependent Child is a Disabled Child prior to their 25th birthday and continues to be a Disabled Child on the last day of the year in which the Child reaches age 30, the Child's eligibility will be extended for as long as the parent is a Subscriber, the disability continues and the Child continues to meet the Plan's eligibility requirements in all aspects other than age.

In order for the Plan to confirm the status of a Disabled Child, the Subscriber must contact Client Services who will initiate the confirmation process with the Medical Board. The third-party administrator designated by the Medical Trust is the Medical Board that will review satisfactory proof of disability and determine the status of the Disabled Child. The designated third-party administrator will contact the Subscriber with the request for documentation. The Plan may require, at any time, a physician's statement certifying the ongoing physical or mental disability.

Children of Surviving Spouses of Limited Means

The Children's Health Insurance Program (CHIP) is a federal program through which the government assists states in providing affordable health insurance to families with children. The program was designed with the intent to offer health coverage to uninsured children in families with incomes that are modest but too high to qualify for Medicaid.

Surviving Spouses of limited means may find it more financially advantageous to cover their minor Children through CHIP or minor and adult dependent Children through Medicaid. For such persons, Surviving Spouses may opt to (1) cover their minor Children or adult Dependent Children in a government plan, (2) decline coverage from the Plan for the Dependents so covered, and (3) retain the eligibility to re-enroll these Dependents should they lose coverage under the government plan on account of (i) bankruptcy or termination of the government plan, (ii) loss of eligibility under the government plan due to income changes, or (iii) other loss of eligibility for the government plan, not including reaching a limiting age. Dependents must satisfy all other eligibility criteria of the Plan in order to re-enroll. See the HIPAA Special Enrollment section for more details.

Children Subject to a Qualified Medical Child Support Order (QMCSO)

A QMCSO is a judgment, decree or order (including approval of a settlement agreement) or administrative notice that is issued pursuant to a state domestic relations law (including a community property law) or through an administrative process, which directs that a Child must be covered under a health plan. The Plan has delegated to the applicable Participating Group the responsibility to determine if a medical child support order is qualified. If the Participating Group determines that a separated or divorced Spouse or any state child support or Medicaid agency has obtained a QMCSO, and if the Participating Group offers Dependent coverage, the Plan will allow the Subscriber to provide coverage for any Children named in the QMCSO.

To be qualified, a medical child support order must satisfy all of the following:

- The order recognizes or creates a Child's right to receive group health benefits for which the Subscriber is eligible

⁶ Fully insured plans may not cover children up to age 30; as the eligibility rules of the regional or local plans vary and will apply, please confirm prior to enrollment.

- The order specifies the Subscriber's name and last known address and the Child's name and last known address, except that the name and address of an official of a state or political subdivision may be substituted for the Child's mailing address
- The order provides a description of the coverage to be provided or the manner in which the type of coverage is to be determined
- The order states the period to which it applies
- If the order is a National Medical Support Notice, it meets the requirements above

The QMCSO may not require the Plan to provide any type or form of benefit or option not otherwise provided under the Plan.

Children of a Subscriber who must be covered under the Plan in accordance with a QMCSO will be covered beginning on the date the order is approved and continuing until the date or age stipulated. However, Children may not be covered beyond the eligibility age permitted under the Plan.

If a QMCSO requires that the Subscriber provide health coverage for the Subscriber's Children and the Subscriber does not enroll the Children, the Participating Group will enroll the Children upon application from the Subscriber's separated or divorced Spouse, the state child support agency or Medicaid agency, provided it is required to do so by law. The Participating Group will withhold from the Subscriber's pay their share of the cost of such coverage.

If a QMCSO requires a separated or divorced ex-Spouse of a Subscriber to cover a Child, the Subscriber may change elections and drop coverage for the Child. However, the Subscriber may not drop coverage for the Child until the other plan's coverage begins. Subscribers may not otherwise drop coverage for a Child covered pursuant to a QMCSO unless they submit written evidence to the Participating Group that the QMCSO is no longer in effect.

Leaves of Absence

Leaves of absence encompass all approved leaves with or without pay, including leaves due to workers' compensation, Family and Medical Leave Act, and the sentence of suspension or restriction on ministry of a priest in accordance with Title IV, Canon 19, Section 7.⁷

If otherwise permitted by the Subscriber's employer, a Subscriber on a leave of absence may choose to decrease the Coverage Tier for the duration of the leave or Extension of Benefit and increase it again upon return from leave. It is necessary to notify the Participating Group and the Plan within 30 days of the start date of the leave to decrease the Coverage Tier and also within 30 days of the end date of the leave to increase the Coverage Tier once the Subscriber returns to work.

If the leave of absence is paid leave, or a legally mandated unpaid leave, the Member can retain their active coverage. If the leave of absence is unpaid, and otherwise not legally mandated, then the Member will be terminated and a letter will be sent offering an Extension of Benefits. Upon the Member's return, the employer can reinstate the Member.

Termination of Individual Coverage

The Group Administrator must submit a request to terminate coverage for a Subscriber through MLPS or an enrollment form no later than 30 days after the termination event. If the Plan receives a termination request thereafter, then the Participating Group (or Subscriber if billed directly) will be required to pay the applicable monthly contributions to the Plan up to the coverage termination date.

⁷ The Constitution and Canons of the Episcopal Church, 2018.

Coverage ends the earliest of:

- The last day of the month in which:
 - The Subscriber no longer meets the eligibility requirements (e.g. Employee resigns or Seminarian graduates from seminary)
 - The Dependent no longer meets the eligibility requirements for any reasons other than death or turning age 30⁸ (e.g., Spouse is no longer eligible due to divorce or Subscriber ceases to be a Dependent's legal guardian)
 - Monthly contributions cease
 - The Participating Group's participation with the Plan terminates
- The last day of the year in which an enrolled Dependent Child reaches age 30, except if the Child is a Disabled Child in accordance with the terms of the Plan⁸
- The date the Plan ceases to exist

When a termination event occurs, the Subscriber or Eligible Individual must notify the Group Administrator as soon as possible. The Group Administrator should request supporting documentation regarding such event.

Coverage termination dates resulting from a Significant Life Event where a Subscriber loses or declines coverage will be the last day of the month in which the Significant Life Event occurred, unless otherwise specified.

For Cause

Upon written notice to the Subscriber, the eligibility of the Subscriber and their Dependent(s) may be immediately terminated if the Subscriber or Dependent(s):

- Threaten the safety of the Plan Administrator, Cigna, any Group Administrator or any Provider, or any personnel of any of the foregoing.
- Commit theft from the Plan Administrator, Cigna, any Group Administrator or any Provider.
- Performs an act that constitutes fraud or makes an intentional misrepresentation of material fact in procuring coverage, such as knowingly (1) misrepresenting participation status, (2) presenting an invalid prescription or physician order, or (3) misusing or letting someone else misuse an ID card to obtain care under false pretenses. Note: Any Subscriber's or Dependent's fraud will be reported to the authorities for prosecution and appropriate civil remedies will be pursued.

Termination will be effective as soon as administratively practicable following the date notice is sent, and in no event later than the first of the month immediately following such date. All rights cease as of the date of termination, including the right to enroll in the Extension of Benefits program following the termination of coverage.

Persons barred from enrolling:

You cannot enroll if you have had your eligibility terminated for cause due to your actions.

⁸ Fully insured plans may not cover children up to age 30; as the eligibility rules of the regional or local plans vary and will apply please confirm prior to enrollment.

Death and Surviving Dependents

The coverage termination date will be the last day of the month in which the Subscriber's death occurred. The new coverage effective date for the Surviving Dependents who enroll in the Extension of Benefits program will be the first day of the month following the Subscriber's death date.

If a Surviving Spouse remarries, any new Dependents acquired after the primary Subscriber's death are ineligible for coverage under the Plan, unless the Dependent is a Child of the Subscriber born or adopted up to 12 months after the Subscriber's death. The same rules apply to Surviving Domestic Partners who engage in a new Domestic Partner relationship.

Employee/Seminarian

When an Employee or Seminarian enrolled in the EHP dies, their Surviving Dependents who are also enrolled in the EHP at that time are offered an Extension of Benefits. The coverage termination date will be the last day of the month in which the Subscriber's death occurred. The new coverage effective date for the Surviving Dependents who choose to enroll in the Extension of Benefits program will be the first day of the month following the Subscriber's date of death.

Post-65 Former Employee or Pre-65 Former Employee enrolled in Medicare

When a Post-65 Former Employee or a Pre-65 Former Employee enrolled in Medicare and enrolled in the GMAP dies, Surviving Spouses and Surviving Domestic Partners enrolled in the GMAP at the time of the Member's death can remain covered in the GMAP. Children enrolled in the EHP may remain in the EHP until the last day of the year in which they turn 30⁹ or later if the Child is a Disabled Child in accordance with the terms of the Plan. If the Surviving Dependents leave the EHP, they may not return to the Plan, unless they are eligible to enroll in the GMAP.

Pre-65 Former Employee or Cleric receiving Benefits under The Church Pension Fund Clergy Long-Term Disability Plan

When a Pre-65 Former Employee enrolled in the EHP or a cleric enrolled in the EHP and receiving benefits under The Church Pension Fund Clergy Long-Term Disability Plan who is enrolled in Medicare dies, the Surviving Spouse or Surviving Domestic Partner who is also enrolled in the EHP can remain covered until becoming Medicare-eligible, at which time the individual must actively enroll in the GMAP if eligible. Enrolled Children may remain in the EHP until the last day of the year in which they turn 30⁹ or later if the Child is a Disabled Child in accordance with the terms of the Plan. If the Surviving Dependents leave the EHP, they may not return to the Plan, unless they are eligible to enroll in the GMAP.

Dependents

If an enrolled Dependent dies, the termination date for the deceased Dependent is the end of the month in which the death occurred. The Subscriber's Coverage Tier and associated monthly contribution may change as a result, beginning on the first day of the month following the death date.

⁹ Fully insured plans may not cover children up to age 30; as the eligibility rules of the regional or local plans vary and will apply please confirm prior to enrollment.

Divorce or Dissolution of a Domestic Partnership

The divorced Spouse (or former Domestic Partner) and/or Subscriber must notify the Participating Group and the Plan of events that may cause a loss of coverage. The coverage termination date is the first of the month following the effective date of the divorce (or of the dissolution of the Domestic Partnership).

Employees and Seminararians

The Spouse/Domestic Partner enrolled in the EHP or the EHP SEE will be offered an Extension of Benefits only and will not be considered eligible for the GMAP at a later date. Please see the Extension of Benefits section for more details.

Post-65 Former Employees or Pre-65 Former Employee with Dependents under age 65

The Pre-65 Spouse or Domestic Partner enrolled in the EHP who gets divorced from (or dissolves a Domestic Partnership with) a Post-65 Former Employee or Pre-65 Former Employee can stay enrolled in the EHP. However, if the Spouse or Domestic Partner leaves the EHP, then they cannot enroll again with the Plan until they become eligible for the GMAP. The Spouse or Domestic Partner can leave the GMAP and join again at future Annual Enrollment periods.

Post-65 Former Employees or Pre-65 Former Employees with Dependents in the GMAP

The Spouse or Domestic Partner enrolled in the GMAP who gets divorced from (or dissolves a Domestic Partnership with) a Post-65 Former Employee or Pre-65 Former Employee can stay enrolled in the GMAP. The Spouse or Domestic Partner can leave the GMAP and join again at future Annual Enrollment periods.

Extension of Benefits Program for the EHP

The Plan's Extension of Benefits program is similar, but not identical, to the healthcare continuation coverage provided under Federal law (known as "COBRA") for non-church plans. Because the Plan is a church plan as described under Section 3(33) of ERISA, the Plan is exempt from COBRA requirements.¹⁰ Nonetheless, Subscribers and/or their enrolled Dependents will have the opportunity to continue benefits for a limited time in certain instances when coverage through the EHP would otherwise cease. Individuals who elect to continue coverage must pay for the coverage.

The option to extend coverage depends on whether the individual was covered as an Employee, Spouse, Domestic Partner or Dependent Child.

- Employees who are terminated are offered an extension of 36 months starting on the first day of the month following the termination event.
- Spouses and Domestic Partners whose coverage is terminated as a result of the Employee's termination, the Employee's death, divorce, legal separation or termination of a Domestic Partnership are offered an extension of 36 months starting on the first day of the month following the termination event.
 - If the couple divorces while on an Extension of Benefits, the divorced spouse of the former Employee may choose to remain on their own extension for the remaining period of the current extension.
 - Note that, with respect to former Domestic Partners, an Extension of Benefits will only be available if the Participating Group offers coverage to Domestic Partners generally.

¹⁰ Under Section 4980B(d) of the Code and Treasury Regulation Section 54.4980 B-2, Q. and A. No. 4.

- Dependent Children whose coverage is terminated are offered an extension of up to 36 months starting on the first day of the month following the termination event.
- Seminarians who cease to be a Seminarian are offered an extension of 36 months starting on the first day of the month following graduation or other separation event.
- Employees whose Medical Trust coverage terminates under the terms of The Church Pension Fund Clergy Long-Term Disability Plan are offered an extension of 36 months starting on the first day of the month following the termination under The Church Pension Fund Long-Term Disability Plan.

Note: Regardless of the type of severance payment agreed upon between the employer and Employee (lump sum or monthly payments), if any, coverage under the Extension of Benefits program is effective the first of the month following the termination date in the Employee's record.

Newly acquired Dependents during an Extension of Benefits period are eligible for coverage under the extension, provided that the Plan is notified within 30 days of the Significant Life Event.

The Plan notifies individuals regarding their eligibility for an Extension of Benefits within 5 business days of receiving a termination notice from the Group Administrator. The notification includes an enrollment form and an invoice for contributions that are due and an explanation of the monthly contributions and duration of the extension. If the current Plan is no longer available, an alternate option may be offered. The termination date is the last day of the month in which the separation event occurred.

Recipients of an Extension of Benefits offer have 21 calendar days to respond from the day the offer is mailed by the Plan (45 calendar days when a result of the death of the Subscriber). Responses must include a payment to cover the contributions that are due. Otherwise, enrollment in the extension is considered declined.

Coverage in effect at the time of separation continues until the last day of the month in which the event occurs. Coverage under the Extension of Benefits program is effective the first of the month following the separation event so that there is no coverage gap between the termination date and enrollment in the Extension of Benefits.

The Plan will maintain the coverage and invoice the Member directly, without the involvement of the Group Administrator. Note, however, that the employer is required to provide the SBC for the applicable Plans to the Members on the Extension of Benefits prior to Annual Enrollment each year. No conversion option is available at the end of the Extension of Benefits. If the Participating Group ceases to offer the Plan at the annual renewal, the Member will be notified during Annual Enrollment of the need to change plans for the upcoming year.

The Plan will notify Members on an Extension of Benefits of any cost change to the Plan in advance of the new Plan Year.

Coverage under the Extension of Benefits program will cease on the earliest of the following:

- The date that required monthly contributions to the Plan are 60 days overdue
- The date the Member becomes a Post-65 Former Employee
- The first of the month following the date the Member is hired by another Participating Group and is an Eligible Individual
- The last day of the month of the Extension of Benefit period
- The last day of the month after the individual submits a written notice to terminate coverage for medical, dental or both (30 days-notice required)

- The date a Participating Group's participation in the Plan is terminated (whether by the Participating Group or the Medical Trust) and the Participating Group enrolls in another group health plan. (The Group Administrator will be notified by the Plan of all individuals participating in the Extension of Benefits program)
- Upon death of the Member (surviving Dependents may continue coverage under the remaining period of the Extension of Benefits)
- The date the Plan ceases to exist

Important Notes

Required Monthly Contributions

The Plan does not pro-rate contribution requirements for any health Plan regardless of the termination date or the effective date. Any monthly contribution rate change will be effective the first day of the month following the change. Contributions for coverage with a retroactive effective date must be paid upon enrollment.

One Type of Coverage

The Plan prohibits two Members who are each enrolled from covering each other in the same Plan (EHP, EHP SEE or GMAP). Therefore, an individual may not participate in the Plan as a Subscriber and as a Dependent in the same Plan. If two Members both work for The Episcopal Church in Participating Groups who offer different Plans, an individual may enroll as the Subscriber in one and as a Dependent in the other (e.g., Subscriber in medical Plan, Dependent in dental Plan).

Plan Sponsor

We maintain contractual relationships with various health plan vendors on your behalf. We are the plan sponsor and plan administrator of all Medical Trust health plans except for a) Health Savings Accounts under the Consumer-Directed Health Plan/Health Savings Account arrangements, which are maintained by individual Members, and b) any fully-funded healthcare plan options offered by us other than the UnitedHealthcare Group Medicare Advantage (PPO) Plan. For the UnitedHealthcare Group Medicare Advantage (PPO) Plan, The Medical Trust is the plan sponsor.

The Medical Trust will be responsible for the preparation and delivery of the Forms 1094-B and 1095-B for Members who participate in the Plans that we sponsor.

CHAPTER 3

Cigna Dental PPO Network

The Medical Trust dental plans described in this Plan Document Handbook use the Cigna Dental Participating Provider Organization (PPO) Network (“the network”) to provide dental benefits for you and your Eligible Dependents.

A dental PPO is a group of dental care providers that has agreed to provide dental care services at a contracted rate. The participating providers have been carefully selected by Cigna. The qualifications of each provider have been reviewed by Cigna so that you and your dependents will be provided quality care at a fee significantly less than is common in the geographic area in which you live.

Some Providers contract with Cigna to provide services to Members as part of the Cigna Dental PPO Network. Cigna's network consists of two tiers of contracted Providers. The first tier, Cigna DPPO Advantage, offers the highest discounts, and because the contracted rate results in savings to both you and the Plans, you are reimbursed at a higher level if you use Cigna DPPO Advantage Providers. Cigna DPPO Advantage Providers are also referred to as in-network providers. The second tier of Cigna's network, the Cigna DPPO, still offers contracted rates, but these discounts are lower than the Cigna DPPO Advantage. The term Out-of-Network refers to dental care Providers that do not participate in the network. The Cigna DPPO Providers and the Out-of-Network providers are reimbursed at the same level of benefits.

You can access the dental provider directory:

- Via the Internet at **www.cigna.com**
- By calling the toll-free number: (800) 244-6224

CHOOSING A NETWORK PROVIDER

Network services are dental care services provided by a dentist or dental care facility that participates in the network, which is available to Plan Members. When you choose network care, you get these advantages:

Choice—You can choose any provider participating in the network.

Convenience—Usually, there are no claim forms to file.

Discounts—Your out-of-pocket cost may be lower due to the PPO contracted rate.

CHOOSING AN OUT-OF-NETWORK PROVIDER

Out-of-Network services are dental care services provided by a licensed Provider that does not participate in the network. When you use Out-of-Network Services:

- You pay an annual Deductible and Coinsurance, plus the balance of the provider's actual charge
- You will usually have to pay the provider when you receive care
- You may need to file a claim with Cigna to be reimbursed by the Plan

CHAPTER 4

COVERAGE FOR THE DENTAL PLAN

When all of the provisions of the Plans are satisfied, the Plans will provide benefits as outlined on the Schedules of Benefits for the following lists of covered dental services. These lists are intended to give you a general description as to what's covered by the Plans. The Plan may agree to cover expenses for a service not listed. To be considered, the service should be identified using the American Dental Association Uniform Code of Dental Procedures and Nomenclature, or by description and then submitted to Cigna.

Covered Dental Expense means that portion of a dentist's charge that is payable for a service delivered to a covered person provided:

- The service is ordered or prescribed by a dentist
- Is essential for the necessary care of teeth
- The service is within the scope of coverage limitations
- The Deductible amount in the schedule has been met
- The maximum benefit in the schedule has not been exceeded
- The charge does not exceed the amount allowed under the Alternate Benefit Provision
- For Class I, II or III, the service is started and completed while coverage is in effect

COVERED BENEFITS

Refer to the Summaries of Benefits and Coverage (SBCs) in Chapter 1 to see your covered benefits, exclusions, and limitations.

The SBCs list common dental procedures and are not exhaustive.

Contact Cigna if you have any questions about your benefits.

EXCLUSIONS AND LIMITATIONS - BASIC DENTAL AND DENTAL & ORTHODONTIA PPO PLANS

WHAT'S NOT COVERED

Covered expenses will not include, and no payment will be made for:

- Services performed solely for cosmetic reasons
- Replacement of a lost or stolen appliance
- Replacement of a bridge, crown or denture within five years after the date it was originally installed unless: (a) the replacement is made necessary by the placement of an original opposing full denture or the necessary extraction of natural teeth; or (b) the bridge, crown or denture, while in the mouth, has been damaged beyond repair as a result of an injury received while a person is insured for these benefits
- Any replacement of a bridge, crown or denture which is or can be made useable according to common dental standards
- Procedures, appliances or restorations (except full dentures) whose main purpose is to: (a) change vertical dimension; (b) diagnose or treat conditions or dysfunction of the temporomandibular joint; (c) stabilize periodontally involved teeth; or (d) restore occlusion
- Porcelain or acrylic veneers of crowns or pontics on, or replacing the upper and lower first, second and third molars

- Bite registrations, precision or semiprecision attachments, or splinting
- Instruction for plaque control, oral hygiene, and diet
- Stress breakers
- Myofunctional therapy
- Athletic mouth guards
- Dental services that do not meet common dental standards
- Services that are deemed to be medical services
- Services and supplies received from a hospital
- Travel expenses of a dentist or a covered person
- Expenses for preparing dental reports, itemized bills, or claim forms
- Expenses for telephone calls or broken appointment
- Services for which benefits are not payable according to the "General Limitations" section

GENERAL LIMITATIONS

No payment will be made for expenses incurred for you or any one of your dependents:

- For services rendered by anyone other than a covered dentist
- For complications arising from any noncovered services or treatment
- For, or in connection with, an injury arising out of, or in the course of, any employment for wage or profit
- For, or in connection with, a sickness which is covered under any workers' compensation or similar law
- For charges made by a hospital owned or operated by, or which provides care or performs services for, the United States Government, if such charges are directly related to a military service-connected condition
- Services or supplies received as a result of dental disease, defect, or injury due to an act of war, declared or undeclared
- To the extent that payment is unlawful where the person resides when the expenses are incurred
- For charges which the person is not legally required to pay
- For charges which would not have been made if the person had no insurance
- Expenses incurred for services rendered prior to the date of coverage or after the date the coverage ends under these Plans
- To the extent that billed charges exceed the rate of reimbursement as described in the Schedule of Benefits
- For charges for unnecessary care, treatment, or surgery
- To the extent that you or any of your dependents is in any way paid or entitled to payment for those expenses by or through a public program, other than Medicaid
- For, or in connection with, experimental procedures or treatment methods not approved by the American Dental Association or the appropriate dental specialty society

EXCLUSIONS AND LIMITATIONS – PREVENTIVE DENTAL PPO PLAN

WHAT'S NOT COVERED

Covered expenses will not include, and no payment will be made for:

- Services performed solely for cosmetic reasons
- Replacement of a lost or stolen appliance
- Replacement of a bridge, crown or denture within five years after the date it was originally installed unless: (a) the replacement is made necessary by the placement of an original opposing full denture or the necessary extraction of natural teeth; or (b) the bridge, crown or denture, while in the mouth, has been damaged beyond repair as a result of an injury received while a person is insured for these benefits

- Any replacement of a bridge, crown, or denture which is or can be made useable according to common dental standards
- Procedures, appliances or restorations (except full dentures) whose main purpose is to: (a) change vertical dimension; (b) diagnose or treat conditions or dysfunction of the temporomandibular joint; (c) stabilize periodontally involved teeth; or (d) restore occlusion
- Porcelain or acrylic veneers of crowns or pontics on, or replacing the upper and lower first, second, and third molars
- Bite registrations, precision or semiprecision attachments, or splinting
- Topical application of sealant
- Space maintainers
- Injections of antibiotic drugs
- Any periodontal procedure, including scaling and root planing, with the exception of periodontal prophylaxis
- Recementation of crowns, bridges, or dentures
- Instruction for plaque control, oral hygiene, and diet
- Expenses for telephone calls, telephone consultations, or broken appointments
- Expenses for preparing or copying dental reports, itemized bills, or claim forms
- Travel expenses of a dentist or a covered person
- Dental services that do not meet common dental standards
- Expenses incurred for services rendered prior to the date of coverage or after the date coverage ends under this Plan
- General anesthesia
- Intravenous sedation
- Local anesthesia if billed separately
- Overdentures
- Myofunctional therapy
- Oral surgery, except for simple extractions
- Please note that oral surgery may be covered under your medical plan
- Osseous surgery — Flap entry and closure is part of the allowance for osseous surgery and not a separate dental service
- Athletic mouth guards
- Stress breakers
- Services for which benefits are not payable according to the "General Limitations" section

GENERAL LIMITATIONS

No payment will be made for expenses incurred for you or any one of your dependents:

- For, or in connection with, an injury arising out of, or in the course of, any employment for wage or profit
- For or in connection with a sickness which is covered under any workers' compensation or similar law
- For charges made by a hospital owned or operated by or which provides care or performs services for, the United States Government, if such charges are directly related to a military service-connected condition
- Services or supplies received as a result of dental disease, defect, or injury due to an act of war, declared or undeclared
- To the extent that payment is unlawful where the person resides when the expenses are incurred
- For charges which the person is not legally required to pay
- For charges which would not have been made if the person had no insurance
- For services rendered by anyone other than a covered dentist
- To the extent that billed charges exceed the rate of reimbursement as described in the Schedule

- For charges for unnecessary care, treatment or surgery
- To the extent that you or any of your dependents is in any way paid or entitled to payment for those expenses by or through a public program, other than Medicaid
- For or in connection with experimental procedures or treatment methods not approved by the American Dental Association or the appropriate dental specialty society
- For complications arising from any noncovered services or treatment
- Services that are deemed to be medical services
- Services and supplies received from a hospital

CHAPTER 5

DETAILS AND DEFINITIONS

All benefits provided under these Plans must satisfy some basic conditions. The following conditions and definitions are commonly included in dental benefit plans, but are often overlooked or misunderstood.

Alternate Benefit Provision

If more than one covered service will treat a dental condition, payment is limited to the least costly service provided it is a professionally accepted, necessary, and appropriate treatment.

If the covered person requests or accepts a more costly covered service, they are responsible for expenses that exceed the amount covered for the least costly service. Therefore, Cigna recommends Predetermination of Benefits before major treatment begins.

Annual Enrollment

The annual period of time during which Subscribers and other Eligible Individuals may elect and/or change Plans for the following Plan Year for themselves and their Eligible Dependents.

Benefits

Your right to payment for Covered Health Services that are available under the Plan. Your right to Benefits is subject to the terms, conditions, limitations, and exclusions of the Plan, including this Plan Document Handbook, the Summary of Benefits and Coverage, and any applicable amendments.

Coinsurance

The term coinsurance means the percentage of charges for covered expenses that a covered person is required to pay under the Plan.

Contracted Fee (Cigna Dental Preferred Provider)

The term Contracted Fee refers to the total compensation level that a provider has agreed to accept as payment for dental procedures and services performed on a covered person.

Copayment

Copayments (Copays) are the fixed amounts to be paid by you or your Dependents for a Covered Health Service, usually when you receive the service. The amount can vary by the type of Covered Health Service. These Copayments do not apply to your annual Deductible, but do apply to your Out-of-Pocket Limit.

The Copayment amounts are shown on the Summary of Benefits and Coverage.

Coverage Tier

Coverage Tiers represent coverage classifications based on the number of Members covered. Contribution rates correspond to the Coverage Tier type (Single, Subscriber + Spouse/Domestic Partner, Subscriber +

Child, Subscriber + Children, Family).

Deductibles

Deductibles are expenses to be paid by you or your Dependent before Benefits are payable under this Plan. Deductibles are in addition to any Coinsurance. Once the deductible maximum in the Summary of Benefits and Coverage has been reached, you and your family need not satisfy any further dental deductible for the rest of that Plan Year.

Dentist

The term Dentist means a person practicing dentistry or oral surgery within the scope of their license. It will also include a physician operating within the scope of their license when performing any of the dental services described in the Plan.

Dependent

A Spouse, Domestic Partner, or Child of a Subscriber who meets the qualifications listed in Chapter 2, "Eligibility and Enrollment." A "Surviving Dependent" means a Surviving Child, Surviving Domestic Partner, or Surviving Spouse, as applicable.

Child(ren)

A Subscriber's, Subscriber's Spouse's, or, if Domestic Partner Benefits are provided by the Participating Group, a Domestic Partner's biological child, stepchild, legal ward¹¹, foster child¹², legally adopted child; or a child who has been placed with the Subscriber, Subscriber's Spouse, or if applicable, Domestic Partner, for adoption.

Domestic Partners

Two adults who have chosen to share one another's lives in a mutually exclusive partnership that resembles marriage. The Plan requires completion of the Domestic Partnership Affidavit to confirm that the requirements of the Plan are met. A "Domestic Partnership" refers to the partnership between two Domestic Partners.

Spouse

A person's lawfully married husband or wife evidenced by a marriage certificate or, in the case of a common-law Spouse, evidenced by a written court order.

Surviving Child

A Child of a Subscriber who meets the qualifications listed in Chapter 2, "Eligibility and Enrollment" and is enrolled in the Plan at the time of the Subscriber's death. A Surviving Child shall also include a Child of a Subscriber born or adopted within 12 months of the Subscriber's death.

Surviving Domestic Partner

A Domestic Partner of a Subscriber who meets the qualifications listed in Chapter 2, "Eligibility and Enrollment" and is enrolled in the Plan at the time of the Subscriber's death.

¹¹ A legal ward is a child placed under the care of a guardian by an authority of law.

¹² A foster child is an individual who is placed with the Subscriber, Subscriber's Spouse, or if applicable, the Subscriber's Domestic Partner, by an authorized placement agency or by judgment, decree, or other order of any court of competent jurisdiction.

Surviving Spouse

A Spouse of a Subscriber who meets the qualifications listed in Chapter 2 “Eligibility and Enrollment” and is enrolled in the Plan at the time of the Subscriber’s death.

Disabled Child

An eligible Child who is receiving Social Security disability benefits or has been determined by the Medical Trust (or its delegate) to have become totally and permanently impaired physically or mentally prior to age 25, to the extent that they are incapable of self-support, and such impairment continues without interruption up to the time of the Subscriber’s death and continues without interruption thereafter up to the time of such individual’s death. The Medical Trust (or its delegate) may, in its sole discretion, require periodic certification of an individual’s continuing disability.

Eligible Dependent

An individual who meets the definition of an Eligible Dependent in Chapter 2, “Eligibility and Enrollment” of this handbook.

Eligible Individual

An individual who meets the definition of an Eligible Individual in Chapter 2, “Eligibility and Enrollment” of this handbook.

Eligible Small Employer

An employer that is eligible to participate in the Medical Trust plans and that employs fewer than 20 employees for each of the 20 or more calendar weeks in the current and preceding year and has been approved by the Centers for Medicare and Medicaid Services (CMS) as a small employer under the Medicare Secondary Payer Rules.

Emergency Care to Relieve Pain

The benefit percentage for emergency services incurred for charges made by a non-participating provider is the same benefit percentage as for participating provider charges. Dental emergency services are required immediately to either alleviate pain or to treat the sudden onset of an acute dental condition. These are usually minor procedures performed in response to serious symptoms, which temporarily relieve significant pain, but do not effect a definitive cure, and which, if not rendered, will likely result in a more serious dental or medical complication.

Employee

An individual who is normally scheduled to work and is compensated for 1,000 or more hours per year whose income must be reported on a Form W-2 or an international equivalent by a Participating Group, including individuals on an approved leave of absence, short-term disability, or long-term disability.

Pre-65 Former Employee

A former Employee of a Participating Group of the Episcopal Health Plan (EHP):

- (a) Who at the time of separation from active employment was either participating in the EHP or eligible to participate in the EHP as an exempt employee or a non-exempt employee who was normally scheduled to work and was compensated for 1,000 or more hours per year, and

- (b) At the time of separation from employment with The Episcopal Church was at least 55 years of age, or if younger, was eligible for a disability retirement benefit under a pension plan sponsored by The Church Pension Fund or its affiliates prior to December 31, 2017, and
- (c) If a Lay Employee, has five (5) or more years of continuous service with The Episcopal Church OR, if a cleric, has a vested benefit under The Church Pension Fund Clergy Pension Plan

Post-65 Former Employee

Clergy

A former Employee who:

- (a) Is age 65 or older, and
- (b) Has earned a minimum of five years of Credited Service under The Church Pension Fund Clergy Pension Plan.

Lay

A former Employee who:

- (a) Is age 65 or older and
- (b) Who at the time of separation from active employment was normally scheduled to work and was compensated for 1,000 or more hours per year for a minimum of 5 years AND either (1) Participated in a pension plan sponsored by The Church Pension Fund for a minimum of 5 years OR (2) is a former Employee of a Participating Group of the EHP.

Member of Religious Order who:

- (a) Is age 65 or older, and
- (b) Either (1) meets the definition of Post-65 Former Employee Clergy above OR (2) is a former Member of a Religious Order that is a Participating Group of the EHP

Seasonal Employee

An Employee, who normally performs work during certain seasons or periods of the year, whose compensated employment is scheduled to last less than 5 months in a year and who is compensated for less than 1,000 hours per Plan Year.

Temporary Employee

An Employee who is scheduled to be employed for a limited time only or whose work is contemplated or intended for a particular project or need, usually of a short duration such as 3 months, and who is compensated for less than 1,000 hours per Plan Year.

Expense Incurred

The date a dental service or treatment is performed, except for the following services or treatments:

- Dentures, crowns, or bridgework—the date they are seeded or cemented
- Root canal therapy—the date the pulp chamber is opened

Group Administrator

The individual authorized by the Participating Group to administer its employee benefits program.

Health Insurance Portability and Accountability Act of 1996 (HIPAA)

The Health Insurance Portability and Accountability Act of 1996, as amended, and the regulations issued thereunder. HIPAA is a federal law that, among other things, provides rights and protections for participants and beneficiaries in group health plans by regulating the portability and continuity of group health coverage. HIPAA limits exclusions based on preexisting conditions, prohibits discrimination based on health status factors, and gives individuals a special opportunity to enroll in a group health plan in certain circumstances. The Administrative Simplification Provisions of HIPAA address the privacy and security of certain health information.

HIPAA Special Enrollment Event

An event as described in Chapter 2, "Eligibility and Enrollment," where, as a result of the event, the Subscriber is eligible to enroll themselves and their Eligible Dependents for coverage under the Plan outside of the Annual Enrollment period.

Identification Card

The latest card given to you by Cigna showing your identification and account numbers. Also known as an "ID Card."

Maximum Reimbursable Charge

The Maximum Reimbursable Charge (MRC) is determined by Cigna based on the lesser of:

- The provider's normal charge for a similar service or supply; or
- The 80th percentile of all charges made by providers of such service or supply in the geographic area where it is received.

For out-of-network services, the healthcare professional may bill the customer the difference between the healthcare professional's normal charge and the Maximum Reimbursable Charge as determined by Cigna, in addition to applicable Deductibles, Copayments and Coinsurance. Out-of-network benefits are subject to a Plan Year Deductible and Maximum Reimbursable Charge limitations.

To determine if a charge exceeds the Maximum Reimbursable Charge, the nature and severity of the injury or sickness may be considered.

Cigna uses a database selected by Cigna to determine the charges made by providers in an area. If sufficient data is unavailable in the database for that geographic area to determine the Maximum Reimbursable Charge, then state, regional or national data may be used. If sufficient data is unavailable in the database for that geographic area to determine the Maximum Reimbursable Charge, then data in the database for similar services may be used.

The Maximum Reimbursable Charge is subject to all other benefit limitations and applicable coding and payment methodologies determined by Cigna. Additional information about how the Maximum Reimbursable Charge is determined is available upon request.

Medicaid

A state program of medical aid for needy persons established under Title XIX of the Social Security Act of 1965 as amended.

Medical Board

The Medical Board of The Church Pension Fund, as may be appointed by the Chief Executive Officer and President of The Church Pension Fund from time to time. As of January 1, 2022, the Medical Board is Aflac Incorporated (formerly known as Zurich American Life Insurance Company).

Medicare

Parts A, B, C and D of the insurance program established by Title XVIII, United States Social Security Act, as amended by 42 U.S.C. Sections 1394, et seq. and as later amended.

Medicare Secondary Payer (MSP)

The term used when Medicare pays secondary to an active plan covering a Medicare beneficiary.

Medicare Secondary Payer (MSP) – Small Employer Exception (SEE)

An exception to the MSP rules that applies to an eligible small employer. If eligible for the SEE, Medicare becomes the primary payer and the Medical Trust will pay secondary.

Member

A Subscriber or enrolled Eligible Dependent.

Member of a Religious Order

A postulant, novice or professed Member of Episcopal Religious Orders, as defined in Title III, Canon 14, 1¹³ (a “Religious Order”) who has been accepted or received by the Religious Order.

Outbreak Period

The Outbreak Period is the period between March 1, 2020, and a future date that is 60 days after the announced end of the national emergency caused by COVID-19.

Participating Group

A diocese, congregation, agency, school, organization, or other body subject to the authority of and/or associated or affiliated with The Episcopal Church, which has elected to participate in the Plan.

Participating Provider (Cigna Dental Preferred Provider)

The term Participating Provider means a dentist, or a professional corporation, professional association, partnership, or other entity which has entered into a contract with Cigna to provide dental services at predetermined fees.

The providers qualifying as participating providers may change from time to time. For a list of the current participating providers, please use the provider search feature of **www.cigna.com** or call member services.

¹³ The Constitution and Canons of the Episcopal Church, 2018

Plan

The health Plans maintained by the Medical Trust for the benefit of Members. The Plan is intended to qualify as a “church plan” as defined by Section 414(e) of the Internal Revenue Code and is exempt from the requirements of the Employee Retirement Income Security Act of 1974, as amended (ERISA).

Episcopal Health Plan (EHP)

A program of health Plan options through which Eligible Individuals and Eligible Dependents of The Episcopal Church are provided health Benefits.

Medicare Secondary Payer (MSP) Small Employer Exception (SEE) Plan

A program of health Plans through which Eligible Individuals and Eligible Dependents of the Episcopal Church are provided health Benefits. Benefits are provided through the Medical Trust. This Plan is applicable only to those small employers and individuals enrolled in Medicare who apply and are certified by the Centers for Medicare & Medicaid Services (CMS) as meeting the criteria to participate as a result of meeting the small employer definition and the benefits coordinating with Medicare.

Plan Administrator

The person or entity named by the Plan Sponsor to manage the Plan and answer questions about Plan details. **The Plan Administrator is not Cigna. The Plan Administrator is the Medical Trust.**

Plan Sponsor

The legal entity that has adopted the Plan and has authority regarding its operation, amendment, and termination. **The Plan Sponsor is not Cigna. The Plan Sponsor is the Medical Trust.**

Plan Year

The word “year,” or Plan Year, as used in this Plan Document Handbook, refers to the Plan Year, which is the 12-month period beginning January 1 and ending December 31. All annual benefit maximums and Deductibles accumulate during the Plan Year.

Predetermination of Benefits

Predetermination of Benefits is a voluntary review of a dentist’s proposed treatment plan and expected charges. It is not preauthorization of service and is not required.

The treatment plan should include supporting pre-operative x-rays and other diagnostic materials as requested by Cigna’s dental consultant. If there is a change in the treatment plan, a revised plan should be submitted.

Cigna will determine covered dental expenses for the proposed treatment plan. If there is no Predetermination of Benefits, Cigna will determine covered dental expenses when it receives a claim.

Review of proposed treatment is advised whenever extensive dental work is recommended (when charges exceed \$200).

Predetermination of Benefits is not a guarantee of a set payment. Payment is based on the services that

are actually delivered and the coverage in force at the time services are completed.

Provider

A duly licensed person or facility that provides services within the scope of an applicable license and is a person or facility that the Plan approves. This includes any Provider rendering services which are required by applicable state law to be covered when rendered by such Provider.

Network Provider

A Provider that has entered into a contract, either directly or indirectly, with Cigna to provide covered dental services to Members through negotiated reimbursement arrangements. The name of the Network is on your Identification Card.

Out-of-Network Provider

A Provider that does not have an agreement or contract with Cigna to provide services to Members at the time services are rendered.

Seminarian

A full-time student, as defined by the seminary, enrolled at a participating seminary of the Association of Episcopal Seminaries.

Significant Life Event

An event as described in Chapter 2, "Eligibility and Enrollment," where, as a result of the event, the Subscriber is eligible to make certain mid-year election changes.

Subscriber

The primary individual enrolled in the Plan who meets the qualifications listed in Chapter 2, "Eligibility and Enrollment."

CHAPTER 6

COORDINATION OF BENEFITS

This section applies if you or any one of your Dependents is covered under the Basic Dental PPO Plan or the Dental & Orthodontia PPO Plan and another plan. This section determines how benefits payable from all such Plans will be coordinated. You should file all claims with each plan.

Please note that the Preventive Dental PPO Plan does not coordinate benefits with any other health or dental plan.

For the purposes of this section, the following terms have the meanings set forth below:

Plan

Any of the following that provides benefits or services for dental care or treatment:

- Group insurance and/or group-type coverage, whether insured or self-insured which neither can be purchased by the general public, nor is individually underwritten, including closed panel coverage
- Governmental benefits as permitted by law, excepting Medicaid, Medicare, and Medicare supplement policies
- Medical benefits coverage of group, group-type, and individual automobile contracts

Each plan or part of a plan which has the right to coordinate benefits will be considered a separate plan.

Closed Panel Plan

A plan that provides medical or dental benefits primarily in the form of services through a panel of employed or contracted providers, and that limits or excludes benefits provided by providers outside of the panel, except in the case of emergency or if referred by a provider within the panel.

Primary Plan

The plan that determines and provides or pays benefits without taking into consideration the existence of any other plan.

Secondary Plan

A plan that determines, and may reduce its benefits after taking into consideration, the benefits provided or paid by the primary plan. A secondary plan may also recover from the primary plan the reasonable cash value of any services it provided to you.

Allowable Expense

A necessary, reasonable and customary service or expense, including deductibles, coinsurance, or copayments, that is covered in full or in part by any plan covering you. When a plan provides benefits in the form of services, the reasonable cash value of each service is the allowable expense and is a paid benefit.

Examples of expenses or services that are not allowable expenses include, but are not limited to the following:

- An expense or service or a portion of an expense or service that is not covered by any of the plans is not an allowable expense.
- If you are covered by two or more plans that provide services or supplies on the basis of reasonable and customary fees, any amount in excess of the highest reasonable and customary fee is not an allowable expense.
- If you are covered by one plan that provides services or supplies on the basis of reasonable and customary fees and one plan that provides services and supplies on the basis of negotiated fees, the primary plan's fee arrangement shall be the allowable expense.
- If your benefits are reduced under the primary plan (through the imposition of a higher copayment amount, higher coinsurance percentage, a deductible and/or a penalty) because you did not comply with plan provisions or because you did not use a preferred provider, the amount of the reduction is not an allowable expense. Such plan provisions include second surgical opinions and precertification of admissions or services.

Claim Determination Period

The Claim Determination Period is a calendar year, but does not include any part of a year during which you are not covered under a Medical Trust dental plan or any date before this section or any similar provision takes effect.

Reasonable Cash Value

The reasonable cash value is an amount which a duly licensed provider of healthcare services usually charges patients and which is within the range of fees usually charged for the same service by other healthcare providers located within the immediate geographic area where the healthcare service is rendered under similar or comparable circumstances.

Order of Benefit Determination Rules

A plan that does not have a coordination of benefits rule consistent with this section shall always be the primary plan. If the plan does have a coordination of benefits rule consistent with this section, the first of the following rules that applies to the situation is the one to use:

1. The plan that covers you as an enrollee or an employee shall be the primary plan and the plan that covers you as a dependent shall be the secondary plan
2. If you are a dependent child whose parents are not divorced or legally separated, the primary plan shall be the plan which covers the parent whose birthday falls first in the calendar year as an enrollee or employee
3. If you are the dependent of divorced or separated parents, benefits for the dependent shall be determined in the following order:
 - first, if a court decree states that one parent is responsible for the child's healthcare expenses or health coverage and the plan for that parent has actual knowledge of the terms of the order, but only from the time of actual knowledge
 - then, the plan of the parent with custody of the child
 - then, the plan of the spouse of the parent with custody of the child
 - then, the plan of the parent not having custody of the child
 - finally, the plan of the spouse of the parent not having custody of the child

4. The plan that covers you as an active employee (or as that employee's dependent) shall be the primary plan and the plan that covers you as laid-off or retired employee (or as that employee's dependent) shall be the secondary plan. If the other plan does not have a similar provision and, as a result, the plans cannot agree on the order of benefit determination, this paragraph shall not apply.
5. The plan that covers you under a right of continuation which is provided by federal or state law shall be the secondary plan and the plan that covers you as an active employee or retiree (or as that employee's dependent) shall be the primary plan. If the other plan does not have a similar provision and, as a result, the plans cannot agree on the order of benefit determination, this paragraph shall not apply.

If none of the above rules determines the order of benefits, the plan that has covered you for the longer period of time shall be primary.

Effects of Benefits On This Plan

If this Plan is the Secondary Plan, this Plan may reduce benefits so that the total benefits paid by all plans during a Claim Determination Period are not more than 100% of the total of all allowable expenses.

The difference between the amount that this Plan would have paid if this Plan had been the Primary Plan, and the benefit payments that this Plan had actually paid as the Secondary Plan, will be recorded as a benefit reserve for you.

Cigna will use this benefit reserve to pay any allowable expense not otherwise paid during the Claim Determination Period.

As each claim is submitted, Cigna will determine the following:

- The Medical Trust's obligation to provide services and supplies under these Plans
- Whether a benefit reserve has been recorded for you
- Whether there are any unpaid allowable expenses during the Claims Determination Period

If there is a benefit reserve, Cigna will use the benefit reserve recorded for you to pay up to 100% of the total of all allowable expenses. At the end of the Claim Determination Period, your benefit reserve will return to zero and a new benefit reserve will be calculated for each new Claim Determination Period.

CHAPTER 7

OTHER IMPORTANT PLAN PROVISIONS

Assignment of Benefits

You may not assign to any party, including, but not limited to, a Provider of healthcare services or items, your right to Benefits under this Plan, nor may you assign any administrative, statutory, or legal rights or causes of action you may have, including, but not limited to, any right to make a claim for Plan Benefits, to request Plan or other documents, to file appeals of denied claims or grievances, or to file lawsuits. Any attempt to assign such rights shall be void and unenforceable under all circumstances. Further, Benefits, rights and interests under the Plan shall not be subject in any manner to any other form of alienation, sale, transfer, assignment, pledge, encumbrance, charge, garnishment, or execution of levy of any kind, either voluntary or involuntary, by any person, and any such attempts shall be void.

You may, however, authorize Cigna to pay any healthcare Benefits under this policy to a Network Provider or Out-of-Network Provider. When you authorize the payment of your healthcare Benefits to a Network Provider, you authorize the payment of the entire amount of the Benefits due on that claim. If a Provider is overpaid because of accepting duplicate payments from you and Cigna, it is the Provider's responsibility to reimburse the overpayment to you. Cigna may pay all healthcare Benefits for Covered Health Services directly to a Network Provider without your authorization. You may not interpret or rely upon this discrete authorization or permission to pay any healthcare Benefits to a Network Provider or Out-of-Network Provider as the authority to assign any other rights under this policy to any party, including, but not limited to, a Provider of healthcare services or items. No payment by the Plan pursuant to such authorization shall be considered recognition by the Plan of a duty or obligation to pay a provider of services or supplies except to the extent the Plan actually chooses to do so.

Even if the payment of healthcare Benefits to an Out-of-Network Provider has been authorized by you, Cigna may, at its option, make payment of Benefits to you. When Benefits are paid to you or your Dependent, you or your Dependents are responsible for reimbursing the Out-of-Network Provider.

If any person to whom Benefits are payable is a minor or, in the opinion of Cigna is not able to give a valid receipt for any payment due him, such payment will be made to his legal guardian. If no request for payment has been made by his legal guardian, Cigna may, at its option make payment to the person or institution appearing to have assumed his custody and support.

When a Member passes away, Cigna may receive notice that an executor of the estate has been established. The executor has the same rights as our Member and Benefit payments for unassigned claims should be made payable to the executor.

Payment as described above will release the Plan and Cigna from all liability to the extent of any payment made.

Alternate Payee Provision

Benefits are generally payable to the Provider of services or supplies. The Plan may choose to make payments to a Member's separated/divorced Spouse, state child support agencies, or Medicaid agencies if required by a qualified medical child support order (QMCSO) or state Medicaid law.

Any payment made by the Plan in accordance with this provision will fully release the Plan of its liability to the Member.

Unclaimed Property

If the Plan cannot provide Benefits to a Member because after a reasonable search, the Plan cannot locate the Member within a period of two (2) years after the payment of Benefits becomes due, such amounts otherwise due to the Member shall be considered “unclaimed property.” Unclaimed property amounts will be considered forfeitures that are deemed to occur as of the end of the two-year period. All forfeitures shall be and remain Plan assets, and in no event shall any such forfeiture escheat to, or otherwise be paid to, any governmental unit under any escheat or unclaimed property law.

Reliance on Documents and Information

Information required by the Medical Trust may be provided in any form or document that the Medical Trust considers acceptable and reliable. The Medical Trust relies on the information provided by individuals when evaluating coverage and Benefits under the Plans. All such information, therefore, must be accurate, truthful, and complete. The Medical Trust is entitled to conclusively rely upon, and will be protected for any action taken in good faith in relying upon, any information the Member or Dependents provide to the Medical Trust. In addition, any fraudulent statement, omission or concealment of facts, misrepresentation, or incorrect information may result in the denial of the claim, cancellation or rescission of coverage, or any other legal remedy available to the Plan.

No Waiver

The failure of the Medical Trust to enforce strictly any term or provision of the Plan will not be construed as a waiver of such term or provision. The Medical Trust reserves the right to enforce strictly any term or provision of the Plan at any time.

Dentist/Patient Relationship

This Plan is not intended to disturb the Dentist/patient relationship. Dentists and other healthcare providers are not agents or delegates of the employer, the Medical Trust, the ECCEBT, or Cigna. Nothing contained in the Plan will require you or your dependent to commence or continue dental treatment by a particular provider.

Furthermore, nothing in these Plans will limit or otherwise restrict a Dentist’s judgment with respect to the Dentist’s ultimate responsibility for patient care in the provision of dental services to you or your dependent.

The Plan is Not a Contract of Employment

Nothing contained in the Plan will be construed as a contract or condition of employment between The Episcopal Church, the Medical Trust or the employer and any employee. All employees are subject to discharge to the same extent as if these Plans had never been adopted.

Plan Administration

In administering the Plan, the Medical Trust has full discretion and authority to interpret Plan provisions, make factual determinations, and address other issues that may arise. Subject to any right that a Member has to appeal a decision, the Medical Trust determinations are final and binding. To the extent

that the Medical Trust delegates administrative authority under the Plan(s) to another party, such as Cigna, that party shall act with the same discretion and authority as the Medical Trust.

Right to Amend or Terminate the Plan

The Medical Trust reserves the right to amend, modify, or terminate the Plans in any manner, for any reason, at any time, and, unless required by law, without prior notification.

No Guarantee of Tax Consequences

Although the Plan intends to offer some Benefits on a tax-favored basis, there is no guarantee that any particular tax result will apply. Nothing in this Plan Document Handbook constitutes tax, medical, financial or legal advice. If you have questions about the tax, financial, or legal consequences of a Benefit, you should consult your personal tax, legal, or financial advisor.

Plan Information and Rights

The Plan(s) described in this Plan Document Handbook are sponsored and administered by the Church Pension Group Services Corporation (“CPGSC”), also known as The Episcopal Church Medical Trust (the “Medical Trust”). 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 (“ECCEBT”), a Voluntary Employees’ Beneficiary Association within the meaning of section 501(c)(9) of the Internal Revenue Code.

This Plan Document Handbook should not be viewed as an offer of coverage, or investment, tax, medical, or other advice. By participating in and accepting benefits from the Plan, you agree to the terms of the Plan set forth in this Plan Document Handbook.

The Plan, and this Plan Document Handbook, are governed by, and the rights and obligations of the Medical Trust, ECCEBT, Cigna and the Members shall be interpreted, construed and enforced in accordance with, the laws of the State of New York without regard to the conflict of law principles thereof.

The Church Pension Fund and its affiliates, including but not limited to the Medical Trust, CPGSC and ECCEBT (collectively, “CPG”), retain the right to amend, terminate, or modify the terms of the Plan, as well as any post-retirement health subsidy, at any time, for any reason, and unless required by applicable law, without notice.

The Plan is a church plan within the meaning of section 3(33) of the Employee Retirement Income Security Act (“ERISA”) and section 414(e) of the Internal Revenue Code and is exempt from ERISA. 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. Additionally, the Plan may be exempt from federal and state laws that may otherwise apply to health insurance arrangements. The Plan does not cover all healthcare expenses, and Members should read this document carefully to determine which Benefits are covered, as well as any applicable exclusions, limitations, and procedures.

CPG does not provide any healthcare services and therefore cannot guarantee any results or outcomes. 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 Network Provider composition is subject to change.

Unauthorized Use of Identification Card

If you permit your Identification Card to be used by someone else or if you use the card before coverage is in effect or after coverage has ended, you will be liable for payment of any expenses incurred resulting from the unauthorized use. Fraudulent misuse could also result in termination of the coverage. Fraudulent statements on enrollment forms and/or claims for services or payment involving all media (paper or electronic) may invalidate any payment or claims for services and be grounds for voiding the Member's coverage. This includes fraudulent acts to obtain medical services and/or prescription drugs.

Additional Information on Covered and Excluded Benefits

If you would like to receive additional information regarding a specific drugs, dental test, device, or procedure that is either a covered or excluded benefit under these Plans, you may contact Cigna at (800) 244-6224, or via the Internet by logging on to **www.mycigna.com**.

CHAPTER 8

SUBROGATION AND RIGHT OF RECOVERY

DEFINITIONS

As used throughout this chapter, the term “responsible party” means any party (other than the Plan) actually, possibly, or potentially responsible for making any payment to a covered person due to a covered person’s injury, illness, or condition. The term “responsible party” includes the liability insurer of such party or any insurance coverage.

For purposes of this provision, the term “insurance coverage” refers to any coverage providing medical expense coverage or liability coverage including, but not limited to, uninsured motorist coverage, underinsured motorist coverage, personal umbrella coverage, medical payments coverage, workers’ compensation coverage, no-fault automobile insurance coverage, or any first party insurance coverage.

For purposes of this provision, a “covered person” includes anyone on whose behalf the Plan pays or provides any Benefit including, but not limited to, the representative of the Plan Member’s estate, heir, descendant, a minor Child or Dependent of any Plan Member or person entitled to receive any Benefits from the Plan.

SUBROGATION

Immediately upon paying or providing any Benefit under this Plan, the Plan shall be subrogated to (i.e., stand in the place of) all rights of recovery a covered person has against any responsible party with respect to any payment made by the responsible party to a covered person due to a covered person’s injury, illness, or condition to the full extent of Benefits provided or to be provided by the Plan.

The right of subrogation means the Plan is entitled to pursue any claims that the covered person may have in order to recover the Benefits paid or payable by the Plan.

REIMBURSEMENT

In addition, if a covered person receives any payment from any responsible party or insurance coverage as a result of an injury, illness, or condition, the Plan has the right to recover from, and be reimbursed by, the covered person for all amounts this Plan has paid and will pay as a result of that injury, illness, or condition, up to and including the full amount the covered person receives from any responsible party.

CONSTRUCTIVE TRUST

By accepting Benefits (whether the payment of such Benefits is made to the covered person or made on behalf of the covered person to any Provider) from the Plan, the covered person agrees that if they receive any payment from any responsible party as a result of an injury, illness, or condition, they will serve as a constructive trustee over the funds that constitute such payment. Failure to hold such funds in trust will be deemed a breach of the covered person’s fiduciary duty to the Plan.

LIEN RIGHTS

Further, the Plan will automatically have a lien to the extent of Benefits paid by the Plan for treatment of the illness, injury, or condition for which the responsible party is liable. The lien shall be imposed upon any recovery whether by settlement, judgment, or otherwise related to treatment for any illness, injury, or

condition for which the Plan paid Benefits. The lien may be enforced against any party who possesses funds or proceeds representing the amount of Benefits paid by the Plan including, but not limited to, the covered person, the covered person's representative or agent; responsible party; responsible party's insurer, representative, or agent; and/or any other source possessing funds representing the amount of Benefits paid by the Plan.

FIRST-PRIORITY CLAIM

By accepting Benefits (whether the payment of such Benefits is made to the covered person or made on behalf of the covered person to any Provider) from the Plan, the covered person acknowledges that this Plan's recovery rights are a first-priority claim against all responsible parties and are to be paid to the Plan before any other claim for the covered person's damages. Further, this first priority right to payment is superior to any and all claims, debts or liens asserted by any medical providers, including but not limited to hospitals or emergency treatment facilities, that assert a right to payment from funds payable from or recovered from an allegedly responsible third party and/or insurance carrier. Such superiority shall be notwithstanding anything to the contrary in any agreement between the covered person and such medical provider, whenever such agreement may be entered into, unless the Plan has provided an express written waiver of this provision.

This Plan shall be entitled to full reimbursement on a first-dollar basis from any responsible party's payments, even if such payment to the Plan will result in a recovery to the covered person which is insufficient to make the covered person whole or to compensate the covered person in part or in whole for the damages sustained. The Plan is not required to participate in or pay court costs or attorney fees to any attorney hired by the covered person to pursue the covered person's damage claim.

APPLICABILITY TO ALL SETTLEMENTS AND JUDGMENTS

The terms of this entire subrogation and right of recovery provision shall apply, and the Plan is entitled to full recovery regardless of whether any liability for payment is admitted by any responsible party and regardless of whether the settlement or judgment received by the covered person identifies the medical Benefits the Plan provided or purports to allocate any portion of such settlement or judgment to payment of expenses other than medical expenses. The Plan is entitled to recover from any and all settlements or judgments, even those designated as pain and suffering, non-economic damages, and/or general damages only.

COOPERATION

The covered person shall fully cooperate with the Plan's efforts to recover its Benefits paid. It is the duty of the covered person to notify the Plan within 30 days of the date when any notice is given to any party, including an insurance company or attorney, of the covered person's intention to pursue or investigate a claim to recover damages or obtain compensation due to injury, illness, or condition sustained by the covered person. The covered person and their agents shall provide all information requested by the Plan, Cigna or its representative including, but not limited to, completing, signing and submitting any applications or other forms or statements as the Plan, Cigna or its representative may reasonably request. Failure to provide this information may result in the institution of court proceedings against the covered person. The covered person shall make any court appearances reasonably requested by the Plan.

The covered person shall do nothing to prejudice the Plan's subrogation or recovery interest or to prejudice the Plan's ability to enforce the terms of this Plan provision. This includes, but is not limited to,

refraining from making any settlement or recovery that attempts to reduce or exclude the full cost of all Benefits provided by the Plan.

The covered person acknowledges that the Plan has the right to conduct an investigation regarding the injury, illness, or condition to identify any responsible party. The Plan reserves the right to notify the responsible party and their agents of its lien. Agents include, but are not limited to, insurance companies and attorneys.

FAILURE TO REIMBURSE OR COOPERATE

In the event of any failure by the covered person to provide reimbursement or failure to appropriately cooperate with the Plan's efforts to recover Benefits paid, the covered person's health benefits may be suspended, until the Plan has fully recovered amounts due hereunder, or terminated.

The Plan retains the option to collect any costs including court and attorneys' fees incurred by the Plan resulting from its efforts to obtain reimbursement of Benefits paid.

The covered person's failure to cooperate with the Plan or Cigna or otherwise to comply with the terms of this Subrogation and Right of Recovery Chapter is considered a breach of contract. As such, the Plan has the right to terminate benefits to the covered person, the covered person's dependents or the subscriber, deny future benefits, take legal action against the covered person, and/or set off from any future benefits the value of benefits the Plan has paid relating to any sickness, injury or other medical condition caused or alleged to have been caused by any third party to the extent not recovered by the Plan due to the covered person or the covered person's representative not cooperating with the Plan, Cigna or their respective agents, or otherwise failing to abide by the terms of the Plan, including this Subrogation and Right of Recovery Chapter. If the Plan incurs attorneys' fees and costs to collect third-party settlement funds held by the covered person or the covered person's representative, the Plan has the right to recover those fees and costs from the covered person. The covered person will also be required to pay interest on any amounts the covered person holds which should have been returned to the Plan, at the prime rate from time to time published by *The Wall Street Journal*.

The Plan's subrogation and reimbursement rights apply to full and partial settlements, judgments, or other recoveries paid or payable to the covered person or the covered person's representative, estate, heirs or beneficiaries, no matter how those proceeds are captioned or characterized. Payments include, but are not limited to, economic, non-economic, pecuniary, consortium and punitive damages. The Plan is not required to help the covered person to pursue their claim for damages or personal injuries, and no amount of associated costs, including attorneys' fees, shall be deducted from the Plan's recovery without the Plan's express written consent. No so-called "Fund Doctrine" or "Common Fund Doctrine" or "Attorney's Fund Doctrine" shall defeat this right.

Regardless of whether the covered person has been fully compensated or made whole, the Plan may collect from the covered person the proceeds of any full or partial recovery that the covered person or their legal representative obtains, whether in the form of a settlement (either before or after any determination of liability) or judgment, no matter how those proceeds are captioned or characterized. Proceeds from which the Plan may collect include, but are not limited to, economic, non-economic, pecuniary, consortium and punitive damages. No "collateral source" rule, any "Made-Whole Doctrine" or "Make-Whole Doctrine," claim of unjust enrichment, nor any other equitable limitation shall limit the Plan's subrogation or reimbursement rights.

Benefits paid by the Plan may also be benefits advanced.

The Plan's rights to recovery will not be reduced due to the covered person's own negligence, including due to the application of any contributory or comparative negligence defenses.

By participating in and accepting benefits from the Plan, the covered person agrees to assign to the Plan any benefits, claims or rights of recovery the covered person has under any automobile policy – including but not limited to no-fault benefits, PIP benefits and/or medical payment benefits – other coverage or against any third party, to the full extent of the benefits the Plan has paid for the sickness, injury or other medical condition. By agreeing to provide this assignment in exchange for participating in and accepting benefits, the covered person acknowledges and recognizes the Plan's right to assert, pursue and recover on any such claim, and the covered person agrees to this assignment voluntarily.

The Plan may, at its option, take necessary and appropriate action to preserve its rights under the provisions of this Subrogation and Right of Recovery Chapter, including but not limited to providing or exchanging medical payment information with an insurer, the insurer's legal representative or other third party; filing a reimbursement lawsuit to recover the full amount of medical benefits the covered person receives for the sickness, injury or other medical condition out of any settlement, judgment or other recovery from any third party considered responsible; and filing suit in the covered person's name or the covered person's estate's name, which does not obligate the Plan in any way to pay the covered person part of any recovery the Plan might obtain.

The covered person may not accept any settlement that does not fully reimburse the Plan, without its written approval.

In the case of the covered person's death, giving rise to any wrongful death or survival claim, the provisions of this Subrogation and Right of Recovery Chapter apply to the covered person's estate, the personal representative of the covered person's estate, and the covered person's heirs or beneficiaries. In the case of the covered person's death, the Plan's right of reimbursement and right of subrogation shall apply if a claim can be brought on behalf of the covered person or the covered person's estate that can include a claim for past medical expenses or damages.

The obligation to reimburse the Plan is not extinguished by a release of claims or settlement agreement of any kind (other than by a written agreement between the covered person and the Plan).

No allocation of damages, settlement funds or any other recovery, by the covered person, the covered person's estate, the personal representative of the covered person's estate, the covered person's heirs, the covered person's beneficiaries or any other person or party, shall be valid if it does not reimburse the Plan for 100% of its interest, unless the Plan provides written consent to such allocation.

The provisions of this Subrogation and Right of Recovery Chapter apply to the parent(s), guardian(s), or other representative(s) of a Dependent child who incurs a sickness, injury or other medical condition caused by any third party. If a parent or guardian may bring a claim for damages arising out of a minor's sickness, injury or other medical condition, the terms of this Subrogation and Right of Recovery Chapter shall apply to that claim.

If any third party causes or is alleged to have caused the covered person to suffer a sickness, injury or other medical condition while the covered person is covered under this Plan, the provisions of this Subrogation and Right of Recovery Chapter continue to apply, even after the covered person is no longer covered.

If the covered person's estate, parent, guardian, or conservator asserts a claim against a third party based on the covered person's injury or illness, the covered person's estate, parent, guardian, or conservator and any settlement or judgment recovered by the estate, parent, guardian, or conservator

shall be subject to the Plan's liens and other rights to the same extent as if the covered person had asserted the claim against the third party. The Plan may assign its rights to enforce liens and other rights.

INTERPRETATION

In the event that any claim is made that any part of this subrogation and right of recovery provision is ambiguous or questions arise concerning the meaning or intent of any of its terms, Cigna shall have the sole authority and discretion to resolve all disputes regarding the interpretation of this provision. Any such interpretations shall be final and binding.

JURISDICTION

By accepting Benefits (whether the payment of such Benefits is made to the covered person or made on behalf of the covered person to any Provider) from the Plan, the covered person agrees that any court proceeding with respect to this provision may be brought in any court of competent jurisdiction as the Plan may elect. By accepting such Benefits, the covered person hereby submits to each such jurisdiction, waiving whatever rights may correspond to them by reason of present or future domicile.

CHAPTER 9

HOW TO FILE A CLAIM

The prompt filing of any required claim form will result in faster payment of your claim. You may get the required claim forms from Cigna Dental. All fully completed claim forms and bills should be sent directly to the address listed on the back of your ID card. Itemized copies of your bills should be sent with the claim form. If you have any additional bills after the first treatment, file them periodically.

Claim Reminders

- Be sure to use your Member ID and account number when you file dental claim forms, or when you call Cigna Dental
- Your Member ID is the ID shown on your Cigna Dental ID card
- Your account number is the 7-digit policy number shown on your Cigna Dental ID card
- Prompt filing of any required claim forms results in faster payment of your claims

The Plans will provide you with notice of the claim determination within a reasonable period of time, but no later than 30 days after receipt of the claim. This time period will be delayed, if the Plans request additional information, until the requested information is received by the Plans. The Plans may also request a 15-day extension if matters beyond its control require the extension and notice is provided to you within the 30-day period.

If you have any questions regarding your claim, please call (800) 244-6224. All claims must be received by the Plans within 180 days following the end of the year in which expenses were incurred.

The claims address is:

Cigna Dental
P.O. Box 188037
Chattanooga, TN 37422-8037

How to Appeal a Denial of Benefits

When You Have a Complaint or Appeal

For the purposes of this section, any reference to "you," "your," or "Member" also refers to a representative or provider designated by you to act on your behalf, unless otherwise noted.

"Physician Reviewers" are licensed Dentists depending on the care, service, or treatment under review.

We want you to be completely satisfied with the care you receive. That is why we have established a process for addressing your concerns and solving your problems.

Start With Member Services

We are here to listen and help. If you have a concern regarding a person, a service, the quality of care, or contractual benefits, you may call the toll-free number on your Identification Card, explanation of benefits, or claim form and explain your concern to one of the Cigna Member Services representatives. You may also express that concern in writing.

Cigna will try to resolve the matter on your initial contact. If more time is needed to review or investigate your concern, Cigna will get back to you as soon as possible, but in any case within 30 days. If you are not satisfied with the results of a coverage decision, you may start the appeals procedure.

Appeals Procedure

The Plan has a two-step appeals procedure for coverage decisions. To initiate an appeal, you must submit a request for an appeal in writing to Cigna within 180 days of receipt of a denial notice. You should state the reason why you feel your appeal should be approved and include any information supporting your appeal. If you are unable or choose not to write, you may ask Cigna to register your appeal by telephone. Call or write Cigna at the toll-free number on your Identification Card, explanation of benefits, or claim form.

Level One Appeal

Your appeal will be reviewed and the decision made by someone not involved in the initial decision. Appeals involving medical or dental necessity or clinical appropriateness will be considered by a dental care professional.

Your written request should include:

- Specific request for a voluntary review
- Enrollee's name, address, and ID number
- Service for which coverage was denied
- Any relevant information that was not provided during the initial review

Please submit this information to:

Cigna Dental Appeals
PO Box 188044
Chattanooga, TN 37422

For level-one appeals, Cigna will respond in writing with a decision within 30 calendar days of receiving an appeal for a post-service coverage determination. If more time or information is needed to make the determination, Cigna will notify you in writing to request an extension of up to 15 calendar days and to specify any additional information needed to complete the review.

Level Two Appeal

If you are not satisfied with Cigna's appeal decisions, you may request to have your appeal reviewed by the Plan Administrator. The Plans offer this voluntary review for covered individuals following the required first-level appeal with Cigna. If you wish to pursue a voluntary review, please send a written request within 60 days of the date Cigna notified you of its second-level appeal decision.

Your written request should include:

- Specific request for a voluntary review
- Enrollee's name, address, and ID number
- Service for which coverage was denied

- Any new, relevant information that was not provided during the internal appeal
- Signed, written authorization for healthcare providers to release relevant medical information to the Plan

Please submit this information to:

The Episcopal Church Medical Trust
Attn: Clinical Management
PO Box 2745
New York, NY 10163

You generally will receive a written response to a second-level appeal within 60 days after it is received by the Plan. If the Plan needs additional time (up to 90 days) to review the second-level appeal, you will be notified of the reason(s) for the delay and the anticipated response date, which may not exceed a total of 150 days from the date CPG receives the appeal.

The Plan Administrator has the exclusive right to interpret and administer the Plan, and these decisions are conclusive and binding.

Requirements relating to Filing a Lawsuit

No lawsuit or legal action of any kind related to a Benefit decision may be filed by you in a court of law or in any other forum, unless it is commenced within one (1) year of the Plan's final decision on the claim or other request for Benefits. If the Plan decides an appeal is untimely, the Plan's latest decision on the merits of the underlying claim or benefit request is the final decision date. You must exhaust the Plan's mandatory internal appeals procedure, not including any voluntary level of appeal, before filing a lawsuit or taking other legal action of any kind against the Plan. As a Member of one of the Medical Trust's Plans, you have consented to the venue and exclusive jurisdiction of the courts located in New York City in the State of New York.

CHAPTER 10

PRIVACY

JOINT NOTICE OF PRIVACY PRACTICES

This chapter describes how medical information about you may be used and disclosed and how you can get access to this information. Please review it carefully.

INTRODUCTION

Church Pension Group Services Corporation, doing business as The Episcopal Church Medical Trust (Medical Trust), is the Plan Sponsor of certain group health plans (each a Plan and together the Plans) that are subject to the Health Insurance Portability and Accountability Act of 1996 and the regulations enacted thereunder (HIPAA).

HIPAA places certain restrictions on the use and disclosure of Protected Health Information (PHI) and requires the Medical Trust to provide this Joint Notice of Privacy Practices (the "Notice") to you. PHI is your individually identifiable health information that is created, received, transmitted, or maintained by the Plans or its business associates, regardless of the form of the information. It does not include employment records held by your employer in its role as an employer. This Notice describes how your PHI may be used and disclosed by the Plans and by Employees of the Medical Trust that are responsible for internal administration of the Plans.

It also describes your rights regarding the use and disclosure of such PHI and how you can gain access to it.

WHAT THIS NOTICE APPLIES TO

This Notice applies only to health Benefits offered under the Plans. The health Benefits offered under the Plans include, but may not be limited to, medical Benefits, prescription drug Benefits, dental Benefits, the healthcare flexible spending account, and any healthcare or medical services offered under the Employee Assistance Program benefit. This Notice does not apply to Benefits offered under the Plans that are not health Benefits. Some of the Plans provide Benefits through the purchase of insurance. If you are enrolled in an insured Plan, you will also receive a separate notice from that Plan, which applies to your rights under that Plan.

DUTIES AND OBLIGATIONS OF THE PLAN

The privacy of your PHI is protected by HIPAA. The Plans are required by law to:

- Maintain the privacy of your PHI
- Provide you with a notice of the Plans' legal duties and privacy practices with respect to your PHI
- Abide by the terms of the Notice currently in effect

WHEN THE PLAN MAY USE AND DISCLOSE YOUR PHI

The following categories describe the ways the Plans are required to use and disclose your PHI without obtaining your written authorization:

- Disclosures to You. The Plans will disclose your PHI to you or your personal representative within the legally specified period following a request.
- Government Audit. The Plans will make your PHI available to the U.S. Department of Health and Human Services when it requests information relating to the privacy of PHI.
- As Required by Law. The Plans will disclose your PHI when required to do so by federal, state, or local law. For example, the Plans may disclose your PHI when required by national security laws or public health disclosure laws.

The following categories describe the ways that the Plans may use and disclose your PHI without obtaining your written authorization:

- Treatment. The Plans may disclose your PHI to your Providers for treatment, including the provision of care or the management of that care. For example, the Plans might disclose PHI to assist in diagnosing a medical condition or for pre-certification activities.
- Payment. The Plans may use and disclose your PHI to pay Benefits. For example, the Plans might use or disclose PHI when processing payments, sending Explanations of Benefits (EOBs) to you, reviewing the medical or dental necessity of services rendered, conducting claims appeals and coordinating the payment of Benefits between multiple medical Plans.
- Health Care Operations. The Plans may use and disclose your PHI for Plan operational purposes. For example, the Plans may use or disclose PHI for quality assessment and claim audits.
- Public Health Risks. The Plans may disclose your PHI for certain required public health activities (such as reporting disease outbreaks) or to prevent serious harm to you or other potential victims where abuse, neglect, or domestic violence is involved.
- National Security and Intelligence Activities. The Plans may disclose your PHI for specialized government functions (such as national security and intelligence activities).
- Health Oversight Activities. The Plans may disclose your PHI to health oversight agencies for activities authorized by law (such as audits, inspections, investigations, and licensure).
- Lawsuits and Disputes. The Plans may disclose your PHI in the course of any judicial or administrative proceeding in response to a court's or administrative tribunal's order, subpoena, discovery request, or other lawful process.
- Law Enforcement. The Plans may disclose your PHI for a law enforcement purpose to a law enforcement official, if certain legal conditions are met (such as providing limited information to locate a missing person).
- Research. The Plans may disclose your PHI for research studies that meet all privacy law requirements (such as research related to the prevention of disease or disability).
- To Avert a Serious Threat to Health or Safety. The Plans may disclose your PHI to avert a serious threat to the health or safety of you or any other person.
- Workers' Compensation. The Plans may disclose your PHI to the extent necessary to comply with laws and regulations related to workers' compensation or similar programs.
- Coroners, Medical Examiners, and Funeral Directors. The Plans may disclose your PHI to coroners, medical examiners, or funeral directors for purposes of identifying a decedent, determining a cause of death, or carrying out their respective duties with respect to a decedent.
- Organ and Tissue Donation. If you are an organ donor, the Plans may release your PHI to organizations that handle organ procurement or organ, eye, or tissue transplantation or to an organ donation bank, as necessary to facilitate organ or tissue donation and transplantation.
- Military and Veterans. If you are a Member of the armed forces, the Plans may release your PHI as required by military command authorities.
- Inmates. If you are an inmate of a correctional institution or under the custody of a law enforcement official, the Plans may release your PHI to the correctional institution or law enforcement official. This release would be necessary (1) for the institution to provide you with healthcare; (2) to protect your health and safety or the health and safety of others; or (3) for the safety and security of the correctional institution.
- Business Associates. The Plans may contract with other businesses for certain Plan administrative services. The Plans may release your PHI to one or more of their business associates for Plan administration if the business associate agrees in writing to protect the privacy of your information.
- Plan Sponsor. The Episcopal Church Medical Trust, as sponsor of the Plans, will have access to your PHI for Plan administration purposes. Unless you authorize the Plans otherwise in writing (or your individual identifying data is deleted from the information), your PHI will be available only to the individuals who need this information to conduct these Plan administration activities, but this release of your PHI will be limited to the minimum disclosure required, unless otherwise permitted or required by law.

The following categories describe the ways that the Plans may use and disclose your PHI upon obtaining your written authorization:

- Most uses and disclosures of psychotherapy notes
- Uses and disclosures of PHI for marketing purposes
- Uses and disclosures that constitute a sale of PHI
- Any other use or disclosure of your PHI not identified in this section will be made only with your written authorization.

AUTHORIZING RELEASE OF YOUR PHI

To authorize release of your PHI, you must complete a medical information authorization form. An authorization form is available at cpg.org or by calling (800) 480-9967. You have the right to limit the type of information that you authorize the Plans to disclose and the persons to whom it should be disclosed. You may revoke your written authorization at any time. The revocation will be followed to the extent action on the authorization has not yet been taken.

INTERACTION WITH STATE PRIVACY LAWS

If the state in which you reside provides more stringent privacy protections than HIPAA, the more stringent state law will still apply to protect your rights. If you have a question about your rights under any particular federal or state law, please contact the Church Pension Group Privacy Officer. Contact information is included at the end of this Notice.

FUNDRAISING

The Plans may contact you to support their fundraising activities. You have the right to opt out of receiving such communications.

UNDERWRITING

The Plans are prohibited from using or disclosing PHI that is genetic information for underwriting purposes.

YOUR RIGHTS WITH RESPECT TO YOUR PHI

You have the following rights regarding PHI the Plans maintain about you:

Right to Request Restrictions. You have the right to request that the Plans restrict their uses and disclosures of your PHI. You will be required to provide specific information as to the disclosures that you wish to restrict and the reasons for your request. The Plans are not required to agree to a requested restriction, but may in certain circumstances. To request a restriction, please write to the Church Pension Group Privacy Officer and provide specific information as to the disclosures that you wish to restrict and the reasons for your request.

Right to Request Confidential Communications. You have the right to request that the Plans' confidential communications of your PHI be sent to another location or by alternative means. For example, you may ask that all EOBs be sent to your office rather than your home address. The Plans are not required to accommodate your request unless your request is reasonable and you state that the ordinary communication process could endanger you. To request confidential communications, please submit a written request to the Church Pension Group Privacy Officer.

Right to Inspect and Copy. You have the right to inspect and obtain a copy of the PHI held by the Plans. However, access to psychotherapy notes, information compiled in reasonable anticipation of or for use in legal proceedings, and under certain other, relatively unusual circumstances, may be denied. Your request should be made in writing to the Church Pension Group Privacy Officer. A reasonable fee may be imposed for copying and mailing the requested information. You may contact the Medical Trust Plan Administration at jservais@cpg.org for a full explanation of the Medical Trust's fee structure.

Right to Amend. You have the right to request that the Plans amend your PHI or record if you believe the information is incorrect or incomplete. To request an amendment, you must submit a written request to the Medical Trust Plan Administration at jservais@cpg.org. Your request must list the specific PHI you want amended and explain why it is incorrect or incomplete and be signed by you or your authorized representative. All amendment requests will be considered carefully. However, your request may be denied if the PHI or record that is subject to the request:

- Is not part of the medical information kept by or for the Plans
- Was not created by or on behalf of the Plans or its third-party administrators, unless the person or entity that created the information is no longer available to make the amendment
- Is not part of the information that you are permitted to inspect and copy; or
- Is inaccurate and incomplete

Right to an Accounting of Disclosures. You have the right to receive information about when your PHI has been disclosed to others. Certain exceptions apply to this rule. For example, a Plan does not need to account for disclosures made to you or with your written authorization, or for disclosures that occurred more than six years before your request. To request an accounting of disclosures, you must submit your request in writing to the Medical Trust Plan Administration at jservais@cpg.org and indicate in what form you want the accounting (e.g., paper or electronic). Your request must state a time period of no longer than six years and may not include dates before your coverage became effective. The Plan Administrator will then notify you of any additional information required for the accounting request. A Plan will provide you with the date on which a disclosure was made, the name of the person or entity to whom PHI was disclosed, a description of the PHI that was disclosed, the reason for the disclosure and certain other information. If you request this accounting more than once in a 12-month period, you may be charged a reasonable, cost-based fee for responding to these additional requests. You may contact Medical Trust Plan Administration at jservais@cpg.org for a full explanation of the Medical Trust's fee structure.

Breach Notification. You have the right to receive a notification from the Plans if there is a breach of your unsecured PHI.

Right to a Paper Copy of This Notice. You are entitled to get a paper copy of this Notice at any time, even if you have agreed to receive it electronically. To obtain a paper copy of this Notice, please contact the Church Pension Group Privacy Officer.

If You Are a Person in the European Union, the Following Provisions Will Also Be Applicable to You: For the purposes of the General Data Protection Regulation 2016/679 (the "GDPR"), the Data Controller is Church Pension Group Services Corporation registered in the State of Delaware in the United States with a registered address at 19 East 34th Street, New York, NY 10016.

You can request further information from our Privacy Officer at privacy@cpg.org.

In addition to your rights with respect to your PHI addressed above, you may have additional or overlapping rights under the GDPR. GDPR rights regarding your PHI include the following:

- You may access and export a copy of PHI;
- You may request deletion of, and update to PHI;
- You have the right to be informed about any automated decision-making of PHI including the significance and consequences of such processing for you;
- You may also object to or restrict the Plans' use of PHI. For example, you can object at any time to the Plans' use of PHI for direct marketing purposes.
- Where you believe that the Plans have not complied with its obligations under this Privacy Policy or the applicable law, you have the right to make a complaint to an EU Data Protection Authority;
- If the Plans obtained your consent to use your PHI, you may withdraw that consent at any time.

Data Retention

We only retain PHI collected for a limited time period as long as we need it to fulfill the purposes for which we initially collected it, unless otherwise required by law.

Data Transfers

We maintain servers in the United States and Canada, and your information may be processed on servers located in the United States and Canada. Data protection laws vary among countries, with some providing more protection than others. Regardless of where your information is processed, we apply the same protections described in this policy.

IF YOU BELIEVE YOUR PRIVACY RIGHTS HAVE BEEN VIOLATED

If you believe your privacy rights have been violated by any Plan, you may file a complaint with the Church Pension Group Privacy Officer and with the Secretary of the U.S. Department of Health and Human Services.

All complaints must be filed in writing. You will not be retaliated against for filing a complaint. To contact the Church

Pension Group Privacy Officer:

Privacy Officer
The Church Pension Group
19 East 34th Street
New York, NY 10016
(212) 592-8365
privacy@cpg.org

To contact the Secretary of the U.S. Department of Health and Human Services:
U.S. Department of Health and Human Services

Office of Civil Rights
200 Independence Avenue, SW
Washington, DC 20201
(202) 619-0257 | (877) 696-6775 (toll-free)
hhs.gov/contactus.html

EFFECTIVE DATE

This Notice is effective as of August 29, 2018.

CHANGES

Each Plan sponsored by the Medical Trust reserves the right to change the terms of this Notice and information practices and to make the new provisions effective for all PHI it maintains, including any PHI it currently maintains as well as PHI it receives or holds in the future, as permitted by applicable law. Any material amendment to the terms of this Notice, and these information practices will be provided to you via mail or electronically with your prior written consent.

FOR MORE INFORMATION

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

THE EPISCOPAL CHURCH MEDICAL TRUST

www.cpg.org

(800) 480-9967

e-mail: **mtcustserv@cpg.org**

Monday through Friday, except holidays, 8:30 AM – 8:00 PM ET

Cigna DENTAL

www.cigna.com

(800) 244-6224

Monday through Friday, 8:00 AM – 6:00 PM

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 (and their eligible dependents) of The Episcopal Church. 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 ("ECCEBT"), 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 health care expenses, so members should read this Plan Document Handbook carefully to determine which benefits are covered, as well as any applicable exclusions, limitations, and procedures.

This Plan Document Handbook should not be viewed as an offer of coverage, or investment, tax, medical, or other advice. By participating in and accepting benefits from the Plan, you agree to the terms of the Plan set forth in this Plan Document Handbook.

The Plan, and this Plan Document Handbook, are governed by, and the rights and obligations of the Medical Trust, ECCEBT, Anthem and the Members shall be interpreted, construed and enforced in accordance with, the laws of the State of New York without regard to the conflict of law principles thereof.

The Church Pension Fund and its affiliates, including but not limited to CPGSC and ECCEBT (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 applicable law, without notice.

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.