EPISCOPAL CHURCH MEDICAL TRUST

Plan Document Handbook

PPO Plans

Open Access Plus PPO 100
Open Access Plus PPO 90
Open Access Plus PPO 80
Open Access Plus PPO 70

CDHPs

Consumer-Directed Health Plan 15 (CDHP-15)
Consumer-Directed Health Plan 20 (CDHP-20)
Consumer-Directed Health Plan 40 (CDHP-40)

Benefits effective as of January 2022

Cigna

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INTRODUCTION

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.

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 *cpg.org*; or call Client Services at (800) 480-9967.

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

CHAPTER 1
IMPORTANT NOTICES

NEWBORNS' AND MOTHERS' HEALTH PROTECTION ACT OF 1996

The Plans cover Physician and Hospital care for mother and baby, including prenatal care, delivery and postpartum care. In accordance with the Newborns' and Mothers' Health Protection Act of 1996 (NMHPA), you and your newly born Child are covered for a minimum of 48 hours of Inpatient care following a vaginal delivery, or 96 hours following a cesarean section. However, your Provider may, after consulting with you, discharge you earlier than 48 hours after a vaginal delivery, or 96 hours following a cesarean section.

WOMEN'S HEALTH AND CANCER RIGHTS ACT OF 1998

The Plans, as required by the Women's Health and Cancer Rights Act of 1998 (WHCRA), provide Benefits for mastectomy-related services including all stages of reconstruction and surgery to achieve symmetry between the breasts, prostheses, and complications resulting from a mastectomy, including lymphedema.

For more information, contact the Plan Administrator.

For more information about any of these Notices, please contact the Plan at:

The Episcopal Church Medical Trust
19 East 34th Street
New York, NY 10016

If you prefer to discuss your questions by phone or email, contact Client Services at (800) 480-9967 or e-mail: *mtcustserv@cpg.org*.

CHAPTER 2
ELIGIBILITY AND ENROLLMENT

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.

Eligibility for the Episcopal Health Plan (EHP)

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 30[1] years of age or younger on December 31 of the current year**
- A Disabled Child, 30[1] 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.*

Ineligible Individuals

Individuals described below are <u>not</u> 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

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[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.

- 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 for 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 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/Spouse/Domestic Partner for adoption
- An Eligible Individual or Eligible Dependent 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 17)

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 provided 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 healthcare 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 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 30[2] years of age or younger on December 31 of the current year
- A Disabled Child, 30[2] years of age or older on December 31 of the current year, provided the disability began before the age of 25**

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[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.

**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 17)

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 healthcare 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 <u>into</u> an area where the HMO and PPO are available, the Subscriber may elect a new Plan. Conversely, if a Subscriber moved <u>out of</u> 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 themself 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 <u>required</u> 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 personalized 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 Tier[3]
- Options to add or remove Eligible Dependents
- The deadline for submitting Plan elections
- 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.

[3] Employer/Employee cost share information is not provided.

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 they become 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 they become 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 become 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 become 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 30.[4]

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 9-10 for information on HIPAA Special Enrollment extensions due to COVID-19.

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[4] 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.

[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.

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 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 9-10 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 9-10 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 or 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
- 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

[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 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 their 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.

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)

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

    - The Dependent no longer meets the eligibility requirements for any reasons other than death or turning age 30[8] (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 Plan[8]
- 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, the Claims Administrator, any Group Administrator or any Provider, or any personnel of any of the foregoing.
- Commit theft from the Plan Administrator, the Claims Administrator, 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.

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

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[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.

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 30[8] 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/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 30[8] 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.

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 Seminarians

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.[9] 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.
- 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

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

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
THE CIGNA NETWORK

Your health Plan is a Preferred Provider Organization (PPO), which is a comprehensive Plan. The Plan is divided into two sets of Benefits, Network Benefits and Out-of-Network Benefits. If you choose a Network Provider, you will receive Network Benefits. Utilizing this method means you will not have to pay as much money. Your out-of-pocket expenses will be higher when you use Out-of-Network Providers.

All Covered Health Services must be Medically Necessary and not Experimental, Investigational and Unproven. Coverage or certification of services that are not Medically Necessary or Experimental, Investigational and Unproven may be denied.

Furthermore, nothing in this Plan will limit or otherwise restrict a Physician's medical judgment with respect to their ultimate responsibility for patient care in the provision of medical services to you and/or your Dependent(s).

The Medical Trust has prepared this Plan Document Handbook to help you understand your Benefits and this Plan. Please read it carefully. Your Benefits are affected by certain limitations and conditions that require you to be a wise consumer of health services and to use only those services you need. Also, Benefits are not provided for certain kinds of treatments or services, even if your Provider recommends them.

CIGNA HEALTHCARE

When you select a Network Provider, this Plan pays a greater share of the costs than if you select an Out-of-Network Provider. Network Providers include Physicians, Hospitals and Other Healthcare Professionals and Other Healthcare Facilities. Call the number on the back of your Cigna ID Card or consult *myCigna.com* for a list of Network Providers in your area. Network Providers are committed to providing you and your Eligible Dependents appropriate care while lowering medical costs.

For services from Network Providers:

- You will not need to file claims. Network Providers will file claims for Covered Health Services for you. You will still need to pay any Coinsurance, Copayments, and Deductibles that apply. You may be billed by your Network Provider(s) for any Non-Covered Health Services you get or when you have not followed the terms of your Plan.
- Prior Authorization will be done by the Network Provider.

If you receive Covered Health Services from an Out-of-Network Provider after Cigna failed to provide you with accurate information in their Provider directory at *myCigna.com*, or after Cigna failed to respond to your telephone or web-based inquiry within the time required by Federal law, Covered Health Services will be covered at the Network level.

OUT-OF-NETWORK SERVICES

When you do not use a Network Provider, Covered Health Services are covered at the Out-of-Network Benefit level, unless otherwise indicated in this Plan Document Handbook.

For services from an Out-of-Network Provider:

- There is no limit to what an Out-of-Network Provider can charge unless your claim involves a Surprise Billing Claim
- The Out-of-Network Provider may charge you the difference between their bill and the Plan's Maximum Reimbursable Charge plus any Deductible and/or Coinsurance/Copayments unless your claim involves a Surprise Billing Claim
- You may have higher cost sharing amounts (i.e., Deductibles, Coinsurance, and/or Copayments) unless your claim involves a Surprise Billing Claim
- You will have to pay for services that are not Medically Necessary

- You will have to pay for Non-Covered Health Services
- You may have to file claims
- You must make sure any necessary Prior Authorization is done (See Chapter 4, “Prior Authorization and Case Management”).

SURPRISE BILLING CLAIMS – OUT-OF-NETWORK CHARGES FOR CERTAIN SERVICES

Unless the Out-of-Network Provider gives you proper notice of its charges (as described in more detail below) and you give written consent to such charges (your consent following such proper notice, your "Out-of-Network Consent”), charges for services furnished by an Out-of-Network Provider in a Network Facility while you are receiving Network services at that Network facility: (i) are payable at the Network cost-sharing level; and (ii) the allowed amount used to determine the Plan's Benefit payment is the “recognized amount” determined in accordance with applicable state of Federal law, or, if less, the amount actually billed by the Out-of-Network provider.

Unless the Out-of-Network Provider obtains a Member’s Out-of-Network Consent, the Member is responsible for applicable Network cost-sharing amounts (any Deductible, Copay or Coinsurance), and the Member is not responsible for any charges that may be made in excess of the allowed amount. If the Out-of-Network Provider bills you for an amount higher than the amount you owe as indicated on the Explanation of Benefits (EOB), contact Cigna Customer Service at the phone number on your ID Card.

SURPRISE BILLING CLAIMS – OUT-OF-NETWORK EMERGENCY SERVICES CHARGES

1. Emergency Services are covered at the Network cost-sharing level if services are received from an Out-of-Network Provider.
2. The allowed amount used to determine the Plan's Benefit payment for covered Emergency Services rendered in an Out-of-Network Hospital, or by an Out-of-Network provider in a Network Hospital, is the “recognized amount” determined in accordance with applicable state of Federal law, or, if less, the amount actually billed by the Out-of-Network provider.
3. The allowed amount used to determine the Plan’s Benefit payment when additional services are provided after the Member is stabilized and as part of outpatient observation or an inpatient or outpatient stay with respect to the visit in which the Emergency Services are provided ("Post-Stabilization Services”) is also the “recognized amount” (or lower amount actually billed) as described above, unless the Out-of-Network Provider obtains the Member’s Out-of-Network Consent, as permitted under Federal law. Post-Stabilization Services for which you provide your Out-of-Network Consent are not deemed to be Emergency Services for the purposes of these cost-sharing principles.

The Member is responsible for applicable Network cost-sharing amounts (any Deductible, Copay or Coinsurance) for such Emergency Services. The Member is not responsible for any charges that may be made in excess of the allowed amount for such Emergency Services. If the Out-of-Network Provider bills you for an amount higher than the amount you owe as indicated on the Explanation of Benefits (EOB) for such Emergency Services, contact Cigna Customer Service at the phone number on your ID Card.

SURPRISE BILLING CLAIMS – OUT-OF-NETWORK CONSENT

In order to obtain a Member’s “Out-of-Network Consent,” the Out-of-Network Provider must provide the Member with written notice of its charges not later than 72 hours prior to the delivery of services, unless the appointment was made less than 72 hours prior to the services being delivered, in which case the notice and consent may be given on the date on which the appointment is scheduled. In a situation where a Member is provided the notice and consent documents on the day the services are to be provided, including for post-stabilization services, the documents must be provided no later than 3 hours prior to the provision of services. The notice must contain a good faith estimate of the charges for the services. The notice must be physically separate from and not attached to or incorporated into any other documents. The documents must not be hidden or included among other forms, and a representative of the provider or facility must be physically present or available by phone to explain the documents and estimates to the Member, and answer any questions, as necessary. In order for an Out-of-Network Provider to properly obtain an Out-of-Network Consent, the notice must be signed by the Member.

An Out-of-Network Consent may not be obtained for ancillary services provided by an Out-of-Network Provider in a

Network Facility (e.g., an Out-of-Network anesthesiologist providing services in a Network Facility) or for unforeseen, urgent medical needs that arise at the time the covered service is provided.

If an Out-of-Network Provider obtains a Member's Out-of-Network Consent, the cost-sharing principles described under "Out-Of-Network Services," above, will apply.

Coinsurance and Copayments

Coinsurance and Copayments are the responsibility of the Member. Any required Coinsurance and Copayment amounts are shown on your Summary of Benefits and Coverage, which is available at *cpg.org/mtdocs.*

Calendar Year Deductible

Before the Plan begins to pay Benefits (except for most Preventive Care and most services requiring a Copayment), you must meet any Deductible required. Deductible amounts are described in the Summary of Benefits and Coverage. It's important to note that Deductibles for Network Benefits and Out-of-Network Benefits accumulate separately.

This Plan Document Handbook describes Covered Health Services available in conjunction with your medical Plan. You can access these services by calling the toll-free number shown on the back of your ID Card.

Choice of Primary Care Physician

This medical Plan does not require that you select a Primary Care Physician or obtain a referral from a Primary Care Physician in order to receive all Benefits available to you under this medical Plan. Notwithstanding, a Primary Care Physician may serve an important role in meeting your healthcare needs by providing or arranging for medical care for you and your Eligible Dependents. For this reason, we encourage the use of Primary Care Physicians and provide you with the opportunity to select a Primary Care Physician from a list provided by Cigna for yourself and your Eligible Dependents. If you choose to select a Primary Care Physician, the Primary Care Physician you select for yourself may be different from the Primary Care Physician you select for each of your Eligible Dependents.

Cigna One Guide®

Making healthcare decisions can be confusing. You may have many questions. Cigna's One Guide® service is there to help you find the answers to the questions you have.

One Guide® combines digital technology with personalized customer service. With One Guide®, you have the one-on-one support you need to take control of your health and your health spending. Whether it's choosing a Plan, finding a Provider, or exploring ways to improve your health, One Guide® is there to help.

One Guide® uses data to learn about you, so it can deliver customized alerts, notifications, and other helpful messages, At the same time, it offers you the human touch when you need it most— for health coaching, specialized support, or cost-saving guidance.

You can access a personal guide via app, chat, online, or phone, whenever you need guidance, support, or answers. To get started, just call the number on the back of your Cigna ID Card.

Personal Health Team

We all have different needs when it comes to improving our health. No matter your issue, its important to understand your condition, your medicine and your options. Cigna's experts can provide quick answers and information.

Cigna's team of compassionate, reliable health specialists, including nurses, coaches, nutritionists, clinicians and counselors, will listen, understand and help you find solutions:

- Build or maintain good eating and exercise habits
- Provide support and encouragement to set and meet your health goals

- Better control and cope with health conditions like arthritis, back pain, high blood pressure and more
- Learn health and wellness skills and tactics online at your pace

Talk to your Personal Health Team today. Call the number on the back of your Cigna ID Card.

CIGNA TREATMENT DECISION SUPPORT COACHING

Cigna Treatment Decision Support Coaching provide unbiased information and education on treatment options for common health conditions such as back pain, coronary artery disease, benign uterine conditions, osteoarthritis of the hip or knee, breast cancer, and prostate cancer.

Cigna Treatment Decision Support Coaching help Members to:

- Clarify their values and preferences
- Become fully informed of all treatment alternatives with similar anticipated positive outcomes available for their condition
- Communicate their questions and needs to their physician to establish the treatment plan that is right for them

The goals of Cigna's Treatment Decision Support Coaching is to improve the Member's relationship with their Physician and enable the Member to be an active participant in their treatment. When given decision aids, information, and the opportunity to include their own preferences and values in the decision-making process, Members may choose less invasive options.

Talk to a Cigna Treatment Decision Support Coach today. Call the number on the back of your Cigna ID Card.

THE CIGNA HEALTHCARE 24-HOUR HEALTH INFORMATION LINE℠

No matter where you are in the U.S., helpful health information is as close as the nearest phone. Just call the Cigna Healthcare 24-Hour Health Information Line℠, toll-free at (800) 564-9286.

- You can speak to a registered Nurse for answers to your health questions, assistance in locating nearby medical Facilities, and helpful self-care tips.
- You can listen to informative, recorded audiotapes on hundreds of health topics.
- This service is available 24 hours a day, seven days a week.

CIGNA COACHING AND SUPPORT FOR AUTISM PROGRAM

With the Cigna Coaching and Support for Autism program, you have access to a dedicated team of licensed mental health professionals with extensive expertise. They'll provide confidential, one-on-one support to:

- Help you understand the ASD diagnosis
- Explain treatment choices covered under your Benefits plan
- Help coordinate care between your behavioral and health care Providers
- Help you find a qualified Provider in your Plan's Cigna network
- Help you find local and state support, including early intervention programs in your area
- Help explain and review Medical Necessity guidelines for intensive treatment, such as Applied Behavioral Analysis (ABA) or a higher level of care
- Provide information about local resources, such as support groups and respite programs
- Guide you to a variety of resources and tools on *myCigna.com* and other sites
- Offer referrals to other Cigna programs available through your Plan
- Provide ongoing coaching and support for all of your concerns

PERSONAL HEALTH RECORD (PHR)

Through *myCigna.com*, Cigna provides the WebMD® Personal Health Record (PHR) that offers a single, secure online location for Members to easily access and store their complete health history. Members can share personal

health information with their Physicians, Providers and family members to help them manage and take control of their own healthcare. In addition to storing health information the WebMD® PHR also offers several easy-to-use tools and information to help empower individuals to make smart decisions about their health.

My Health Assessment

Taking a health assessment on *myCigna.com* is easy, confidential and only takes about 15 minutes. Follow these simple steps to get started.

Step 1: Know your numbers
Before you start, you'll need some basic information.

- Blood pressure numbers
- Cholesterol levels
- Height, weight and waist measurement

Step 2: Go to *myCigna.com*

- Log in to *myCigna.com*
- Click on Take your health assessment
- Get started

Step 3: See where you stand
After you're finished, the program will analyze your answers and create a personal health report, including:

- Information about potential risks
- What you can do now to get healthier
- Where to find resources and support

Step 4: Get moving
With a better understanding of your health and potential risk factors, it's time to take action.

- Cigna may invite you to take part in a helpful online coaching program
- Share your report with your Provider and create a plan to improve your health
- Use the tools and resources on *myCigna.com* to set and achieve healthy goals

The more you know about your health, the easier it is to take care of it. Log in to *myCigna.com* and take your health assessment today.

My Health Assistant

Check out Cigna's online coaching program. It's fun and motivating. And it can help you reach big health and wellness goals in small, easy-to-do steps.

Powered by WebMD®, you can work with the My Health Assistant online program anytime.

- Choose your long-term personal health and wellness goals
- Find suggested activities to help you reach the goals you've chosen
- Have a weekly plan created just for you – you check in to track and update your progress
- Receive friendly reminders and encouragement

Getting started just takes minutes. To enroll online, visit *myCigna.com*, click on Manage My Health and select My Health Assistant Online Coaching from the drop down menu.

CHAPTER 4
PRIOR AUTHORIZATION AND CASE MANAGEMENT

PRIOR AUTHORIZATION

The term Prior Authorization means the approval that a Network Provider must receive from the Review Organization, prior to services being rendered, in order for certain services and Benefits to be covered under this Plan.

Services that require Prior Authorization include, but are not limited to:

- Inpatient Hospital services, except for 48/96 hour maternity stays
- Inpatient services at any participating Other Healthcare Facility
- Residential treatment
- Outpatient Facility services
- Partial hospitalization
- Intensive outpatient programs
- Advanced radiological imaging
- Non-emergency ambulance
- Certain Medical Pharmaceuticals
- Home Health Care services
- Radiation therapy
- Transplant services

CERTIFICATION REQUIREMENTS – OUT-OF-NETWORK

Pre-Admission Certification/Continued Stay Review for Hospital Confinement

Pre-Admission Certification (PAC) and Continued Stay Review (CSR) refer to the process used to certify the Medical Necessity and length of a Hospital Confinement when you or your Eligible Dependent require treatment in a Hospital:

- As a registered bed patient, except for 48/96 hour maternity stays
- For mental health or substance use disorder residential treatment services

You or your Eligible Dependent should request PAC prior to any non-emergency treatment in a Hospital described above. In the case of an emergency admission, you should contact the Review Organization within two business days after the admission. For an admission due to pregnancy, we recommend you call the Review Organization by the end of the third month of pregnancy, or earlier. CSR should be requested, prior to the end of the certified length of stay, for continued Hospital Confinement.

Covered Health Services incurred for which Benefits will not be payable under this Plan for the following services:

- Hospital Charges for Bed and Board, for treatment listed above for which PAC was performed, which are made for any day in excess of the number of days certified through PAC or CSR; and
- Any Hospital Charges for treatment listed above for which PAC was requested, but which was not certified as Medically Necessary.

PAC and CSR are performed through a utilization review program by a Review Organization with which Cigna has contracted.

In any case, those expenses incurred for which payment is excluded by the terms set forth above will not be considered as expenses incurred for the purpose of any other part of this Plan, except for the "Coordination of Benefits" section.

OUTPATIENT CERTIFICATION REQUIREMENTS – OUT-OF-NETWORK

Outpatient certification refers to the process used to certify the Medical Necessity of Outpatient diagnostic testing and Outpatient procedures, including, but not limited to, those listed in this section when performed as an Outpatient in a Free-Standing Surgical Facility, Other Healthcare Facility or a Physician's office. You or your Eligible Dependent should call the toll-free number on the back of your ID Card to determine if Outpatient certification is required prior to any Outpatient diagnostic testing or procedures.

Outpatient certification is performed through a utilization review program by a Review Organization with which Cigna has contracted. Outpatient certification should only be requested for non-emergency procedures or services, and should be requested by you or your Eligible Dependent at least four business days (Monday through Friday) prior to having the procedure performed or the service rendered.

Outpatient Diagnostic Testing and Outpatient Procedures include, but are not limited to:

- Advanced radiological imaging – CT Scans, MRI, MRA or PET scans.
- Home Health Care Services.
- Medical Pharmaceuticals.
- Radiation Therapy.

CASE MANAGEMENT

Case Management is a service provided through a Review Organization, which assists individuals with treatment needs that extend beyond the acute care setting. The goal of Case Management is to ensure that patients receive appropriate care in the most effective setting possible whether at home, as an Outpatient, or an Inpatient in a Hospital or specialized Facility. Should the need for Case Management arise, a Case Management professional will work closely with the patient, their family and the attending Physician to determine appropriate treatment options that will best meet the patient's needs and keep costs manageable. The Case Manager will help coordinate the treatment program and arrange for necessary resources. Case Managers are also available to answer questions and provide ongoing support for the family in times of medical crisis.

Case Managers are registered Nurses (RNs) and other credentialed healthcare professionals, each trained in a clinical specialty area such as trauma, high-risk pregnancy and neonates, oncology, mental health or substance use disorder, rehabilitation, or general medicine and surgery. A Case Manager trained in the appropriate clinical specialty area will be assigned to you or your Eligible Dependent. In addition, Case Managers are supported by a panel of Physician advisors who offer guidance on up-to-date treatment programs and medical technology. While the Case Manager recommends alternate treatment programs and helps coordinate needed resources, the patient's attending Physician remains responsible for the actual medical care.

- You, your Eligible Dependent, or an attending Physician can request Case Management services by calling the toll-free number shown on your ID Card during normal business hours, Monday through Friday. In addition, your employer, a claim office or a utilization review program may refer an individual for Case Management.
- The Review Organization assesses each case to determine whether Case Management is appropriate.
- You or your Eligible Dependent is contacted by an assigned Case Manager who explains in detail how the program works. Participation in the program is voluntary—no penalty or Benefit reduction is imposed if you do not wish to participate in Case Management.
- Following an initial assessment, the Case Manager works with you, your family and Physician to determine the needs of the patient and to identify what alternate treatment programs are available (for example, in-home medical care in lieu of an extended Hospital convalescence). You are not penalized if the alternate treatment program is not followed.
- The Case Manager arranges for alternate treatment services and supplies, as needed (e.g., nursing services or a Hospital bed and other Durable Medical Equipment for the home).
- The Case Manager also acts as a liaison between the insurer, the patient, their family and Physician as needed (for example, by helping you to understand a complex medical diagnosis or treatment plan).
- Once the alternate treatment program is in place, the Case Manager continues to manage the case to ensure the treatment program remains appropriate to the patient's needs.

While participation in Case Management is strictly voluntary, Case Management professionals can offer quality, cost-

effective treatment alternatives, as well as provide assistance in obtaining needed medical resources and ongoing family support in a time of need.

MEDICAL PHARMACEUTICALS

The Plan covers Charges made for Medical Pharmaceuticals that are administered in an Inpatient setting, Outpatient setting, Physician's office, or in a covered person's home.

Benefits under this section are provided only for Medical Pharmaceuticals which, due to their characteristics (as determined by Cigna), are required to be administered, or the administration of which must be directly supervised, by a qualified Physician. Benefits payable under this section include Medical Pharmaceuticals whose administration may initially, or typically, require Physician oversight but may be self-administered under certain conditions specified in the product's Food and Drug Administration (FDA) labeling.

Certain Medical Pharmaceuticals are subject to Prior Authorization requirements or other coverage conditions. Additionally, certain Medical Pharmaceuticals are subject to step therapy requirements. This means that in order to receive Benefits for such Medical Pharmaceuticals, you are required to try a different Medical Pharmaceutical and/or prescription drug product first.

Utilization management requirements or other coverage conditions are based on a number of factors, which may include clinical and economic factors. Clinical factors may include, but are not limited to, the P&T Committee's evaluations of the place in therapy, relative safety or relative efficacy of Medical Pharmaceuticals as well as whether certain supply limits or other utilization management requirements should apply. Economic factors may include, but are not limited to, the Medical Pharmaceutical's cost including, but not limited to, assessments on the cost effectiveness of the Medical Pharmaceuticals and available rebates.

Regardless of its eligibility for coverage under this Plan, whether a particular prescription drug product is appropriate for you or any of your Dependents is a determination that is made by you (or your Dependent) and the prescribing Physician.

The coverage criteria for a Medical Pharmaceutical may change periodically for various reasons. For example, a Medical Pharmaceutical may be removed from the market, a new Medical Pharmaceutical in the same therapeutic class as a Medical Pharmaceutical may become available, or other market events may occur. Market events that may affect the coverage status of a Medical Pharmaceutical include, but are not limited to, an increase in the cost of a Medical Pharmaceutical.

CHAPTER 5
COVERAGE

Payment terms apply to all Covered Health Services. Please refer to the Schedule of Benefits and Coverage for details, including applicable Deductible, Copayment and Coinsurance information. All Covered Health Services must be Medically Necessary and not Experimental, Investigational and Unproven, whether provided through Network Providers or Out-of-Network Providers.

ACUPUNCTURE

Acupuncture by an acupuncturist who acts within the scope of their license. Limited to 20 visits per Plan Year (unlimited when used for smoking cessation). Visit maximum is combined for Network Providers and Out-of-Network Providers.

ALLERGY SERVICES

Allergy testing and treatment.

AMBULANCE SERVICE

Medically Necessary Ambulance Services are a Covered Health Service when:

- You are transported by a state licensed vehicle that is designed, equipped, and used only to transport the sick and injured and staffed by Emergency Medical Technicians (EMT), paramedics or other certified medical professionals. This includes ground, water, fixed wing, and rotary wing air transportation.

And one or more of the following criteria are met:

- For ground ambulance, you are taken:
  - From your home, the scene of an accident or medical emergency to a Hospital
  - Between Hospitals, including when the Claims Administrator requires you to move from a Hospital that is an Out-of-Network Provider to a Hospital that is a Network Provider
  - Between a Hospital and a Skilled Nursing Facility or other approved Facility
- For air or water ambulance, you are taken:
  - From the scene of an accident or medical emergency to a Hospital
  - Between Hospitals, including when the Claims Administrator requires you to move from a Hospital that is an Out-of-Network Provider to a Hospital that is a Network Provider
  - Between a Hospital and an approved Facility

Ambulance Services are subject to Medical Necessity reviews by the Claims Administrator. Emergency ground Ambulance Services do not require Prior Authorization/precertification and are allowed regardless of whether the Provider is a Network Provider or Out-of-Network Provider.

Non-emergency Ambulance Services are subject to Medical Necessity reviews by the Claims Administrator. When using an air ambulance, for non-emergency transportation, the Claims Administrator reserves the right to select the air ambulance Provider. If you do not use the air ambulance Provider the Claims Administrator selects, the Out-of-Network Provider may bill you for any Charges that exceed the Plan's Maximum Reimbursable Charge.

You must be taken to the nearest Facility that can give care for your condition. In certain cases, the Claims Administrator may approve Benefits for transportation to a Facility that is not the nearest Facility.

Benefits also include Medically Necessary treatment of a Sickness or Injury by medical professionals from an ambulance service, even if you are not taken to a Facility.

Ambulance Services are not covered when another type of transportation can be used without endangering your health. Ambulance Services for your convenience or the convenience of your family or Physician are not a Covered Health Service.

Other non-covered Ambulance Services include, but are not limited Ambulance Services to:

- A Physician's office or clinic
- A morgue or funeral home

Important Notes on Air Ambulance Benefits. Benefits are only available for air ambulance when it is not appropriate to use a ground or water ambulance. For example, if using a ground ambulance would endanger your health and your medical condition requires a more rapid transport to a Facility than the ground ambulance can provide, the Plan will cover the air ambulance. Air ambulance will also be covered if you are in an area that a ground or water ambulance cannot reach.

Air ambulance will not be covered if you are taken to a Hospital that is not an acute care Hospital (such as a Skilled Nursing Facility or a rehabilitation Facility), or if you are taken to a Physician's office or your home.

Hospital to Hospital Transport. If you are moving from one Hospital to another, air ambulance will only be covered if using a ground ambulance would endanger your health and if the Hospital that first treats cannot give you the medical services you need. Certain specialized services are not available at all Hospitals. For example, burn care, cardiac care, trauma care, and critical care are only available at certain Hospitals. To be covered, you must be taken to the closest Hospital that can treat you.
Coverage is not available for air ambulance transfers simply because you, your family, or your Provider prefers a specific Hospital or Physician.

Applied Behavioral Analysis (ABA)

Rendered by behavioral Providers, is an intensive behavior intervention program used to treat autism spectrum disorders. ABA implements and evaluates environmental modifications using behavioral stimuli and consequences to produce socially significant improvement in behavior.

ABA therapy is not a comprehensive form of short-term rehabilitation.

Assistant Surgery

Services rendered by an assistant surgeon are covered based on Medical Necessity.

Bariatric Surgery

Surgical treatment of obesity is only covered for patients meeting Medical Necessity criteria, as defined by the Claims Administrator.

Breast Cancer Care

Covered Health Services are provided for Inpatient care following a mastectomy or lymph node dissection until the completion of an appropriate period of stay as determined by the attending Physician in consultation with the Member. Follow-up visits are also included and may be conducted

at home or at the Physician's office as determined by the attending Physician in consultation with the Member.

BREAST RECONSTRUCTIVE SURGERY

Covered Health Services are provided following a mastectomy for reconstruction of the breast on which the mastectomy was performed, surgery and reconstruction of the other breast to produce a symmetrical appearance, and prostheses and treatment of physical complications, including lymphedemas.

CHIROPRACTIC CARE

Limited to 20 days per Plan Year. Visit maximum is combined for Network Providers and Out-of- Network Providers.

CLINICAL TRIALS

Benefits include coverage for services, such as routine patient care costs, given to you as a participant in an approved clinical trial if the services are Covered Health Services under this Plan. An "approved clinical trial" means a phase I, phase II, phase III, or phase IV clinical trial that studies the prevention, detection, or treatment of cancer or other life-threatening conditions. The term life- threatening condition means any disease or condition from which death is likely unless the disease or condition is treated.

Benefits are limited to the following trials:

1. Federally funded trials approved or funded by one of the following:

    a. The National Institutes of Health
    b. The Centers for Disease Control and Prevention
    c. The Agency for Health Care Research and Quality
    d. The Centers for Medicare & Medicaid Services
    e. Cooperative group or center of any of the entities described in (a) through (d) or the Department of Defense or the Department of Veterans Affairs
    f. A qualified non-governmental research entity identified in the guidelines issued by the National Institutes of Health for center support grants
    g. Any of the following in i-iii below if the study or investigation has been reviewed and approved through a system of peer review that the Secretary of Health and Human Services determines 1) to be comparable to the system of peer review of studies and investigations used by the National Institutes of Health, and 2) assures unbiased review of the highest scientific standards by qualified individuals who have no interest in the outcome of the review
        i. The Department of Veterans Affairs
        ii. The Department of Defense
        iii. The Department of Energy
2. Studies or investigations done as part of an investigational new drug application reviewed by the Food and Drug Administration
3. Studies or investigations done for drug trials that are exempt from the investigational new drug application.

Your Plan may require you to use a Network Provider to maximize your Benefits.

Routine patient care costs include items, services, and drugs provided to you in connection with an approved clinical trial that would otherwise be covered by this Plan.

All other requests for clinical trials services, including requests that are not part of approved clinical

trials will be reviewed according to the Claims Administrator's Clinical Coverage Guidelines, related policies and procedures.

Your Plan is not required to provide Benefits for the following services. The Plan reserves the right to exclude any of the following services:

- The Experimental, Investigational and Unproven Service, item, device, or service
- Items used and services that are provided only to satisfy data collection and analysis needs and that are not used in the direct clinical management of the patient
- A service that is clearly inconsistent with widely accepted and established standards of care for a particular diagnosis
- Any item or service that is paid for, or should have been paid for, by the sponsor of the trial

DENTAL SERVICES

Your Plan includes Benefits for the extraction of impacted wisdom teeth and dental work required for the initial repair of an Injury to the jaw, sound natural teeth, mouth or face which are required as a result of an accident and are not excessive in scope, duration, or intensity to provide safe, adequate, and appropriate treatment without adversely affecting the Member's condition.

Treatment must begin within 12 months from the date of the Injury.

Other Dental Services

Your Plan also includes Benefits for Hospital Charges and anesthetics provided for dental care if the Member meets Medical Necessity as determined by the Claims Administrator.

DIABETES

Equipment and Outpatient self-management training and education, including nutritional counseling for individuals with insulin-dependent diabetes, insulin-using diabetes, gestational diabetes, and non- insulin using diabetes as prescribed by the Physician. Covered Health Services for Outpatient self- management training and education must be provided by a certified, registered, or licensed healthcare professional with expertise in diabetes. Screenings for gestational diabetes are covered under Preventive Services.

DIALYSIS OUTPATIENT TREATMENT

The Plan covers dialysis Outpatient treatment by a Network Provider only. Dialysis Outpatient treatment provided by an Out-of-Network Provider is not covered. If applicable, the Plan will pay secondary to Medicare Part B.

DURABLE MEDICAL EQUIPMENT, MEDICAL SERVICES AND SUPPLIES

The Plan covers the purchase or rental of Durable Medical Equipment that is ordered or prescribed by a Physician and provided by a vendor approved by Cigna for use outside a Hospital or Other Healthcare Facility. Refer to the Glossary of Terms for the definition of Durable Medical Equipment.

Coverage for repair, replacement or duplicate equipment or external prosthetic appliances and devices is provided only when required due to anatomical change (e.g., significant weight gain or loss, atrophy, and growth) and/or reasonable wear and tear. All maintenance and repairs that result from a person's misuse are the Member's responsibility.

Coverage for Durable Medical Equipment is limited to the lowest-cost alternative as determined by the utilization review Physician.

Such equipment includes, but is not limited to, beds, respirators, wheel chairs, and dialysis machines.

Contact Cigna for more information about covered medical services and supplies.

Please see "Supplies or Equipment (Including Durable Medical Equipment) Not Medically Necessary" in Chapter 6, "Exclusions and Limitations" for medical services and supplies that are NOT covered. Contact Cigna for information about covered medical services and supplies.

EMERGENCY SERVICES

LIFE-THREATENING MEDICAL EMERGENCY OR SERIOUS ACCIDENTAL INJURY

The Plan provides Benefits for emergency health services when required for stabilization and initiation of treatment of an Emergency Medical Condition, as provided by or under the direction of a Physician.

Medically Necessary services will be covered whether you get care from a Network or Out-of-Network Provider. Emergency health services you get from an Out-of-Network Provider will be covered as a Network service and will not require Prior Authorization. The Out-of-Network Provider can only charge you any applicable Deductible, Coinsurance, and/or Copayment and cannot bill you for the difference between the Maximum Reimbursable Charge and their billed charges until your condition is stable as described under "Surprise Billing Claims – Out-of-Network Emergency Services Charges," above. Your cost shares will be based on the Maximum Reimbursable Charge and will be applied to your Network Deductible and Network Out-of-Pocket Limit.

Treatment you get after your condition has stabilized are not emergency health services. If you receive such services from an Out-of-Network Provider, please refer to the Out-of-Network Services section of this Plan Document Handbook for more details on how this will impact your benefits.

For the definition of an Emergency Medical Condition, please refer to Chapter 14, "Glossary."

In an emergency, call 911 for an ambulance or go directly to the nearest emergency room. You pay only your cost share for a visit to an emergency room. You must notify Cigna within two (2) business days of the admission. If you make an emergency visit to your Physician's office, you pay the same cost share as for an office visit.

Benefits for treatment of an Emergency Medical Condition are limited to the initial visit for an Emergency Medical Condition. If a Network Provider provides all follow-up care, you will receive maximum Benefits.

These emergency services are covered:

- Treatment in a Hospital emergency room or other emergency care Facility for a condition that can be classified as an Emergency Medical Condition or Injuries received in an accident
- Outpatient professional services, X-ray and/or lab services performed at the emergency room and billed by the Facility as part of the emergency room visit
- Advanced radiological imaging (MRIs, MRAs, CAT Scans, PET Scans, etc.) billed by the Facility as part of the emergency room visit
- Ambulance Services

If time permits, speak to your Physician to direct you to the best place for treatment. Be sure to show your ID Card at the emergency room, and if you are admitted, notify the Claims Administrator within two (2) business days of admission.

FOOT CARE

Covered Health Services include routine foot care for diabetes, peripheral vascular and circulatory disease, severe foot Injury, as well as podiatric surgery when Medically Necessary.

GENDER REASSIGNMENT SURGERY

Covered but Prior Authorization/precertification is required.

GENERAL ANESTHESIA SERVICES

Covered when ordered by the attending Physician and administered by another Physician who customarily bills for such services, in connection with a covered procedure.

Such anesthesia service includes the following procedures when given to cause muscle relaxation, loss of feeling, or loss of consciousness:

- Spinal or regional anesthesia
- Injection or inhalation of a drug or other agent (local infiltration is excluded)

Anesthesia services administered by a Certified Registered Nurse Anesthetist (CRNA) are only covered when billed by the supervising anesthesiologist.

GENETIC TESTING

Genetic testing is covered when Medically Necessary and not Experimental, Investigational and Unproven.

HABILITATIVE SERVICES

Benefits include habilitative healthcare services and devices that help you keep, learn, or improve skills and functioning for daily living. Examples include therapy for a Child who isn't walking or talking at the expected age. These services may include physical and occupational therapy, speech- language pathology, and other services for people with impairments in a variety of Inpatient and/or Outpatient settings.

HEARING AIDS

Limited to $1,500 per ear every three years. Limit applies to hearing aid device only. Replacement parts, batteries, and repairs are not covered. Audiologist office visits are billed separately and not applied to the $1,500 maximum per ear.

HOME HEALTH CARE SERVICES

Home Health Care provides a program for the Member's care and treatment in the home. The program consists of required intermittent skilled care, which may include observation, evaluation, teaching, and nursing services consistent with the diagnosis, established and approved in writing by the Member's attending Physician. Services may be performed by either Network Providers or Out-of- Network Providers. Limited to 210 days per Plan Year. Visit maximum is combined for Network Benefits and Out-of-Network Benefits. This limit does not apply to visits related to Mental Health and Substance Use Disorder treatment or home infusion services.

Covered Health Services:

- Visits by an RN or LPN. Benefits cannot be provided for services if the Nurse is a Member's family member.
- Visits by a qualified physiotherapist or speech therapist and by an inhalation therapist certified by the National Board of Respiratory Therapy.

- Visits to render services and/or supplies of a licensed Medical Social Services Worker when Medically Necessary to enable the Member to understand the emotional, social, and environmental factors resulting from or affecting the Member's illness.
- Visits by a home health nursing aide when rendered under the direct supervision of an RN.
- Nutritional guidance when Medically Necessary.
- Oxygen and its administration.
- Dialysis treatment
- Home infusion therapy (see Home Infusion Services below)
- Purchase or rental of dialysis equipment
- Private duty nursing

Covered Health Services for Home Health Care do not include:

- Food, housing, homemaker services, sitters, home-delivered meals
- Home Health Care services which are not Medically Necessary or of a non-skilled level of care
- Services and/or supplies which are not included in the Home Health Care plan
- Services of a person who ordinarily resides in the Member's home or is a member of the family of either the Member or Member's Spouse
- Any services for any period during which the Member is not under the continuing care of a Physician
- Convalescent or Custodial Services where the Member has spent a period of time for recovery of an illness or surgery and where skilled care is not required or the services being rendered are only for aid in daily living, i.e., for the convenience of the Member
- Maintenance Care

HOME INFUSION SERVICES

Home infusion therapy is the administration of drugs in your home (See "Home Health Care Services" above) using intravenous (into the bloodstream), subcutaneous (under the skin), and epidural (into the membranes surrounding the spinal cord) routes. Home infusion includes intravenous delivery of parenteral nutrition when nutritional needs cannot be met by oral or enteral routes, as determined by a Physician.

HOSPICE CARE SERVICES

You are eligible for Hospice Care Services if your Physician and the Hospice medical director certify that you are terminally ill. You may access Hospice Care Services while participating in a clinical trial or continuing disease modifying therapy, as ordered by your treating Provider. Disease modifying therapy treats the underlying Terminal Illness.

The services and supplies listed below are Covered Health Services when given by a Hospice for the palliative care of pain and other symptoms that are part of a terminal disease. Palliative care means care that controls pain and relieves symptoms, but is not meant to cure a Terminal Illness. Covered Health Services include:

- Care from an interdisciplinary team with the development and maintenance of an appropriate plan of care
- Short-term Inpatient Hospital care when needed in periods of crisis or as respite care
- Skilled nursing services, home health aide services, and homemaker services given by or under the supervision of a registered Nurse
- Social services and counseling services from a licensed social worker
- Nutritional support such as intravenous feeding and feeding tubes
- Physical Therapy, occupational therapy, speech therapy, and respiratory therapy given by a licensed therapist
- Pharmaceuticals, medical equipment, and supplies needed for the palliative care of your condition, including oxygen and related respiratory therapy supplies
- Bereavement (grief) services, including a review of the needs of the bereaved family and the development of a care plan to meet those needs, both before and after the Member's death.

Bereavement services are available to surviving Members of the immediate family for one year after the Member's death. The surviving Member of the immediate family must be enrolled in the Plan to be eligible for bereavement services.

Benefits for services beyond those listed above that are given for disease modification or palliation, such as but not limited to, chemotherapy and radiation therapy, are available to a Member in Hospice. These services are covered under other parts of this Plan Document Handbook.

HOSPITAL SERVICES

You may receive treatment at a Hospital that is a Network Provider or an Out-of-Network Provider. However, payment is significantly reduced if services are received at a Hospital that is an Out-of- Network Provider. Your Plan provides Covered Health Services when the following services are Medically Necessary:

Inpatient Services

- Inpatient room Charges. Covered Health Services include Semiprivate Room and board, general nursing care and intensive or cardiac care. If you stay in a private room, the Maximum Reimbursable Charge is based on the Hospital's prevalent Semiprivate Room rate. If you are admitted to Hospital that has only private rooms, the Maximum Reimbursable Charge is based on the Hospital's prevalent room rate.

Service and Supplies

- Services and supplies provided and billed by the Hospital while you're an Inpatient, including the use of operating, recovery and delivery rooms. Laboratory and diagnostic examinations, intravenous solutions, basal metabolism studies, electrocardiograms, electroencephalograms, X-ray examinations, and radiation and speech therapy are also covered.
- Convenience items (such as radios, TV's, record, tape or CD players, telephones, visitors' meals, etc.) will not be covered.

Remember to call the Review Organization at (800) 244-6224 at least two weeks prior to any planned surgery or Hospital admission. For an emergency admission, call the Review Organization within two (2) business days. Otherwise, your Benefits may be denied for each Hospital admission or surgery that is not precertified.

The Medical Necessity and length of any Hospital stay are subject to the Review Organization's guidelines. If the Review Organization determines that the admission or surgery is not Medically Necessary, no Benefits will be paid. See Chapter 4, "Prior Authorization and Case Management" of this Plan Document Handbook for additional information.

If surgery is performed in a Hospital that is a Network Provider, you will receive Network Benefits for the anesthesiologist, pathologist, and radiologist, whether or not they are a Network Provider. If you choose to use a surgeon who is an Out-of-Network Provider, your Out-of-Network Benefits will apply. This may also apply to assistant surgeons.

If you follow the notification and certification requirements outlined above, your Benefits will be unaffected, and you and the Plan avoid expenses related to unnecessary healthcare. However, if you do not follow the procedures required by this Plan, the Plan may deny all related covered Hospital expenses. In addition, if you fail to follow the requirements to preauthorize and the Review Organization retrospectively reviews the treatment and/or services you received and determines they were not Medically Necessary, Benefits may be denied, and you may be responsible for all noncovered expenses.

The penalty assessed when you do not follow the notification and certification procedures required by the Plan does not apply toward your Out-of-Pocket Maximum.

When all of the provisions of this Plan are satisfied, the Plan will provide Benefits as outlined in the Summary

of Benefits and Coverage.

HUMAN ORGAN AND TISSUE TRANSPLANT SERVICES

The Cigna LIFESOURCE Transplant Network® provides quality transplant care.

A dedicated transplant case manager helps you make the most of your healthcare Benefits. Our transplant case managers are experienced registered Nurses with extensive backgrounds in transplant, critical care and/or community care. Once it has been determined that you are a candidate for transplantation, call Cigna LIFESOURCE toll-free at (800) 668-9682.

Transplant services include the recipient's medical, surgical, and Hospital services; Inpatient immunosuppressive medications; and costs for organ or bone marrow/stem cell procurement. Transplant services are covered only if they are required to perform any of the following human-to-human organ or tissue transplants:

- Allogeneic bone marrow/stem cell
- Autologous bone marrow/stem cell
- Cornea
- Heart
- Heart/lung
- Kidney
- Kidney/pancreas
- Liver
- Lung
- Pancreas or intestine which includes small bowel,-liver or multi-viscera

Implantation procedures are also covered for artificial heart, percutaneous ventricular assist device (PVAD), extracorporeal membrane oxygenation (ECMO) ventricular assist device (VAD) and intra-aortic balloon pump (IABP) are also covered.

All transplant services, other than cornea transplants, are payable at 100% when received at Cigna LIFESOURCE Transplant Network® Facilities. Cornea transplants are not covered at Cigna LIFESOURCE Transplant Network® Facilities. Transplant services, including cornea, when received from Network Provider Facilities other than Cigna LIFESOURCE Transplant Network® Facilities are payable at the Network level. Transplant services received at any other Facilities, including Out-of-Network Providers and Network Providers not specifically contracted with Cigna for transplant services, are not covered.

Coverage for organ procurement costs are limited to costs directly related to the procurement of an organ, from a cadaver or a live donor. Organ procurement costs shall consist of surgery necessary for organ removal, organ transportation, and the transportation, hospitalization and surgery of a live donor. Compatibility testing undertaken prior to procurement is covered if Medically Necessary.

Costs related to the search for, and identification of a bone marrow or stem cell donor for an allogeneic transplant, are also covered.

Transplant Travel Services

Charges made for non-taxable travel expenses incurred by you in connection with a preapproved organ/tissue transplant are covered subject to the following conditions and limitations. Transplant travel Benefits are not available for cornea transplants. Benefits for transportation and lodging are available to you only if you are the recipient of a preapproved organ/tissue transplant from a designated Cigna LIFESOURCE Transplant Network® Facility. The term recipient is defined to include a person receiving authorized transplant related services during any of the following: (a) evaluation, (b) candidacy, (c) transplant event, or (d) post-transplant care. Travel expenses for the person receiving the transplant will include Charges for: transportation to and from the transplant site (including Charges for a rental car used during a period of care at the transplant Facility); and lodging while at, or traveling to and from, the

transplant site. There is a $10,000 per transplant per lifetime limit for travel and lodging.

In addition to your coverage for the Charges associated with the items above, such Charges will also be considered covered travel expenses for one companion to accompany you. The term companion includes your Spouse, a member of your family, your legal guardian, or any person not related to you, but actively involved as your caregiver who is at least 18 years of age. The following are specifically excluded travel expenses:

- Any expenses that if reimbursed would be taxable income
- Alcohol or tobacco products
- Charges for transportation that exceed coach class rates
- Food and meals
- Laundry bills
- Telephone bills
- Travel costs incurred due to travel within 60 miles of your home

These Benefits are only available when the covered person is the recipient of an organ transplant and the transplant services are received at a Cigna LIFESOURCE Transplant Network® Facility. Travel expenses for the designated live donor for a covered recipient are covered subject to the same conditions and limitations noted above. Charges for the expenses of a donor companion are not covered. No Benefits are available when the covered person is a donor.

If you choose not to have a transplant performed at a Network Provider Facility, including facilities other than a Cigna LIFESOURCE Transplant Network® Facility, you must still follow the certification requirements outlined in Chapter 4, “Prior Authorization and Case Management.” If you do not follow the procedures required by this Plan, the Benefits will be denied.

The penalty assessed when you do not follow the notification and Prior Authorization procedures required by the Plan does not apply toward your Out-of-Pocket Limit.

HYPNOSIS

Coverage for hypnosis is covered for up to 6 visits per Plan Year. Benefits are unlimited when related to smoking cessation.

MATERNITY CARE

Covered Health Services are provided for Maternity Care as stated in the Summary of Benefits and Coverage.

Routine newborn nursery care is part of the mother’s maternity Benefits. Benefits are provided for well-baby pediatrician visits performed in the Hospital.

Under Federal law, the Plan may not restrict the length of stay to less than the 48/96 hour periods or require Prior Authorization/precertification for either length of stay. The length of hospitalization which is Medically Necessary will be determined by the Member’s attending Physician in consultation with the mother. Should the mother or infant be discharged before 48 hours following a normal delivery or 96 hours following a cesarean section delivery, the Member will have access to two post-discharge follow-up visits within the 48 or 96 hour period. These visits may be provided either in the Physician’s office or in the Member’s home by a Home Health Care Agency. The determination of the medically appropriate place of service and the type of Provider rendering the service will be made by the Member’s attending Physician.

Cigna Healthcare Healthy Babies®

The Cigna Healthcare Healthy Babies® program provides education and support for covered mothers-to-be along with special attention for high-risk pregnancies. The program includes:

- Access to a valuable toll-free information line staffed by experienced registered Nurses
- Educational materials from a recognized source of information on pregnancy and babies— the March of Dimes®
- Support and coordination of your pregnancy care needs by a registered Nurse case manager if you or your baby are identified as having special healthcare needs.
- Post-delivery support and services. Once your baby arrives, Cigna Healthcare continues to provide access to the services you'll need. You'll have a wide selection of credentialed Cigna participating pediatricians and family doctors to choose from to provide your new baby's medical care.

It's easy to enroll in the Cigna Healthcare Healthy Babies® program. Just call the toll-free number on your Cigna ID Card.

MENTAL HEALTH AND SUBSTANCE USE DISORDER SERVICES

Behavioral health includes Mental Health and Substance Use Disorders Services.

Mental health services are services that are required to treat a disorder that impairs the behavior, emotional reaction or thought processes.

Substance use disorder is defined as the psychological or physical dependence on alcohol or other mind-altering drugs that requires diagnosis, care, and treatment.

Inpatient Mental Health Services

Services that are provided by a Hospital while you or your Dependent is Confined in a Hospital for the treatment and evaluation of mental health. Inpatient mental health services include mental health residential treatment services.

Mental health residential treatment services are services provided by a Hospital for the evaluation and treatment of the psychological and social functional disturbances that are a result of subacute mental health conditions.

Mental health residential treatment center means an institution which specializes in the treatment of psychological and social disturbances that are the result of mental health conditions; provides a subacute, structured, psychotherapeutic treatment program, under the supervision of Physicians; provides 24-hour care, in which a person lives in an open setting; and is licensed in accordance with the laws of the appropriate legally authorized agency as a residential treatment center.

Outpatient Mental Health Services

Services of Providers who are qualified to treat mental health when treatment is provided on an Outpatient basis, while you or your Dependent is not Confined in a Hospital, and is provided in an individual, group, or mental health partial hospitalization program or intensive outpatient therapy program.

Partial hospitalization services are rendered not less than 4 hours and not more than 12 hours in any 24-hour period by a certified/licensed Mental health program in accordance with the laws of the appropriate, legally authorized agency.

A mental health intensive outpatient therapy program consists of distinct levels or phases of treatment that are provided by a certified/licensed Mental health program in accordance with the laws of the appropriate, legally authorized agency. Intensive outpatient therapy programs provide a combination of individual, family, and/or group therapy in a day, totaling nine or more hours in a week.

Inpatient Substance Use Disorder Rehabilitation Services

Services provided for rehabilitation, while you or your Dependent is Confined in a Hospital, when required for the diagnosis and treatment of abuse or addiction to alcohol and/or drugs. Inpatient substance use disorder

services include residential treatment services.

Services that are provided by a Hospital for the evaluation and treatment of the psychological and social functional disturbances that are a result of subacute substance use disorder conditions.

An institution which specializes in the treatment of psychological and social disturbances that are the result of substance use disorder; provides a subacute, structured, psychotherapeutic treatment program, under the supervision of Physicians; provides 24-hour care, in which a person lives in an open setting; and is licensed in accordance with the laws of the appropriate legally authorized agency as a residential treatment center.

Outpatient Substance Use Disorder Rehabilitation Services

Services provided for the diagnosis and treatment of substance use disorder or addiction to alcohol and/or drugs, while you or your Dependent is not Confined in a Hospital, including Outpatient rehabilitation in an individual, or a substance use disorder partial hospitalization or intensive outpatient therapy program.

Substance use disorder partial hospitalization services are rendered no less than 4 hours and not more than 12 hours in any 24-hour period by a certified/licensed substance use disorder program in accordance with the laws or the appropriate legally authorized agency.

A substance use disorder intensive outpatient therapy program consists of distinct levels or phases of treatment that are provided by a certified/licensed substance use disorder program in accordance with the laws of the appropriate legally authorized agency. Intensive outpatient therapy programs provide a combination of individual, family, and/or group therapy in a day, totaling nine or more hours in a week.

Detoxification and related medical ancillary services are provided when required for the diagnosis and treatment of addiction to alcohol and/or drugs. Cigna will decide, based on the Medical Necessity of each situation, whether such services will be provided in an Inpatient or Outpatient setting.

Home Health Care Services

See “Home Health Care Services” section above for a description of coverage.

Colleague Group Benefits

Colleague group Benefits are available to Employees or Spouses for a family total of 24 90-minute sessions per Plan Year. Employees may use up to 12 of the 24 colleague group sessions for individual consultation. The Plan will cover 70% to the maximum reimbursable fee (MRF) of $40.00. For example, if you participate in a colleague group and your facilitator charges $75.00 a session, the Plan will reimburse $40.00 (70% of $75.00 is $52.50, but the MRF is $40.00). The Member will be responsible for the remaining charges.

Cigna Employee Assistance Program (EAP)

The Cigna Employee Assistance Program (EAP), managed by Cigna Behavioral Health (CBH), is available to all Members enrolled in any active Medical Trust medical Plan and their Dependents*. Dependents do not need to be enrolled in the Member’s medical Plan to use the EAP. This Benefit is available to other members of your household. The EAP offers an array of services designed to assist you with work, life, and family issues. EAP services are free, confidential, and available 24/7, through *mycigna.com* or by phone.

EAP services include:

- Phone and website access 24/7
- In-person counseling (up to 10 sessions per issue with $0 Copayment)
- Immediate help during a crisis
- Local resources in your community on a wide range of topics, including elder and child care providers, support groups, and so much more

- Tips and guidance to help balance work with family life, including a free legal or financial consultation

To access the Cigna EAP services, register on the EAP website at *mycigna.com* and use the employer ID "Episcopal" or call (866) 395-7794. If you are already registered because you are enrolled in another Cigna product (dental, for instance), you do not need to register again.

Pastoral Support Network (PSN)

The Pastoral Support Network (PSN) offers counseling and support services with a particular sensitivity to the unique issues priests and their families may experience. If there's an issue with which you'd like assistance, you can talk with a PSN counselor over the phone or get a referral for a counseling professional in your area.

The PSN is part of your EAP benefit and is completely confidential. Neither your congregation/employer nor the Episcopal Church Medical Trust will be notified when you use the services.

The PSN is offered at no cost and is available to all the family members in your household. For more information or to talk with a PSN specialist, call (866) 395-7794.

NUTRITIONAL COUNSELING

Nutritional counseling is covered, but is limited to 6 visits per Plan Year (limit applies to office/Outpatient setting only). Visit maximum is combined for Network Providers and Out-of-Network Providers.

This Benefit is unlimited if related to a diagnosis of diabetes.

ONLINE VISITS

Cigna Telehealth Connection lets you get the care you need—including most prescriptions—for a wide range of minor conditions.[10] Now you can connect with a board-certified doctor via secure video chat or phone, without leaving your home or office. When, where, and how it works best for you.

Cigna provides access to Telehealth services through MDLIVE. If you pre-register with MDLIVE, you can speak with a doctor, day or night.

You can get help with:

- Acne
- Allergies
- Cold and flu
- Fever
- Headache
- Rash
- Sore throat
- Stomach ache

Telemedicine is not meant to replace your Primary Care Physician. However, televisits can be a convenient and cost-effective alternative to going to an Urgent Care center and less expensive than going to an emergency room. You will pay the same cost share as visiting your Primary Care Physician.

MDLIVE should not be used for emergency care. If you experience a medical emergency, call 911 immediately.

[10] Some services may not be available in all areas. Visit *MDLIVEforCigna.com* for more information.

You will be informed of the cost share before your session begins. For more information, including cost share, and to register for one or both so you'll be ready to use a telemedicine service when and where you need it, go to *MDLIVEforCigna.com*.

To use these services from your home computer, you will need a high-speed Internet connection, a webcam, and audio capability.

To use a mobile device, search for MDLIVE in the App Store® or Google Play™. For instructions and support, go to *MDLIVEforCigna.com*.

Most states allow prescriptions through telemedicine, but some states require a face-to-face visit. The laws may change, so check the websites above to see if there have been changes in your state. Please note that doctors using MDLIVE are not able to prescribe controlled substances or lifestyle drugs.

Oral Surgery

Covered Health Services include the following:

- Fracture of facial bones
- Removal of impacted wisdom teeth
- Lesions of the mouth, lip, or tongue which require a pathological exam
- Incision of accessory sinuses, mouth salivary glands, or ducts
- Dislocations of the jaw
- Treatment of temporomandibular joint syndrome (TMJ) or myofascial pain including only removable appliances for TMJ repositioning and related surgery and diagnostic services. Covered Health Services do not include fixed or removable appliances that involve movement or repositioning of the teeth, or operative restoration of teeth (fillings), or prosthetics (crowns, bridges, dentures).
- Plastic repair of the mouth or lip necessary to correct traumatic Injuries or Congenital Anomalies that will lead to functional impairments
- Oral/surgical correction of accidental Injuries as indicated in the "Dental Services" section.
- Treatment of non-dental lesions, such as removal of tumors and biopsies.
- Incision and drainage of infection of soft tissue not including odontogenic cysts or abscesses.

Orthognathic Surgery

Orthognathic surgery to repair or correct a severe facial deformity or disfigurement that orthodontics alone cannot correct, provided:

- The deformity, disfigurement or severe Congenital Anomaly is accompanied by a documented clinically significant functional impairment, and there is a reasonable expectation that the procedure will result in meaningful functional improvement
- The orthognathic surgery is Medically Necessary as a result of tumor, trauma, disease

Repeat or subsequent orthognathic surgeries for the same condition are covered only when the previous orthognathic surgery met the above requirements, and there is a high probability of significant additional improvement as determined to be Medically Necessary by the Claims Administrator.

Other Covered Health Services

Your Plan provides the following services when Medically Necessary:

- Chemotherapy and radioisotope, radiation, and nuclear medicine therapy
- Diagnostic X-ray and laboratory procedures

- Dressings, splints, and casts when provided by a Physician
- Lymphedema treatment
- Obstructive sleep apnea diagnosis and treatment
- Oxygen, blood and components, and administration
- Naturopathy services received in a Provider's office
- Pacemakers and electrodes
- Use of operating and treatment rooms and equipment

Out-of-Network Free-Standing Surgical Facility

Any services rendered or supplies provided while you are a patient or receiving services at or from a Free-Standing Surgical Facility that is an Out-of-Network Provider will be payable at the Maximum Reimbursable Charge and are subject to any required Copayments, Coinsurance or Deductibles.

Outpatient Laboratory Services, CT Scans, and MRIs

Covered Health Services include X-rays, laboratory services, ultrasounds (including routine pregnancy-related ultrasounds), magnetic resonance imaging (MRI), including magnetic resonance angiography (MRA), and computerized axial tomography (CAT) scan. Certain services require Prior Authorization or precertification.

Outpatient Hospital Services

The Plan provides the following Outpatient services when Medically Necessary: pre-admission tests, surgery, diagnostic X-rays, and laboratory services. Charges from an Outpatient department of a Hospital that is a Network Provider or a Freestanding Ambulatory Facility that is a Network Provider are covered at regular Plan Benefits. Benefits for treatment at a Hospital that is an Out-of-Network Provider are explained under "Hospital Services." Certain procedures require Prior Authorization or precertification.

Outpatient Short-Term Rehabilitation

- Physical Therapy, Speech and Hearing Therapy, Cognitive Therapy and Occupational Therapy are covered at 60 days per Plan Year per type of therapy, not combined with any other therapy. Includes Speech, Physical and Occupational therapy for Autism Spectrum Disorders and developmental delays
- Pulmonary rehabilitation limited to 18 days per Plan Year, not combined with any other therapy
- Cardiac rehabilitation limited to 36 days per Plan Year, not combined with any other therapy
- Vision therapy, limited to 16 visits per Plan Year, not combined with any other therapy

Note that all visit maximums are combined for Network Providers and Out-of-Network Providers.

Physician Services

You may receive treatment from a Network Provider or Out-of-Network Provider. However, payment is significantly reduced if services are received from an Out-of-Network Provider. Such services are subject to your Deductible and any Copayment/Coinsurance. Office and home visits are covered.

Prescription Drugs

For coverage information, see Chapter 7, "Pharmacy Benefits."

Preventive Services

Preventive services include screenings and other services for adults and Children. All recommended

preventive services will be covered as required by the Affordable Care Act (ACA). This means many Preventive Care services are covered with no Deductible, Copayments, or Coinsurance when you use a Network Provider.

Certain Benefits for Members who have current symptoms or a diagnosed health problem may be covered under diagnostic services instead of this Benefit, if the coverage does not fall within ACA- recommended preventive services.

Covered Health Services fall under the following broad groups:

- Services with an "A" or "B" rating from the United States Preventive Services Task Force. Examples of these services are screenings for:
  - Breast cancer
  - Cervical cancer
  - Colorectal cancer
  - High blood pressure
  - Type 2 Diabetes Mellitus
  - Cholesterol
  - Child and adult obesity
- Immunizations for Children, adolescents, and adults recommended by the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention
- Preventive Care and screenings for infants, Children, and adolescents as provided for in the comprehensive guidelines supported by the Health Resources and Services Administration
- Preventive Care and screening for women as listed in the guidelines supported by the Health Resources and Services Administration, including the following:
  - Women's contraceptives, sterilization procedures, and counseling. Coverage includes contraceptive devices such as diaphragms, intra uterine devices (IUDs), and implants.
  - Breastfeeding support, supplies and counseling
  - Gestational diabetes screening
- Preventive Care services for tobacco cessation for Members age 18 and older as recommended by the United States Preventive Services Task Force including counseling
- Bowel preparations.

Please note that certain age and gender and quantity limitations apply.

Preventive services may change per Plan Year according to federal guidelines in effect as of January 1 of each year. For a comprehensive list of Preventive Care services, please visit *uspreventiveservicestaskforce.org*.

You may call Member Services using the number on your Identification Card for additional information about these services.

PROSTHETIC APPLIANCES

Prosthetic devices to improve or correct conditions resulting from Accidental Injury or illness are covered if Medically Necessary and ordered by a Physician.

Prosthetic devices include: artificial limbs and accessories; artificial eyes, one pair of glasses or contact lenses for eyes used after surgical removal of the lens of the eye(s); arm braces; leg braces (and attached shoes); cochlear implants; and external breast prostheses used after breast removal.

Replacement of artificial limbs and eyes are covered if required due to a change in the patient's physical condition or if a replacement is less expensive than repair of existing equipment.

Wigs and artificial hairpieces are covered, but only after chemotherapy or radiation therapy (limited to

$700 per Plan Year).

The following items are excluded: corrective shoes; dentures; replacing teeth or structures directly supporting teeth (except to correct traumatic Injuries); electrical or magnetic continence aids (either anal or urethral); and implants for cosmetic purposes except for reconstruction following a mastectomy.

Reconstructive Surgery

Charges made for reconstructive surgery or therapy to repair or correct a severe physical deformity or disfigurement which is accompanied by functional deficit; (other than abnormalities of the jaw or conditions related to TMJ disorder) provided that: the surgery or therapy restores or improves function; reconstruction is required as a result of Medically Necessary, non-cosmetic surgery; or the surgery or therapy is performed prior to age 19 and is required as a result of the congenital absence or agenesis (lack of formation or development) of a body part. Repeat or subsequent surgeries for the same condition are covered only when there is the probability of significant additional improvement as determined by the utilization review Physician.

Note: Coverage for reconstructive services does not apply to orthognathic surgery. See the “Orthognathic Surgery” section above for that Benefit.

Reproductive Health Services

Contraceptive Benefits

Benefits include, but are not limited to, oral contraceptive drugs, injectable, contraceptive drugs and patches. Benefits also include contraceptive devices such as diaphragms, intra uterine devices (IUDs) and implants. Certain contraceptives are covered under the “Preventive Services” Benefit. Certain contraceptives may be covered under your pharmacy Benefit.

Sterilization Services

Benefits include sterilization services and services to reverse a non-elective sterilization that resulted from an illness or Injury. Reversals of elective sterilizations are not covered. Sterilizations for women are covered under the “Preventive Services” Benefit.

Termination of Pregnancy

Your Plan includes Benefits for a therapeutic termination of pregnancy, which is a termination recommended by a Provider that is performed to save the life or health of the mother, or as a result of incest or rape. Your Plan also provides Benefits for an elective (voluntary) termination of pregnancy, which is performed for reasons other than those described above.

Infertility Coverage

Your Plan also includes Benefits for the diagnosis and treatment of infertility. Covered Health Services include diagnostic and exploratory procedures to determine whether a Member suffers from infertility. This includes surgical procedures to correct a diagnosed disease or condition affecting the reproductive organs. This includes, but is not limited to, endometriosis, (tissue lining the uterus moves to other parts of the body), collapsed/clogged fallopian tubes or testicular failure. Covered fertilization services including artificial insemination, in-vitro fertilization, GIFT (gamete intra-fallopian transfer), or ZIFT (zygote intra-fallopian transfer) procedures.

There is a lifetime Benefit Maximum of $10,000 for services covered under your health Plan and a lifetime Benefit Maximum of $10,000 for services covered under your prescription drug Plan. Your cost shares and Deductibles do not count against your Benefit Maximums.

Infertility Prescription Drugs

Freedom Fertility Pharmacy, part of the Express Scripts family of specialty pharmacies, is dedicated solely to the needs of fertility patients. A team of highly-trained fertility pharmacists are available 24 hours a day, seven days a week to meet the fertility prescription drug needs of our Members.

You can contact Freedom Fertility by calling (800) 660-4283 or visiting its website at *freedomfertility.com*.

RETAIL HEALTH CLINIC

Benefits are provided for Covered Health Services received at a Retail Health Clinic.

SKILLED NURSING FACILITY CARE/REHABILITATION HOSPITAL

Benefits are provided as outlined in the Summary of Benefits and Coverage. This care must be ordered by the attending Physician. All Skilled Nursing Facility and rehabilitation Hospital admissions must be pre-certified.

Covered Health Services include:

- Semiprivate Room or ward room Charges including general nursing service, meals, and special diets. If a Member stays in a private room, this Plan pays the Semiprivate Room rate toward the Charge for the private room
- Use of special care rooms
- Pathology and radiology
- Physical or speech therapy
- Oxygen and other gas therapy
- Drugs and solutions used while a patient
- Gauze, cotton, fabrics, solutions, plaster, and other materials used in dressings, bandages, and casts
- This Benefit is available only if the patient requires a Physician's continuous care and 24 hour-a-day nursing care

Benefits will not be provided when:

- A Member reaches the maximum level of recovery possible and no longer requires other than routine care
- Care is primarily Custodial Services, not requiring definitive medical or 24 hour-a-daynursing service
- No specific medical conditions exist that require care in a Skilled Nursing Facility
- The care rendered is convalescent care

SMOKING CESSATION

Smoking cessation services are covered, including counseling.

SURGICAL CARE

Surgical procedures including the usual pre- and post-operative care. Some procedures may require Prior Authorization or precertification.

URGENT CARE

Urgent Care is defined as care that requires prompt attention to avoid adverse consequences but does not pose an immediate threat to a person's life. Urgent Care is usually delivered in a walk-in setting and without

an appointment. Services may be received at an Urgent Care center, a clinic, or a Physician's office.

Sometimes, you have a need for medical care that is not an emergency (e.g. bronchitis, high fever, sprained ankle), but can't wait for a regular appointment. If you need Urgent Care, try to contact your Physician or your Physician's backup. You can also call Cigna for advice, 24 hours a day, 7 days a week.

CHAPTER 6
MEDICAL EXCLUSIONS AND LIMITATIONS

Cigna will not provide Benefits for any of the services, treatments, items, or supplies described in this chapter, regardless of Medical Necessity or recommendation of a Provider. This list is intended to give you a description of services and supplies not covered by Cigna but is not intended to be all-inclusive. Some of the services listed in this chapter as not covered by Cigna may be covered by your pharmacy, dental, or vision Plans.

ADMISSIONS FOR NON-INPATIENT SERVICES

Admission or continued Hospital or Skilled Nursing Facility stay for medical care or diagnostic studies not medically required on an Inpatient basis.

ADMINISTRATIVE CHARGES

Charges for failure to keep a scheduled visit; completion of claim forms or medical records or reports unless otherwise required by law; for Physician or Hospital's stand-by services, for holiday or overtime rates; membership, administrative, or access fees charged by Physicians other than Providers (e.g. educational brochures or calling a patient to provide test results); specific medical reports including those not directly related to the treatment of the Member (e,g. employment or insurance physicals, reports prepared in connection with litigation).

BEFORE COVERAGE BEGINS/AFTER COVERAGE ENDS

Services rendered or supplies provided before coverage begins (i.e., before a Member's effective date of coverage) or after coverage ends.

BLOOD

Cord blood storage and fees associated with the collection or donation of blood or blood products, except for autologous donation in anticipation of scheduled services where in the utilization review Physician's opinion the likelihood of excess blood loss is such that transfusion is an expected adjunct to surgery.

Blood administration for the purpose of general improvement in physical condition.

CERTAIN PROVIDERS

Services you get from a Provider that is not licensed by law to provide Covered Health Services, Christian Science Practitioners, and separate charges for interns, residents, house Physicians or other health care professionals who are employed by the covered Facility. Examples include, but are not limited to, masseurs or masseuses (massage therapists) and physical therapist technicians.

COMFORT AND CONVENIENCE ITEMS

Personal comfort items such as those that are furnished primarily for your personal comfort or convenience, including those services and supplies not directly related to medical care, such as guest's meals and accommodations, barber services, telephone charges, radio and television rentals, homemaker services, travel expenses, home remodeling to accommodate a health need, and take- home supplies.

Cosmetic Services

Treatments, services, prescription drugs, equipment or supplies given for cosmetic purposes. Cosmetic Services are meant to preserve, change, or improve how you look or are given for social reasons. No Benefits are available for surgery or treatments to change the texture or look of your skin or to change the size, shape, or look of facial or body features (such as your nose, eyes, ears, cheeks, chin, chest, or breasts). This exclusion does not apply to reconstructive surgery for breast symmetry after a mastectomy and surgery to correct birth defects and birth abnormalities.

Court-Ordered Services

Services required by a court order as a condition of parole or probation (unless Medically Necessary and approved by the Plan).

Crime and Incarceration

Care received while incarcerated in a Federal, state, or local penal institution or required while in custody of Federal, state, or local law enforcement authorities unless otherwise required by law or regulation.

Custodial Care and Rest Care

Custodial Services, domiciliary care, rest cures, or travel expenses even if recommended for health reasons by a Physician. Inpatient room and board charges in connection with a Hospital or Skilled Nursing Facility stay primarily for environmental change, Physical Therapy, or treatment of chronic pain.

Daily Room Charges

Daily room charges while the Plan is paying for an Intensive Care Unit, cardiac care, or other special care unit.

Dental Care

Dental care and treatment and oral surgery (by Physicians or dentists) including dental surgery (with the exception of the removal of impacted wisdom teeth); dental appliances; dental prostheses such as crowns, bridges, or dentures; implants; orthodontic care; operative restoration of teeth (fillings); dental extractions; endodontic care; apicoectomies; excision of radicular cysts or granuloma; treatment of dental caries, gingivitis, or periodontal disease by ginivectomies or other periodontal surgery, vestibuloplasties; alveoplasties; dental procedures involving teeth and their bone or tissue supporting structures, frenulectomy. Any treatment of teeth, gums, or tooth-related service except otherwise specified as covered in this Plan Document Handbook.

Educational Services

Educational services for remedial education including evaluation or treatment of learning impairments, minimal brain dysfunctions, learning disorders, behavioral training, and cognitive rehabilitation. This includes educational services, treatment or testing and training related to behavioral problems, including but not limited to, services for conditions related to autistic disease of childhood (except to the same extent that the Plan provides for neurological disorders and Applied Behavioral Analysis), hyperkinetic syndromes, including attention deficit disorder and attention deficit hyperactivity disorder, learning disabilities, behavioral problems, and mental and intellectual disability special education, including lessons in sign language to instruct a Member, whose ability to speak has been lost or impaired, to function without that ability, is not covered.

EXCESSIVE EXPENSES

Expenses in excess of the Plan's Maximum Reimbursable Charge.

EXPENSES INCURRED OUTSIDE OF THE UNITED STATES

Expenses incurred outside the United States other than expenses for Medically Necessary urgent or emergent care while temporarily traveling abroad.

EXPERIMENTAL, INVESTIGATIONAL AND UNPROVEN SERVICES

Treatments, procedures, equipment, drugs, devices, or supplies (hereafter called "services") which are, in the Claims Administrator's judgment, Experimental, Investigational and Unproven (as such term is defined in Chapter 14, "Glossary") for the diagnosis for which the Member is being treated. An Experimental, Investigational and Unproven service is not made eligible for coverage by the fact that other treatment is considered by a Member's Physician to be ineffective or not as effective as the service or that the service is prescribed as the most likely to prolong life.

FAMILY MEMBERS

Services rendered by a Provider who is a close relative or member of your household. Close relative means wife or husband, parent or grandparent, Child, brother or sister, by blood, marriage (including in-laws) or adoption.

FOOT CARE

Foot care only to improve comfort or appearance, routine care of corns, calluses, toenails (except surgical removal or care rendered as treatment of the diabetic foot or ingrown toenail), flat feet, fallen arches, weak feet, chronic foot strain, or asymptomatic complaints related to the feet. Coverage is available, however, for Medically Necessary foot care required as part of the treatment of diabetes, for Members with peripheral vascular or circulatory disease, and for severe foot Injury.

FREE SERVICES

Services and supplies for which you have no legal obligation to pay, or for which no charge has been made or would be made if you had no health insurance coverage.

GENETIC SCREENING

Genetic screening or pre-implantations genetic screening. General population-based genetic screening is a testing method performed in the absence of any symptoms or any significant, proven risk factors for genetically linked inheritable disease.

GOVERNMENT PROGRAMS

Treatment where payment is made by a local, state, or Federal government (except Medicaid), or for which payment would be made if the Member had applied for such Benefits. Services that can be provided through a government program for which you as a Member of the community are eligible for participation. Such programs include, but are not limited to, school speech and reading programs.

HAIR

Hair transplants, wig maintenance, or prescriptions or medications related to hair growth.

Health Spa

Expenses incurred at a health spa or similar Facility.

Hearing Aid Replacements, Batteries, and Repairs

Expenses incurred for hearing aid replacements, batteries, and repairs are not covered.

Illegal Services

Treatments, procedures, equipment, drugs, devices, supplies or any other plan benefit, in each case, that are illegal under applicable law.

Inpatient Rehabilitation Programs

Inpatient rehabilitation in the Hospital or Hospital-based rehabilitation Facility, when the Member is medically stable and does not require skilled nursing care or the constant availability of a Physician or:

- The treatment is for Maintenance Care; or
- The Member has no restorative potential; or
- The treatment is for congenital learning or neurological disability/disorder; or
- The treatment is for communication training, educational training, or vocational training

Maintenance Care

Services which are solely performed to preserve the present level of function or prevent regression of functions for an illness, Injury, or condition which is resolved or stable.

Maternity Care

Cord blood storage, days in the Hospital that are not Medically Necessary, parenting, prenatal, or birthing classes, Lamaze classes, and services provided by a doula (labor aide).

Never Events

The Plan will not pay for errors in medical care that are clearly identifiable, preventable, and serious in their consequences for patients, which indicate a problem exists in the safety and credibility of a Facility. The Provider will be expected to absorb such costs. This exclusion includes, but is not limited to, such errors as operating on the wrong side of the body, operating on the wrong part of the body, using the wrong procedure, or operating on the wrong patient.

Not Medically Necessary Services

Care, supplies, or equipment not Medically Necessary, as determined by the Claims Administrator, for the treatment of an Injury or illness. This includes, but is not limited to, care which does not meet the Claims Administrator's medical policy, clinical coverage guidelines, or benefit policy guidelines.

Nutrition and Weight Loss Treatment and Services

Any services or supplies for the treatment of obesity, including but not limited to, weight reduction, medical care or prescription drugs, or dietary control (except as related to covered nutritional counseling); nutritional supplements, services, supplies and/or nutritional sustenance products (food) related to enteral feeding except when it's the sole means of nutrition; food supplements; electrolyte formulas; any services or supplies that involve weight reduction as the main method of treatment, including medical or counseling; weight loss

programs including, but not limited to, commercial weight loss programs (Weight Watchers, Jenny Craig, and LA Weight Loss), nutritional supplements, appetite suppressants, and supplies of a similar nature. This exclusion does not apply to bariatric surgery when approved by the Plan.

OIG Excluded Drugs

Any service, drug, drug regimen, treatment, or supply, furnished, ordered, or prescribed by a Provider identified as an excluded individual or entity on the U.S. Department of Health and Human Services Office of Inspector General List of Excluded Individuals/Entities (OIG List), the General Services Administration System for Award Management (GSA List), State Medicaid exclusion lists or other exclusion/sanctioned lists as published by Federal or state regulatory agencies. This exclusion does not apply to emergency care.

Prescription Drugs

Refer to Chapter 7, “Pharmacy Benefits,” for exclusions under the pharmacy Benefit.

Private Duty Nursing

Except when provided through the Home Health Care benefit.

Private Rooms

Reimbursement for private rooms is excluded. See the “Hospital Services” section of Chapter 5, “Coverage” for more information.

Reproductive Services

Collection and storage of semen, fees or direct payment to a donor for sperm or ovum donations, monthly fees for maintenance and/or storage of frozen embryos, oral contraceptives (these may be covered under your pharmacy Benefit), reversal of voluntary sterilization, and surrogate parenting.

Research Screenings

For examinations related to research screenings, unless required by law.

Residential Accommodations

Residential accommodations to treat medical or behavioral health conditions, *except when provided in a Hospital, Hospice, Skilled Nursing Facility, or Residential Treatment Center*. This exclusion includes procedures, equipment, services, supplies or charges for the following:

a. Domiciliary care provided in a residential institution, treatment center, halfway house, or school because a Member’s own home arrangements are not available or are unsuitable, and consisting chiefly of room and board, even if therapy is included.
b. Care provided or billed by a hotel, health resort, convalescent home, rest home, nursing home, or other extended care Facility home for the aged, infirmary, school infirmary, institution providing education in special environments, supervised living or halfway house, or any similar Facility or institution.
c. Services or care provided or billed by a school, Custodial Services center for the developmentally impaired or outward bound programs, even if psychotherapy is included.

Routine Examinations

Routine physical examinations, screenings procedures, and immunizations necessitated by employment,

foreign travel, recreational camps, or retreats or any insurance program which are not called for by known symptoms and illness or Injury except those which may be specifically listed as covered in this Plan Document Handbook.

Safe Surroundings

Care furnished to provide a safe surrounding, including the charges for providing a surrounding free from exposure that can worsen the disease or Injury.

Shoes and Orthotics

Shoe inserts (except when prescribed by a Physician for diabetes, peripheral vascular or circulatory disease, or a severe Injury when deemed Medically Necessary), and orthopedic shoes (except when an orthopedic shoe is joined to a brace).

Spider Veins

Treatment of telangiectatic dermal veins (spider veins) by any method.

Supplies or Equipment (Including Durable Medical Equipment) Not Medically Necessary

Supplies or equipment not Medically Necessary for the treatment of an Injury or illness. Items that are considered not Medically Necessary include, but are not limited to any of the following situations:

1. The item is intended to be used for athletic, exercise, or recreational activities as opposed to assisting the individual in the activities of daily living; or
2. The item is intended for environmental control or a home modification (for example, electronic door openers, air cleaners, ramps, elevators, stair glides, wheelchair attachments or accessories for stair-climbing, etc.); or
3. The item includes an additional feature or accessory, or is a non-standard or deluxe item that is primarily for the comfort and convenience of the individual (for example, customized options on wheelchairs, hand controls to drive, electric vehicle lifts for wheelchairs, etc.); or
4. The item is specifically designed for outdoor use (for example, specially designed manual wheelchairs for beach access, specially designed power mobility devices for rough terrain, manual wheelchairs for sports, etc.); or
5. The item represents a duplicative piece of equipment that is intended to be used as a backup device, for multiple residences, or for traveling, etc. (for example, back-up manual wheelchair when a power wheelchair is the individual's primary means of mobility, a second wheeled mobility device specifically for work or school use, car seats); or
6. The item represents a product upgrade to a current piece of equipment that is either fully functional or replacement of a device when the item can be cost-effectively repaired.

Aids or devices that assist with non-verbal communications, including but not limited to communication boards, prerecorded speech devices, laptop computers, desktop computers, Personal Digital Assistants (PDAs), Braille typewriters, visual alert systems for the deaf, and memory books.

Durable Medical Equipment items that are not covered include but are not limited to those that are listed below:

- Bed Related Items: bed trays, over the bed tables, bed wedges, pillows, custom bedroom equipment, mattresses, including nonpower mattresses, custom mattresses and posturepedic mattresses.
- Bath Related Items: bath lifts, nonportable whirlpools, bathtub rails, toilet rails, raised toilet seats, bath benches, bath stools, hand held showers, paraffin baths, bath mats, and spas.

- Fixtures to Real Property: ceiling lifts and wheelchair ramps.
- Car/Van Modifications.
- Air Quality Items: room humidifiers, vaporizers and air purifiers.
- Other Equipment: centrifuges, needleless injectors, heat lamps, heating pads, cryounits, cryotherapy machines, ultraviolet cabinets, that emit Ultraviolet A (UVA) rays sheepskin pads and boots, postural drainage board, AC/DC adaptors, scales (baby and adult), stair gliders, elevators, saunas, cervical and lumbar traction devices, exercise equipment and diathermy machines.

THERAPY SERVICES

Services for Outpatient therapy or rehabilitation other than those specifically listed as covered in the Plan Document Handbook. Excluded forms of therapy include, but are not limited to: vestibular rehabilitation, primal therapy, chelation therapy, cranial sacral therapy, rolfing, psychodrama, megavitamin therapy, purging, wilderness therapy, boot camp therapy, hardening programs, dance therapy, movement therapy, applied kinesiology, return to work services, work hardening programs, driver safety courses, recreational therapy, aversion therapy, bioenergetics therapy, in-home wrap around therapy, electromagnetic therapy, salabrasion, chemosurgery, and other such skin abrasion procedures associated with the removal of scars, tattoos, actinic changes which are performed as a treatment for acne.

TRANSPORTATION

Transportation provided by other than a state licensed professional Ambulance Service, and Ambulance Services that are not Medically Necessary. Transportation to another area for medical care is also excluded except as stated in this Plan Document Handbook. Ambulance transportation from the Hospital to the home is not covered.

THERMOGRAMS AND THERMOGRAPHY

VISION CARE

Vision care services and supplies, including but not limited to: eyeglasses, contact lenses, and related examinations and services. Analysis of vision or the testing of its acuity except as otherwise indicated in the Plan Document Handbook. Services or devices to correct vision or for advice on such services. This exclusion does not apply to orthoctic training; or for initial prosthetic lenses or sclera shells following intraocular surgery, or for soft contact lenses due to a medical condition such as diabetes.

VISION SURGERIES

Related to radial keratotomy or keratomileusis or excimer laser photo refractive keratectomy; and surgery, services, or supplies for the surgical correction of nearsightedness and/or astigmatism or any other correction of vision due to a refractive problem.

WAIVED COST SHARE OUT-OF-NETWORK

For any service for which you are responsible under the terms of this Plan to pay a Copayment, Coinsurance, or Deductible, and the Copayment, Coinsurance, or Deductible is waived by an Out-of- Network Provider.

WAIVED FEES

Any portion of a Provider’s fee or charge which is ordinarily due from a Member but which has been waived. If a Provider routinely waives (does not require the Member to pay) a Deductible or out-of-pocket expenses, the Claims Administrator will calculate the actual Provider fee or charge by the amount waived.

War/Military Duty

Any disease or Injury resulting from a war, declared or not, or any military duty or any release of nuclear energy. Also excluded are charges for services directly related to military service provided or available from the Department of Veterans Affairs or military Facilities except as required by law.

Workers' Compensation

Care for any condition or Injury recognized or allowed as a compensable loss through any workers' compensation, occupational disease or similar law. If Workers' Compensation Act Benefits are not available to you, this exclusion does not apply. This exclusion applies if you receive Benefits in whole or in part. This exclusion also applies whether or not you claim the Benefits or compensation. It also applies whether or not you recover from any third party.

CHAPTER 7
PHARMACY BENEFITS

The prescription drug Benefit is administered by Express Scripts and is separate from the other components of your medical Plan. There are three ways to fill your prescriptions. You can use one of many participating retail pharmacies nationwide, home delivery (for long-term needs), or any nonparticipating retail pharmacy. You will receive the highest possible Benefit under the prescription drug program when you purchase medications at a participating retail pharmacy (you must present your ID Card) or through the mail-order pharmacy. Additional information about the prescription drug program, including the location of participating pharmacies in your area, is available through the Express Scripts website at *express- scripts.com* or their Member Services department at (800) 841-3361.

You must present your ID Card when receiving drugs and services from a network pharmacy. The network pharmacy will verify eligibility. You will be required to pay any applicable Deductibles or Copayments at the time the prescription is obtained. The pharmacist should notify you if a generic drug is available; however, it is in your best interest to also ask the pharmacist about generic equivalents that may be available. To obtain maximum Benefits from the program, you should usually choose generic drugs when available.

DRUG FORMULARY

Express Scripts includes a Formulary Management Program designed to control costs for you and the Plan. The formulary includes all U.S. Food and Drug Administration (FDA)-approved drugs that have been placed in tiers based on their clinical effectiveness, safety, and cost. Tier 1 includes generic drugs; Tier 2 includes preferred brand-name drugs; and Tier 3 includes non-preferred brand-name drugs and non- sedating antihistamines.

You should share the formulary with your Physician or practitioner when they prescribe a drug, and encourage them to prescribe a generic or preferred drug if possible. By choosing generic or preferred brand-name drugs, you may decrease your out-of-pocket expenses. While all currently FDA-approved drugs are included on the formulary list, your Plan may elect to exclude some drugs. Please review “What’s Covered” and “What’s Not Covered” in this section for further information on exclusions.

It is always up to you and your Physician to decide which prescriptions are best for you. You are never required to use generic drugs or drugs that are on the Express Scripts formulary list. If you prefer, you can use non-preferred brand-name drugs and pay a higher cost share.

It is also important to note that drugs included on the formulary list are routinely updated. To find the most up-to-date list of covered drugs, visit Express Scripts at *express-scripts.com*, or call their Member Services department at (800) 841-3361. It should be noted that all drugs listed on the formulary may not be covered due to Plan exclusions and limitations.

GENERIC MEDICATIONS

Generic medications and their brand-name counterparts have the same active ingredients and are manufactured according to the same strict federal regulations.

Generic drugs may differ in color, size, or shape, but the FDA requires that the active ingredients have the same strength, purity, and quality as their brand-name counterparts.

For this reason, the Plan will cover the cost of the generic equivalent if you purchase a brand-name medication when there is a generic available. You will be charged the generic Copayment and the cost difference between the brand-name and the generic medication.

If you have questions or concerns about generic medication, speak to your Physician or your pharmacist, and they will be able to help you.

WHAT'S COVERED

The following is intended to provide a general description of covered drugs and supplies under the retail and home delivery pharmacy programs. All FDA-approved drugs requiring a prescription to dispense are covered, unless specifically excluded under this Plan:

- Diabetic supplies
- Federal legend drugs (all drugs approved by the FDA and that require a prescription), except those listed under "What's Not Covered" in this chapter
- Insulin
- Legend contraceptive medications—oral, injectable, patch, ring
- Legend smoking cessation treatment
- Needles and syringes
- Over-the-counter and legend prenatal vitamins

Brand non-sedating antihistamine drugs will be paid as non-preferred, regardless of the drug's formulary status as preferred or non-preferred.

COVERAGE MANAGEMENT PROGRAMS

Some medications are covered only for specific medical conditions or for a specific quantity and duration. An Express Scripts pharmacist, in cooperation with your Physician, determines coverage based on clinical guidelines and the manufacturer's specifications to review the appropriateness of the medication, dosage, and duration prescribed for certain conditions.

Coverage Management Programs help ensure the appropriateness of coverage for specific drugs and specific amounts of drugs. The following programs are included:

- *Traditional prior authorization (TPA)*—Requires the Member to obtain pre-approval through a coverage review. A coverage review is performed to determine whether the use of the medication qualifies for coverage.
- *Smart prior authorization (SPA)*—For some medications, a set of rules, called Smart Rules™, is automatically implemented to determine if the medication qualifies for coverage.
- By applying factors that are on file with Express Scripts, such as the Member's medical history, drug history, age, or sex, Smart Rules can often eliminate the need for a coverage review. If the claim is rejected, a coverage review can be initiated.
- *Step Therapy*—Step Therapy rules encourage appropriate use of medications.
- *Dose and Quantity Duration*—Encourage appropriate dosing over the course of therapy. Coverage is determined based on drug history. Quantity duration rules limit coverage for certain quantities of medications within a defined time period. A prescription that exceeds the dosage or quantity allowed will require coverage review.
- *Dispensing quantity*—The quantity of drug covered for each Copayment is based primarily on the common uses of a drug and how frequently the drug is administered (e.g., episodic use (migraine therapy); chronic use (antihypertensive therapy); or defined course of therapy use (anti-infective therapy).
- *Dose optimization*—Rules focus on switching those Members currently taking two tablets or capsules a day to taking one a day of the higher strength. The medications in this program are generally dosed once daily and are priced similarly across most strengths by the manufacturer. This voluntary program notifies the Member that a single strength is available.

If your prescription requires review or authorization, Express Scripts will work with you, your pharmacist, and your Physician to determine if the medication, as prescribed by your Physician, is covered under the prescription drug program.

If you have any questions regarding coverage of a specific drug, please check the Express Scripts website or call the Member Services department.

WHAT'S NOT COVERED

The Plan will not provide Benefits for any of the items listed in this section, regardless of Medical Necessity or a prescription from a Provider:

- Compounded medications
- Medication for which the cost is recoverable under any workers' compensation or occupational disease law, or from any state or governmental agency
- Medication for which there is no legal obligation to pay, or medication furnished by a drug or medical service for which no charge is made to the individual
- Medication that is to be taken by or administered to an individual, in whole or in part, while they are a patient in a licensed Hospital, rest home, sanitarium, extended care Facility, Skilled Nursing Facility, convalescent Hospital, nursing home, or similar institution that operates on its premises, or allows to be operated on its premises, a Facility for dispensing pharmaceuticals
- Non-federal legend drugs
- Any prescription refilled in excess of the number of refills specified by the Physician or practitioner, or any refill dispensed after one year from the Physician's or practitioner's original order
- Drugs whose sole purpose is to promote or stimulate hair growth (e.g., Rogaine or Propecia) or for cosmetic purposes only (e.g., Renova or Vaniqa)
- Drugs labeled "Caution: Limited by federal law to investigational use" or other Experimental, Investigational and Unproven drugs, even though a charge is made to the individual
- Certain immunization agents
- Blood products
- Immune globulins
- Topical dental fluorides
- Therapeutic devices or appliances
- Mifeprex
- Contraceptive devices
- Drugs to treat impotency for females only
- Yohimbine
- Lamisil
- Seasonale at a retail pharmacy

This is not an exhaustive list of exclusions. If you have any questions regarding coverage of a specific drug, please check the Express Scripts website or call the Member Services department.

USING A RETAIL PHARMACY

When you need a drug for a limited time, use a participating retail pharmacy to maximize your Benefits.

For maintenance medications, the retail pharmacy program allows for a total of three fills at a retail pharmacy (one original fill and two refills). Maintenance medications are prescriptions commonly used to treat conditions that are considered chronic or long-term. These conditions usually require regular, daily use of medicines. Examples of maintenance medications are those used to treat high blood pressure, heart disease, asthma, and diabetes. Additional fills will not be covered by the Plan. Each fill can be for no more than a 30-day supply. Note that you are allowed a total of three fills, even if each is for less than 30 days.

The amount you pay for prescription drugs depends on whether you use an Express Scripts participating retail pharmacy or a nonparticipating pharmacy. At a participating pharmacy, there are
no claim forms to file; you simply pay your portion at the pharmacy. Please refer to the Summary of Benefits and Coverage for details about retail Copayments.

At a nonparticipating pharmacy, you must pay in full for your prescription and submit a claim for reimbursement. If the pharmacy charges you more than the allowed amount (based on pricing at a participating pharmacy), you will be reimbursed based on the allowed amount minus the Copayment. You should mail your claims for reimbursement to the address on the form.

Any reimbursement will be sent directly to you and made according to the Plan's prescription drug Benefit, as

outlined on the Summary of Benefits and Coverage. If any request for reimbursement is denied or reduced other than for Copayments, please refer to the appeal provisions in the Chapter 8, "Claims and Appeals."

USING HOME DELIVERY

Home delivery should be used for maintenance medications. You can receive up to a 90-day supply of medication for one Copayment. Prescriptions must be filled as prescribed by your Physician—refills cannot be combined to equal a 90-day supply. Please refer to the Summary of Benefits and Coverage for details about home delivery Copayments.

The prescription drug program will maintain a retail refill limit policy. The retail refill limit requires that you use home delivery if you are prescribed a maintenance medication, rather than refilling multiple prescriptions for the same drug at a retail pharmacy. If you or a covered Dependent receives a prescription for a maintenance medication, and you do not use home delivery, your prescriptions may not be covered.

In some circumstances, you may not be required to use home delivery. For example, there are several categories of medications that are uniquely appropriate for multiple refills at your local pharmacy (and are therefore exempt from the retail refill limit provision, as outlined above).

If you have a prescription for any of the following medications, the Express Scripts prescription drug program allows you to receive multiple refills at your local retail pharmacy:

- Anti-infectives, including antibiotics (Amoxicillin, Biaxin), antivirals (Zovirax, Famvir), antifungals (Diflucan), and drops used in the eyes and ears (Polysporin Ophth, Cipro Otic). Please note that drops must be prescribed specifically to treat infection. For example, glaucoma drops are not covered.
- Prescription cough medications, including Phenergan with Codeine, Tessalon, and Tussionex.
- Medications to treat acute pain, both narcotic (Vicodin, Percodan, etc.) and non-narcotic (Darvocet). Please note that long-term pain medications, such as NSAIDs, do not meet the necessary retail requirements.
- Medications that require a new written prescription each time you need them, as refills are prohibited by federal law (e.g., Percodan, Ritalin, and Nembutal)
- Medications used to treat both attention deficit disorder (Ritalin, Cylert) and narcolepsy (Dexedrine)

To order medications from home delivery, simply log on to the Express Scripts website to request that the pharmacist contact your Physician (to order prescriptions, you must be a registered Member for security reasons). You will need to confirm your information and provide the contact information for your Physician. If you prefer, you can have your Physician call (888) 327-9791 for instructions to fax your prescription. You will receive your medication in approximately seven to ten days. If you have a written prescription to mail in, you will need to complete an order form (available from the Express Scripts website or by calling their Member Services department) to include with your prescription. The prescription and order form should be mailed to the address on the form.

Once you have initiated your prescription delivery through mail-order, you can request refills online or via the Member Services department. Refills requested by 12:00 noon are filled and shipped the same day.

As a temporary exception due to the COVID-19 pandemic, Express Scripts is granting CVS and Walgreens (via its Walgreens Express™ delivery program) a limited out-of-network delivery exception and will permit them to provide free home delivery of prescriptions to Express Scripts members. This exception is solely due to the COVID-19 pandemic and is a temporary exception that may be terminated by Express Scripts at any time during the 2022 Plan Year.

EXPRESS SCRIPTS SPECIAL CARE PHARMACY (ACCREDO)

Express Scripts offers enhanced pharmacy services for some conditions, such as anemia, hepatitis C, multiple sclerosis, asthma, growth hormone deficiency, and rheumatoid arthritis that are treated with specialty medications. These special services include:

- Access to Nurses who are trained in specialty medications.
- Answers to your questions about specialty medications from a pharmacist 24 hours a day, 7 days a week.

- Coordination of home care and other healthcare services.

Drug Utilization Review

When you have your prescription filled, the pharmacist and/or Express Scripts may access information about previous prescriptions electronically and check pharmacy records for drugs that conflict or interact with the medicine being dispensed. If there is a question, the pharmacist will work with you and your Physician before dispensing the medication. This is an automatic feature available only with prescriptions purchased through a participating pharmacy and the mail-order pharmacy.

SaveOnSP Copay Assistance Program

The Episcopal Church Medical Trust has collaborated with SaveOnSP to help our Members save money on certain specialty medications.

SaveOnSP works in conjunction with The Medical Trust's current pharmacy program through Express Scripts. Participants in the SaveOnSP program will continue to receive their specialty medications through Accredo, Express Scripts' specialty home delivery provider, but will receive these specialty pharmacy medications free of charge ($0). SaveOnSP will leverage manufacturer's copay assistance program to provide savings both to the participant and to The Medical Trust. The list of specialty pharmacy medications included in the program can be found at *SaveonSP.com/cpg*.

Copays for these medications will be set to the maximum available manufacturer copay assistance and will be paid through the SaveOnSP program. When participating in the SaveOnSP program, your cost will be $0. Eligible Members who choose to decline enrollment would be responsible for the full amount of the 30% coinsurance.

You are eligible to enroll in the SaveOnSP program if you are currently taking certain specialty pharmacy medications considered non-Essential Health Benefits under the Plan, or if you begin taking one of these medications at a later date, and you are enrolled in a Cigna PPO Plan. Members enrolled in a Consumer Directed Health Plan are NOT eligible to participate in the SaveOnSP program. Newly identified Members will receive a phone call from a SaveOnSP representative prior to the first fill under the program.

As these specialty medications are non-Essential Health Benefits as defined by the Affordable Care Act, the coinsurance amounts will not count towards your Deductible or Out-of-Pocket Limit, even if you choose not to enroll in the SaveOnSP program. Non-Essential Health Benefits are Benefits that do not qualify as "Essential Health Benefits" covered under the Affordable Care Act.

Enrollment in this program is voluntary. However, if a Member chooses not to enroll in the SaveOnSP program, they will be responsible for the increased coinsurance.

If you have any further questions or concerns, contact SaveOnSP at (800) 683-1074.

Emergency Pharmacist Consultation

Access to pharmacists is available 24 hours a day, 7 days a week, for emergency consultation.

Pharmacy Locator

A voice-activated system for locating participating retail pharmacies within specific zip codes is available by calling the Member Services department at (800) 841-3361. This information is also available via the website at *express-scripts.com*.

Telecommunications For the Deaf

Call (800) 759-1089. Service is available Sunday through Friday, from 8:00AM to 12:00 midnight ET and on Saturday, from 8:00AM to 6:00PM ET.

Printed Materials For the Visually Impaired

Large-print or braille labels are available upon request for prescriptions for home delivery.

Filing a Claim

See Chapter 8, “Claims and Appeals” for information on claims and appeals.

CHAPTER 8
CLAIMS AND APPEALS

This chapter describes the claims and appeals procedures for services received from Cigna, Cigna Behavioral Health, and Express Scripts.

FILING A CLAIM

There's no paperwork for Network Benefits. Just show your Identification Card and pay your share of the cost, if any; your Provider will submit a claim to Cigna for reimbursement. Claims for Out-of-Network Benefits can be submitted by the Provider if the provider is able and willing to file on your behalf. If the Provider is not submitting on your behalf, you must send your completed claim form and itemized bills to the claims address listed on the claim form.

You may get the required claim forms from the website listed on your Identification Card or by using the toll-free number on your Identification Card.

CLAIM REMINDERS

- Be sure to use your Member ID and group number when you file Cigna's claim forms, or when you call your Cigna claim office. Your Member ID and group number are on the front of your Benefit Identification Card.
- Be sure to follow the instructions listed on the back of the claim form carefully when submitting a claim to Cigna.
- Be sure to use your Member ID and account/group number when you file Cigna's claim forms, or when you call your Cigna claim office.
    - Your Member ID is the ID shown on your Benefit Identification Card.
    - Your account/group number is shown on your Benefit Identification Card.
- Be sure to follow the instructions listed on the back of the claim form carefully when submitted a claim to Cigna.

TIMELY FILING OF OUT-OF-NETWORK CLAIMS

Cigna will consider claims for coverage under our Plans when proof of loss (a claim) is submitted within 180 days for Out-of-Network Benefits after services are rendered. If services are rendered on consecutive days, such as for a Hospital Confinement, the limit will be counted from the last date of service. If claims are not submitted within 180 days for Out-of-Network Benefits, the claim will not be considered valid and will be denied.

WARNING: Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information; or conceals for the purpose of misleading, information concerning any material fact thereto, commits a fraudulent insurance act. Your Providers should file claims for you. However, if you receive Out-of-Network Benefits, you may have to file claims yourself. If your Out-of-Network Provider is unable to file electronically, you or your Providers may submit a claim form for Out-of-Network Benefits. You can find the claim forms for Cigna and Express Scripts at *cpg.org/mtdocs.*

If your Provider is unable to file one of these forms for you, you are responsible for completing and submitting it. Be sure to include the following information when you file your claim:

- Plan participant's name, social security number, and address
- Patient's name, social security number, and address, if different from the participant's
- Provider's name, tax identification number, address, degree, and signature
- Date(s) of service

- Diagnosis
- Procedure codes (describes the treatment or services rendered)
- Signed assignment of Benefits (if payment is to be made to the Provider)
- Explanation of Benefits (EOB) if another plan is the primary payer

You should submit claims for each individual Member. Please do not attach or staple claims together. If additional information is needed to process your claim, you or your Provider will be notified.

If you receive a letter regarding your claim, prompt completion and return of the letter with any requested attachments will expedite processing of the claim.

Send complete information to the appropriate Plan. Send claims for medical services to:

Cigna
PO Box 981106
El Paso, TX 79998-1106

Send claims for behavioral health services to:

Cigna Behavioral Health
PO Box 188022
Chattanooga, TN 37422

Send claims for pharmacy services to:

Express Scripts
Attn: Commercial Claims
PO Box 14711
Lexington, KY 40512-4711

Fax: (608) 741-5475

If you have any questions regarding your claim, please call the appropriate number, listed on the penultimate page of this Plan Document Handbook.

ALL CLAIMS MUST BE RECEIVED WITHIN 180 DAYS FOLLOWING THE DATE SERVICES WERE RECEIVED, OR THEY WILL BE DENIED, AND ANY AMOUNT YOU PAY WILL NOT COUNT TOWARDS YOUR OUT-OF-POCKET LIMIT.

AUTHORIZED REPRESENTATIVE

You may designate someone to act on your behalf (your "Authorized Representative"). If you wish to designate an Authorized Representative to act on your behalf in pursuing a Benefit claim or appeal, the designation must be explicitly stated in writing and it must authorize disclosure of protected health information with respect to the claim by Cigna, Cigna Behavioral Health, or Express Scripts (as appropriate), and the Authorized Representatives to one another. If a document is not sufficient to constitute a designation of an Authorized Representative, as determined by the Claims Administrator, then this Plan will not consider a designation to have been made and will not consider the claim or appeal to have been properly filed. You should carefully consider whether to designate an Authorized Representative. An Authorized Representative may make decisions independent of you, such as whether and how to appeal a claim denial.

HOW TO APPEAL A DENIAL OF BENEFITS

For purposes of these appeal provisions, "claim for Benefits" means a request for Benefits under the Plan. The term includes the following four types of claims:

- A pre-service claim is a claim for Benefits under the Plan for which you have not received the Benefit or for which you may need to obtain approval in advance.
- A concurrent care claim refers to a Plan decision to reduce or terminate a pre-approved ongoing course of treatment before the end of the approved treatment. A concurrent care claim also refers to a request by you to extend a pre-approved course of treatment.
- An urgent care claim (which can be either pre-service or concurrent) is a claim for medical care or treatment in which applying the time periods for Prior Authorization/precertification:
  - Could seriously jeopardize the life or health of the individual or the individual's ability to regain maximum function, or
  - In the opinion of a Physician with knowledge of the individual's medical condition, would subject the individual to severe pain that cannot be adequately managed without the care or treatment that is the subject of the claim, or is a claim involving urgent care.
- A post-service claim is any other claim for Benefits under the Plan for which you have received the service.

If your claim is denied:

- You will be provided with a written notice of the denial.
- You are entitled to a full and fair review of the denial.

NOTICE OF ADVERSE BENEFIT DETERMINATION

If your claim is denied (an "Adverse Benefit Determination"), the notice of the Adverse Benefit Determination (denial) will include:

- Information sufficient to identify the claim involved, including the date of service, the Provider, the claim amount (if applicable), and a statement describing the availability, upon request, of the diagnosis code and its corresponding meaning, and the treatment code and its corresponding meaning
- The specific reason(s) for the denial, including the denial code and its corresponding meaning, as well as a description of the Plan's standard, if any, that was used in the denial
- A reference to the specific Plan provisions on which the denial is based
- If your initial claim is denied, the notice will include the following:
  - A description of any additional material or information needed to perfect your claim
  - An explanation of why the additional material or information is needed
  - A description of the Plan's appeal procedures and the time limits that apply to them
- If your first level appeal is denied, the notice will include a statement describing the voluntary second level appeal and external review process offered by the Plan, if applicable, including information regarding how to initiate a second level appeal or an external review process, and your right to bring a civil action.
- Information about any internal rule, guideline, protocol, or other similar criterion relied upon in making the claim determination or a statement about your right to request a copy of such statement free of charge
- Information about the scientific or clinical judgment for any determination based on Medical Necessity or Experimental, Investigational and Unproven Services, or a statement about your right to request this explanation free of charge
- The availability of, and contact information for, any applicable office of health insurance consumer assistance or ombudsman who may assist you
- A statement that you are entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to the claimant's claim for Benefits
- Any other information required by applicable law
- For claims involving urgent and/or concurrent care:
  - The Claims Administrator's notice will also include a description of the applicable urgent and/or concurrent review process
  - The Claims Administrator may notify you orally and then furnish a written notification no more than three calendar days later

APPEALS

You have the right to appeal an Adverse Benefit Determination to the Plan that denied the requested service. You must file the appeal within the applicable timeframes described below. You will have the opportunity to submit written comments, documents, records, and other information supporting your claim. The Claims Administrator's review of your claim will take into account all information you submit, regardless of whether it was submitted or considered in the initial Benefit determination.

The Plan provides for one mandatory level of appeal and an additional voluntary level of appeal. The time frame allowed for the Claims Administrator to complete its review is dependent upon the type of review involved (e.g., pre-service, concurrent, post-service, urgent, etc.).

URGENT PRE-SERVICE AND CONCURRENT APPEALS (FIRST AND VOLUNTARY SECOND LEVEL)

For urgent pre-service and concurrent services, you may obtain an expedited appeal. You or your Authorized Representative may request it orally or in writing. All necessary information, including the Claims Administrator's decision, can be sent between the Claims Administrator and you by telephone, facsimile, or other similar method. To file an appeal for a claim involving urgent pre-service or concurrent care, you or your Authorized Representative must contact the Claims Administrator at the number shown on your Identification Card and provide at least the following information:

- The identity of the claimant and the identification number from their ID Card
- The date(s) of the medical service
- The specific medical condition or symptom
- The Provider's name
- The service or supply for which approval of Benefits was sought
- Any reasons why the appeal should be processed on a more expedited basis
- Any documentation or other information to support the appeal request

The Claims Administrator will respond within 72 hours from the request of the appeal. If your appeal is denied, you may request a second-level appeal. An appropriate reviewer who did not make the determination on the initial appeal will conduct the second-level appeal. Again, the Claims Administrator will respond within 72 hours of the receipt of the second-level appeal. If your second-level appeal is denied, you may request an expedited external review.

FIRST-LEVEL APPEALS (POST-SERVICE AND NON-URGENT PRE-SERVICE)

If your non-urgent pre-service or post-service claim is denied, you have the right to appeal. *You or your Authorized Representative must submit the appeal in writing within 180 days from the date of the Adverse Benefit Determination.*

You or your Authorized Representative must submit a request for review as follows: For services under your medical Plan:

Cigna
PO Box 188011
Chattanooga, TN 37422

For behavioral health services:

Cigna Behavioral Health Appeals
PO Box 188064
Chattanooga, TN 37422

For prescription drug services:

Express Scripts
PO Box 631850
Irving, TX 75063-0030
Attn: Appeals

Upon request, the Claims Administrator will provide, without charge, reasonable access to, and copies of, all documents, records, and other information relevant to your claim. "*Relevant*" means that the document, record, or other information:

- Was relied on in making the Benefit determination
- Was submitted, considered, or produced in the course of making the Benefit determination
- Demonstrates compliance with processes and safeguards to ensure that claim determinations are made in accordance with the terms of the Plan, applied consistently for similarly situated claimants
- Is a statement of the Plan's policy or guidance about the treatment or Benefit relative to your diagnosis

The Claims Administrator will also provide you, free of charge, with any new or additional evidence considered, relied upon, or generated in connection with your claim. In addition, before you receive an Adverse Benefit Determination based on a new or additional rationale, the Claims Administrator will provide you, free of charge, with the rationale.

When the Claims Administrator considers your appeal, the Claims Administrator will not defer to the initial Benefit review. The review will be conducted by an appropriate reviewer who did not make the initial determination and who does not work for the person who made the initial determination.

If the denial was based in whole or in part on a medical judgment, including whether the treatment is considered an Experimental, Investigational and Unproven Service, or not Medically Necessary, the reviewer will consult with a healthcare professional who has the appropriate training and experience in the medical field involved in making the judgment.

NOTIFICATION OF THE OUTCOME OF THE NON-URGENT APPEAL

If you appeal a non-urgent pre-service claim, the Claims Administrator will notify you of the outcome of the appeal within 15 days after receipt of your request for appeal.

If you appeal a post-service claim, the Claims Administrator will notify you of the outcome of the appeal within 30 days after receipt of your request for appeal.

If you appeal a pharmacy Benefit claim, the Claims Administrator will notify you of the outcome of the appeal within 30 days after receipt of your request for appeal.

APPEAL DENIAL

If your appeal is denied, that denial will be considered an Adverse Benefit Determination. The notification from the Claims Administrator will include all of the information set forth in the above section entitled "Notice of Adverse Benefit Determination."

VOLUNTARY SECOND-LEVEL APPEALS (POST-SERVICE AND NON-URGENT PRE-SERVICE)

If you are dissatisfied with the Claims Administrator's first-level appeal decision, a voluntary second-level appeal is available. Your appeal must be received within 60 days of receiving the Adverse Benefit Determination of the first appeal. If you would like to initiate a second-level appeal, you or your Authorized Representative must submit the following information:

- Your name and the identification number from your ID Card
- The date(s) of medical service(s)
- The Provider's name

- Any other documentation or other information to support the appeal request

For a post-service appeal involving Cigna, Cigna Behavioral Health, or Express Scripts, send your second- level appeal to:

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

For a non-urgent pre-service appeal involving Cigna or Cigna Behavioral Health, send your second-level appeals to:

Cigna
PO Box 188011
Chattanooga, TN 37422

Cigna Behavioral Health Appeals
PO Box 188064
Chattanooga, TN 37422

A healthcare professional with the appropriate training and experience who was not involved in the original claim or first-level appeal will review the second-level appeal and make a determination. You will be notified of the outcome within a reasonable period of time, but not later than 30 days, after receipt of the second-level appeal.

External Review Program

If your first-level appeal is denied, and either your second-level appeal is also denied or you elect not to submit a second-level appeal, you may have the right to request an external review. "External review" is a review of an Adverse Benefit Determination by an Independent Review Organization/External Review Organization (ERO) or by the State Insurance Commissioner, if applicable.

The Episcopal Church Medical Trust has contracted with Health Advocate to facilitate the external review program. Health Advocate will rotate between several EROs to conduct the review of your appeal.

Only Adverse Benefit Determinations involving medical judgment, such as a denial based on Medical Necessity, determinations involving a rescission of coverage, and determinations involving Surprise Billing Claims will be eligible for external review. For example, external review will not be available for a denial based on your ineligibility to participate in the Plan (except to the extent that it involves a rescission of coverage).

The External Review Request Form includes an Appointment of Authorized Representative section. If you would like to designate an Authorized Representative now, you should complete the Appointment of Authorized Representative section of the form. Additionally, the Authorized Representative should provide notice of commencement of the action on your behalf to you, which we may verify with you prior to recognizing the Authorized Representative status. In any event, a Provider with knowledge of your medical condition acting in connection with an urgent care claim will be recognized by this Plan as your Authorized Representative.

A "Final External Review Decision" is a determination by an ERO at the conclusion of an external review. You must complete the first-level appeal for the Plan involved before you can request external review, other than in a case where the Plan or its designee, does not strictly adhere to all claim determination and appeal requirements under federal law (deemed exhaustion).

Subject to verification procedures that the Plan may establish, your Authorized Representative may act on your behalf in filing and pursuing this voluntary appeal. You may file a voluntary appeal for external review of any Adverse Benefit Determination that qualifies as set forth below.

The notice of Adverse Benefit Determination that you receive from the Plan or its designee will describe the process to follow if you wish to pursue an external review, and will include a copy of the *Request for External Review Form*. *You*

must submit the Request for External Review Form within four (4) months of the date you received the Adverse Benefit Determination notice. If the last filing date would fall on a Saturday, Sunday, or federal holiday, the last filing date is extended to the next day that is not a Saturday, Sunday, or federal holiday. You also must include a copy of the notice of Adverse Benefit Determination and all other pertinent information that supports your request.

The external review process under this Plan gives you the opportunity to receive a review of an Adverse Benefit Determination conducted pursuant to applicable law. Your request will be eligible for external review if the following are satisfied:

- The Plan or its designee, does not strictly adhere to all claim determination and appeal requirements under federal law,
- The mandatory level of appeal has been exhausted, or
- The appeal relates to a rescission, defined as a cancellation or discontinuance of coverage which has retroactive effect.

Send your request for an external review along with all required information to:

The Episcopal Church Medical Trust
c/o Health Advocate
PO Box 977
Blue Bell, PA 19422

Phone: (866) 695-8622 (toll-free)
Fax: (610) 941-4200

If you file a voluntary external appeal, any applicable statute of limitations will be tolled while the appeal is pending. The filing of a claim will have no effect on your rights to any other Benefits under the Plan.

However, the appeal is voluntary and you are not required to undertake it before pursuing legal action. If you choose not to file for an external voluntary review, the Plan will not assert that you have failed to exhaust your administrative remedies because of that choice.

REQUEST FOR EXTERNAL REVIEW

You cannot request an external review if the Adverse Benefit Determination (denial) was based upon your eligibility for Benefits.

If upon the final standard level of appeal, the coverage denial is upheld and it is determined that you are eligible for external review, you will be informed in writing of the steps necessary to request an external review.

The Medical Trust has contracted with Health Advocate to coordinate the external review process. Health Advocate refers the case for review to a neutral, independent clinical reviewer with appropriate expertise in the area in question. The decision of the independent external expert reviewer is binding on you, your heirs, the health Plan vendor (Cigna, Cigna Behavioral Health, or Express Scripts), and the Medical Trust unless otherwise allowed by law.

PRELIMINARY REVIEW

Within 5 business days following the date of receipt of the request, the Plan or its designee must provide a preliminary review determining whether:

You were covered under the Plan at the time the service was requested or provided

- The determination does not relate to eligibility
- You have exhausted the mandatory internal appeals process (unless deemed exhaustion applies)
- You have provided all paperwork necessary to complete the external review

Within one (1) business day after completion of the preliminary review, the Plan or its designee must issue to you a

notification in writing. If the request is complete but not eligible for external review, such notification will include the reasons for its ineligibility and contact information for the Employee Benefits Security Administration (EBSA). If the request is not complete, such notification will describe the information or materials needed to make the request complete, and the Plan or its designee must allow you to perfect the request for external review within the four (4) month filing period or within the 48-hour period following the receipt of the notification, whichever is later.

Referral to ERO

The Plan or its designee will assign an ERO accredited as required under federal law, to conduct the external review. The assigned ERO will, in a timely manner, notify you in writing of the request's eligibility and acceptance for external review, and will provide an opportunity for you to submit in writing within 10 business days following the date of receipt, additional information that the ERO must consider when conducting the external review. Within one (1) business day after receiving additional information, the ERO will forward the information to the Plan which may reconsider its adverse decision. If the Plan decides, upon reconsideration, to reverse its decision and provide coverage or payment, it will, within one (1) business day, after making the decision, notify you, the Medical Trust, and the appropriate Plan (Cigna, Cigna Behavioral, or Express Scripts).

The ERO will review all of the information and documents received in a timely manner. In reaching a decision, the assigned ERO will review the claim and not be bound by any decisions or conclusions reached during the Plan's internal claims and appeals process. In addition to the documents and information provided, the assigned ERO, to the extent the information or documents are available and the ERO considers them appropriate, will consider the following in reaching a decision:

- Your medical records
- The attending healthcare professional's recommendation
- Reports from appropriate healthcare professionals and other documents submitted by the Plan or issuer, you, or your treating Provider
- The terms of your Plan to ensure that the ERO's decision is not contrary to the terms of the Plan, unless the terms are inconsistent with applicable law
- Appropriate practice guidelines, which must include applicable evidence-based standards and may include any other practice guidelines developed by the federal government, national, or professional medical societies, boards, and associations
- Any applicable clinical review criteria developed and used by the Plan, unless the criteria are inconsistent with the terms of the Plan or with applicable law
- The opinion of the ERO's clinical reviewers after considering the information described in this notice to the extent the information or documents are available and the clinical reviewers consider appropriate

The assigned ERO must provide written notice of the final external review decision within 45 days after the ERO receives the request for the external review. The ERO must deliver the notice of final external review decision to you, the Medical Trust, and the Plan vendor (Cigna, Cigna Behavioral Health, or Express Scripts). After a final external review decision, the ERO must maintain records of all claims and notices associated with the external review process for six years. An ERO must make such records available for examination by the claimant, Plan, or state or federal oversight agency upon request, except where such disclosure would violate state or federal privacy laws.

Upon receipt of a notice of a final external review decision reversing the Adverse Benefit Determination, the Plan immediately must provide coverage or payment (including immediately authorizing or immediately paying Benefits) for the claim.

Expedited External Review

The Plan must allow you to request an expedited external review at the time you receive (a) An Adverse Benefit Determination if the Adverse Benefit Determination involves a medical condition for which the timeframe for completion of an expedited internal appeal would seriously jeopardize your life or health or would jeopardize your ability to regain maximum function and you have filed a request for an expedited internal appeal; or (b) An Adverse Benefit Determination that concerns an admission, availability of care, continued stay, or healthcare item or service regarding an issue for which you received emergency services, but have not been discharged from a Facility. Immediately upon receipt of the request for expedited external review, the Plan or its designee will determine whether the request meets

the reviewability requirements set forth above for standard external review. The Plan or its designee must immediately send you a notice of its eligibility determination.

Referral of Expedited Review to ERO

Upon a determination that a request is eligible for external review following preliminary review, the Plan or its designee will assign an ERO. The ERO shall render a decision as expeditiously as your medical condition or circumstances require, but in no event more than 72 hours after the ERO receives the request for an expedited external review. If the notice is not in writing, within 48 hours after the date of providing that notice, the assigned ERO must provide written confirmation of the decision to you, the Medical Trust, and the Plan.

Extensions Due to COVID-19 Pandemic

The timeframe for a claimant to file (1) a benefit claim, (2) an appeal of an adverse benefit determination, (3) a request for an external review after receipt of an adverse benefit determination or final internal adverse benefit determination, and (4) information to perfect a request for external review upon a finding that the request was not complete has been extended. 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.

> *Example*: For purposes of this example, assume that the Outbreak Period described above ends on June 29, 2022. On April 15, 2022, a plan member received notice of an adverse benefit determination. Under the health plan, the individual has 60 days within which to file an appeal.

In this example, the Outbreak Period is disregarded and the member's last day to submit an appeal is 60 days after June 29, 2022, which is August 27, 2022.

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 health 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 9
Coordination of Benefits

When a Member is covered under more than one group health Plan that provides coverage for the same expense as the Plan, the Plan will coordinate the Benefits it pays with the payments from the other Plan(s). This coordination is to prevent duplicative payments for any service or supply. One Plan will be considered "primary" and responsible for paying expenses first, and the other Plan will be considered "secondary" and responsible for paying expenses second.

When the Plan is primary, it will pay Benefits according to Plan rules. When the Plan is secondary, the Plan will adjust its payments so that the total amount paid from both Plans, combined, does not exceed the amount this Plan would have paid if it were primary.

The term "group health plan," as it relates to Coordination of Benefits, includes employer or group plans and most government or tax-supported plans, including Medicare and TRICARE. It also includes group insurance and Subscriber contracts, such as union welfare plans and benefits provided under any group or individual automobile no-fault or fault-type policy or contract. Benefits are not coordinated with personal, individual insurance policies, unless otherwise described in this handbook. Members must inform the Plan any time the Member has other group health plan coverage.

The Plan follows specific rules to establish which plan is primary and which plan is secondary in determining the order in which Benefits will be paid. Rules may vary as a result of specific situations, based on the Coordination of Benefits provisions of each plan and due to generally accepted industry criteria. For persons eligible for Medicare, for example, Medical Trust Benefits will generally be primary only as required by federal Medicare rules and regulations and will not be primary for any Employee whose employment status has been terminated (such Employees must enroll in Medicare Parts A and B as soon as they qualify; otherwise, Benefits may be reduced). Further, in determining the Benefits payable under the Plan, the Plan will not take into account the fact that you or any Eligible Dependent(s) are eligible for or receive benefits under a Medicaid plan.

Typically, the following rules apply to coordinate Benefits, in the order stated below, until it is clear which plan is primary:

General Rules

Any group health plan that does not contain a Coordination of Benefits provision will be the primary Plan.

When all plans covering a Member contain a Coordination of Benefits provision, Benefits will be coordinated based on the following rules:

The plan covering a person other than as a Dependent (*e.g.*, an active Employee or retiree) is primary and the plan covering a person as a Dependent is secondary.

If a person is covered by two group health plans and Medicare, and under federal law, Medicare is secondary to the plan covering the person as a Dependent and primary to the plan covering the person as other than a Dependent (*e.g.*, a retiree), then the order of payment is reversed so the plan covering the individual as a Dependent is primary, and the other plan is secondary.

The plan covering a person as an active Employee is primary and the plan covering the person as a retiree is secondary.

Child Covered Under More Than One Plan

The order of Benefits when a Dependent Child is covered by more than one plan is as follows:
The primary plan is the plan of the parent whose birthday (month and day) is earlier in the calendar year if either:

- The parents are married
- The parents are not separated (regardless of whether they ever have been married)
- A court decree awards joint custody without specifying that one parent has the responsibility to provide healthcare coverage

If both parents have the same birthday (month and day), the plan that has covered either of the parents longer is primary.

If the specific terms of a court decree state that one of the parents is responsible for the Child's healthcare coverage or expenses and the plan of that parent has knowledge of the decree, that plan is primary. If the parent designated by the decree has no coverage for the Child, but that parent's Spouse does, the Spouse's plan is primary.

If the parents are not married, are separated (regardless of whether they were ever married), or are divorced and there is no court decree allocating responsibility for the Child's healthcare coverage or expenses, then the order of Benefit determination among the plans is as follows:

- The plan of the custodial parent; then
- The plan of the Spouse of the custodial parent; then
- The plan of the noncustodial parent; then
- The plan of the Spouse of the noncustodial parent

ACTIVE OR INACTIVE EMPLOYEE

The plan that covers a person as an active Employee (or the person's Dependents) who is not laid off, terminated or retired is primary. The plan that covers a person (or the person's Dependents) as a laid-off, terminated or retired Employee is secondary. If both the person and the person's Dependents are covered as retirees, the Dependent's retiree coverage is primary for the Dependent's claims. If the other plan does not have this rule and if, as a result, the plans do not agree on the order of Benefits, this rule is ignored.

CONTINUATION COVERAGE

If a person whose coverage is provided under a right of continuation required by federal or state law or by the Medical Trust's continuation of coverage provisions is also covered under another plan, the plan covering the person as an Employee, Member or retiree (or as that individual's Dependent) is primary and the continuation coverage is secondary. If the other plan does not have this rule and if, as a result, the plans do not agree on the order of Benefits, this rule is ignored.

LONGER OR SHORTER LENGTH OF COVERAGE

The plan that has covered the person for the longer period of time is primary.

If none of the above rules determine which plan is the primary plan, the allowable expenses will be shared equally between the plans. This Plan will never pay more than it would have paid had it been primary.

This Plan provides Benefits relating to medical expenses incurred as a result of an automobile accident on a secondary basis only. Benefits payable under this Plan will be coordinated with, and secondary to, benefits provided or required by any no-fault automobile insurance statute, whether or not a no-fault policy is in effect, and/or any other automobile insurance. Any Benefits provided by this Plan will be subject to the Plan's reimbursement and/or subrogation provisions.

Whenever payments that should have been made by this Plan have been made by any other plan(s), this Plan has the right to pay the other plan(s) any amount necessary to satisfy the terms of the Plan's Coordination of Benefits provision. Amounts paid will be considered Benefits paid under this Plan, and, to the extent of such payments, the Plan will be fully released from any liability regarding the person for whom the payment was made.

CHAPTER 10
MEDICARE SECONDARY PAYER (MSP) – SMALL EMPLOYER EXCEPTION (SEE)

Some Members and/or Spouses are eligible to participate in a Plan that qualifies for the Medicare Secondary Payer (MSP)—Small Employer Exception (SEE) (referred to as "MSP/SEE Plan"). 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.

If you are 65 or over, actively working, and your employer has fewer than 20 Employees in the current year and had fewer than 20 employers in the previous year, you may be eligible to choose a Plan that participates in this program[11].

If you are approved and enrolled, Medicare would become the primary payer of your claims covered under Medicare Part A. Part A is hospitalization insurance that helps cover inpatient care in Hospitals, Skilled Nursing Facilities, Hospices, and Home Health Care situations. The MSP/SEE Plan will act as 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 MSP/SEE Plan.

If you are enrolled in Medicare Part B, the Plan will coordinate with Medicare. Otherwise, for all Benefits covered by Medicare Part B, such as doctor visits, Outpatient procedures, and some prescription drugs, the Plan will remain the primary payer of your Benefits.

WHAT YOUR EMPLOYER NEEDS TO DO

First, your group Benefit administrator must submit an Employer Election Form to the Medical Trust indicating that the employer is eligible for the MSP small employer exception. The administrator must also submit an Employee Certification Form for each Employee and/or Dependent who may be eligible, which must include the Employee's Medicare Health Insurance Claim Number (HICN).

The Medical Trust will submit the completed forms to the Centers for Medicare and Medicaid Services (CMS). CMS needs to approve employers and each individual for them to be eligible to participate in a Plan eligible for the MSP small employer exception.

WHAT YOU NEED TO DO

If you're turning 65 in 2022, will continue to work and your employer participates in the MSP/SEE Plan, you can elect to participate in the program. Please note, however, that even if your employer is enrolled in the program, your participation is not mandatory. You will still have the option to elect other Plans offered by your employer.

You will receive information from the Medical Trust explaining the program and how to enroll.

To participate, you must be enrolled in Medicare Part A, as well as an eligible Plan.

HOW IT WORKS

If you have an Inpatient hospitalization in 2022, the Hospital or Facility will send its billed charges to Medicare. Medicare will then pay the allowed amount minus the Part A Deductible.

The portion of the allowed amount that is not paid by Medicare will then be sent to Cigna who will process the portion not paid by Medicare, minus the Plan's Deductible and your cost share.

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[11] The Consumer-Directed Health Plans are not available as MSP/SEE Plans.

As the secondary payer of claims, Cigna does not look at the Provider status to determine the Benefits. All claims are processed at the Network Benefit level, regardless of whether the Facility is in Cigna's Network. The Provider must, however, participate with Medicare or accept Medicare assignment in order for Medicare to consider the claim for primary payment.

You must pay all the costs up to the Deductible amount before Cigna begins to pay for Covered Health Services you use. Your Copayments and Coinsurance, as well as your Deductible, are applied to your Out-of-Pocket Limit.

If you receive services that are not covered by Medicare but are covered by Cigna, the Plan will process the claim as the primary payer at the Network Benefit or Out-of-Network Benefit level, as appropriate.

If your Dependent Spouse is not yet Medicare-eligible and enrolled in the Plan, the Plan will be the primary payer for all services for them.

If you have any questions about the Plans, the Small Employer Exception or need other assistance, please call our Client Services team at (800) 480-9967, Monday – Friday, 8:30 AM - 8:00 PM ET, or email *mtcustserv@cpg.org*.

CHAPTER 11
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.

CONTINUITY OF CARE

Your Plan uses Network Providers to provide Benefits. Should a Network Provider contract terminate, Continuing Care Patients have a right to elect to continue continued transitional care from that terminated provider under the same terms and conditions for the shorter of a 90-day period or until you are no longer a Continuing Care Patient. A Continuing Care Patient is an individual who, with respect to a provider:

a) Is undergoing a course of treatment for a serious and complex condition from the provider or facility;
b) Is undergoing a course of institutional or inpatient care from the provider or facility;
c) Is scheduled to undergo nonelective surgery from the provider, including receipt of postoperative care from such provider or facility with respect to such a surgery;
d) Is pregnant and undergoing a course of treatment for the pregnancy from the provider or facility; or
e) Is or was determined to be terminally ill (as determined under specified Medicare rules) and is receiving treatment for such illness from such provider or facility.

SPECIAL ELECTION FOR EMPLOYEES AND SPOUSES AGE 65 AND OVER

If a Member remains actively employed after reaching age 65 and is eligible to participate in the Plan, the Member

and/or Spouse may choose to remain covered under the Plan without reduction for Medicare Benefits. A Member and/or Spouse may also choose to end coverage under the Plan and enroll only in Medicare; however, Benefits that are payable under this Plan may not be covered by Medicare and neither the Member or the Spouse may be enrolled in a Group Medicare Advantage Plan or Medicare Supplement Plan sponsored by the Medical Trust. If coverage remains under the Plan, the Plan will be the primary payer of Benefits, and Medicare will be the secondary payer (unless the Member qualifies for a MSP/SEE Plan).

If the Member is under age 65 and the Member's Spouse is over age 65, the Spouse can make their own choice to remain covered under the Plan or to terminate coverage and enroll only in Medicare.

However, the Spouse may not choose to enroll in a Group Medicare Advantage Plan or Medicare Supplement Plan sponsored by the Medical Trust.

Alternative 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 Plan. 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.

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.

Physician/Patient Relationship

This Plan is not intended to disturb the Physician/patient relationship. Physicians and other Providers are not agents or delegates of the employer, the Medical Trust, the ECCEBT, or any Claims Administrator. Nothing contained in the

Plan will require a Member or Dependent to commence or continue medical treatment by a particular Provider. Furthermore, nothing in the Plan will limit or otherwise restrict a Physician's judgment with respect to the Physician's ultimate responsibility for patient care in the provision of medical services to the Member or 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 employer and any Employee.

PLAN ADMINISTRATION

In administering the Plan(s), 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 a Claims Administrator, that party shall act with the same discretion and authority as the Medical Trust.

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.

CHAPTER 12
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, the Claims Administrator or its representative including, but not limited to, completing, signing and submitting any applications or other forms or statements as the Plan, the Claims Administrator 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 the Claims Administrator 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, the Claims Administrator 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.

SURROGACY ARRANGEMENTS

If the covered person enters into a Surrogacy Arrangement, the covered person must pay the Plan charges for Covered Health Services the covered person receives related to conception, pregnancy, delivery, or postpartum care relating to that arrangement ("Surrogacy Health Services"), except that the amount the covered person must pay will not exceed the payments or other compensation the covered person and any other payee are entitled to receive under the Surrogacy Arrangement. A Surrogacy Arrangement is one in which a woman agrees to become pregnant and to surrender the baby (or babies) to another person or persons who intend to raise the child (or children), whether or not the woman receives payment for being a surrogate. Note: This "Surrogacy Arrangements" section does not affect the covered person's obligation to pay cost sharing for these Services; the covered person will be credited any such payments toward the amount the covered person must reimburse the Plan under this paragraph. After the covered person surrenders a baby to the legal parents, the covered person is not obligated to pay for any Services that the baby receives (the legal parents assume financial responsibility for any Services that the baby receives).

By accepting Surrogacy Health Services, the covered person automatically assigns to the Plan the covered person's right to receive payments that are payable to the covered person or any other payee under the Surrogacy Arrangement, regardless of whether those payments are characterized as being for medical expenses. To secure the Plan's rights, the Plan will also have an equitable lien on those payments and on any escrow account, trust, or any other account that holds those payments. Those payments (and amounts in any escrow account, trust, or other account that holds those payments) shall first be applied to satisfy our lien. The assignment and the Plan's lien will not exceed the total amount of the covered person's obligation to the Plan under the preceding paragraph.

The covered person must complete and send all consents, releases, authorizations, lien forms, and other documents that are reasonably necessary to determine the existence of any rights the Plan may have under this "Surrogacy Arrangements" section and to satisfy those rights. The covered person may not agree to waive, release, or reduce the Plan's rights under this "Surrogacy Arrangements" section without the Plan's prior, written consent.

If the covered person's estate, parent, guardian, or conservator asserts a claim against a third party based on the Surrogacy Arrangement, 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 our 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 its 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, the Claims Administrator for the Plan 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 13
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 PLANS

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 PLANS 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 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; and
- 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-partyadministrators, 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.

<u>Data Retention</u>

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

<u>Data Transfers</u>

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.

CHAPTER 14
GLOSSARY

ACCIDENTAL INJURY

Bodily Injury sustained by a Member as the result of an unforeseen event and which is the direct cause independent of disease, bodily infirmity or any other cause) for care which the Member receives. Such care must occur while this Plan is in force. It does not include injuries for which Benefits are provided under any workers' compensation, employer's liability, or similar law.

AMBULANCE SERVICES

A state-licensed emergency vehicle which carries injured or sick persons to a Hospital. Services which offer non-emergency, convalescent or invalid care do not meet this definition.

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.

BED AND BOARD

All Charges made by a Hospital on its own behalf for room and meals and for all general services and activities needed for the care of registered bed patients.

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.

BENEFIT MAXIMUM(S)

Total Plan payments for each covered person are limited to certain maximum Benefit amounts. A Benefit Maximum can apply to specific Benefit categories or to all Benefits. A Benefit Maximum amount also applies to a specific time period, such as a year or lifetime. Whenever the word "lifetime" appears in this handbook in reference to Benefit Maximums, it refers to the period of time you or your Eligible Dependents participate in this Plan or any other Plan sponsored by the Medical Trust.

BIOLOGIC

A virus, therapeutic serum, toxin, antitoxin, vaccine, blood, blood compoenent or derivative, allergenic product, protein (except any chemically synthesized polypeptide), or analogous product, or arsphenamine or derivative of arsphenamine (or any other travelent organic arsenic compound), used for the prevention, treatment, or cure of a disease or condition of human beings, as defined under Section 35(i) of the Public Health Service Act (42 USC 262(i)) (as amended by the Biologics Price Competition and Innovation Act of 2009, title VII of the Patient Protection and Affordable Care Act, Pub. L. No. 111-148 § 7002 (2010), and as may be amended thereafter).

CHARGES

The term, Charges, means the actual billed Charges; except when Cigna has contracted directly or indirectly for a different amount, including where Cigna has directly or indirectly contracted with an entity to arrange for the provision of services and/or supplies through contracts with Providers of such services and/or supplies.

Chiropractic Care

The conservative management of neuromusculoskeletal conditions through manipulation and ancillary physiological treatment rendered to specific joints to restore motion, reduce pain, and improve function

Claims Administrator

The company the Plan Sponsor chose to administer its health Benefits. Cigna was chosen to administer this Plan. The Claims Administrator provides administrative claims payment services only and does not assume any financial risk or obligation with respect to claims.

Coinsurance

Your share of the costs of Covered Health Services, calculated as a percentage (for example, 20%) of the allowed amount for the services. You generally pay Coinsurance plus any Deductibles you owe. (For example, if the Plan's allowed amount for an office visit is $100 and you've met your Deductible, your Coinsurance payment of 20% would be $20. The Plan pays the rest of the allowed amount.)

Congenital Anomaly

A condition or conditions that are present at birth regardless of causation. Such conditions may be hereditary or due to some influence during gestation.

Coordination of Benefits

A provision that is intended to avoid claims payment delays and duplication of Benefits when a person is covered by two or more Plans providing Benefits or services for medical, dental, or other care or treatment. It avoids claims payment delays by establishing an order in which Plans pay their claims and providing an authority for the orderly transfer of information needed to pay claims promptly. It may avoid duplication of Benefits by permitting a reduction of the Benefits of a Plan when, by the rules established by this provision, it does not have to pay its Benefits first.

Copayments

Copayments (Copays) are the fixed amounts to be paid by you or your Dependents for Covered Health Services, 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.

Cosmetic Services

Any non-Medically Necessary treatment, prescription drug, equipment, supplies, surgery or procedure, the primary purpose of which is to improve or change the appearance of any portion of the body, but which does not restore bodily function, correct a disease state, physical appearance or disfigurement caused by an accident, birth defect, or correct or naturally improve a physiological function. Cosmetic Services includes but is not limited to: rhinoplasty, lipectomy, surgery for sagging or extra skin, any augmentation or reduction procedures (e.g., mammoplasty, liposuction, keloids, rhinoplasty and associated surgery) or treatment relating to the consequences or as a result of Cosmetic Services.

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).

COVERED HEALTH SERVICE(S)

Covered Health Services are those health services provided for the purpose of preventing, diagnosing, or treating a Sickness, Injury, mental illness, substance use disorders, or their symptoms.

A Covered Health Service is a healthcare service or supply described in the coverage section as a Covered Health Service, which is not excluded in the Exclusions and Limitations section, including the exclusion from coverage for Experimental, Investigational and Unproven Services.

Covered Health Services must be provided:

- When the Plan is in effect
- Prior to the effective date of any of the individual termination conditions set forth in this Plan Document Handbook
- Only when the person who receives services is a covered person and meets all eligibility requirements specified in the Plan

Decisions about whether to cover new technologies, procedures, and treatments will be consistent with conclusions of prevailing medical research, based on well-conducted randomized trials or cohort studies, as described.

CUSTODIAL SERVICES

Any services that are of a sheltering, protective, or safeguarding nature. Such services may include a stay in an institutional setting, at-home care, or nursing services to care for someone because of age or mental or physical condition. This service primarily helps the person in daily living. Custodial Services also can provide medical services, given mainly to maintain the person's current state of health. These services cannot be intended to greatly improve a medical condition; they are intended to provide care while the patient cannot care for himself or herself. Custodial Services include but are not limited to:

- Services related to watching or protecting a person
- Services related to performing or assisting a person in performing any activities of daily living, such as: walking, grooming, bathing, dressing, getting in or out of bed, toileting, eating, preparing foods, or taking medications that can be self-administered
- Services not required to be performed by trained or skilled medical or paramedical personnel

DEDUCTIBLE(S)

Deductibles are amounts 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 medical Deductible for the rest of that Plan Year.

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 ward[12], foster child[13], legally adopted child;

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

[13] 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.

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.

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.

DETOXIFICATION

The process whereby an alcohol or drug intoxicated or alcohol or drug dependent person is assisted, in a Facility licensed by the appropriate regulatory authority, through the period of time necessary to eliminate, by metabolic or other means, the intoxicating alcohol or drug, alcohol or drug dependent factors or alcohol in combination with drugs as determined by a licensed Physician, while keeping the physiological risk to the patient to a minimum.

DEVELOPMENTAL DELAY

The statistical variation, as defined by standardized, validated developmental screening tests, such as the Denver Developmental Screening Test, in reaching age appropriate verbal/growth/motor skill developmental milestones when there is no apparent medical or psychological problem. It alone does not constitute an illness or any Injury.

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.

DURABLE MEDICAL EQUIPMENT

Items which are:

- Designed for and able to withstand repeated use by more than one person;
- Customarily serve a medical purpose;
- Generally are not useful in the absence of Injury or Sickness;
- Are appropriate for use in the home; and
- Are not disposable.

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 CMS as a small employer under the Medicare Secondary Payer Rules.

EMERGENCY MEDICAL CONDITION

Medical or behavioral health condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in one of the following conditions:

- Placing the health of the individual or the health of another person (or, with respect to a pregnant woman, the health of the woman or her unborn Child) in serious jeopardy
- Serious impairment to bodily functions; or
- Serious dysfunction of any bodily organ or part

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.

THE EPISCOPAL CHURCH CLERGY AND EMPLOYEES' BENEFIT TRUST (ECCEBT)

The Plan funds certain of its benefit plans through this trust that is intended to qualify as a Voluntary Employees' Beneficiary Association (VEBA) under Section 501(c)(9) of the Internal Revenue Code. The main purpose of the ECCEBT is to provide medical benefits and other eligible benefits to eligible Employees, former Employees and/or their Eligible Dependents.

ESSENTIAL HEALTH BENEFITS

Essential Health Benefits means, to the extent covered under the Plan, expenses incurred with respect to Covered Health Services, in at least the following categories: ambulatory services, emergency services, hospitalization, maternity and newborn care, Mental Health and Substance Use Disorder Services, including behavioral health treatment, prescription drugs, rehabilitative and habilitative services and devices, laboratory services, preventive and wellness services, and chronic disease management and pediatric services, including oral and vision care.

EXPERIMENTAL, INVESTIGATIONAL AND UNPROVEN SERVICES

Experimental, Investigational and Unproven Services are medical, surgical, diagnostic, psychiatric, substance use disorder or other healthcare technologies, supplies, treatments, procedures, drug or Biologic therapies or devices that are determined by the utilization review Physician to be:

- Not approved by the U.S. Food and Drug Administration (FDA) or other appropriate regulatory agency to be lawfully marketed
- Not demonstrated, through existing peer-reviewed, evidence-based, scientific literature to be safe and effective for treating or diagnosing the condition or Sickness for which its use is proposed
- The subject of review or approval by an Institutional Review Board for the proposed use except as provided in the "Clinical Trials" sections of this plan
- The subject of an ongoing phase I, II or III clinical trial, except for routine patient care costs related to qualified clinical trials as provided in the "Clinical Trials" sections of this plan

In determining whether drug or Biologic therapies are Experimental, Investigational and Unproven, the utilization review Physician may review, without limitation, U.S. Food and Drug Administration approved labeling, the standard medical reference compendia and peer-reviewed, evidence-based scientific literature.

FREE-STANDING SURGICAL FACILITY

The term Free-Standing Surgical Facility means an institution which meets all of the following requirements:

- It has a medical staff of Physicians, Nurses, and licensed anesthesiologists

- It maintains at least two operating rooms and one recovery room
- It maintains diagnostic laboratory and X-ray Facilities
- It has equipment for emergency care
- It has a blood supply
- It maintains medical records
- It has agreements with Hospitals for immediate acceptance of patients who need Hospital Confinement on an Inpatient basis
- It is licensed in accordance with the laws of the appropriate legally authorized agency

Facility

A Facility, including but not limited to, a Hospital, Free-Standing Surgical Facility, chemical dependency treatment Facility, Skilled Nursing Facility, Home Health Care Agency, or mental health Facility, as defined in this Plan Document Handbook. The Facility must be licensed, accredited, registered, or approved by The Joint Commission or the Commission on Accreditation of Rehabilitation Facilities (CARF), as applicable, or meet specific rules set by the Claims Administrator.

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 themself and their Eligible Dependents for coverage under the Plan outside of the Annual Enrollment period.

Home Health Care

Care, by a licensed program or Provider, for the treatment of a patient in the patient’s home, consisting of required intermittent skilled care, which may include observation, evaluation, teaching and nursing services consistent with the diagnosis, established and approved in writing by the patient’s attending Physician.

Home Health Care Agency

A Provider who renders care through a program for the treatment of a patient in the patient’s home, consisting of required intermittent skilled care, which may include observation, evaluation, teaching, and nursing services consistent with the diagnosis, established and approved in writing by the patient’s attending Physician.

Hospice Care Program

The term Hospice Care Program means:

- A coordinated, interdisciplinary program designed to meet the special physical, psychological, spiritual, and social needs of the terminally ill Member and their families
- A program that provides palliative and supportive medical, nursing and other health services through home or Inpatient care during the illness
- A program for persons who have a Terminal Illness and for the families of those persons

HOSPICE CARE SERVICES

Any services provided by: a Hospital, a Skilled Nursing Facility or a similar institution, a Home Health Care Agency, a Hospice Facility, or any other licensed Facility or agency under a Hospice Care Program.

HOSPICE FACILITY

An institution or part of it which:

- Primarily provides care for Terminally Ill patients
- Is accredited by the National Hospice Organization
- Meets the Standards established by Cigna
- Fulfills any licensing requirements of the state or locality in which it operates

HOSPITAL

- An institution licensed as a Hospital, which: maintains, on the premises, all Facilities necessary for medical and surgical treatment; provides such treatment on an Inpatient basis, for compensation, under the supervision of Physicians; and provides 24-hour service by Registered Graduate Nurses
- An institution which qualifies as a Hospital, a psychiatric Hospital or a tuberculosis Hospital, and a Provider of services under Medicare, if such institution is accredited as a Hospital by the Joint Commission on the Accreditation of Healthcare Organizations
- An institution which: specializes in treatment of Mental Health and Substance Use Disorder or other related illness; provides residential treatment programs; and is licensed in accordance with the laws of the appropriate legally authorized agency.

The term Hospital will not include an institution which is primarily a place for rest, a place for the aged, or a nursing home.

HOSPITAL CONFINEMENT OR CONFINED IN A HOSPITAL

A person will be considered Confined in a Hospital if he is:

- A registered bed patient in a Hospital upon the recommendation of a Physician
- Receiving treatment for Mental Health and Substance Use Disorder Services in a mental health or substance use disorder residential treatment center

IDENTIFICATION CARD

The latest card given to you showing your identification and group numbers, the type of coverage you have, and the date coverage became effective. Also known as an “ID Card.”

INELIGIBLE PROVIDER

A Provider that does not meet the minimum requirements to become a contracted Provider with the Claims Administrator. Services rendered to a Member by such a Provider are not eligible for payment.

INJURY

Bodily harm from an accident.

INPATIENT

A Member who is treated as a registered bed patient in a Hospital and for whom a room and board charge is made.

Intensive Care Unit

A special unit of a Hospital that: (1) treats patients with serious illnesses or Injuries; (2) can provide special life-saving methods and equipment; (3) admits patients without regard to prognosis; and (4) provides constant observation of patients by a specially trained nursing staff.

Maintenance Care

Treatment rendered to keep or maintain the patient's current status.

Maternity Care

Obstetrical care received both before and after the delivery of a Child or Children. It also includes care for miscarriage or abortion. It includes regular nursery care for a newborn infant as long as the mother's Hospital stay is a covered benefit and the newborn infant is an eligible Member under the Plan.

Maximum Reimbursable Charge

The Maximum Reimbursable Charge for Out-of-Network Covered Health Services is determined based on the lesser of:

- the Provider's normal charge for a similar service or supply;
- the amount agreed to by the Provider and the Claims Administrator; or
- a percentage of a fee schedule the Claims Administrator has developed that is based upon a methodology similar to a methodology utilized by Medicare to determine the allowable reimbursement for the same or similar service within the geographic market.

The percentage used to determine the Maximum Reimbursable Charge can be obtained by contacting Member Services/Customer Service.

In some cases, a Medicare based schedule will not be used and the Maximum Reimbursable Charge for Out-of-Network Covered Health Services is instead determined based on the lesser of:

- the Provider's normal charge for a similar service or supply;
- the amount agreed to by the Provider and the Claims Administrator; or
- the 80th percentile of charges made by providers of such service or supply in the geographic area where it is received as compiled in a database selected by the Claims Administrator. If sufficient charge 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 the Claims Administrator. Additional information about how the Claims Administrator determines the Maximum Reimbursable Charge is available upon request.

The Maximum Reimbursable Charge does not apply to Out-of-Network Emergency Services or to services described under "Surprise Billing Claims – Out-of-Network Charges for Certain Services". For all other Out-of-Network Services, the Provider may bill the customer the difference between the Provider's normal charge and the Maximum Reimbursable Charge, in addition to applicable Deductibles, Copayments and Coinsurance. Out-of-Network Benefits are subject to a Plan Year Deductible and Maximum Reimbursable Charge limitations.

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).

Medical Pharmaceutical

An FDA-approved prescription pharmaceutical product, including a Specialty Prescription Drug Product, typically required to be administered in connection with a Covered Health Service by a Physician or other Provider within the scope of the Provider's license. This definition includes certain pharmaceutical products whose administration may initially or typically require Physician oversight but may be self-administered under certain conditions specified in the product's FDA labeling. This definition does not include any Charges for mobile, web-based or other electronic applications or software, even if approved for marketing as a prescription product by the FDA.

Medically Necessary/Medical Necessity

Healthcare services, supplies, and medications provided for the purpose of preventing, evaluating, diagnosing or treating a Sickness, Injury, condition, disease or its symptoms, that are all of the following as determined by a Medical Director or Review Organization:

- Required to diagnose or treat an illness, Injury, disease, or its symptoms
- In accordance with generally accepted standards of medical practice
- Clinically appropriate in terms of type, frequency, extent, site and duration
- Not primarily for the convenience of the patient, Physician, or Other Healthcare Professional
- Not costlier than an alternative service(s), medication(s), or supply(ies) that is at least as likely to produce equivalent therapeutic or diagnostic results with the same safety profile as to the prevention, evaluation, diagnosis, or treatment of your Sickness, Injury, condition, disease or its symptoms
- Rendered in the least intensive setting that is appropriate for the delivery of the services, supplies, or medications. Where applicable, the Medical Director or Review Organization may compare the cost-effectiveness of alternative services, supplies, medications or settings when determining least intensive setting

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, 1[14] (a "Religious Order") who has been accepted or received by the Religious Order.

[14] The Constitution and Canons of the Episcopal Church, 2018

Mental Health and Substance Use Disorder Services

Covered Health Services for the diagnosis and treatment of mental illnesses or substance use disorders. The fact that a condition is listed in the current Diagnostic and Statistical Manual of the American Psychiatric Association does not mean that treatment for the condition is a Covered Health Service.

Network Benefits

Benefits for Covered Health Services that are provided by (or directed by) a Network Physician or other Network Provider in the Provider's office or at a Network Facility.

Network Provider

The term, Network Provider, means a person or entity that has a direct or indirect contractual arrangement with Cigna to provide services and/or supplies the Charges from which are Covered Health Services. It includes an entity that has directly or indirectly contracted with Cigna to arrange, through contracts with Providers of services and/or supplies, for the provision of any services and/or supplies the Charges for which are Covered Health Services.

Non-Covered Health Services

Services that are not Benefits specifically provided under the Plan, are excluded by the Plan, are provided by an Ineligible Provider, or are otherwise not eligible to be Covered Health Services, whether or not they are Medically Necessary.

Nurse

A Registered Graduate Nurse, a Licensed Practical Nurse or a Licensed Vocational Nurse who has the right to use the abbreviation “R.N.,” “L.P.N.,” or “L.V.N.”

Other Healthcare Facility / Other Healthcare Professional

A Facility other than a Hospital or Hospice Facility. Examples of Other Healthcare Facilities include, but are not limited to, licensed Skilled Nursing Facilities, rehabilitation Hospitals and subacute Facilities. Other Healthcare Professional means an individual other than a Physician who is licensed or otherwise authorized under the applicable state law to deliver medical services and supplies. Other Healthcare Professionals include, but are not limited to, physical therapists, registered Nurses and licensed practical Nurses. Other Healthcare Professionals do not include providers such as Certified First Assistants, Certified Operating Room Technicians, Certified Surgical Assistants/Technicians, Licensed Certified Surgical Assistants/Technicians, Licensed Surgical Assistants, Orthopedic Physician Assistants, and Surgical First Assistants.

Out-of-Network Benefits

Benefits for Covered Health Services that are provided by or directed by an Out-of-Network Physician either at a Network Facility or at an Out-of-Network Facility.

Out-of-Network Facility

A Facility that is an Out-of-Network Provider.

Out-of-Network Provider

A Provider, including but not limited to, a Hospital, Free-Standing Surgical Facility, Physician, Skilled Nursing Facility, Hospice, Home Health Care Agency, other medical practitioner or Provider of medical services or supplies, that does not have an agreement or contract with the Claims Administrator to provide services to its Members at the time services are rendered.

Out-of-Pocket Limit

The maximum amount of a Member's cost share payments during a Plan Year. When the Out-of-Pocket Limit is reached, the level of Benefits is increased to 100% of the Maximum Reimbursable Charge for Covered Health Services.

The following costs will never apply to the Out-of-Pocket Limit:

- Any Charges for services or supplies that are not Covered Health Services
- The amount of any reduced Benefits if you don't precertify services when required
- Charges that exceed the Maximum Reimbursable Charge
- Penalties
- Copayments for certain specialty pharmaceutical drugs listed at *www.express-scripts.com*

The annual individual and family Out-of-Pocket Limit amounts are shown on the Summaries of Benefits and Coverage

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.

Outpatient

Outpatient care, sometimes called ambulatory care, is defined as medical care or treatment that does not require an overnight stay in a hospital or medical facility. Outpatient care may be administered in a medical office or a hospital, but most commonly, it is provided in a medical office or Outpatient surgery center.

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.

Patient Protection and Affordable Care Act of 2010 (PPACA)

The Patient Protection and Affordable Care Act of 2010 (Public Law 111-148) as amended by the Health Care and Education Reconciliation Act of 2010 (Public Law 111-152).

Pharmacy & Therapeutics (P&T) Committee

A Cigna committee comprised of physicians and an independent pharmacist that represent a range of clinical specialties. The committee regularly reviews Medical Pharmaceuticals or Prescription Drug Products, including New Prescription Drug Products, for safety and efficacy, the findings of which clinical reviews inform coverage determinations made by the Business Decision Team. The P&T Committee's review may be based on consideration of, without limitation, U.S. Food and Drug Administration-approved labeling, standard medical reference compendia, or scientific studies published in peer-reviewed English-language bio-medical journals.

Physical Therapy

The care of disease or Injury by such methods as massage, hydrotherapy, heat, or similar care.

Physician

A licensed medical practitioner who is practicing within the scope of their license and who is licensed to prescribe and administer drugs or to perform surgery. It will also include any other licensed medical practitioner whose services are required to be covered by law in the locality where the policy is issued if they are:

- Operating within the scope of their license
- Performing a service for which Benefits are provided under this Plan when performed by a Physician

PLAN

The medical Plans (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 medical 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 medical 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 the Claims Administrator. The Plan Administrator is the Medical Trust.

PLAN SPONSOR

The legal entity that has adopted the Plan and has authorityregarding its operation, amendment, and termination. The Plan Sponsor is not the Claims Administrator. 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 Benefit Maximums and annual Deductibles accumulate during the Plan Year.

PREVENTIVE CARE

Routine healthcare, including screenings, check-ups, and patient counseling, to prevent or discover illness, disease, or other health problems.

PRIMARY CARE PHYSICIAN

A Physician who qualifies as a Network Provider in general practice, internal medicine, family practice or pediatrics; and who has been selected by you, as authorized by Cigna, to provide or arrange for medical care for you or any of your Eligible Dependents.

PRIOR AUTHORIZATION

The approval that a Network Provider must receive from the Review Organization, prior to services being rendered, in order for certain services and Benefits to be covered under this Plan.

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. Providers that delivery Covered Health Services are described

throughout this Plan Document Handbook. If you have a question if a Provider is covered, please call the number on the back of your Identification Card.

Residential Treatment Center / Facility

A Provider licensed and operated as required by law, which includes:

- Room, board, and skilled nursing care (either an RN or LVN/LPN) available on site at least eight hours daily with 24 hours availability
- A staff with one or more Physicians available at all times
- Residential treatment takes place in a structured Facility-based setting
- The resources and programming to adequately diagnose, care, and treat a psychiatric and/or substance use disorder
- Facility are designated residential, subacute, or intermediate care and may occur in care systems that provide multiple levels of care.
- Is fully accredited by The Joint Commission (TJC), the Commission on Accreditation of Rehabilitation Facilities (CARF), the National Integrated Accreditation for Healthcare Organizations (NIAHO), or the Council on Accreditation (COA)

The term Residential Treatment Center/Facility does not include a Provider, or that part of a Provider, used mainly for:

- Nursing care
- Rest care
- Convalescent care
- Care of the aged
- Custodial Care
- Educational care

Retail Health Clinic

A Facility that provides limited basic medical care services to Members on a “walk-in” basis. These clinics normally operate in major pharmacies or retail stores. Medical services are typically provided by Physicians Assistants and Nurse Practitioners. Services are limited to routine care and treatment of common illnesses for adults and Children.

Review Organization

An affiliate of Cigna or another entity to which Cigna has delegated responsibility for performing utilization review services. The Review Organization is an organization with a staff of clinicians which may include Physicians, Registered Graduate Nurses, licensed Mental Health and Substance Use Disorder professionals, and other trained staff members who perform utilization review services.

Seminarian

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

Semiprivate Room

A Hospital room which contains two or more beds.

Sickness

A physical or mental illness. It also includes pregnancy. Expenses incurred for routine Hospital and pediatric care of a newborn child prior to discharge from the Hospital nursery will be considered to be incurred as a result of Sickness.

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.

Skilled Nursing Facility

A licensed institution (other than a Hospital, as defined) which specializes in:

- Physical rehabilitation on an Inpatient basis
- Skilled nursing and medical care on an Inpatient basis, but only if that institution: maintains on the premises all facilities necessary for medical treatment; provides such treatment, for compensation, under the supervision of Physicians; and provides Nurses’ services.

Specialist

A Physician who provides specialized services, and is not engaged in general practice, family practice, internal medicine, obstetrics/gynecology, or pediatrics.

Specialty Prescription Drug Product

A Prescription Drug Product or Medical Pharmaceutical considered by Cigna to be a Specialty Prescription Drug Product based on consideration of the following factors, subject to applicable law: whether the Prescription Drug Product or Medical Pharmaceutical is prescribed and used for the treatment of a complex, chronic or rare condition; whether the Prescription Drug Product or Medical Pharmaceutical has a high acquisition cost; and, whether the Prescription Drug Product or Medical Pharmaceutical is subject to limited or restricted distribution, requires special handling and/or requires enhanced patient education, Provider coordination or clinical oversight. A Specialty Prescription Drug Product may not possess all or most of the foregoing characteristics, and the presence of any one such characteristic does not guarantee that a Prescription Drug Product or Medical Pharmaceutical will be considered a Specialty Prescription Drug Product. Specialty Prescription Drug Products may vary by Plan Benefit assignment based on factors such as method or site of clinical administration, or by tier assignment or utilization management requirements based on factors such as acquisition cost. You may determine whether a medication is a Specialty Prescription Drug Product through the website shown on your ID Card or by calling Member Services at the telephone number on your ID Card.

Subscriber

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

Surprise Billing Claim

A claim in respect of charges for Out-of-Network services described under “Surprise Billing Claims – Out-of-Network Charges for Certain Services” or “Surprise Billing Claims – Out-of-Network Emergency Services Charges,” above.

Terminal Illness

A Terminal Illness will be considered to exist if a person becomes terminally ill with a prognosis of six months or less to live, as diagnosed by a Physician.

Urgent Care

Medical, surgical, Hospital or related healthcare services and testing which are not emergency services, but which are determined by Cigna, in accordance with generally accepted medical standards, to have been necessary to treat a condition requiring prompt medical attention. This does not include care that could have been foreseen before leaving the immediate area where you ordinarily receive and/or were scheduled to receive services. Such care includes, but is not limited to, dialysis, scheduled medical treatments or therapy, or care received after a Physician's recommendation that the insured should not travel due to any medical condition.

PLEASE RETURN THIS COMPLETED FORM TO:

Office of Clinical Management
The Episcopal Church Medical Trust
19 East 34th Street
New York, NY 10016
(Confidential Fax: 212.251.8891)

AUTHORIZATION

FOR USE OR DISCLOSURE OF PROTECTED HEALTH INFORMATION

1. INDIVIDUAL AUTHORIZING USE OR DISCLOSURE

____
____
____

[Print name and address of individual who is the subject of the information.]

2. HEALTH PLAN(S) SPONSORED BY CHURCH PENSION GROUP SERVICES CORPORATION MAINTAINING THE RECORDS THAT ARE TO BE USED OR DISCLOSED (each Health Plan)

____
____
____

[Print name and address of each health plan or other specific description]

3. DESCRIPTION OF PROTECTED HEALTH INFORMATION TO BE USED OR DISCLOSED*

____
____
____
____
____

[Specifically describe the information to be used or disclosed. Include meaningful details such as date of service, type of service provided, level of detail to be released, origin of information, etc. Attach additional sheets, if necessary.]

***IMPORTANT NOTE: Unless the authorization is expressly limited, this authorization grants the Health Plan(s) the right to use or disclose ALL of the protected health information identified, including information about any diagnosis or treatment for any medical health, substance abuse, infectious disease (such as HIV/AIDS), cancer, mental health and/or genetic condition, for the purposes described.**

4. PERSON(S) TO WHOM INFORMATION MAY BE DISCLOSED

____
____
____

[Print name of individuals or organizations to receive information, if any.]

5. PURPOSE OF AUTHORIZATION TO USE OR DISCLOSE

____
____
____
____

[List specific purposes here.]

6. DURATION OF AUTHORIZATION

____

____

____

[Specify when authorization will expire by listing (1) a date or (2) an event that relates to the patient or the purpose of the use or disclosure.]

7. TO REVOKE THIS AUTHORIZATION, CONTACT:

Office of Clinical Management
The Episcopal Church Medical Trust
19 East 34th Street
New York, NY 10016
(Confidential Fax: 212.251.8891)

8. AUTHORIZATION AND ACKNOWLEDGEMENT OF PRIVACY RIGHTS

I authorize the Health Plan or Plans identified in item 2 to use and/or disclose the protected health information, as defined under the privacy regulations promulgated pursuant to the Health Insurance Portability and Accountability Act of 1996, described in item 3 to the persons listed in item 4 for the purposes described in item 5. This authorization shall remain in force and effect until the date or event specified in item 6 unless I furnish written notice of revocation to the person specified in item 7.

I understand that:

- a revocation is not effective to the extent that the parties named in this authorization have relied on the use or disclosure of the protected health information prior to the receipt of the revocation;
- information used or disclosed pursuant to this authorization may be subject to redisclosure by the recipient and may no longer be protected by federal or state law; and
- my health care provider(s) and health plan(s) may not condition my treatment, payment, enrollment in a health plan or eligibility for benefits (if applicable) on whether I provide authorization for the requested use or disclosure, except in certain circumstances. For example, if the purpose of a test or exam is to produce a record for my employment, I may be required to complete this authorization form before the test or exam is performed.

____ ____________________

Signature of Individual or Personal Representative Date

If a personal representative is signing the form on behalf of the individual whose protected health information is to be used or disclosed, please print the name of the personal representative and describe their authority to act on behalf of the individual.

____

*[Name of Personal Representative]**

____

____

____

[Authority of Personal Representative]

*Personal representative includes:

- Person who (1) has health care power of attorney, or (2) is the parent or legal guardian of a minor.
- If you are not (1) or (2) above, identify your relationship to the individual and your involvement in the individual's health care. The plan sponsor will determine whether disclosure to you is in the best interest of the individual.

Note to Individual: The decision of whether to accept this authorization is made solely by the person or entity whom you are authorizing to disclose information.

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
cpg.org
(800) 480-9967
Email: *mtcustserv@cpg.org*
Monday through Friday, 8:30 AM – 8:00 PM ET

CIGNA HEALTHCARE
mycigna.com
(800) 244-6224
Monday through Friday, 8:00 AM – 6:00 PM

CIGNA BEHAVIORAL HEALTH (FOR THE EAP)
mycigna.com
(866) 395-7794
24 hours a day, seven days a week

EXPRESS SCRIPTS
express-scripts.com
(800) 841-3361
24 hours a day, 7 days a week

EyeMed Vision Care
eyemedvisioncare.com/ecmt
(866) 723-0513
Monday through Saturday, 8:00 AM – 11:00 PM ET, and Sunday, 11:00 AM – 8:00 PM ET

Health Advocate
healthadvocate.com/ecmt
(866) 695-8622
24 hours a day, 7 days a week
Normal business hours are Monday through Friday, 8:00 AM – 9:00 PM ET

UnitedHealthcare Global Assistance
members.uhcglobal.com
(410) 453-6330 (collect calls accepted)
24 hours a day, 7 days a week

For more information about EyeMed Vision Care, Health Advocate, and UnitedHealthcare Global Assistance, visit: *https://www.cpg.org/active-lay-employees/insurance/health-and-wellness/additional-benefits/*.

Your Rights and Protections Against Surprise Medical Bills

When you get emergency care or are treated by an out-of-network provider at an in-network hospital or ambulatory surgical center, you are protected from balance billing. In these cases, you shouldn't be charged more than your plan's copayments, coinsurance and/or deductible.

What is "balance billing" (sometimes called "surprise billing")?

When you see a doctor or other health care provider, you may owe certain out-of-pocket costs, like a copayment, coinsurance, or deductible. You may have additional costs or have to pay the entire bill if you see a provider or visit a health care facility that isn't in your health plan's network.

"Out-of-network" means providers and facilities that haven't signed a contract with your health plan to provide services. Out-of-network providers may be allowed to bill you for the difference between what your plan pays and the full amount charged for a service. This is called "**balance billing.**" This amount is likely more than in-network costs for the same service and might not count toward your plan's deductible or annual out-of-pocket limit.

"Surprise billing" is an unexpected balance bill. This can happen when you can't control who is involved in your care—like when you have an emergency or when you schedule a visit at an in-network facility but are unexpectedly treated by an out-of-network provider. Surprise medical bills could cost thousands of dollars depending on the procedure or service.

You're protected from balance billing for:

Emergency services

If you have an emergency medical condition and get emergency services from an out-of-network provider or facility, the most they can bill you is your plan's in-network cost-sharing amount (such as copayments, coinsurance, and deductibles). You **can't** be balance billed for these emergency services. This includes services you may get after you're in stable condition, unless you give written consent and give up your protections not to be balanced billed for these post-stabilization services.

Certain services at an in-network hospital or ambulatory surgical center

When you get services from an in-network hospital or ambulatory surgical center, certain providers there may be out-of-network. In these cases, the most those providers can bill you is your plan's in-network cost-sharing amount. This applies to emergency medicine, anesthesia, pathology, radiology, laboratory, neonatology, assistant surgeon, hospitalist, or intensivist services. These providers **can't** balance bill you and may **not** ask you to give up your protections not to be balance billed.

If you get other types of services at these in-network facilities, out-of-network providers **can't** balance bill you, unless you give written consent and give up your protections.

You're never required to give up your protections from balance billing. You also aren't required to get out-of-network care. You can choose a provider or facility in your plan's network.

When balance billing isn't allowed, you also have these protections:

- You're only responsible for paying your share of the cost (like the copayments, coinsurance, and deductible that you would pay if the provider or facility was in-network). Your health plan will pay any additional costs to out-of-network providers and facilities directly.

- Generally, your health plan must:
    - Cover emergency services without requiring you to get approval for services in advance (also known as “prior authorization”).
    - Cover emergency services by out-of-network providers.
    - Base what you owe the provider or facility (cost-sharing) on what it would pay an in-network provider or facility and show that amount in your explanation of benefits.
    - Count any amount you pay for emergency services or out-of-network services toward your in-network deductible and out-of-pocket limit.

If you think you’ve been wrongly billed, contact the federal No Surprises Help Desk at 1-800-985-3059.

Visit https://www.cms.gov/nosurprises/consumers for more information about your rights under federal law.

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, 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 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.