Plan Document Handbook

Anthem Blue Cross and Blue Shield

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Benefits effective as of January 2019

EPISCOPAL CHURCH MEDICAL TRUST

Anthem BlueCross BlueShield

INTRODUCTION

The Episcopal Church Medical Trust (Medical Trust) maintains a series of benefit plans (each a "Plan" and collectively, the "Plans") for the Employees (and their Dependents) of the Protestant Episcopal Church in the United States of America (hereinafter, 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 now serves more than 24,000 active Employees and Eligible Dependents; and over 9,000 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 they are exempt from the requirements of the Employee Retirement Income Security Act of 1974 (ERISA), as amended.

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 compassionate 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 Church offers a level of expertise that is unparalleled. If you have questions about any of our plans, please don't hesitate to contact us. We're looking forward to serving you.

For more information, please visit our website at ***www.cpg.org***; or call Client Services at (800) 480-9967.

Benefits described in this Plan Document Handbook are effective as of January 1, 2019.

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CHAPTER 1
IMPORTANT NOTICES

NEWBORNS' AND MOTHERS' HEALTH PROTECTION ACT OF 1996

The Plan covers 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 email at *mtcustserv@cpg.org*.

NOTICE OF NONDISCRIMINATION

The Medical Trust complies with applicable federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. The Medical Trust does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex.

The Medical Trust:

- Provides free aids and services to people with disabilities to communicate effectively with us, such as qualified interpreters and written information in other formats such as large print materials.
- Provides free language services to people whose primary language is not English, such as information written in other languages.

If you need these services, contact Adriene Clarke, Civil Rights Coordinator.

If you believe the Medical Trust has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can obtain a copy of the grievance procedures or file a grievance with:

Adriene Clarke, Civil Rights Coordinator
Church Pension Group
19 East 34th Street
New York, NY 10016

Phone: 212-592-6299; fax: 212-592-9487; email: *aclarke@cpg.org*.

You can file a grievance by mail, fax, or email. If you need help filing a grievance, Adriene Clarke, Civil Rights Coordinator, is available to help you.

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights, electronically through the Office for Civil Rights Complaint Portal, available at *https://ocrportal.hhs.gov/ocr/portal/lobby.jsf*, or by mail or phone at:

U.S. Department of Health and Human Services, 200 Independence Avenue SW
Room 509F, HHH Building
Washington, DC 20201

Phone: 1-800-368-1019, 1-800-537-7697 (TDD).

Complaint forms are available at *http://www.hhs.gov/ocr/office/file/index.html*.

ATENCION: Si habla espanol, tiene a su disposicion servicios gratuitos de asistencia linguistica. Llame al 1-800-480-9967.

주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 1-800-480-9967.
ةظوحلم: اذإ تنك ثدحتت ركذا ةغلاا، نإف تامدخ ةدعاسملا ةيوغلا رفاوتت كل ناجملاب. لصتا مقرب
1-800-480-9967.

ATENCAO: Se fala portugues, encontram-se disponiveis servicos linguisticos, gratis. Ligue para 1-800-480-9967.

ATTENZIONE: In caso la lingua parlata sia l'italiano, sono disponibili servizi di assistenza linguistica gratuiti. Chiamare il numero 1-800-480-9967.

注意：如果您使用繁體中文，您可以免費獲得語言援助服務。請致電 1-800-480-9967.

PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tumawag sa 1-800-480-9967.

ATANSYON: Si w pale Kreyol Ayisyen, gen sevis ed pou lang ki disponib gratis pou ou. Rele 1-800-480-9967.

UWAGA: Jeżeli mowisz po polsku, możesz skorzystać z bezpłatnej pomocy językowej. Zadzwoń pod numer: 1-800-480-9967.

ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfugung. Rufnummer: 1-800-480-9967.

CHU Y: Nếu bạn noi Tiếng Việt, co cac dịch vụ hỗ trợ ngon ngữ miễn phi danh cho bạn. Gọi số 1-800-480-9967.

ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните: 1-800-480-9967.

ATTENTION : Si vous parlez francais, des services d'aide linguistique vous sont proposes gratuitement. Appelez le: 1-800-480-9967.

注意事項：日本語を話される場合、無料の言語支援をご利用いただけます。 1-800-480-9967.

مهارف یم دشاب. اب سامت دیریگب. **هجوت**: رگا هب نابز یسراف وگتفگ یم دینک، تالیهست ینابز تروصب ناگیار یارب امش 1-800-480-9967

CHAPTER 2
ELIGIBILITY AND ENROLLMENT

ELIGIBILITY FOR THE EPISCOPAL HEALTH PLAN (EHP)

The Medical Trust determines the eligibility rules 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 terms "Eligible Individual" and "Eligible Dependent," as defined below, are used throughout this document and identified with capital letters.

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

Eligible Individuals

- An Exempt Employee
- A Non-Exempt 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 Retired Employee, not eligible for Medicare, as long as his/her 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 his/her 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 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, of a Post-65 Retired Employee enrolled in the MSHP***
- A Pre-65 Surviving Dependent of a deceased Post-65 Retired Employee or Pre-65 Retired Employee***
- A Pre-65 Dependent, of a Pre-65 Retired Employee enrolled in the MSHP****

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

Ineligible Individuals

[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.

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

- A part-time Non-Exempt Employee who is scheduled to work and be compensated for less than 1,000 hours per Plan Year unless such Employee is required to be treated as a Full-Time Employee under the Pay or Play Rules
- A Temporary Employee unless such Employee is required to be treated as a Full-Time Employee under the Pay or Play Rules
- A Seasonal Employee unless such Employee is required to be treated as a Full-Time Employee under the Pay or Play Rules
- A Seminarian who is not a full-time student or not enrolled at a participating seminary of the Association of Episcopal Seminaries
- A parent or other relative of a Subscriber, including grandchildren and in-laws, not listed in the Eligible Dependents section above
- A Post-65 Retired Employee or Pre-65 Retired Employee (or Spouse/Domestic Partner) eligible for Medicare, regardless of whether he or she is 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/Subscriber's Spouse/Domestic Partner for adoption

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 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.

Important Notes

Waiting Periods

The Plan does not require, or allow Participating Groups to require, that an Eligible Individual must be employed or be part of the Participating Group for any length of time before being allowed to participate in the Plan. Additional information on new hires can be found in the Plan Election and Enrollment Guidelines section.

Medicare/Medicaid

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

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

If the Member is approved and enrolled, Medicare would become the primary payer of claims covered under Medicare Part A only. Part A is hospitalization insurance that helps cover inpatient care in hospitals, skilled nursing facilities, hospices, and home health care situations. The EHP SEE will act as the secondary payer of claims. The Plan will coordinate benefit payments with Medicare so that any claims not paid by Medicare will be processed under the EHP.
If the Member is enrolled in Medicare Part B, which covers services such as doctor visits, outpatient procedures, and some prescription drugs, the Anthem Blue Cross and Blue Shield Plan or the Cigna Plan he or she is enrolled in will coordinate benefit payments with Medicare. If the Member is not enrolled in Medicare Part B, the Anthem or Cigna Plan 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 terms "Eligible Individual" and "Eligible Dependent," as defined below, are used throughout this document and identified with capital letters.

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.
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 Exempt Employee

- A Non-Exempt 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 who was eligible to participate in the EHP prior to his/her disability

Eligible Dependents

- A Spouse*
- A Domestic Partner, if Domestic Partner Benefits are elected by the Participating Group
- A Child who is 30 years of age or younger on December 31 of the current year
- A Disabled Child, 30 years of age or older on December 31 of the current year, provided the disability began before the age of 25**

**For information on the eligibility of a former Spouse refer to the Termination of Individual Coverage, under Divorce*
***The Dependent must be enrolled under the Subscriber's Plan.*

Ineligible Individuals

Individuals described below are <u>not</u> 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 Non-Exempt 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

ELIGIBILITY FOR THE MEDICARE SUPPLEMENT HEALTH PLAN (MSHP)

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

Once Medicare becomes a Member's primary coverage, the medical coverage will be coordinated with Medicare. Generally, one becomes eligible for Medicare at age 65, although a person may become eligible sooner if he or she becomes disabled. If a Member chooses not to enroll in Medicare Part B coverage or misses the enrollment deadline, the Plan will pay medical Benefits assuming the Member is covered by both Part A and Part B. United Healthcare will estimate Medicare payments. Therefore, a Member may be responsible for the difference between total billed charges and the combined benefit from the estimated amount covered by Medicare Part A and Part B and the medical plan.

The terms "Eligible Individual" and "Eligible Dependent," as defined below, are used throughout this document and identified with capital letters.

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

Eligible Individuals

- A Post-65 Retired Employee
- A Retired Member of a Religious Order
- A Pre-65 Retired Employee who is enrolled in Medicare
- Cleric receiving Benefits under The Church Pension Fund Clergy Long-Term Disability Plan who is enrolled in Medicare

Eligible Dependents

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

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

Important Notes

Medicare Secondary Payer (MSP)

The Plan must comply with the government's Medicare Secondary Payer (MSP) law, which outlines when Medicare is not responsible for paying first for health claims. The government designed Medicare to provide health coverage for retired individuals. Medicare requires employers' group health plans to be the primary payer of health claims for individuals who are working and eligible for active group health care 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 Plan cannot determine this policy. This policy should comply with the Age Discrimination in Employment Act (ADEA), 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 or Medicare HMOs for Medicare beneficiaries who are otherwise eligible for active group health coverage. Therefore, the Plan does not offer Medicare supplement health plans or Medicare HMOs to Employees and their Spouses over age 65, 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 or 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.

Eligible small employers must apply to the Centers for Medicare and Medicaid Services (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 through EyeMed
- Employee Assistance program through Cigna Behavioral Health
- Health Advocate
- Amplifon Hearing Health Care discounts
- UnitedHealthcare Global Assistance 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 Retired Employee is eligible for employer-provided health Benefits such as coverage under the EHP, Medicare prohibits the Plan from offering the Post-65 Retired Employee coverage under the MSHP. Depending upon the size of the Employer, the Member may be eligible for the EHP SEE.

If the Post-65 Retired 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 Retired Employee may be eligible to purchase the MSHP.

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 Plans' 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 Plans and their administrators rely on information provided by Subscribers when evaluating the coverage and Benefits under the Plans. 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 Plans.

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 his/her elected Plan or Coverage Tier except during Annual Enrollment, unless there is a Significant Life Event or a 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 Retired Employee or Post-65 Retired Employee)
- Judgment, decree or order (e.g., Qualified Medical Child Support Order (QMCSO))
- Change in residence or work site for a Subscriber or Dependent that affects Network access to the current Plan

  For example, if a Subscriber previously resided in an area in which only the PPO was available and then moved into an area where the EPO and PPO are available, the Subscriber may elect a new Plan. Conversely, if a Subscriber moved out of the EPO service area, and was therefore no longer eligible for the EPO, the Subscriber may elect a new Plan.

- Significant change in cost 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 of a Post-65 actively working Subscriber or Subscriber's Spouse to participate in the EHP SEE
- Any other Significant Life Events provided under the applicable regulations and provided for under the employer's Section 125 Plan

IMPORTANT NOTE: A Healthcare 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 a 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 Special Enrollment Events that would allow an Eligible Individual who is not covered by the Plan to enroll him/herself and his or her Eligible Dependents for coverage under the Plan outside of the Annual Enrollment period. 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 Special Enrollment Event, but will have 60 days to enroll in the Plan as a result of a 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 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 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.

ANNUAL ENROLLMENT

Annual Enrollment is the annual period during which Subscribers of the EHP and the EHP SEE 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, a personal login and password, 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[2]
- 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 hire date or date the individual became part of the Participating Group or became 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 active Annual Enrollment in the fall, with changes becoming effective January 1 of the following year.

New plan elections for Seminarians who begin studying in the spring semester may be submitted before the commencement of classes. Plan elections must be submitted before the semester in which the Seminarian is enrolling commences. Seminarians must complete an enrollment form and submit it to the Seminary Group Administrator. 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.

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

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 a 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 he or she becomes eligible. For example, if the date of hire is Monday, June 2, then coverage is effective July 1.

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

If the Employee does not enroll (or is not automatically enrolled by the Participating Group, if applicable) when initially 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 he or she is received or accepted by the Order.

However, if a postulant, novice, or Member is received or accepted by the 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 he or she 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 he or she enrolls 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 when initially eligible, then he or she 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 Retired Employees

A Pre-65 Retired 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 Retired Employee status* is received by the Plan within 30 days of the retirement date.

If the Pre-65 Retired 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 Retired Employee does not make an election change within 30 days of the retirement date, then he or she 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 Retired Employee becomes Medicare-eligible, he or she must actively switch enrollment to the Medicare Supplement Health Plan (MSHP). 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 he or she too must actively switch enrollment to the MSHP. The enrolled Children who are not Disabled may remain in the EHP until the end of the year in which they reach age 30.

If the Pre-65 Retired Employee has a Spouse who becomes age 65 and is not actively working, the Post-65 Spouse of the Pre-65 Retired Employee is allowed to enroll in the MSHP provided he or she is enrolled in Medicare Parts A and B. The Pre-65 Retired Employee remains in the EHP. This reverse split is allowed because the Subscriber is a Pre-65 Retired Employee.

IMPORTANT NOTE: An Employee who terminates his/her employment with a Participating Group prior to meeting the eligibility requirements for a Pre-65 Retired Employee will be offered an Extension of Benefits.

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

Enrollment in the EHP for Pre-65 Retired 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 you were covered under that group's plan and included in the group census.

For these limited circumstances, the Pre-65 Retired 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 he or she becomes Medicare-eligible, at which time the Employee must actively switch enrollment to the MSHP. 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 he or she too must actively switch enrollment to the MSHP.

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.

Health plan elections must be received by the Plan no later than 30 days after a HIPAA Special Enrollment Event or Annual Enrollment.

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.

New Children

A Subscriber's newborn Child is temporarily covered under the Plan for the first 30 days immediately following birth. However, 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.

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, is a legal ward or foster child of the Subscriber/Subscriber's Spouse/Domestic Partner.

Adopted Children

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

Domestic Partners

A Subscriber may enroll his/her 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 his/her eligible Domestic Partner within 30 days after submission of a valid Domestic Partner 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 Retired Employee and his/her Eligible Dependents may split enrollment between the EHP and the MSHP in cases where the Post-65 Retired 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, he or she must actively switch enrollment to the MSHP. 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.

Disabled Child

If the Dependent Child is a Disabled Child prior to his/her 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. Lincoln Financial Group is the third-party administrator who is the Medical Board that will review satisfactory proof of disability and determine the status of the Disabled Child. Lincoln Financial Group will contact the Subscriber with the request for documentation. Satisfactory proof of disability must be confirmed by the Plan no later than 30 days after the end of the month in which the Child reaches age 25. 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 with qualifying incomes 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.
- National Medical Support Notice orders automatically meet the requirements above.

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

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

If a QMCSO requires that the Subscriber provide health coverage for his/her 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 his/her 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.[3]

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 Benefits 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, the Member can retain his/her active coverage. If the leave of absence is unpaid, 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.

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

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 he or she is 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)
  - The Dependent no longer meets the eligibility requirements for any reasons other than death or turning age 30 (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
- The date the Plan ceases to exist

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.

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 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, his/her Surviving Dependents who are also enrolled in the EHP at that time are offered an Extension of Benefits. The coverage termination date will be the last day of the month in which the Subscriber's death occurred. The new coverage effective date for the Surviving Dependents who choose to enroll in the Extension of Benefits Program will be the first day of the month following the Subscriber's date of death.

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

When a Post-65 Retired Employee or a Pre-65 Retired Employee enrolled in Medicare and enrolled in the MSHP dies, Surviving Spouses and Surviving Domestic Partners enrolled in the MSHP at the time of the Member's death can remain covered in the MSHP. Children enrolled in the EHP may remain in the EHP until the last day of the year in which they turn 30 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 MSHP.

- *Pre-65 Retired Employee* or Cleric receiving Benefits under The Church Pension Fund Clergy Long-Term Disability Plan
- When a Pre-65 Retired 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 en-

rolled in Medicare dies, the Surviving Spouse or Surviving Domestic Partner who is also enrolled in the EHP can remain covered until he or she becomes Medicare-eligible, at which time he or she must actively enroll in the MSHP if eligible. His/her enrolled Children may remain in the EHP until the last day of the year in which they turn 30 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 MSHP.

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

The divorced Spouse 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 effective date of the divorce.

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 MSHP at a later date. Please see the Extension of Benefits section for more details.

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

The Pre-65 Spouse or Domestic Partner enrolled in the EHP who gets divorced from a Post-65 Retired Employee or Pre-65 Retired Employee can stay enrolled in the EHP. However, if the Spouse or Domestic Partner leaves the EHP, then he or she cannot enroll again with the Plan until he or she becomes eligible for the MSHP. He or she can leave the MSHP and join again at future Annual Enrollment periods.

Post-65 Retired Employees or Pre-65 Retired Employees with Dependents in the MSHP

The Spouse or Domestic Partner enrolled in the MSHP who gets divorced from a Post-65 Retired Employee or Pre-65 Retired Employee can stay enrolled in the MSHP. He or she can leave the MSHP 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.[4] 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.
- Dependent Children whose coverage is terminated for any reason other than due to attaining age 30 are offered an extension of up to 36 months starting on the first day of the month following the termination event. The extension will end after 36 months for Disabled Children. For non-Disabled Children, the extension will end after 36 months or on the last day of the calendar year in which the Child turns age 30, whichever comes first.[5]
- 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.

Note: Regardless of the type of severance payment agreed upon between the employer and Employee (lump sum or monthly payments), 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 the extension 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.

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

[5] As such, a Dependent who loses coverage because of attaining age 30 will not be eligible for an Extension of Benefits.

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 to ensure there is no coverage gap between the termination date and enrollment in the Extension of Benefits.

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

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

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

- The date that required monthly contributions to the Plan are 60 days overdue
- The date the Member becomes a Post-65 Retired Employee
- The last day of the month of the Extension of Benefits 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
- The date the Plan ceases to exist
- The last day of the calendar year in which a Non-Disabled Dependent Child turns age 30

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 MSHP). 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 third-party administrators and local managed care plans on your behalf. The Episcopal Church Medical Trust is the plan sponsor and plan administrator of all 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 local managed care plan options offered by us. 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 BLUECARD PPO NETWORK

The Medical Trust health plan described in this document is built around a Network of Healthcare Providers available to our Members through the BlueCross and BlueShield Associations BlueCard Preferred Provider Organization (PPO), hereinafter known as the "BlueCard PPO." The suitcase logo on the ID card indicates Membership in the BlueCard PPO Program. A PPO is a group of Healthcare Providers that have agreed to provide medical care services at a contracted rate through the PPO. The term "Healthcare Providers" includes doctors, hospitals, laboratories, and other medical facilities that provide healthcare services.

Some Healthcare Providers contract with Anthem or other BlueCross and/or BlueShield Networks to provide services to Members as part of the BlueCard PPO Network. PPO providers are also referred to as a "Network" or "Network providers." The terms "Non-Network" or "Out-of-Network" refer to Healthcare Providers that do not participate in the BlueCard PPO Network.
You will incur more out-of-pocket costs if you use an Out-of-Network Healthcare Provider.

THE BLUECARD® PPO NETWORK ADVANTAGE

Members using the BlueCard PPO Network for healthcare get:

- Access to a Network of doctors and hospitals across the country
- No out-of-pocket costs for most Preventive Care and a wide variety of hospital and medical services
- Ease of use—no claim forms to file
- Coverage when traveling or temporarily residing outside the Member's service area

ANTHEM'S MEDICAL MANAGEMENT PROGRAM

When seeking healthcare, please note that the Plan is structured so that our Members have the lowest out-of-pocket cost for healthcare coverage when using Network providers. Members have the flexibility of seeking care directly from any type of Network provider, including specialists. For most visits, Members simply choose a Network physician and make an appointment when care is needed.

Providers in the BlueCard PPO Network will maintain traditional Healthcare Provider/patient relationships with our Members for the provision of hospital and other medical services. Such relationships include the right of providers in the BlueCard PPO Network to commence or terminate treatment in accordance with generally accepted principles of medical practice and treatment.

Nothing contained in this Plan will require a provider in the BlueCard PPO Network to commence or continue medical treatment for our Members, and nothing contained in this Plan will require our Members to commence or continue medical treatment with a particular provider in the BlueCard PPO Network. Anthem administers this PPO Plan; however, Members will use PPO providers from local Blue Cross and/or Blue Shield Networks within each state.

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

Please remember to precertify hospital and other facility admissions, maternity care, and other designated services requiring preauthorization in order to ensure maximum Benefits.

Precertification gives you and your doctor an opportunity to learn what the Plan will cover and identify treatment alternatives and the proper setting for care—for instance, a hospital or your home.

Knowing these things in advance can help to save time and money. If precertification is not done when required, Benefits may be denied. Note that precertification does not guarantee coverage or payment of Benefits.

Ask Questions About Your Healthcare Coverage

To find answers, you can:

- Read this Plan Document Handbook.
- Call Anthem's Member Services at (844) 812-9207 when you have questions about your Plan Benefits in general or your Benefits for a specific medical service or supply.
- Call Anthem 24/7 NurseLine® — available to Members 24 hours a day to get recorded general health information or to speak to a nurse to discuss healthcare options and more. Just call the number on the back of your ID card.

Talk to your provider about your care, learn about your Benefits and your options, and ask questions. The BlueCard PPO Network is here to work with you and your provider to see that you get the best Benefits while receiving the quality healthcare you need.

Know the Basics

Choice—our Members can choose any participating provider from the national Network of BlueCard PPO providers.

Freedom—referrals are not needed to see a specialist, so you direct your care.

Broad coverage—Benefits are available for a broad range of healthcare services, including visits to specialists, physical therapy, and home healthcare.

Convenience—usually, there are no claim forms to file. For Out-of-Network services (including Emergency care), you may need to file a claim for reimbursement.

Anthem Health Guides

Imagine making just one phone call and talking with one person when you have a question about your Benefits coverage or your health. That's the idea behind Anthem's Health Guides, a new, enhanced customer service team at Anthem. Members enrolled in Anthem health plans have access to Anthem's Health Guides to help them and their covered family Members:

- Connect with programs and support covered by their Benefits, such as medical coverage and the Healthy Living Program
- Stay on top of exams, tests, or preventive screenings by reminding them to make appointments or helping them to make appointments
- Compare costs on healthcare services, find Network doctors, and much more

Anthem's Health Guides will also connect Members and their covered Dependents to personal health consultants—nurses who can recommend next steps in dealing with health problems. They

can help our Members:

- Make plans to meet goals such as losing weight, eating better, or quitting tobacco
- Get advice from specialized medical professionals
- Arrange care if surgery or a procedure is needed
- Understand what to expect if hospitalized and how to follow a doctor's plan of care afterwards
- Handle a serious or complex condition and get the help needed
- Recommend other no-cost programs that can help along the way

Anthem's personal health consultants may also reach out directly to our Members if they see a need and can assist, such as by offering help with asthma, diabetes, or heart conditions.

If you have any questions regarding the information contained in this section, you may call the Customer Service telephone number (844) 812-9207 and speak with an Anthem Health Guide.

Chapter 4
Precertification and Medical Management

Your Plan includes a number of components of medical management, including precertification, AIM Specialty Health for Imaging, and case management.

Their purpose is to promote the delivery of cost-effective medical care by reviewing the use of procedures and, where appropriate, the setting or place of service in which procedures are performed. Your Plan requires that covered services be Medically Necessary for Benefits to be provided. The Plan does not cover Experimental or Investigative services or drugs. When setting or place of service is part of the review, services that can be safely provided to you in a lower-cost setting will not be considered Medically Necessary if they are performed in a higher-cost setting.

Network providers are required to obtain prior authorization in order for you to receive Benefits for certain services. Prior authorization criteria will be based on multiple sources, including medical policy, clinical guidelines, and pharmacy and therapeutics guidelines. The Claims Administrator may determine that a service that was initially prescribed or requested is not Medically Necessary if you have not previously tried alternative treatments which are more cost effective.

If you have any questions regarding the information contained in this section, you may call the Customer Service telephone number at (844) 812-9207 or visit *www.anthem.com*.

Types of Requests

Precertification: A required review of a service, treatment, or admission for a Benefit coverage determination which must be obtained prior to the service, treatment, or admission start date. For Emergency admissions, you, your authorized representative, or your physician must notify the Claims Administrator within two business days after the admission or as soon as possible within a reasonable period of time. For childbirth admissions, precertification is not required unless there is a complication and/or the mother and baby are not discharged at the same time.

Predetermination: An optional, voluntary prospective or concurrent/continued stay review request for a Benefit coverage determination for a service or treatment. The Claims Administrator will review your Plan to determine if there is an exclusion for the service or treatment. If there is a related clinical coverage guideline, the Benefit coverage review will include a review to determine whether the service meets the definition of Medical Necessity under this Plan or is Experimental/Investigative as that term is defined in this Plan.

Post-service clinical claims review: A retrospective review for a Benefit coverage determination to determine the Medical Necessity or Experimental/Investigative nature of a service, treatment, or admission that did not require precertification and did not have a predetermination review performed. Medical reviews occur for a service, treatment, or admission for which the Claims Administrator has a related clinical coverage guideline and are typically initiated by the Claims Administrator.

Precertification and medical management are not intended to diagnose or treat medical conditions, guarantee Benefits, make payments, or validate eligibility for Plan coverage, but rather they focus on making recommendations regarding the appropriateness and Medical Necessity of specified health services. The final medical decisions regarding treatment are always made between you and your treating physician.

The following list of services requiring Plan notification is not all-inclusive and is subject to change. Please call the Customer Service telephone number on your ID card to confirm the most current list and requirements for this Plan.

Inpatient admission:

- Inclusive of all acute inpatient, skilled nursing facility, long-term acute rehab, and OB delivery stays beyond the federal mandate minimum length of stay (including newborn stays beyond the mother's stay)
- Emergency admissions (requires Plan notification no later than two business days after admission)

Outpatient services:

- Ablative techniques as a treatment for Barrett's Esophagus
- Air ambulance (excludes 911-initiated Emergency transport)
- Balloon and self-expanding absorptive sinus ostial dilation
- Bariatric surgery and other treatments for clinically severe obesity
- Bone-anchored and bone conduction hearing aids
- Breast procedures including reconstructive surgery, implants, and others
- Cardiac resynchronization therapy (CRT) with or without an implantable cardioverter defibrillator (CRT/ICD) for the treatment of heart failure
- Carotid, vertebral, and intracranial artery angioplasty with or without stent placement
- Cervical total disc arthroplasty
- Cochlear implants and auditory brainstem implants
- Computer-assisted musculoskeletal surgical navigational orthopedic procedures of the appendicular system
- Cryoablation for plantar fasciitis and plantar fibroma
- Cryopreservation of oocytes or ovarian tissue
- Cryosurgical ablation of solid tumors outside the liver
- Deep brain, cortical, and cerebellar stimulation
- Diagnostic testing
    - Gene expression profiling for managing breast cancer treatment
    - Genetic testing for cancer susceptibility
- DME/prosthetics
    - Electrical bone growth stimulation
    - Augmentative and alternative communication (AAC) devices/speech generating devices (SGD)
    - External (portable) continuous insulin jnfusion pump
    - Functional electrical stimulation (FES), threshold electrical stimulation (TES)
    - Microprocessor-controlled lower limb prosthesis
    - Oscillatory devices for airway clearance including high frequency chest compression and intrapulmonary percussive ventilation (IPV)
    - Pneumatic pressure devices for lymphedema
    - Wheeled mobility devices: wheelchairs—powered, motorized, with or without power seating systems and power operated vehicles (POVs)
    - Wheeled mobility devices: manual wheelchairs—ultra lightweight
    - Prosthetics: electronic or externally powered and select other prosthetics
    - Standing frame
- Electrothermal shrinkage of joint capsules, ligaments, and tendons
- Extracorporeal shock wave therapy for orthopedic conditions
- Extraosseous subtalar joint implantation and subtalar arthroereisis
- Implantable ambulatory event monitors and mobile cardiac telemetry
- Functional endoscopic sinus surgery
- Gastric electrical stimulation
- Gender reassignment surgery

- Hyperbaric oxygen therapy (systemic/topical)
- Implantable ambulatory event monitors and mobile cardiac telemetry
- Implantable or wearable cardioverter-defibrillator
- Implantable infusion pumps
- Implantable middle ear hearing aids
- Implanted devices for spinal stenosis
- Implanted (epidural and subcutaneous) spinal cord stimulators (SCS)
- Intraocular anterior segment aqueous drainage devices (without extraocular reservoir)
- Locally ablative techniques for treating primary and metastatic liver malignancies
- Lumbar spinal fusion and lumbar total disc arthroplasty
- Lung volume reduction surgery
- Lysis of epidural adhesions
- Mandibular/maxiliary (orthognathic) surgery
- Manipulation under anesthesia of the spine and joints other than the knee
- Maze procedure
- MRI-guided high intensity focused ultrasound ablation of uterine fibroids
- Occipital nerve stimulation
- Oral, pharyngeal, and maxillofacial surgical treatment for obstructive sleep apnea or snoring
- Ovarian and internal iliac vein embolization as a treatment of pelvic congestion syndrome
- Partial left ventriculectomy
- Penile prosthesis implantation
- Percutaneous neurolysis for chronic neck and back pain
- Photocoagulation of macular drusen
- Plastic/reconstructive surgeries:
    - Abdominoplasty, panniculectomy, diastasis recti repair
    - Blepharoplasty
    - Brachioplasty
    - Buttock/thigh lift
    - Chin implant, mentoplasty, osteoplasty mandible
    - Insertion/injection of prosthetic material collagen implants
    - Liposuction/lipectomy
    - Procedures performed on male or female genitalia
    - Procedures performed on the face, jaw, or neck (including facial dermabrasion and scar revision)
    - Procedures performed on the trunk and groin
    - Repair of pectus excavatum/carinatum
    - Rhinoplasty
    - Skin-related procedures
- Percutaneous vertebroplasty, kyphoplasty, and sacroplasty
- Presbyopia and astigmatism-correcting intraocular lenses
- Private duty nursing
- Radiation therapy
    - Intensity modulated radiation therapy (IMRT)
    - Stereotactic radiosurgery (SRS) and stereo body radiotherapy (SBRT)
    - Proton beam therapy
- Radiofrequency ablation to treat tumors outside the liver
- Sacral nerve stimulation as a treatment of neurogenic bladder secondary to spinal cord injury
- Sacroiliac joint fusion
- Septoplasty
- Suprachoroidal injection of a pharmacologic agent
- Surgical and ablative treatments for chronic headaches
- Surgical and minimally invasive treatments for benign prostatic hyperplasia (BPH) and other GU conditions
- Surgical treatment of obstructive sleep apnea and snoring
- Treatment of hyperhidrosis
- Tonsillectomy in children with or without adenoidectomy

- Total ankle replacement
- Transcatheter closure of patent foramen ovale and left atrial appendage for stroke prevention
- Transcatheter uterine artery embolization
- Transmyocardial/preventicular device closure of ventricular septal defects
- Transtympanic micropressure for the teatment of Ménière's Disease
- Treatment of osteochondral defects of the knee and ankle
- Treatment of temporomandibular disorders
- Treatment of varicose veins (lower extremities)
- Vagus nerve stimulation
- Viscocanalostomy and canaloplasty

Human organ and bone marrow/stem cell transplants

- Inpatient admits for all solid organ and bone marrow/stem cell transplants (Including kidney-only transplants)
- Outpatient: all procedures considered to be transplant or transplant-related, including but not limited to:
    - Stem cell/bone marrow transplant (with or without myeloablative therapy)
    - Donor leukocyte infusion

AIM Imaging Cost and Quality Program

The AIM Specialty Health Program for Imaging is an innovative program that has a focus on cost and quality. The program gives you the opportunity to reduce your healthcare expenses (and those of your employer) by selecting high quality, lower cost providers or locations. No matter which provider you choose, there is no effect on your healthcare Benefits. We are bringing this program to you to give you information that helps you to make informed choices about where to go when you need care. The AIM Imaging and Specialty Rx program can be reached at (888) 953-6703.

Here's how the program works:

- Your doctor refers you to a radiology provider for an MRI or CT scan
- AIM works with your doctor to help make sure that you are receiving the right test using evidence-based guidelines
- AIM also reviews the referral to see if there are other providers in your area that are high quality but have a lower price than the one you were referred to
- If AIM finds another provider that meets the quality and price criteria, AIM will give you a call to let you know
- You have the choice — you can see the radiology provider your doctor suggested OR you can choose to see a provider that AIM tells you about. AIM will even help you schedule an appointment with the new provider

AIM Specialty Rx Clinical Site of Care Review

When level of care, setting, or place of service is part of the review, services that can be safely given to you in a lower level of care or lower cost setting/place of care will not be Medically Necessary if they are given in a higher level of care or higher cost setting/place of care.

Right Drug Right Channel

This Plan covers prescription drugs, including specialty drugs, that must be administered to you as part of a doctor's visit, home care visit, or at an outpatient facility when they are Covered Services. This may include drugs for infusion therapy, blood products, certain injectables, and any drug that must be administered by a Provider. This section applies when a Provider orders the drug and a medical Provider administers it to you in a medical setting. Benefits for drugs you inject or get from a retail pharmacy are not covered by Anthem but may be covered by Express Scripts.

Case Management

The Medical Trust has contracted with Anthem to identify and assist individuals with conditions requiring extensive or long-term care. If you or your Dependent has a serious illness or injury or one requiring extended care, a case manager can assist you or your Dependent in identifying and coordinating cost-effective medical care alternatives. The case manager will also coordinate communication among you and all Healthcare Providers involved in your or your Dependent's care. Case management can help with cases such as cancer, stroke, AIDS, chronic illness, hemophilia, and spinal cord and other traumatic injuries.

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.

If you would like case management's assistance following an illness or surgery, contact the Medical Management Program at (844) 812-9207.

Round-the-Clock Support

You may call the Anthem 24/7 NurseLine (877) 825-5276, at any time, day or night, to assess symptoms, understand a medical condition, procedure, prescription, or diagnosis and discharge

from a hospital, and obtain health information and education.

This 24/7 service is a Benefit to you, allowing you to be informed about your healthcare options. There is no penalty for not using it. This service is not meant to replace physician care. If you require medical care, please be sure to see your physician or practitioner.

Virtual Second Opinion

Getting a second opinion can be a very important part of making a decision about care for yourself or a loved one. Many people feel confused when it's time to decide what type of care to get, where to get it, and from whom.

Anthem has partnered with ConsumerMedical, a leader in providing decision support services and expert opinions to those who are managing certain serious health conditions. Depending on your condition, you may get a call from a representative suggesting a virtual second opinion.

With Virtual Second Opinion, you can:

- Learn more about your condition
- Make sure your diagnosis is correct
- Better understand and compare your treatment options
- Find a high-quality doctor
- Gain confidence in the treatment you choose

Together with a registered nurse, you'll go over the details of your diagnosis, your doctor visits, and any tests you've taken. The ConsumerMedical research team will gather educational materials to share with you and help you find top-rated local specialists and hospitals who are experienced in your medical condition and are part of Anthem's Network.

CHAPTER 5
COVERAGE

OUTPATIENT CARE

When you need to visit your Healthcare Providers, you will have a cost share as outlined on your Summary of Benefits and Coverage, except for most Preventive Care, which has no cost share. There are no claim forms to fill out. Remember, any services performed during the visit will be paid as outlined on the Summary of Benefits and Coverage.

The following outpatient medical services are covered:

- Acupuncture (limited to 20 visits per calendar year unless related to smoking cessation)
- Allergy testing
- Cardiac therapy
- Chemotherapy
- Chiropractic services (limited to 20 visits per calendar year)
- Consultation requested by the attending physician for advice on an illness or injury
- Dental services received after an accidental injury to teeth, including replacement of teeth (does not include teeth implants) and any related X-rays
- Diabetes self-management education and diet information, including:
    - Education by a physician, certified nurse practitioner, or Member of his/her staff:
        - At the time of diagnosis
        - When the patient's condition changes significantly
        - When Medically Necessary, education by a certified diabetes nurse educator, certified nutritionist, certified dietitian when referred by a physician, or certified nurse practitioner. This benefit may be limited to a group setting when appropriate.
- Diabetes supplies prescribed by an authorized provider:
    - Blood glucose monitors for the legally blind
    - Testing strips
    - Insulin, syringes, injection aids, cartridges for the legally blind, insulin pumps and appurtenances, and insulin infusion devices
    - Oral agents for controlling blood sugar
    - Data management system
- Dialysis (in-Network only)
- Feet; Medically Necessary treatment of, including treatment of metabolic or peripheral-vascular disease
- Genetic testing
- Hypnosis (limited to six visits per Plan Year unless related to smoking cessation)
- Lymphedema treatment
- Nutritional counseling (limited to six visits per Plan Year)
- Obtrusive sleep apnea; diagnosis and treatment of
- Occupational, speech, physical, or hearing therapy, or any combination of these on an outpatient basis, up to the Plan maximums, if:
    - Prescribed by a physician
    - Given by skilled medical personnel at home, in a therapist's office, or in an outpatient facility
    - Performed by a licensed speech/language pathologist, audiologist, or other therapist qualified to perform the services rendered
- Physician home and office visits
- Podiatric surgery
- Pulmonary therapy
- Radiation therapy
- Smoking cessation, including counseling

- Termination of pregnancy
- X-rays, laboratory services, ultrasounds (including routine pregnancy-related ultrasounds), magnetic resonance imaging (MRI), including magnetic resonance angiography (MRA), computerized axial tomography (CAT) scan

Tips For Visiting Your Doctor

- When you make your appointment, confirm that the doctor is a BlueCard PPO Network provider.
- Arrange ahead of time to have pertinent medical records and test results sent to the doctor.
- If the doctor sends you to a lab or radiologist for tests or x-rays, please visit *www.anthem.com* or call Member Services to confirm that the Healthcare Providers is a BlueCard PPO Network provider.
- Ask about a second opinion anytime you are unsure about surgery or a diagnosis.

Preventive Care

Preventive Care is an important and valuable part of healthcare. Regular physical checkups and appropriate screenings can help detect illness early and promote wellness. Talk with your Healthcare Provider about the Preventive Care services that are right for you.

Your Plan covers most Preventive Care at 100% when you use Network providers. There is no Co-payment, Coinsurance, Deductible, or facility charge.

Screenings and other services are covered as Preventive Care when you have no symptoms and no reason to suspect you might not be healthy. If you get the same service because you have some risk factors or symptoms, and your doctor wants to diagnose what is causing them, the service is not preventive, but instead will be considered under the diagnostic services benefit.

The following preventive services are covered under this policy as required by the Patient Protection and Affordable Care Act (ACA) and are not subject to Deductibles, Copayments, or Coinsurance. Consult with your physician to determine what preventive services are appropriate for you.

Preventive Services for Adults

- Abdominal aortic aneurysm — one-time screening by ultrasonography in men age 65 to 75 who have ever smoked
- Age-appropriate preventive medical examination
- Alcohol misuse screening and counseling
- Blood pressure screening for all adults
- Cholesterol screening for adults at higher risk of cardiovascular disease
- Colorectal cancer screening for adults over 50
- Depression screening for adults
- Discussion with primary care physician regarding risks and benefits of prostate cancer screening in men age 50 or over
- Discussion with physician regarding diet counseling for adults at higher risk for chronic disease
- Discussion with physician regarding aspirin for adults at higher risk of cardiovascular disease
- Hepatitis C screening for adults at increased risk, and one time for everyone born between 1945 and 1965
- Immunizations for adults (doses, recommended ages, and recommended populations vary):
    - Hepatitis A
    - Hepatitis B
    - Herpes zoster
    - Human papillomavirus
    - Influenza
    - Measles, mumps, rubella
    - Meningococcal
    - Pneumococcal
    - Tetanus, diphtheria, pertussis
    - Shingles (chickenpox)
- Obesity screening and counseling
- Screening for all adults at higher risk for sexually transmitted infections and counseling for prevention of sexually transmitted infections, including:
    - Chlamydia
    - Gonorrhea
    - HIV
    - Syphilis
- Tobacco use screening for all adults and cessation interventions for tobacco users
- Type 2 diabetes screening for adults with high blood pressure

Preventive Services for Women, Including Pregnant Women

- Age-appropriate preventive medical examination
- Anemia screening for pregnant women
- Breastfeeding equipment rental
- Cervical cancer screening in women age 21 to 65
- Chlamydia infection screening for sexually active women at higher risk
- Contraceptive devices and contraceptive drugs that have been prescribed and FDA-approved; discussion with primary care physician about contraceptive methods
- Discussion with physician regarding chemoprevention in women at higher risk for breast cancer
- Discussion with physician about folic acid supplements for women who may become pregnant
- Discussion with physician regarding preconception care
- Discussion with physician about interventions to promote and support breastfeeding and comprehensive lactation support and counseling
- Discussion with physician about interpersonal and domestic violence
- Discussion with physician regarding inherited susceptibility to breast and/or ovarian cancer
- Gestational diabetes screening for pregnant women between 24 and 28 weeks of gestation and for pregnant women identified to be at high risk for diabetes
- Gonorrhea screening for all women at higher risk
- Hepatitis B screening for pregnant women at their first prenatal visit
- Mammography screening for breast cancer
- Osteoporosis screening for women age 65 or older and women at higher risk
- Rh incompatibility screening for pregnant women and follow-up testing for women at higher risk
- Syphilis screening for all pregnant women and other women at higher risk
- Urinary tract or other infection screening for pregnant women

Preventive Services for Children

- Age-appropriate preventive medical examination
- Autism screening for Children at age 18 months and 24 months by physician
- Behavioral assessments for Children of all ages by primary care physician
- Cervical dysplasia screening for sexually active females
- Congenital hypothyroidism screening for newborns
- Developmental screening for Children under three years and surveillance throughout childhood by primary care physician
- Discussion with primary care physician regarding obesity screening and counseling
- Discussion with physician regarding fluoride supplements for Children who have no fluoride in their water source
- Discussion with physician regarding alcohol and drug use assessments for adolescents
- Discussion with physician regarding iron supplements for Children age six months to 12 months who are at risk for anemia
- Gonorrhea prevention medication for the eyes of all newborns
- Hearing screening for all newborns
- Height, weight, and body mass index measurements for Children
- Hematocrit or hemoglobin screening for Children
- Hemoglobinopathies or sickle cell screening for newborns
- HIV screening for adolescents at higher risk
- Immunizations for Children from birth to 18 years (doses, recommended ages, and recommended populations vary):
    - Diphtheria, tetanus, pertussis
    - Haemophilus influenzae type B
    - Hepatitis A
    - Hepatitis B

    - Human papillomavirus (HPV)
    - Inactivated poliovirus
    - Influenza
    - Measles, mumps, rubella
    - Meningococcal
    - Pneumococcal
    - Rotavirus
    - Varicella
- Lead screening for Children at risk of exposure
- Medical history for all Children throughout development
- Oral health risk assessment for young Children by primary care physician
- Phenylketonuria (PKU) screening for Children at higher risk of lipid disorders
- Sexually transmitted infection (STI) prevention counseling for adolescents at higher risk
- Tuberculin testing for Children at higher risk of tuberculosis
- Vision screening for all Children

Additional Information about Preventive Services

Preventive and other services provided during the same visit
The following cost-sharing rules apply when a mandated preventive service is provided during an office visit:

- If the preventive service is billed separately from the office visit, then cost sharing may apply to the office visit.
- If the primary purpose of the office visit is not the delivery of the preventive service, then cost sharing may apply to the office visit.
- Deductibles, Copayments, and Coinsurance may also apply to other preventive services that are covered under the Plan but are not part of the Affordable Care Act.

A health professional will determine if a service is Medically Necessary for a Member.
The services listed in the Plan may be subject to age and frequency guidelines and may be subject to cost share outside of these guidelines.

Preventive services may change per Plan Year according to federal guidelines in effect as of January 1 of each year.

Tips For Using Preventive Care

- Visit your doctor once a year for a checkup. Take the screening tests appropriate for your gender and age to help identify illness or the risk of serious illness.
- Get routine mammograms, especially if you have a family history of breast cancer.
- Keep your Children healthy by getting routine checkups and Preventive Care, including certain immunizations.

TELEMEDICINE
LIVEHEALTH® ONLINE

With LiveHealth Online, you have a doctor by your side 24/7[1]. LiveHealth Online lets you talk face-to-face with a doctor through your mobile device or a computer with a webcam. No appointments, no driving, and no waiting at an Urgent Care Center.

To use LiveHealth Online just go to ***livehealthonline.com***. You will need high-speed Internet access, a webcam or built-in camera, and audio capability.

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

Use LiveHealth Online for common health concerns like colds, the flu, fevers, rashes, infections, allergies, and more. It's faster, easier, and more convenient than a visit to an Urgent Care Center.

LiveHealth Online is not meant to replace your primary care physician. It's a convenient option for care when your physician is not available. LiveHealth Online connects you with a board-certified doctor in just a couple of minutes. Plus, you can get a LiveHealth Online visit summary from the *MyHealth* tab to print, email, or fax to your primary doctor.

When you need to see a doctor, simply go to ***livehealthonline.com*** or access the LiveHealth Online mobile app. Select the state you are located in when you log on and answer a few questions. If you're traveling, be sure to change your state back when you get home.

Once connected, you can talk and interact with the doctor as if you were in a private exam room.

Members enrolled in a PPO Plan will pay the same Copayment as for an office visit. Members enrolled in a CDHP who have not met their Deductible will pay a flat fee based on the type of visit. Payment must be made at the time of your visit with a credit or debit card.

LiveHealth Online should not be used for Emergency care. If you experience a medical Emergency, call 911 immediately.

If you establish a LiveHealth Online account, you can allow doctors to access and review your health information from past visits. You can also keep track of your own health information by self-reporting at ***livehealthonline.com***. Once you sign in, go to the *MyHealth* tab and then select Health Record.

Establishing an account allows you to securely store your personal and health information. Plus, you can easily connect with doctors in the future and share your health history and schedule online visits at times that fit your schedule.

Prescription availability is defined by physician judgment. The laws may change, so check the LiveHealth website to see if there have been changes in your state. Please note that doctors using LiveHealth Online are not able to prescribe controlled substances or lifestyle drugs.

[1] Some services may not be available in all areas. Visit ***www.livehealthonline.com*** to learn more.

Hospital Care

The Plan covers most or all of the cost of your Medically Necessary care when you stay at a Network hospital for surgery or treatment of an illness or injury.

When Outpatient Hospital Care Is Covered

You are also covered for same-day (outpatient) hospital services, such as chemotherapy or radiation therapy, cardiac rehabilitation, and kidney dialysis. Same-day surgery services are surgical or invasive diagnostic procedures that:

- Are performed in a same-day or hospital outpatient surgical facility
- Require the use of both surgical operating and postoperative recovery rooms
- Require either local or general anesthesia
- Do not require inpatient hospital admission because it is not appropriate or Medically Necessary
- Would justify an inpatient hospital admission in the absence of a same-day surgery program

Anthem's Medical Management Program

Remember to call the Medical Management Program at (844) 812-9207 at least two weeks prior to any planned surgery or hospital admission. For an Emergency admission, call Medical Management 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 Medical Management Program guidelines. If Medical Management determines that the admission or surgery is not Medically Necessary, no Benefits will be paid. See the "Medical Management" section of this Plan Document Handbook for additional information.

If surgery is performed in a Network hospital, you will receive Network Benefits for the anesthesiologist, pathologist, and radiologist, whether or not they are in the Network.

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 Medical Management retrospectively reviews the treatment and/or services you received and determines they were not Medically Necessary, Benefits will be denied, and you will 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 for the services and supplies listed in this section. This list is intended to give you a general description of services and supplies covered by the Plan.

The following are covered services and limitations for both inpatient and outpatient (same-day) care:

- Anesthesiology services, including consultation before surgery
- Assistant surgeon's expenses
- Breast cancer surgery (lumpectomy, mastectomy), including:
    - Reconstruction following surgery
    - Surgery on the other breast to produce a symmetrical appearance

    - Prostheses
    - Treatment of physical complications at any stage of a mastectomy, including lymphedemas
- Chemotherapy and radiation therapy, including medications, in a hospital outpatient department, doctor's office, or facility. Medications that are part of outpatient hospital treatment are covered if they are prescribed by the hospital and filled by the hospital pharmacy.
- Circumcision for newborns or when Medically Necessary
- Diabetic nutritional counseling
- Gender reassignment surgery
- Hospital charges for dental services if hospitalization is necessary to safeguard the health of the patient
- Human organ and tissue transplants. Please refer to the "Transplant Care" section of this Plan Document Handbook for further information.
- Kidney dialysis treatment (including hemodialysis and peritoneal dialysis) is covered in the following settings until the patient becomes eligible for end-stage renal disease dialysis Benefits under Medicare:
    - At home, when provided, supervised, and arranged by a physician and the patient has registered with an approved kidney disease treatment center (professional assistance to perform dialysis and any furniture, electrical, plumbing, or other fixtures needed in the home to permit home dialysis treatment are not covered)
    - In a hospital-based or free-standing facility
- Laboratory services, X-rays, MRIs, MRAs, PET scans, CAT scans, ultrasounds
- Operating rooms, recovery rooms, treatment rooms
- Oral surgery, limited to:
    - Extraction of impacted wisdom teeth
    - Treatment of an injury to sound and natural teeth if treatment is finished within six months of the date of injury
- Outpatient surgery
- Physician charges
- Podiatry surgery
- Preadmission testing (PAT)
- Reconstructive surgery when needed to correct damage caused by a birth defect resulting in the malformation or absence of a body part or an accidental injury
- Related Medically Necessary ancillary services (e.g. supplies, equipment, social services, therapy services)
- Removal of breast or other prosthetic implants when Medically Necessary
- Restorative physical rehabilitation services in an inpatient setting up to the Plan maximums if:
    - Prescribed by a physician
    - To restore physical functioning
    - Approved by Anthem
- Room and board in a semiprivate room with general nursing services
- Specialty care units (e.g. intensive care unit, cardiac care unit)
- Surgeon's charges for the performance of a surgical procedure
- Surgical reproductive sterilization
- Surgical treatment of morbid obesity
- Two or more surgical procedures performed during one operating session.

Tips For Getting Hospital Care

- If your doctor prescribes pre-surgical testing, have your tests performed within seven days prior to surgery at the hospital where surgery will be performed.
- If you are having same-day surgery, often the hospital or outpatient facility requires that

someone meet you after the surgery to take you home. Ask about their policy and make arrangements for transportation before you go in for surgery.

Emergency and Urgent Care

The Plan provides Benefits for Emergency health services when required for stabilization and initiation of treatment as provided by or under the direction of a physician. Network Benefits are paid for Emergency health services even if the services are provided by an Out-of-Network provider, but the cost share under the Plan for Emergency care is higher than the cost share for a doctor's visit (see your Summary of Benefits and Coverage for cost share information). To be covered as Emergency care, the condition must be one in which a prudent layperson, who has an average knowledge of medicine and health, could reasonably expect that without Emergency care, the condition would:

- Place your health in serious jeopardy
- Cause serious problems with your body functions, organs, or parts
- Cause serious disfigurement
- In the case of behavioral health, place you or others in serious jeopardy

Emergency Assistance

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. This cost share is waived[2] if you are admitted to the hospital as an inpatient within two (2) business days. You must notify Anthem's Medical Management Program at (844) 812-9207 within two (2) business days of the admission. If you make an Emergency visit to your doctor's office, you pay the same cost share as for an office visit.

Benefits for treatment in a hospital Emergency room are limited to the initial visit for an Emergency condition. If a physician or practitioner in the Network 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 a medical Emergency
- Ground or air transportation (subject to review for Medical Necessity) provided by a professional ambulance service to a hospital or Emergency care facility that is equipped to treat a condition that can be classified as a medical Emergency
- Treatment in a hospital Emergency room or other Emergency care facility for injuries received in an accident

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 Medical Management within two (2) business days of admission. If the hospital does not participate in the BlueCard PPO Network, you may need to file a claim.

If you have an Emergency outside of the United States and need to visit a hospital that participates in the Blue Cross Blue Shield Global Core, show your ID card and call the Blue Cross Blue Shield Global Core Service Center at (800) 810-2583 or call collect at (804) 673-1177. The hospital will submit its bill through the Blue Cross Blue Shield Global Core. If the hospital does not participate, you will need to file a claim.

Urgent Care

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 the Anthem 24/7 at (877) Talk2RN

[2] The cost share is not waived in the Consumer-Directed Health Plans (CDHPs).

((877) 825-5276) for advice, 24 hours a day, seven days a week.

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 doctor's office.

Maternity Care

The Plan covers physician and hospital care for mother and baby, including prenatal care, delivery and postpartum care. See Chapter 1 for more details about the Newborns' and Mothers' Health Protection Act of 1996 (NMHPA).

Anthem's Medical Management Program

Call the Medical Management Program at (844) 812-9207 within the first three months of a pregnancy and again within 48 hours after delivery of the baby.

Our specially trained nurses are available to support you during and after your pregnancy. Call with questions or to get information during normal business hours. A nurse will work with you and your doctor to identify high-risk pregnancies and, if necessary, will refer you to Network specialists who are trained to deal with complicated pregnancies and home care.

You can participate in this program as soon as you call the Medical Management Program to let them know you are pregnant.

The Summary of Benefits and Coverage provides information on what is covered and cost shares. The following are additional covered services and limitations:

- Amniocentesis, including the associated genetic counseling and genetic testing
- Circumcision of newborn males prior to discharge (after discharge, circumcision must be Medically Necessary)
- Home care with precertification
- Parent education and assistance and training in breast or bottle feeding, if available
- Rh (D) blood typing and antibody testing at first pregnancy-related visit
- Screening and counseling for alcohol misuse, smoking, bacteriuria, iron deficiency, and sexually transmitted diseases, including HIV
- Semiprivate room and board
- Services of a certified nurse-midwife affiliated with a licensed facility. The nurse-midwife's services must be provided under the direction of a physician.
- Special care for the baby if the baby stays in the hospital longer than the mother. Call the Medical Management Program to precertify the hospital stay if the newborn's stay is expected to be more than 48 hours following a normal delivery or 96 hours after a Cesarean section.
- Ultrasounds

Specialized Maternity Program

The specialized maternity program is an optional service provided for your Benefit. The Plan's cost share will not be reduced if you choose not to participate in the program.

The primary objective of the specialized maternity program is to identify high-risk pregnancies to promote positive outcomes for the mother and baby, and to assist in coordinating cost-effective care. You are encouraged to call the Medical Management Program's toll-free number at (844) 812- 9207 during the first trimester of your pregnancy. However, you may call at any time during your pregnancy. When you call, a nurse will ask you questions about your general health and medical history. This information may be provided to your physician or practitioner and will help determine whether a nurse can provide you with additional support during and/or after your pregnancy.

If appropriate, a case manager will follow your case and coordinate communication among you and all Healthcare Providers involved in your care.

Infertility Coverage

Once a diagnosis of infertility has been made, the Plan will cover services related to its treatment. This benefit is available to the Member and the Member's Spouse or Domestic Partner (where applicable).

To be eligible for infertility benefits, the Member:

- Must have failed to achieve pregnancy after one year of regular, unprotected heterosexual intercourse (or six months if the woman is over 35 years of age), or must have failed to conceive after six trials of medically supervised artificial insemination over a one-year period
- Has been unable to carry a pregnancy to term

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 Benefits include:

- Ovulation induction
- Insemination procedures (artificial insemination (AI) and intrauterine insemination (IUI))
- Assisted reproductive technologies, including (but not limited to):
    - Embryo transfer
    - Gamete intrafallopian transfer
    - In vitro fertilization
    - Zygote intrafallopian transfer
    - Uterine embryo lavage

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 ***www.freedomfertility.com.***

Transplant Care
BlueCross BlueShield (BCBS) National Transplant Program

We wish to provide you and your family with a human organ and tissue transplant Benefit that helps you obtain quality care and financially protects you from significant healthcare expenses. The BCBS National Transplant Program is a coordinated set of transplant services provided through a special Network of transplant facilities. It is designed to help you obtain the transplant services that are appropriate for you and eligible for reimbursement under this Plan. It includes case management and some services not otherwise covered by this Plan. The medical professionals who conduct the program focus their review on the appropriateness of the proposed transplant procedures. Only those procedures that are covered and certified as Medically Necessary will be eligible under the Plan.

Please note that because transplantation is a highly specialized area, not all BlueCard PPO Network hospitals are part of the BCBS National Transplant Program.

If you receive your transplant services at a Blue Distinction Center, the Plan will pay 100% of eligible costs after your Deductible (if applicable). Your usual cost shares will apply if you receive your services at any other BlueCard PPO hospital. Transplant services received Out-of-Network are not covered.

Anthem's Medical Management Program

To enroll in the BCBS National Transplant Program, you are required to call Anthem's Medical Management Program at (844) 812-9207 as soon as the possibility of a transplant is discussed with your physician. When you call, it will be necessary to provide the program with all the information needed to complete the review. In order to receive the highest level of Benefits, you must choose one facility within the special Network of Blue Distinction Centers. Transplant-related services must be received at the facility you choose in order to be covered under the National Transplant Program Benefit. All transplant Benefits include pre-transplant evaluation expenses, even if the transplant does not occur. There is a $10,000 travel and lodging limit per lifetime.

Covered Transplants

When all of the provisions of the BCBS National Transplant Program are satisfied, the Plan will provide Benefits only for the services and supplies listed in this section.

The following transplants are covered:

- Allogenic/autologous bone marrow
- Cornea
- Heart
- Heart/lung
- Lung
- Double lung
- Liver
- Kidney
- Kidney/pancreas
- Small bowel

The following services are covered:

- Donor expenses, if not covered under any other plan
- If the patient is a minor, the Plan will consider expenses for two individuals to accompany the patient. Benefits also include travel to and from lodging near a designated transplant facility for the pre-transplant evaluation.
- Organ procurement (bone marrow donor search is not covered)

- Pharmacy supplies and services provided by the BCBS National Transplant Program facility for immunosuppressant and other transplant-related medications while hospitalized
- Physician services related to the transplant events listed in this section
- Pre-transplant evaluation
- Transplant procedures and associated hospitalization
- Transplant-related follow-up care provided by the designated transplant facility for up to one year
- Transplant-related services provided by the BCBS National Transplant Program facility that are associated with the transplant events listed in this section, including laboratory and other diagnostic services
- Travel and lodging expenses for the patient/donor and one other individual if the patient/donor lives at least 100 miles from the designated facility

Travel and lodging expenses are limited to $10,000 per lifetime.

When the required review procedures for the BCBS National Transplant Program are followed and you use one of the designated transplant facilities, your Benefits will be unaffected and you and the Plan avoid unnecessary expenses. However, if a transplant procedure is not performed at a BCBS National Transplant Program facility or through a PPO facility, the Plan will not cover any transplant-related expenses, including, but not limited to, organ donor costs and travel and lodging expenses.

If you choose not to have a transplant performed at a Blue Distinction Center, you must still follow the Medical Management Program prior notification and certification requirements outlined in the previous section. 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 certification procedures required by the Plan does not apply toward your Out-of-Pocket Maximum.

Durable Medical Equipment, Medical Supplies, and Prosthetic Devices

The Plan covers Medically Necessary Durable Medical Equipment (DME), medical supplies, and prosthetic devices. Refer to the Glossary for a definition of Durable Medical Equipment.

Anthem's Medical Management Program

You must contact Anthem's Medical Management program at (844) 812-9207 before ordering DME, medical supplies and/or prosthetic devices. Anthem's Medical Management case manager can help locate a DME supplier for you and coordinate communication among you and all Healthcare Providers involved in arranging for and obtaining medical supplies and/or prosthetic devices.

If more than one piece of DME or prosthesis can meet your needs, Benefits are available only for the most cost-effective piece of equipment. The decision to rent or purchase DME is at the discretion of Anthem Blue Cross and Blue Shield.

What is Covered

Medical equipment that is all of the following:

- Used to serve a medical purpose with respect to treatment of a sickness, injury, or their symptoms
- Not disposable
- Not of use to a person in the absence of a sickness, injury, or their symptoms
- Durable enough to withstand repeated use
- Not implantable within the body
- Appropriate for use—and primarily used—within the home

Examples of DME include:

- Braces that stabilize an injured body part and braces to treat curvature of the spine
- Delivery pumps for tube feedings (including tubing and connectors)
- Diabetic and ostomy supplies
- Mechanical equipment necessary for the treatment of chronic or acute respiratory failure
- Orthopedic or corrective shoes and other supportive appliances for the feet only in connection with the treatment of diabetes or peripheral vascular disease
- Oxygen and the purchase or rental of equipment for its use
- Standard hospital bed
- Standard wheelchair, walker, or cane

In addition, replacement of purchased equipment, appliances, or prosthetic devices may be covered if:

- The equipment, supply, or appliance is worn out or no longer functions
- Repair is not possible or would equal or exceed the cost of replacement
- Individual's needs have changed and the current equipment is no longer usable due to weight gain, rapid growth, or deterioration of function

The following medical supplies and services are covered:

- Allergy injections, including the serum
- Artificial limbs and eyes and replacement of artificial limbs and eyes if required due to a change in the patient's physical condition or if a replacement is less expensive than repair of existing equipment
- Blood and/or plasma and the equipment for its administration

- Compression garments
- Contraceptive devices, including diaphragms, IUDs, and Norplant implants
- Depo-Provera injections given at a doctor's office or family planning clinic. Contraceptive injectables dispensed at a pharmacy may be available through the Prescription Drug Program
- DME, including expenses related to necessary repairs and maintenance. A statement is required from the prescribing physician describing how long the equipment is expected to be necessary. This statement will determine whether the equipment will be rented or purchased.
- Initial prescription contact lenses or eyeglasses, including the examination and fitting of the lenses, to replace the human lens lost through intraocular surgery
- Insulin infusion pumps
- Original fitting, adjustment, and placement of orthopedic braces, casts, splints, crutches, cervical collars, head halters, traction apparatus, or prosthetic appliances to replace lost body parts or to aid in their function when impaired. Replacement of such devices will be covered if the replacement is necessary due to a change in the patient's physical condition.
- Orthopedic or corrective shoes and other supportive appliances for the feet only in connection with the treatment of diabetes or peripheral vascular disease
- Oxygen and rental of equipment required for its use, not to exceed the purchase price of such equipment
- Wigs and artificial hairpieces, only after chemotherapy or radiation therapy (limited to $700 per Plan Year)
- Sterile surgical supplies after surgery

Skilled Nursing Facility Care

The Plan provides Benefits for care in a skilled nursing facility or inpatient acute rehabilitation facility under certain conditions for a limited time. Skilled care is healthcare given when you need skilled nursing or rehabilitation staff to manage, observe, and evaluate your care. Your level of care must be above the level of custodial or maintenance care. To be eligible, your provider must submit:

- A written treatment plan
- A projected length of stay
- An explanation of the services the patient needs

Anthem's Medical Management Program

The Medical Management case manager can help locate a skilled nursing facility for you and coordinate communication among you and all Healthcare Providers involved in arranging and obtaining these services. You can reach a case manager by calling Anthem's Medical Management Program at (844) 812-9207.

What's Covered

Coverage includes:

- Room and board in a semi-private room (a room with two or more beds), including general nursing care
- Physician services
- Medical social services
- Physical, occupational, and speech therapy
- Respiratory therapy
- Medications and medical supplies, including Durable Medical Equipment
- X-rays and laboratory services

Please note that, in general, the intent of skilled nursing is to provide Benefits for covered persons who are convalescing from an injury or illness that requires an intensity of care or a combination of skilled nursing, rehabilitation, and facility services which are less than those of a general acute hospital but greater than those available in the home setting. The covered person is expected to improve to a predictable level of recovery.

Home Health Care

Many healthcare treatments that were once offered only in a hospital or a doctor's office can now be delivered safely in your home. Home Health Care can be an alternative to an extended stay in a hospital or a skilled nursing facility.

Anthem's Medical Management Program

The Medical Management Program case manager can help locate a home health care provider for you and coordinate communication among you and all Healthcare Providers involved in arranging and obtaining home health care services. You can arrange for a case manager by calling Anthem's Medical Management Program at (844) 812-9207.

What's Covered

You have to meet certain guidelines to be eligible to use home healthcare Benefits, including:

- You are homebound
- Your home health care needs are for skilled care
- Your care is not custodial
- Your doctor has certified home health care as Medically Necessary, a plan of care has been established, and the plan of care is reviewed regularly by your doctor.

The following services are covered:

- Intermittent, part time skilled nursing care visits by a healthcare professional such as a registered nurse (RN), a licensed practical nurse (LPN), or a physical therapist. Examples of skilled nursing care include IV medication, injections, dressing changes, and prescription drug education.
- Home health aide
- Physical, speech, or occupational therapy, if restorative
- Medical social worker visits
- Durable Medical Equipment and medical supplies
- Laboratory tests

Every visit by a nurse or other health care provider is equal to one visit. A visit is defined as a period of 2 hours or less. Home Health Services are subject to a maximum of 16 hours in total per day.

Home Infusion Services

Home infusion therapy is the administration of drugs in your home 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.

Covered services include:

- Administration
- Care coordination
- Nursing visits related to infusion

Hospice Care

Hospice care that is recommended by a physician for a person who is terminally ill and has been diagnosed as having less than six months to live is covered by the Plan. Hospice care is an integrated program that provides comfort and support services for the terminally ill. Hospice care includes physical, psychological, social, and spiritual care for the terminally ill person, as well as short-term grief counseling for immediate family Members. Benefits are available when hospice care is received from a licensed hospice agency.

Anthem's Medical Management Program

The Medical Management case manager can help locate a hospice provider and coordinate communication between you and your Healthcare Providers in order to arrange hospice services. You can reach a case manager by calling Anthem's Medical Management Program at (844) 812-9207.

What's Covered

The following are covered services and limitations:

- Nursing care provided by or under the supervision of a registered nurse
- Physician services
- Physical, occupational, or speech therapy for the purposes of symptom control or to enable the normal activities of daily living
- Medical social worker services
- Home health aide
- Laboratory tests and X-rays, chemotherapy, and radiation therapy
- Durable Medical Equipment and medical supplies
- Counseling and bereavement services
- Treatment for pain relief, including medications

Clinical Trials

Benefits are available for routine patient care costs incurred during participation in a qualifying clinical trial for the treatment of cancer or other life-threatening disease or condition. For purposes of this Benefit, a life-threatening disease or condition is one from which the likelihood of death is probable unless the course of the disease or condition is interrupted.

Benefits include the reasonable and necessary items and services used to prevent, diagnose and treat complications arising from participation in a qualifying clinical trial. The subject or purpose of the trial must be the evaluation of an item or service that meets the definition of a Covered Health Service and is not otherwise excluded under the Plan.

Benefits are available only when the Member is clinically eligible for participation in the qualifying clinical trial and the referring health care professional is a participating Healthcare Provider and has concluded that the individual's participation in such trial would be appropriate, or the Member provides medical or scientific information establishing that the individual's participation in the study would be appropriate.

Routine patient care costs for qualifying clinical trials include:

- Covered Health Services for which Benefits are typically provided absent a clinical trial
- Covered Health Services required solely for the provision of the investigational item or service, the clinically appropriate monitoring of the effects of the item or service, or the prevention of complications
- Covered Health Services needed for reasonable and necessary care arising from the provision of an Investigational item or service.

Routine costs for clinical trials do not include:

- The experimental or investigational service or item
- Items and services provided solely 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
- Items and services provided by the research sponsors free of charge for any person enrolled in the trial
- Travel and lodging expenses

A qualifying clinical trial means a Phase I, Phase II, Phase III or Phase IV clinical trial that is conducted in relation to the prevention, detection, or treatment of cancer or other life-threatening diseases or conditions and which falls under any of the following categories:

- Federally funded trials. The study or investigation is approved or funded (which may include funding through in-kind contributions) by one or more of the following:

– National Institutes of Health (NIH), which includes the National Cancer Institute (NCI))
– Centers for Disease Control and Prevention (CDC)
– Agency for Healthcare Research and Quality (AHRQ)
– Centers for Medicare and Medicaid Services (CMS)
– A cooperative group or center of any of the entities described above or the Department of Defense (DOD) or the Department of Veterans Affairs (VA)
– A qualified non-governmental research entity identified in the guidelines issued by the National Institutes of Health for center support grants
– The Department of Veterans Affairs, the Department of Defense, or the Department of Energy, as long as the study or investigation has been reviewed and approved through a system of peer re-

view that is determined by the Secretary of Health and Human Services to meet *both* of the following criteria:

  - Comparable to the system of peer review of studies and investigations used by the National Institutes of Health
  - Ensures unbiased review of the highest scientific standards by qualified individuals who have no interest in the outcome of the review
- A study or investigation conducted under an investigational new drug application reviewed by the U.S. Food and Drug Administration
- A study or investigation that is a drug trial exempt from having such an investigational new drug application
- A clinical trial with a written protocol that describes a scientifically sound study and has been approved by all relevant institutional review boards (IRBs) before participants are enrolled in the clinical trial. The Plan may, at any time, request documentation about the clinical trial.

CHAPTER 6
MEDICAL EXCLUSIONS AND LIMITATIONS

Anthem BCBS will not provide Benefits for any of the services, treatments, items, or supplies described in this section, regardless of Medical Necessity or recommendation of a Healthcare Providers. This list is intended to give you a description of services and supplies not covered by Anthem. This section uses headings to help you find specific exclusions more easily. **Some of the services listed in this chapter as not covered by Anthem may be covered by your pharmacy, behavioral health, dental, or vision plans.**

ALTERNATIVE TREATMENTS

- Acupressure
- Aromatherapy
- Holistic or homeopathic care
- Massage therapy
- Rolfing

COMFORT OR CONVENIENCE

- Beauty/barber services
- Computer/internet services
- Guest services, housekeepers, monitoring services
- Home remodeling to accommodate a health need (such as, but not limited to, ramps, electric chairlifts, and swimming pools)
- Supplies, equipment, and similar incidental services and supplies for personal comfort. Examples include (but are not limited to):
    - Air conditioners
    - Air purifiers and filters
    - Batteries and battery chargers
    - Dehumidifiers
    - Humidifiers
    - Heating pads
    - Hot water bottles
    - Water beds
    - Hot tubs
    - Any other clothing or equipment that could be used in the absence of an illness or injury
- Telephone
- Television

DENTAL

- Dental care except as described in the Coverage section
- Preventive Care, diagnosis, treatment of or related to the teeth, jawbones, or gums. Examples include all of the following:
    - Restoration and replacement of teeth, except as a result of accidental injury
    - Services to improve dental clinical outcomes
- Dental implants

- False teeth
- Dental braces
- Dental X-rays, supplies, and appliances and all associated expenses, including hospitalizations and anesthesia. The only exceptions to this are for any of the following:
    - Transplant preparation
    - Initiation of immunosuppressives
    - The direct treatment of acute traumatic injury, cancer, or cleft palate
- Treatment of congenitally missing, malpositioned, or supernumerary teeth, except as part of a Congenital Anomaly
- Excision of maxillary or mandibular cysts for the diagnoses of odontogenic, dentigerous, or radicular cysts

Drugs (please check the pharmacy benefits chapter to see what's covered under the Pharmacy Plan)

- Prescription drug products for outpatient use that are filled by a prescription order or refill
- Non-injectable medications given in a physician's office except as required in an Emergency
- Over-the-counter drugs and treatment

Emergency

- Use of the Emergency room:
    - To treat routine ailments
    - Because you have no regular physician
    - Because it is late at night and the need for treatment is not sudden and serious

Experimental/Investigative Services

- Experimental/Investigative Services are excluded even if recommended by your physician. The fact that an Experimental/Investigative Service, treatment, device, or pharmacological regimen is the only available treatment for a particular condition will not result in Benefits if the procedure is considered to be an Experimental/Investigative Service in the treatment of that particular condition. See the Glossary for more on these services.

Foot Care

- Hygienic and preventive maintenance foot care. Examples include (but are not limited to):
    - Cleaning and soaking the feet
    - Applying skin creams in order to maintain skin tone
    - Other services that are performed when there is not a localized illness, injury, or symptom involving the foot
- Nail trimming, cutting, or debriding
- Routine foot care (including the cutting or removal of corns and calluses) (except for diabetes and peripheral vascular disease)
- Shoe orthotics except for custom molded shoe inserts prescribed to treat a disease or illness of the foot
- Symptomatic complaints of the feet, except capsular or bone surgery related to bunions and hammertoes
- Treatment of flat feet

Home Health Care

- Assistance in the activities of daily living, including but not limited to eating, bathing, dressing, or other custodial services or self-care activities, homemaker services (including meals delivered to your home), and services primarily for rest, domiciliary, or convalescent care

- Full-time nursing care
- Nursing and home health aide services provided outside of the home (such as school, vacation, work, or recreational activities)
- Services or supplies that are not part of the home health care plan
- Services of a person who usually lives with you or who is a Member of your or your Spouse's family
- Transportation

Hospital Care – Inpatient

- Any part of a hospital stay that is primarily custodial
- Diagnostic inpatient stays, unless connected with specific symptoms that, if not treated on an inpatient basis, could result in serious bodily harm or risk to life
- Cosmetic Procedures
- Hospital services received in clinic settings that do not meet the Plan's definition of a hospital or other covered facility
- Personal or comfort items such as personal care kits provided on admission to a hospital, television, telephone, newborn infant photographs, complimentary meals, birth announcements, and other articles which are not for the specific treatment of an injury or sickness
- Private duty nursing
- Private room. If you use a private room, you need to pay the difference between the cost for the private room and the hospital's average charge for a semiprivate room. The additional cost cannot be applied to your Deductible or Coinsurance.

Hospital Care – Outpatient

- Routine medical care, including, but not limited to:
    - Collection or storage of your own semen or bone marrow
    - Drug administration or injection, excluding chemotherapy
    - Inoculation or vaccination

Maternity

- Cord blood storage
- Days in the hospital that are not Medically Necessary (beyond the 48-hour/96-hour limits)
- Medical and hospital care and costs for the infant Child of a Dependent, unless this infant Child is otherwise eligible under this plan
- Out-of-Network birthing center facilities (may be covered at the Out-of-Network level. Contact your health plan for more information)
- Parenting, prenatal, or birthing classes
- Private-duty nursing
- Private room charges in excess of the cost of a semiprivate room
- Services that are not Medically Necessary
- Services provided by a doula (labor aide)

Medical Equipment and Supplies

- Devices used specifically as safety items or to affect performance related to sports-related activities
- Elastic stockings exceeding two pairs per calendar year
- False teeth
- Foot orthotics except in the treatment of diabetes or peripheral vascular disease
- Hearing aids
- Prescribed or non-prescribed medical supplies. Examples include:
    - Ace bandages

    - Gauzes and dressings
- Tubing, nasal cannulas, connectors, and masks are not covered except when used with Durable Medical Equipment as described in the coverage section

Nutrition

- Megavitamin and nutrition-based therapy
- Nutritional and electrolyte formulas, including infant formula, donor breast milk, nutritional supplements, dietary supplements, electrolyte supplements, diets for weight control or treatment of obesity (including liquid diets or food), food of any kind (diabetic, low fat, cholesterol), oral vitamins, and oral minerals except when the sole source of nutrition or when a certain nutritional formula treats a specific inborn error of metabolism

Outpatient Care

- Craniosacral/cranial therapy, dance therapy, movement therapy, applied kinesiology, prolotherapy, rolfing, and extracorporeal shock wave lithotripsy (ESWL) for musculoskeletal and orthopedic conditions
- Flu vaccines supplied by a government agency, or otherwise provided at no cost to you
- Free screening services offered by a government health department.
- 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.
- Massage therapy
- Membership costs or fees associated with health clubs and weight loss programs
- Nonsurgical treatment of morbid obesity
- Services, such as laboratory X-ray and imaging or pharmacy services as required by law, from a facility in which the referring physician or his/her immediate family Member has a financial interest or relationship
- Screening tests done at your place of work at no cost to you
- Services received from a personal trainer
- Tests done by a mobile screening unit, unless a doctor not affiliated with the mobile unit prescribes the tests
- Therapy or treatment intended primarily to improve or maintain general physical condition or for the purpose of enhancing job, school, athletic, or recreational performance, including but not limited to routine, long term, or maintenance care which is provided after the resolution of the acute medical problem and when significant therapeutic improvement is not expected

Physical Appearance

- Cosmetic Procedures (see Cosmetics, dietary supplements, and health and beauty aids)
- Liposuction
- Medical and surgical services, initial and repeat, intended for the treatment or control of obesity, except for treatment of clinically severe (morbid) obesity as shown in the Coverage chapter, including:
    - Medical and surgical services to alter appearance or physical changes that are the result of any surgery performed for the management of obesity or clinically severe (morbid) obesity
    - Weight loss programs or treatments, whether prescribed or recommended by a physician or under medical supervision
- Removal of skin tags or blemishes
- Removal of tattoos (except for tattoos applied to assist in covered medical treatments, such as markers for radiation therapy)

- Replacement of an existing breast implant if the earlier breast implant was performed as a Cosmetic Procedure
    - Note: Replacement of an existing breast implant is considered reconstructive if the initial breast implant followed mastectomy.

Providers

- Medical treatment when payment is denied by a primary plan because treatment was received from a non-participating provider
- Services given by an unlicensed Healthcare Providers or performed outside the scope of the provider's license
- Services performed by a provider who is a family Member by birth or marriage, including Spouse, brother, sister, parent, or Child. This includes any service the provider may perform on himself or herself.
- Services performed by a provider with your same legal residence
- Services provided at a free-standing or hospital-based diagnostic facility without an order written by a physician or other provider, or services that are self-directed to a free-standing or hospital-based diagnostic facility
- Except for mammography testing, services ordered by a physician or other provider who is an Employee or representative of a free-standing or hospital-based diagnostic facility, when that physician or other provider:
    - Has not been actively involved in your medical care prior to ordering the service
    - Is not actively involved in your medical care after the service is received
- Submitted charges for a non-covered person
- Submitted charges for services or supplies that are not rendered
- Submitted charges for failure to keep an appointment
- Treatment not prescribed or recommended by a Healthcare Providers

Reproduction

- Collection of 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)
- Over-the-counter contraceptives
- Reversal of voluntary sterilization
- Surrogate parenting

Services Provided Under Another Plan or By Direction of State or Federal law

- Care required by state or federal law to be supplied by a school system or school district, or at a public facility
- Court-ordered treatment or hospitalization, unless such treatment is prescribed by a physician and listed as covered in the Plans
- Health services for treatment of military service-related disabilities, when you are legally entitled to other coverage and facilities are reasonably available to you
- Health services or supplies furnished, paid for, or for which Benefits are provided or required by reason of past or present service of any covered person in the armed forces of a government
- Health services for which other coverage is required by federal, state, or local law to be purchased or provided through other arrangements. This includes, but is not limited to, coverage required by workers' compensation, no-fault auto insurance, or similar legislation. If coverage under workers' compensation or similar legislation is optional for you because you could elect it, or could have it elected for you, Benefits will not be paid for any injury, sickness, or mental illness that would have been covered under workers' compensation or similar legislation had that coverage been elected.

Skilled Nursing and Hospice Care

- Any type of facility that provides primarily custodial, rest, or domiciliary care
- Assistance with daily living activities
- Convalescent care
- Financial or legal counseling
- Funeral arrangements
- Infirmaries at schools, colleges, or camps
- Rest cures
- Rest homes
- Sanitarium-type care
- Spas, sanitariums, and health resorts

Smoking Cessation

- Transdermal patches or nicotine gum (may be covered under your pharmacy benefit)

Transplants

- Any multiple organ transplant not listed as a Covered Health Service in the coverage section of this document, unless determined to be a proven procedure for the involved diagnosis
- Health services for organ and tissue transplants, except those described in the coverage section of this document
- Health services connected with the removal of an organ or tissue from you for purposes of a transplant to another person (donor costs for removal are payable for a transplant through the organ recipient's Benefits under the Plan)
- Health services for transplants involving mechanical or animal organs
- Transplant services that are not performed at a designated facility

Vision and Hearing (some vision services may be covered under your EyeMed Vision Care Benefit)

- Fitting charge for hearing aids
- Eyeglasses or contact lenses, and related fitting charges, unless following cataract surgery or treatment of keratoconus
- Eye examinations for the diagnosis or treatment of a refractive error
- Purchase cost of eyeglasses, contact lenses, or hearing aids
- Routine refractions and surgical treatment for the correction of a refractive error, including radial keratotomy

Other Exclusions

- 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 Assistances (PDAs), Braille typewriters, visual alert systems for the deaf, and memory books
- Any disease or injury resulting from a war, declared or not, or any military duty or any release of nuclear energy. Also excluded charges for care for military service disabilities treatable through governmental services if you are legally entitled to such treatment and facilities are reasonably available.
- Biofeedback
- Blood administration for the purpose of general improvement in physical condition

- Charges for the delivery of medical and health-related services via telecommunications technologies, including telephone and internet, unless provided as specifically described in the Coverage chapter
- Cost of biologicals that are immunizations or medications for the purpose of travel, or to protect against occupational hazards and risks
- Educational, vocational, or training services and supplies
- Expenses for copying or preparing medical reports, itemized bills, or claim forms
- Expenses for failure to keep an appointment
- 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 is that the likelihood of excess blood loss is such that transfusion is an expected adjunct to surgery
- For or in connection with an injury or sickness arising out of, or in the course of, any employment for wage or profit
- Mailing and/or shipping and handling expenses (There may be certain exceptions. Contact your health Plan for more information.)
- Maintenance care
- Non-medical counseling and/or ancillary services including, but not limited to, custodial services, educational services, vocational counseling, training and rehabilitation services, behavioral training, biofeedback, neurofeedback, sleep therapy, return to work services, work hardening programs, and driver safety courses
- Sales tax (There may be certain exceptions. Contact your Plan for more information.)
- Services usually given without charge, even if charges are billed
- Charges arising out of or related to any violation of a healthcare-related state or federal law or which themselves are a violation of a healthcare-related state or federal law
- Unless otherwise covered in this Plan, reports, evaluations, physical examinations, or hospitalizations not required for health reasons including, but not limited to for employment, insurance or government licenses, and court-ordered, forensic or custodial evaluations

CHAPTER 7
BEHAVIORAL HEALTH BENEFITS

Inpatient and outpatient behavioral health Benefits are available for Members enrolled in this Plan.

If you are enrolled in an Anthem PPO Plan, your behavioral health Benefits are provided through Cigna Behavioral Health. Visit *www.mycigna.com* or call (866) 395-7794.

If you are enrolled in an Anthem Consumer-Directed Health Plan (CDHP), your behavioral health Benefits are provided through Anthem Behavioral Health. Visit *www.anthem.com* or call (866) 621-0554.

OUTPATIENT BENEFITS

The following outpatient services are covered:

- Individual therapy
- Family therapy
- Couples therapy (including pre-marital counseling)
- Group therapy
- Telehealth visits
    - For Members enrolled in a PPO, telemedicine is covered through Cigna Behavioral Health
    - For Members enrolled in a CDHP, telemedicine is through LiveHealth Online (see page 39)
- Psychological testing when Medically Necessary
- Medication management
- Partial hospitalization when Medically Necessary
- Intensive outpatient programs when Medically Necessary
- Transcranial magnetic stimulation when Medically Necessary
- Applied Behavior Analysis (ABA) when Medically Necessary, including but not limited to:
    - Discrete Trial Training (DTT)
    - Early Intensive Behavioral Intervention (EIBI)
    - Pivotal Response Training (PRT)
    - Verbal Behavior Intervention (VBI)

COLLEAGUE GROUP BENEFITS

The colleague group benefit is available to Employees or Spouses for a family total of 24 90-minute sessions per 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.

For Members enrolled in an Anthem CDHP, colleague group Benefits are subject to your annual Deductible and are reimbursed at your Coinsurance level.

INPATIENT BENEFITS

To find a Network facility, contact your plan at the phone number listed above. You may seek care at an Out-of-Network facility, but you may have to pay a larger portion of the costs.

For Emergency admissions, notification must be received within 48 hours of the admission. The following inpatient services are covered based on Medical Necessity:

- Semiprivate room and board
- Private room and board expenses, limited to the cost of a semiprivate room

- Drugs, dressings, and other Medically Necessary supplies

Preauthorization

Preauthorization is required for inpatient care, partial hospitalization, residential care, transcranial magnetic stimulation, intensive outpatient care, and applied behavior analysis services. Failure to obtain preauthorization may result in a denial of covered Benefits paid by the Plan.

Exclusions

The following outpatient services are NOT covered under your behavioral health benefit:

- Treatment that is an Experiment or Investigative services, primarily for research or not in keeping with national standards of practice and not demonstrated through existing peer-reviewed, evidence based scientific literature to be safe and effective for treating or diagnosing the condition or illness for which its use is proposed
- Co-dependency therapy
- Regressive therapy
- Educational, vocational or employment testing, training, or services
- Educational therapy or services for learning disabilities or mental retardation
- Treatment for personal growth and development
- Treatment required by state or federal law to be provided to a child by the school system or school district
- Neuro-psych testing
- Sanitarium, rest, or custodial care
- Vocational or occupational training
- Aversion therapy
- Bio-feedback, neuro-bio-feedback
- Aromatherapy, massage therapy, reiki
- Thought field, energy, art, or dance therapy
- Custodial care: treatment that is not expected to reduce the disability to the extent necessary to enable the individual to function outside a protected, monitored or controlled environment
- Therapeutic foster care
- Group home
- Halfway houses
- Three quarter houses
- Wilderness programs
- Residential/therapeutic schools
- Camps
- Court ordered, forensic, or custodial evaluations
- Court ordered treatment unless deemed to be Medically Necessary
- Weight loss programs

Employee Assistance Program (EAP)

The Employee Assistance Program (EAP), managed by Cigna Behavioral Health (CBH), is available to all Members and their Dependents* enrolled in any active Medical Trust medical plan. 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 the CBH website or by phone.

EAP services include:

- Phone and website access 24/7
- In-person counseling (up to 10 sessions per issue with $0 copay)
- 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 *www.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 Pastoral Support Network 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 Pastoral Support Network 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.

Filing a Claim

See Chapter 9 for claims and appeals information.

*Dependents do not need to be enrolled in the Member's medical plan to use the EAP.

CHAPTER 8
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 the 60,000 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 ***www.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 he or she prescribes a drug, and encourage him or her 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 doctor 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 ***www.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 he or she 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 section
- Insulin
- Legend contraceptive medications—oral, injectable, patch, ring
- Legend smoking cessation treatment
- Needles and syringes
- Over-the-counter and legend prenatal vitamins
- State-restricted drugs

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.

Examples of medications that may require review are:

- Alzheimer's therapy (e.g., Cognex, Aricept, Exelon, Reminyl)
- Botox/Myobloc
- COX II Medications (e.g., Celebrex)
- Drugs to treat impotency for males only (except Yohimbine), drugs for treatment of impotence related to diabetes, peripheral vascular disease or side effects of the medications to treat it, post-prostatectomy/orchiectomy, post-radiation therapy related to treatment of prostate cancer, and syndromes affecting sexual functioning. Limited to six tablets per month.
- Elidel
- Erythroid stimulants
- Gleevec
- Hepsera
- Interferons (e.g., Alpha, Beta, Gamma, Pegasys)
- Lotronex for females only
- Lupron 1mg
- Migraine agents (e.g., Imitrex, Zomig, Maxalt)
- Myeloid stimulants
- Multiple Sclerosis therapy (e.g., Avonex, Copaxone, Betaseron)
- Neumega
- Panretin gel
- Penlac solution
- Protopic ointment
- Regranex gel
- Retin-A (tretinoin) (co-brands cream only)
- Targretin gel
- Xolair

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 Healthcare 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 he or she is 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 or Investigational drugs, even though a charge is made to the individual
- Immunization agents
- Blood products
- Immune globulins
- Topical dental fluorides
- Therapeutic devices or appliances
- Mifeprex
- Contraceptive devices
- Drugs to treat impotency for females only
- Yohimbine
- Human growth hormones
- Fertility agents
- Appetite suppressants and weight-loss agents
- Lamisil
- Seasonale at a retail pharmacy

Using a Retail Pharmacy

When you need a drug for a limited time, use a participating retail pharmacy to maximize your Benefits. The retail pharmacy program allows for a total of three fills of a maintenance medication at a retail pharmacy (one original fill and two refills). 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 allowable amount (based on pricing at a participating pharmacy), you will be reimbursed based on the allowable 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 Claims and Appeals chapter.

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 re-

ceives 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.

Express Scripts Special Care Pharmacy

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.

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 *www.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.

Health Education Programs

These programs, based on medical practices, promote good healthcare for cardiovascular health, respiratory health, and diabetes by providing in-depth education and support tools to Members in order to improve their self-management skills.

The programs are designed to enhance communication between patients and physicians, decrease the rates of short-term and long-term disease complications, improve overall health outcomes (including quality of life), and improve patient satisfaction with medical care.

You will be contacted by Express Scripts if participation in a health education program is appropriate for your condition.

Filing a Claim

See Chapter 9 for information on claims and appeals.

CHAPTER 9
CLAIMS AND APPEALS

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

FILING A CLAIM

Your Healthcare Providers should file claims for you. However, if you receive Out-of-Network services, you may have to file claims yourself. If your Out-of-Network provider is unable to file electronically, you or your Healthcare Providers may submit a claim form for Out-of-Network services. You can find the claim forms for Anthem BCBS, Cigna Behavioral, and Express Scripts at *www.cpg.org/forms-and-publications/forms/health-plans/#Claims*

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If your Healthcare 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 Healthcare Providers 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:

Anthem Blue Cross and Blue Shield
PO Box 105187
Atlanta, GA 30348-5187

Send claims for Mental Health and substance use disorder services to:

Cigna Behavioral Health
P.O. 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 last 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 Anthem, 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. 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 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, the notice of the Adverse Benefit Determination (denial) will include:

- Information sufficient to identify the claim involved, including the date of service, the health care 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 review procedures and the time limits that apply to them
- If your second level claim is denied, the notice will include a statement describing the voluntary external review process offered by the Plan, if applicable, including information regarding how to initiate 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 or Investigative service, 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. See page 77.

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:

Anthem National Accounts
ATTN: Appeals
PO Box 105568
Atlanta, GA 30348

For behavioral health services:

Cigna Behavioral Health Appeals
P.O. Box 188064
Chattanooga, TN 37422

For prescription drug services:

Express Scripts
P.O. 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 on review 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 or Investigative 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 betermination. 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 Anthem, Express Scripts, or Cigna Behavioral Health, 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 Anthem or Cigna Behavioral Health, send

your second level appeal to:

Anthem National Accounts
PO Box 105568
Atlanta, GA 30348
Attn: Appeals

Cigna Behavioral Health Appeals
P.O. 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, and determinations involving a rescission of coverage 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 Healthcare 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 de- scribe 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 Ad- verse 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 (Anthem, Cigna, or Express Scripts), and the Medical Trust unless otherwise allowed by law.

Preliminary Review

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

- 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 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 (Anthem, Cigna 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 (Anthem, Cigna 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 health care 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.

Requirement to File an Appeal Before 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 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 10
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 11
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. 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 Employees in the previous year, you may be eligible to choose a plan that participates in this program.[8]

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, your Cigna 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 2019, will continue to work, and your employer participates in the MSP/Small Employer Exception program, 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 Cigna Plan.

HOW IT WORKS

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

If you have an inpatient hospitalization in 2019, 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, which will process the portion not paid by Medicare, minus the Plan's Deductible and your cost share. The chart below shows an example of how this will work.

Part A Billed Charges	$10,000.00
Medicare Allowed	$2,700.00
Medicare's Payment	
Medicare Paid	$1,336.00
Medicare's Deductible	$1,364.00
PPO 90 Plan Payment	
Plan Allowed (amount not paid by Medicare)	$1,336.00
Plan's Maximum Liability minus Deductible times Co-insurance	$1,336.00 -500 $836.00 x 90% $752.40
Plan Pays	**$752.40**
Member Pays ($500 Deductible + 10% Coinsurance)	**$583.60**

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 level, regardless of whether the facility is in Cigna's Network.

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

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 or Out-of-Network level, as appropriate.

If your Dependent Spouse is not yet Medicare-eligible and enrolled in your Cigna plan, Cigna will be the primary payer for all services for him or her.

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 12
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.

You may, however, authorize Cigna to pay any healthcare Benefits under this policy to a participating or non-participating provider. When you authorize the payment of your healthcare Benefits to a participating or non-participating 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 Services directly to a participating provider without your authorization. You may not interpret or rely upon this discrete authorization or permission to pay any healthcare Benefits to a participating or non-participating 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.

Even if the payment of healthcare Benefits to a non-participating 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 non-participating 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 one of our participants passes away, Cigna may receive notice that an executor of the estate has been established. The executor has the same rights as our insured and Benefit payments for unassigned claims should be made payable to the executor.

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

SPECIAL ELECTION FOR EMPLOYEES AND SPOUSES AGE 65 AND OVER

If a Member remains actively employed after reaching age 65, 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 Medicare Supplement Plan sponsored by the Medical Trust. If coverage remains under the Plan, the Plan will be the primary payor of Benefits, and Medicare will be the secondary payor (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 his or her 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 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 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 Healthcare 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 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 contains only a partial description of the Plan and is intended for informational purposes only. It should not be viewed as a contract, an offer of coverage, or investment, tax, medical, or other advice.

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 law, without notice.

The Plan is a church plan within the meaning of section 3(33) of the Employee Retirement Income Security Act and section 414(e) of the Internal Revenue Code. Not all Plans are available in all areas of the United States, and not all Plans are available on both a self-funded and fully insured basis. The 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. 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.

CHAPTER 13
SUBROGATION AND RIGHT OF RECOVERY

DEFINITIONS

As used throughout this chapter, the term “responsible party” means any party 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 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.

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 he or she receives any payment from any responsible party as a result of an injury, illness, or condition, he or she 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.

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 his or her agents shall provide all information requested by the Plan, the Claims Administrator or its representative including, but not limited to, completing and submitting any applications or other forms or statements as the Plan may reasonably request. Failure to provide this information may result in the termination of health Benefits for the covered person or the institution of court proceedings against the covered person.

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 his or her agents of its lien. Agents include, but are not limited to, insurance companies and attorneys.

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.

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 him or her by reason of his or her present or future domicile.

CHAPTER 14
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 health care flexible spending account, and any health care 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 health care; (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 ***www.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 ***astill@cpg.org*** for a full explanation of ECMT'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 ***astill@cpg.org***. Your request must list the specific PHI you want amended and explain why it is incorrect or incomplete and be signed by you or your authorized representative. All amendment requests will be considered carefully. However, your request may be denied if the PHI or record that is subject to the request:

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

Right to an Accounting of Disclosures. You have the right to receive information about when your PHI has been disclosed to others. Certain exceptions apply to this rule. For example, a Plan does not need to account for disclosures made to you or with your written authorization, or for disclosures that occurred more than six years before your request. To request an accounting of disclosures, you must submit your request in writing to the Medical Trust Plan Administration at ***astill@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 Medical Trust 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 ***astill@cpg.org*** for a full explanation of the Medical Trust's fee structure.

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

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

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

You can request further information from our Privacy Officer at ***Privacy@cpg.org***.
In addition to your rights with respect to your PHI addressed above, you may have additional or overlapping rights under the GDPR. GDPR rights regarding your PHI include the following:

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

Data Retention
We only retain PHI collected for a limited time period as long as we need it to fulfill the purposes for which have initially collected it, unless otherwise required by law.
Data Transfers
We maintain servers in the United States and Canada, and your information may be processed on servers located in the United States and Canada. Data protection laws vary among countries, with some providing more protection than others. Regardless of where your information is processed, we apply the same protections described in this policy.

IF YOU BELIEVE YOUR PRIVACY RIGHTS HAVE BEEN VIOLATED

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

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

To contact the Church Pension Group Privacy Officer:

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

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

Office of Civil Rights
200 Independence Avenue, SW
Washington, DC 20201
(202) 619-0257 | (877) 696-6775 (toll-free)
www.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 15
Glossary

Annual Enrollment

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

Active Annual Enrollment
During an Active Annual Enrollment, a Subscriber, Eligible Individual, or Eligible Dependent is required by the Plan to take specific actions to prevent any loss of coverage. An Active Annual Enrollment generally takes place for a Participating Group upon first joining the Plan, or when a plan ceases to be available for the upcoming Plan Year, or when there is a significant change to the existing Plan options.

Passive Annual Enrollment
During a Passive Annual Enrollment, a Subscriber, Eligible Individual, or Eligible Dependent is not required by the Plan to take any action[3]. However, the Plan encourages Subscribers, Eligible Individuals, and Eligible Dependents to log on to the Annual Enrollment website to verify demographic information and existing coverage and to update any data that is not accurate.

Benefits

Your right to payment for Covered Health Services that arise 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.

Billed Group

A Participating Group or one of its congregations, schools or other bodies, including Employees and Pre-65 Retired Employees or Post-65 Retired Employees, that is billed by the Plan and responsible for paying monthly contributions. Also sometimes called a "List Bill."

Claims Administrator

The company, or its affiliate, that provides certain claim administration services for the Plan.

Coinsurance

Coinsurance percentages represent the percentage of covered expenses paid by you and the Plan after satisfaction of any applicable Deductible. These percentages apply only to covered expenses that do not exceed reasonable and customary charges. You are responsible for all non-covered expenses, including any amount that exceeds the reasonable and customary charge for covered expenses.

[3] Note, however, that some states may require a new signed authorization from the Employee when the amount of the payroll deduction increases.

Congenital Anomaly

A physical developmental defect that is present at birth and is identified within the first twelve months of birth.

Copayments

Copayments (Copays) are the first-dollar amounts you must pay for certain covered services under the Plan that are usually paid at the time the service is performed (e.g., physician office visits or Emergency room visits). These Copayments do not apply to your annual Deductible but do apply to your Out-of-Pocket Maximum.

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

Cosmetic Procedures

Procedures or services that change or improve appearance without significantly improving physiological function, as determined by the Claims Administrator. Reshaping a nose with a prominent bump is one example of a Cosmetic Procedure because appearance would be improved, but there would be no improvement in function, such as breathing.

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 disorder, 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 or Investigative 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 Care

Custodial Care includes activities of daily living such as bathing, feeding, administration of oral medicines, or other services that can be provided by persons without the training of a Healthcare Provider.

Deductible(s)

A Deductible is the amount of covered expenses each covered individual must pay during each year before the

Plan will consider expenses for reimbursement, with the exception of preventive services. The individual Deductible applies separately to each covered person[4]. The family Deductible applies collectively to all covered persons in the same family. When the family Deductible is satisfied, no further Deductible will be applied for any covered family Member during the remainder of that year.

Denominational Health Plan

A Church-wide program of healthcare benefit plans authorized by General Convention and administered by The Church Pension Fund (CPF), with Benefits provided through the Medical Trust.

Dependent

A Spouse, Domestic Partner, or Child of a Subscriber who meets the qualifications listed in the eligibility chapter.

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[5], foster child[6], legally adopted child; or a child who has been placed with the Subscriber, Subscriber's Spouse, or if applicable, Domestic Partner, for adoption.

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

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 the Eligibility and Enrollment chapter 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 the Eligibility and Enrollment chapter 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 the Eligibility and Enrollment chapter and is enrolled in the Plan at the time of the Subscriber's death.

Disabled Child

An eligible Child who 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 he or she is incapable of self-support,

[4] For Subscribers enrolled in the Anthem BCBS CDHP-15 (other than those with Single coverage), the family Deductible must be met before the Plan begins to pay for covered services.

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

[6] 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.

and such impairment continues without interruption thereafter. The Medical Trust (or its delegate) may, in its sole discretion, require periodic certification of an individual's continuing disability.

Durable Medical Equipment

Medical equipment that is all of the following:

- Used to serve a medical purpose with respect to treatment of a sickness, injury, or their symptoms
- Not disposable
- Not of use to a person in the absence of a sickness, injury, or their symptoms
- Durable enough to withstand repeated use
- Not implantable within the body
- Appropriate for use—and primarily used—within the home

Eligible Dependent

An individual who meets the definition of an Eligible Dependent in the Eligibility and Enrollment chapter of this handbook.

Eligible Expenses

Eligible Expenses for Covered Health Services, incurred while the Plan is in effect, are determined as stated below.

The Plan has delegated to the Claims Administrator the discretion and authority to initially determine on our behalf whether a treatment or supply is a Covered Health Service and how the Eligible Expense will be determined.

For Network Benefits, Eligible Expenses are based on either of the following:

- When Covered Health Services are received from Network providers, Eligible Expenses are the contracted fee(s) with that provider.
- When Covered Health Services are received from Out-of-Network providers as a result of an Emergency or as otherwise arranged by the Claims Administrator, Eligible Expenses are the fee(s) that are negotiated with the Out-of-Network provider.

When you receive Covered Health Services from Network providers, you are responsible for the Copayment and amounts in excess of any Plan maximum, but you are not responsible for any difference between the Eligible Expenses and the amount the provider bills.

For Out-of-Network Benefits, Eligible Expenses are determined by either:

- Calculating Eligible Expenses based on available data resources of competitive fees in that geographic area
- Applying the negotiated rates agreed to by the Out-of-Network provider and either the Claims Administrator or one of its vendors, affiliates, or subcontractors.

Eligible Expenses are determined solely in accordance with the Claims Administrator's reimbursement policy guidelines. The reimbursement policy guidelines are developed in the Claims Administrator's discretion following evaluation and validation of all provider billings in accordance with one or more of the following methodologies:

- As indicated in the most recent edition of the *Current Procedural Terminology (CPT)*, a publication of the American Medical Association
- As reported by generally recognized professionals or publications
- As used for Medicare
- As determined by medical staff and outside medical consultants pursuant to other appropriate sources or by determination that the Claims Administrator accepts

When you receive Covered Health Services from Out-of-Network providers, you are responsible for the Coinsurance and amounts in excess of any Plan maximum and are also responsible for any difference between the Eligible Expenses and the amount the provider bills.

See Maximum Allowed Amount.

Eligible Individual

This definition can be found in the Eligibility for the Episcopal Health Plan (EHP) and the Episcopal Health Plan for Qualified Small Employer Exception Members (EHP SEE) sections of the Plan Document Handbook.

Emergency

A serious medical condition or symptom resulting from injury, sickness or mental illness which meets both of the following criteria:

- Arises suddenly
- In the judgment of a reasonable person, requires immediate care and treatment, generally received within 24 hours of onset, to avoid jeopardy to life or health

Employee

An individual whose income must be reported on a Form W-2 or international equivalent by a Participating Group, including individuals on an approved leave of absence, short-term disability, or long-term disability.

Exempt Employee
An Employee who is not subject to the overtime provisions of the Fair Labor Standards Act[7] or other applicable state law due to the nature of the work, education requirements of the position, and salary range, as determined solely by the employer.

Non-Exempt Employee
An individual who is entitled to overtime compensation under the Fair Labor Standards Act or other applicable state law, as determined solely by the employer.

Pre-65 Retired 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

Priest
An individual ordained to the priesthood in the Episcopal Church pursuant to the Constitution and Canons

[7] For purposes of these definitions, it is assumed that the Fair Labor Standards Act applies to the employer. See ***www.dol.gov/whd/overtime_pay.htm***

or a person who has been received as a Priest into the Episcopal Church from another Christian denomination in accordance with the Constitution and Canons.

Post-65 Retired Employee
Clergy
A former Employee who:

a) Is age 65 or older, and
b) Has a vested Benefit 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 either 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 for a minimum of five (5) years AND either (1) participated in a pension plan sponsored by The Church Pension Fund for a minimum of five (5) years OR (2) was 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 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 five 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 three months, and who is compensated for less than 1,000 hours per Plan Year.

The Episcopal Church Clergy and Employees' Benefit Trust (ECCEBT)

A voluntary Employees' beneficiary association (VEBA) under Section 501(c)(9) of the Internal Revenue Code that funds Benefits provided under the Plan. The purpose of the ECCEBT is to provide medical and other eligible Benefits to eligible Employees, former Employees, and/or their Eligible Dependents.

Experimental/Investigative

Any drug, biologic, device, diagnostic, product equipment, procedure, treatment, service, or supply used in or directly related to the diagnosis, evaluation, or treatment of a disease, injury, illness, or other health condition which the Claims Administrator determines to be unproven.

The Claims Administrator will deem any drug, biologic, device, diagnostic, product, equipment, procedure, treatment, service, or supply to be Experimental/Investigative if the Claims Administrator determines that one or more of the following criteria apply when the service is rendered with respect to the use for which Benefits are sought. The drug, biologic, device, product, equipment, procedure, treatment, service, or supply:

- Cannot be legally marketed in the United States without the final approval of the Food and Drug Administration (FDA), or other licensing or regulatory agency, and such final approval has not been granted; or
- Has been determined by the FDA to be contraindicated for the specific use; or
- Is subject to review and approval of an Institutional Review Board (IRB) or other body serving a similar function; or

- Is provided pursuant to informed consent documents that describe the drug, biologic, device, diagnostic, product, equipment, procedure, treatment, service, or supply as Experimental/Investigative, or otherwise indicate that the safety, toxicity, or efficacy of the drug, biologic, device, diagnostic, product, equipment, procedure, treatment, service, or supply is under evaluation.

Any service not deemed Experimental/Investigative based on the criteria above may still be deemed Experimental/Investigative by the Claims Administrator. In determining whether a service is Experimental/Investigative, the Claims Administrator will consider the information described below and assess whether:

- The scientific evidence is conclusory concerning the effect of the service on health outcomes
- The evidence demonstrates the service improves net health outcomes of the total population for whom the service might be proposed by producing beneficial effects that outweigh any harmful effects
- The evidence demonstrates the service has been shown to be as beneficial for the total population for whom the service might be proposed as any established alternatives
- The evidence demonstrates the service has been shown to improve the net health outcomes of the total population for whom the service might be proposed under the usual conditions of medical practice outside clinical investigatory settings

The information considered or evaluated by the Claims Administrator to determine whether a drug, biologic, device, diagnostic, product, equipment, procedure, treatment, service, or supply is Experimental/Investigative under the above criteria may include one or more items from the following list, which is not all inclusive:

- Published authoritative, peer-reviewed medical or scientific literature, or the absence thereof
- Evaluations of national medical associations, consensus panels, and other technology evaluation bodies
- Documents issued by and/or filed with the FDA or other federal, state or local agency with the authority to approve, regulate, or investigate the use of the drug, biologic, device, diagnostic, product, equipment, procedure, treatment, service, or supply
- Documents of an IRB or other similar body performing substantially the same function
- Consent documents and/or the written protocols used by the treating physicians, other medical professionals, or facilities or by other treating physicians or other medical professionals or facilities studying substantially the same drug, biologic, device, diagnostic, product, equipment, procedure, treatment, service, or supply
- Medical records
- The opinions of consulting Providers and other experts in the field

The Claims Administrator has the sole authority and discretion to identify and weigh all information and determine all questions pertaining to whether a drug, biologic, device, diagnostic, product, equipment, procedure, treatment, service, or supply is Experimental/Investigative.

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.

Healthcare Providers

The Plan provides Benefits only for Covered Health Services and supplies rendered by a physician, practitioner, nurse, hospital, or specialized treatment facility.

Maximum Allowed Amount

For Covered Services you receive from an Out-of-Network provider, the Plan will only pay Benefits up to the Maximum Allowed Amount. For this Plan, the Maximum Allowed Amount will be one of the following as determined by the Claims Administrator:

- An amount based on the Claims Administrator's Out-of-Network Provider fee schedule/rate, which the Claims Administrator has established through its discretion, and which the Claims Administrator reserves the right to modify from time to time after considering one or more of the following: reimbursement amounts accepted by like/similar providers contracted with the Claims Administrator, reimbursement amounts paid by the Centers for Medicare and Medicaid Services (CMS) for the same services or supplies, and other industry cost, reimbursement and utilization data
- An amount based on reimbursement or cost information from CMS. When basing the Maximum Allowed amount upon the level or method of reimbursement used by CMS, Anthem will update such information, which is unadjusted for geographic locality, no less than annually
- An amount based on information provided by a third-party vendor, which may reflect one or more of the following factors: (1) the complexity or severity of treatment; (2) level of skill and experience required for the treatment; or (3) comparable providers' fees and costs to deliver care
- An amount negotiated by the Claims Administrator or a third-party vendor which has been agreed to by the Healthcare Provider. This may include rates for services coordinated through case management
- An amount based on or derived from the total charges billed by the Out-of-Network provider

Healthcare Providers who are not contracted for this Plan but are contracted for other products with the Claims Administrator are also considered Out-of-Network. For this Plan, the Maximum Allowed Amount for services from these Healthcare Providers will be determined by one of the five methods shown above unless the contract between the Claims Administrator and that provider specifies a different amount.

Unlike Network Providers, Out-of-Network Providers may send you a bill and collect for the amount of the Provider's charge that exceeds the Plan's Maximum Allowed Amount. You are responsible for paying the difference between the Maximum Allowed Amount and the amount the Healthcare Provider charges. This amount can be significant. Choosing a Network Provider will likely result in lower out of pocket costs to you. Please calling Customer Service for help in finding a Network Provider or go to *www.anthem.com*.

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.

Medical Life Participant System (MLPS)

The Medical Life Participant System (MLPS) is a web-based tool designed to make the administration of Benefits easy and efficient. MLPS processes health and group life Benefits enrollments in real time and allows Group Administrators to view bills and payment histories, create reports, and generate mailing lists.

Medical Necessity or Medically Necessary

Procedures, treatments, supplies, devices, equipment, facilities or drugs (all services) that a medical practitioner, exercising prudent clinical judgment, would provide to a covered individual for the purpose of preventing, evaluating, diagnosing, or treating an illness, injury, disease or its symptoms, and that are:

- In accordance with generally accepted standards of medical practice
- Clinically appropriate in terms of type, frequency, extent, site, and duration and considered effective for the covered individual's illness, injury, or disease
- Not primarily for the convenience of the covered individual, physician, or other Healthcare Provider
- Not costlier than an alternative service or sequence of services at least as likely to produce equivalent therapeutic or diagnostic results as to the diagnosis or treatment of that covered individual's illness, injury, or disease

For these purposes, "generally accepted standards of medical practice" means standards that are based on credible scientific evidence published in peer-reviewed medical literature generally recognized by the relevant medical community, national physician specialty society recommendations, the views of medical practitioners practicing in relevant clinical areas, and any other relevant factors.

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[8] who has been accepted or received by the Religious Order.

Mental Health Services

Covered Health Services for the diagnosis and treatment of mental illnesses. 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

When used to describe a Healthcare Provider of healthcare services, this means a Healthcare Provider that has a participation agreement in effect with the Claims Administrator or an affiliate (directly or through one or more other organizations) to provide Covered Health Services to covered persons.

A Healthcare Provider may enter into an agreement to provide only certain Covered Health Services, but not all Covered Health Services, or to be a Network provider for only some products. In this case, the Healthcare Provider will be a Network provider for the health services and products included in the participation agreement, and an Out-of-Network provider for other health services and products. The participation status of providers will change from time to time.

Network Benefits

Benefits for Covered Health Services that are provided by (or directed by) a Network physician or other Network provider in the Healthcare Provider's office or at a Network or Out-of-Network facility.

Out-of-Network

A Healthcare Provider, including but not limited to, a hospital, freestanding ambulatory facility (surgical center), 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 Plan to provide services to its Members at the time services are rendered. Benefit payments and other provisions of the Plan are limited when a Member uses the services of Out-of-Network providers.

[8] The Constitution and Canons of the Episcopal Church, 2012

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-Pocket Maximum

An Out-of-Pocket Maximum is the maximum amount of Covered Health Services you must pay during a year before the Plan begins to pay 100% of covered charges. The individual Out-of-Pocket Maximum applies separately to each covered person. When a covered person reaches the annual Out-of-Pocket Maximum, the Plan will pay 100% of additional covered expenses for that individual during the remainder of that Plan Year[9].

The family Out-of-Pocket Maximum applies collectively to all covered persons in the same family. When the annual family Out-of-Pocket Maximum is reached, the Plan will pay 100% of Covered Services for any covered family Member during the remainder of that Plan Year.

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

- Any charges for services or supplies that are not Covered Health Services
- Copayments for Covered Health Services available by an optional rider
- The amount of any reduced Benefits if you don't precertify services when required
- Charges that exceed Eligible Expenses
- Penalties

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

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.

Plan

The medical and dental 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 and dental plan options through which Eligible Individuals and Eligible Dependents of The Episcopal Church are provided health Benefits.

Episcopal Health Plan (EHP) for qualified Small Employer Exception (SEE) Members
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 Year

The word “year” or Plan Year, as used in this Plan Document Handbook, refers to the Plan Year which is the 12-

[9] For Members enrolled in the Anthem BCBS CDHP-15 (other than those with Single coverage), the family Out-of-Pocket Maximum must be met before the Plan begins to pay 100% of covered services for any enrolled Member.

month period beginning January 1 and ending December 31. All Benefit Maximums and annual Deductibles accumulate during the Plan Year.

Preventive Care

Medical services aimed at early detection and intervention. Preventive Care focuses on wellness, health promotion, and other activities that reduce the likelihood of illness or injury.

Seminarian

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

Significant Life Event

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

Subscriber

The primary individual enrolled in the Plan who meets the qualifications listed in the Eligibility and Enrollment chapter.

Urgent Care Center

A facility, other than a hospital, that provides Covered Health Services that are required to prevent serious deterioration of your health, and that are required as a result of an unforeseen sickness, injury, or the onset of acute or severe symptoms.

EPISCOPAL CHURCH MEDICAL TRUST

2018-2019 Consumer-Directed Health Plan / Health Savings Account fact sheet for members

Your Consumer-Directed Health Plan

A Consumer-Directed Health Plan (CDHP),[1] coupled with an interest-bearing Health Savings Account (HSA), is a health plan that works a little differently from what you might be accustomed to.

Understanding how a CDHP / HSA functions will help you get the most from your benefits. This fact sheet provides CDHP / HSA basics, including how to get started after you enroll and how to use your CDHP / HSA benefits actively. The Episcopal Church Medical Trust (Medical Trust) offers seven CDHPs: three through Anthem Blue Cross and Blue Shield (Anthem BCBS), three through Cigna, and one through Kaiser. See details below about the plans.

CDHP overview

A CDHP is designed to have a high deductible, a requirement that allows you to set up an HSA. This annual deductible applies to most covered medical, behavioral, and pharmacy benefits. It does not apply to most preventive care services. That means you pay 100 percent of your medical, behavioral, and prescription drug expenses until you have met your annual deductible. **Most preventive services are covered at 100 percent with no cost-sharing.**

Once you have met the annual deductible, the plan shares expenses with you. You will then pay coinsurance for eligible services, but the total amount you pay will be limited to the annual out-of-pocket limit, which is the combined total of your annual deductible and annual coinsurance ceiling.

HSA overview

A qualified CDHP — such as those offered through the Medical Trust from Anthem BCBS, Cigna, and Kaiser — allows employees to open an HSA, provided the HSA eligibility requirements are otherwise met. (See next section.)

With an HSA, you may choose to fund expenses out-of-pocket and let the tax-favored funds grow in your HSA for future healthcare expenses, or you may use them as needed. You, your employer, and / or others have the option to contribute to the account. Contributions are tax-free up to federal annual limits.

You should also understand these basic aspects of how an HSA works:

- Accounts are owned by the employee
- Accounts are portable from employer to employer
- Unused funds roll over from year to year
- HSA funds can earn interest
- Funds in the HSA may be invested (once any applicable minimum threshold is met)
- Withdrawals from the HSA are not subject to federal income tax when they are used to pay for qualified medical expenses[1]

[1]Consumer-Directed Health Plan / Health Savings Account (CDHP / HSA) is used throughout to refer to the Cigna and Anthem BCBS HDHPs, where they are alike. Any differences in the plans will be clearly noted within the text.

HSA eligibility

To open an HSA, you must be enrolled in a qualifying CDHP. Generally, you are not permitted to be covered by other, disqualifying types of health plans, with these exceptions: AFLAC-type coverage, separate dental and vision coverage, and disability coverage. Disqualifying health coverage includes Medicare, TRICARE, non-CDHP coverage under a plan of your spouse's or domestic partner's employer, or healthcare flexible spending account (FSA) coverage. However, you are permitted coverage under a limited-purpose flexible spending account (LPFSA) or limited-purpose health reimbursement account (HRA). LPFSAs and limited-purpose HRAs are designed to work with HSAs. Contact your employer to see if an LPFSA or limited-purpose HRA is offered.

Also note that you may not be claimed as a dependent on another individual's tax return.

CDHP basics

Preventive care services

Certain preventive care services are covered at 100 percent in-network. This means that you do not need to meet the deductible before the plan pays for recommended routine visits such as adult physicals, well-child visits, and OB / GYN annual exams. Depending on factors such as age and family history, other preventive care services may also be fully covered.

Annual deductible (medical and pharmacy)

Your deductible is an integrated medical and pharmacy deductible. This means both your medical and pharmacy expenses count toward your deductible. It is important to keep in mind that your network and out-of-network deductibles accumulate separately.

Coinsurance

Once you meet your annual deductible[2], you will pay coinsurance for eligible services. Coinsurance is a percentage of the allowed expense that you must pay. (The Medical Trust's CDHPs differ from other employer-provided plans, which often use copayments in addition to or instead of coinsurance.) The percentage you pay is lower when you use network providers than when using out-of-network providers.

After you pay your coinsurance, the plan pays the remainder of the bill for eligible services from network providers. For out-of-network provider services, you are responsible for coinsurance and any charges above the allowed amount, making out-of-network providers more costly than network providers in most cases.
Note: The Kaiser CDHP covers network services only.

CDHP annual out-of-pocket limit

Your plan sets a limit on the amount you will have to pay out-of-pocket for services each year. This is your "out-of-pocket limit" and is equal to the combined total of your annual coinsurance maximum and annual deductible.

After you reach the out-of-pocket limit[3], the plan will pay 100 percent of eligible charges for the remainder of the plan year.

It is important to note that your network and out-of-network out-of-pocket limits accumulate separately.

Network = savings

You will usually pay less for services from network providers than you will from out-of-network providers, for two reasons. First, your network coinsurance is lower than your out-of-network coinsurance. Second, network providers can bill you based only on a certain amount, the "allowed amount."

The allowed amount is what our plan vendors — Anthem BCBS, Kaiser, and Cigna — have negotiated with service providers on behalf of the Medical Trust. These discounted rates for medical services from

2 Members enrolled in a CDHP-15 with covered dependents must meet the family deductible before the plan pays for any covered member.
3 Members enrolled in a CDHP-15 with covered dependents must reach the family out-of-pocket limit before the plan begins to pay 100% of covered services for any covered member.

network providers can save you lots of money.

If you use an out-of-network provider, you will be responsible for 100 percent of charges above the allowed amount, which is based on the maximum reimbursable amount, as determined by the plan. **Note:** The Kaiser CDHP covers network services only.

You can use money from your HSA to pay for these charges, but only your portion of the allowed amount counts toward the annual deductible and annual out-of-pocket limit.

Using network providers

Remember, going to a network provider should make things easier for you overall and may have significant cost-saving advantages.

1. Provide your health plan membership information when you call to make the appointment.
2. If you see a network provider, you are not required to make payment at the time of service.[4] Your network provider will code the visit and bill it to your plan.
3. If you choose to pay out-of-pocket at the time of service, be sure that the service and your related payment are run through the vendor claims system so that any network discount will apply and your payment will be credited toward your network deductible.
4. Anthem BCBS, Cigna, or Kaiser will send you an Explanation of Benefits (EOB) informing you of the cost share you will pay for the services based on the negotiated rates and plan coverage.
5. You may make payment by using your HSA debit card, or you can use another bank card and either reimburse yourself with funds from your HSA or let your health savings remain in the HSA for future use.
6. Many preventive care services are paid at 100 percent in-network; all other services are subject to the annual deductible and, if applicable, coinsurance.

Using out-of-network providers

It is important to note that if you see an out-of-network provider, you may be required to make payment at the time of service. **Note:** The Kaiser CDHP covers network services only.

1. Provide your health plan membership information when you call to make the appointment.
2. You may make payment by using your HSA debit card, or you can use another bank card and either reimburse yourself with funds from your HSA[4] or let your health savings remain in the HSA for future use.
3. Be sure that the service and your related payment are run through the vendor claims system so that your payment will be credited toward your out-of-network deductible and coinsurance maximum as applicable.

Prescription benefits

Prescriptions must be paid for at the time of service at a retail pharmacy or through a mail-order pharmacy.

1. Provide the pharmacy with your Express Scripts card to ensure purchases are applied toward your annual deductible and coinsurance maximum, as applicable.
2. You will be paying the negotiated rate. (Coinsurance amounts begin once you have met your annual deductible.)
3. You may make payment by using your HSA[5] debit card, or you can use another bank card and either reimburse yourself with funds from your HSA or let your health savings remain in the HSA for future use.

Using your HSA contributions

Making regular contributions to your Health Savings Account is a simple and convenient way to build up your

[4] *We encourage you to wait for your Explanation of Benefits from Anthem BCBS, Cigna, or Kaiser before making payment to ensure that the negotiated rate for service is applied.*

[5] *Note that some banks have fees associated with reimbursing yourself through your debit card. Check with your financial institution about any such fees.*

HSA balance, creating tax-favored savings for future qualified medical expenses.

Keep your receipts
The IRS requires you to keep records to show that HSA distributions were used to pay for or reimburse qualified medical expenses that had not been previously paid or reimbursed from another source.

Note that you may cover dependents under a CDHP even if they are not your federal tax code dependents for HSA purposes. For example, your 25-year-old child may not be a tax dependent, but he or she would still be eligible for coverage from the CDHP. Because your child is not a tax dependent, she or he will not be eligible to have expenses reimbursed from the HSA even though the child is covered under the CDHP.

If you do not use all of your HSA funds in one calendar year, the remaining money rolls over for use in future years. If you change plans or retire, the HSA is still yours and can be used for qualified medical expenses.

Tax-free advantage

You pay absolutely no federal taxes on any contributions (up to applicable limits), interest earned, or investment profits in your HSA. If you make a contribution into your HSA with money on which you have already been taxed, you can take a corresponding deduction on your federal income tax return, again, up to applicable limits. In addition, you are not subject to federal income tax when you withdraw money to pay for qualified medical expenses.

However, if you withdraw money for reasons other than to pay for qualified medical expenses, you will pay taxes and an IRS-determined penalty (currently 20 percent) on the amount of the withdrawal. The penalty does not apply if you are 65-plus years of age, or disabled, or if you have died and your HSA is being used by your spouse who is 65-plus years of age. (Spouses who are under 65 must then use the money for eligible expenses or pay a penalty.) If you have died and your beneficiary is someone other your spouse, then the HSA ceases to be an HSA and the money in the account is fully taxable to the beneficiary.

Remember: Keep your receipts; you may need them during an audit.

HSA funding options

HealthEquity – Members who enroll in any CDHP through the Medical Trust will automatically have an HSA set up by HealthEquity, who will also send them a welcome kit. If the member uses HealthEquity as the HSA vendor, there are no setup fees for the HSA and maintenance fees are waived for the subscribing member only. If a subscribing member's employment is terminated or the member is no longer enrolled in a CDHP through the Medical Trust, she or he will be responsible for all fees.

HealthEquity also offers other advantages, including access to web-based tools that can assist you in tracking and monitoring your HSA activity.

Local bank chosen by your employer – In some cases, your employer may choose to use an institution other than HealthEquity for HSA funding. If so, you will receive information from your employer concerning the HSA funding process.

Financial institution of your choice – Members who do not wish to use HealthEquity as their HSA vendor can choose, after consulting with their employer, to establish an HSA with any appropriate institution (e.g., those qualified to administer IRAs), but they will be responsible for all fees.

If you do so, however, please keep in mind that you may not be able to direct to that financial institution contributions by your employer (if any) or tax-advantaged salary reduction contributions. Please check with your employer and the institution. Consequently, you may lose valuable employer contributions and the ability to make contributions through convenient payroll deduction. (You will still be able to make after-tax contributions up to the applicable contribution limit and claim a corresponding deduction on your federal income tax return.)

If you establish an HSA with HealthEquity (to receive employer contributions and your pre-tax contributions), you may then transfer any funds to an HSA with another bank.

Annual HSA Employer and Employee Combined Contribution Limits

2018	2019
Individual $3,450	Individual $3,500
Family $6,900	Family $7,000

If you are age 55 or older, you may make additional catch-up contributions of up to $1,000 for 2018 and 2019.

Timing of HSA contributions

Contributions to an HSA cannot occur until after the first of the month in which the CDHP becomes effective, and your HSA has been opened. What that means is if your plan becomes effective on January 1, contributions cannot be made until after that date. If you have medical expenses on January 1 before your account is funded, you can pay out-of-pocket and reimburse yourself from your HSA once the funds are there. No reimbursement is permitted for expenses incurred before you open your HSA. So, for example, if you delay and do not complete the requisite paperwork to open the account until February 1, expenses incurred in January cannot be reimbursed.

Employer HSA contributions

Each employer (diocese, parish, school, or other Episcopal organization) establishes its HSA contribution policy in line with IRS requirements.

Your employer's HSA contribution policy will define the amount of funds, if any, your employer will contribute to your HSA, the frequency with which these contributions will be made (bi-weekly, monthly, quarterly, or annually), and who will be eligible for such contributions.

Your employer is responsible for communicating its contribution policy to you.

Employee HSA contributions

Once your HSA is opened, you may begin contributing funds into your HSA. To contribute, you can make pre-tax contributions through automatic payroll deductions (if available) or through an after-tax contribution that you mail in. (You can then take a corresponding deduction on your taxes at the end of the tax year.) You must make HSA contributions for a given calendar year by the tax filing deadline for that year (generally the following April 15, but in some years the date may differ due to the calendar).

Be mindful that your own contributions and any funding you will receive from your employer does not exceed the annual limits for HSA contributions.

Qualified medical expenses

Qualified medical expenses include, but are not limited to, deductibles and coinsurance, prescription drugs, mental health and substance use disorder treatment, as well as dental and vision services. HSA distributions can be used for qualified medical expenses for you, your spouse, and your federal tax code dependents. A list of qualified medical expenses can be found on the IRS website.

Funds in the HSA are yours to determine how best to use. You may use them right away to cover deductibles and coinsurance amounts, or you may choose to use your own money and pay out-of-pocket, and reserve the funds in your HSA as your tax-favored health savings for future expenses.

Managing HSA funds

If, for instance, in March you have $1,000 in your HSA and a $1,500 medical bill, you can use the $1,000 in the HSA and pay the additional $500 from your own funds. Throughout the year, the IRS allows you to reimburse yourself the remaining $500 from the HSA, as contributions are made into the account. You are responsible for keeping documentation to prove that the HSA funds being reimbursed were used for qualified medical expenses.

Tax information

Your HSA custodian will provide the following forms to both you and the IRS annually:

Form 5498-SA – This form details HSA contributions made by you and your employer for the year.

Form 1099-SA – This form reports all HSA distributions made during the year.

Your employer must report to you on your Form W-2, in box 12 with code W, all employer HSA contributions as well as any HSA amounts contributed by you (from your paycheck) on a pre-tax basis through an Internal Revenue Code section 125 cafeteria plan. You will be responsible for completing Form 8889, which details HSA contributions, when you file your Form 1040. Also, please note that any additional amounts contributed to your HSA must be reported on Form 8889 and may be eligible to be claimed as a tax deduction, which could lower your taxable income.

Domestic partners and same-gender spouses

If your group allows domestic partners to be covered as dependents on your health plan, then your domestic partner can be enrolled in the CDHP. However, the IRS does not permit an employee's HSA funds to be used to cover the healthcare expenses of domestic partners, unless the domestic partner otherwise qualifies as your federal tax code dependent.

The domestic partner can open his or her own HSA, which your employer may or may not choose to fund. Note, however, that an employer contribution to an HSA of a non-employee domestic partner would be included in the employee's taxable income.

Same-gender couples who are legally married can use the account in the same way as a different-gender married couple.

Additional benefits

CDHP members have access to the Medical Trust's value-added benefits, such as vision care through EyeMed, the Employee Assistance Program (EAP) through Cigna Behavioral Health, Health Advocate, Amplifon Hearing Health Care discounts, and UnitedHealthcare Global Travel Assistance. For more information about these value-added benefits, please visit our website at ***www.cpg.org***.

Members may use their HSA funds, if available, to cover any applicable coinsurance amounts under these benefits.

U.S. Treasury Department HSA information

The HSA section of the IRS website has links to informational brochures, up-to-date regulations, FAQs, IRS forms, and publications, including these:

Publication 502 – A list of qualified medical expenses

Publication 969 – A detailed explanation of HSAs and how the IRS treats them

Questions?

For assistance with HSA procedures and account questions, members using HealthEquity can reach its Member Services team 24/7 at (866) 346-5800 or email ***memberservices@healthequity.com***. Otherwise, please contact our Client Services team at (800) 480-9967, Monday to Friday, 8:30AM – 8:00PM ET, excluding holidays, or email ***mtcustserv@cpg.org***.

This document contains only a partial description of the Medical Trust Plans and is intended for informational purposes only. It should not be viewed as a contract, an offer of coverage, or investment, tax, medical, or other advice. In the event of a conflict between this document and the official Plan documents (summary of benefits and coverage, Plan Handbooks), the official Plan documents will govern. The Church Pension Fund and its affiliates, including but not limited to the Medical Trust and the ECCEBT, retain the right to amend, terminate, or modify the terms of any benefit plans described in this document at any time, as well as any post-retirement health subsidy, for any reason, and unless required by law, without notice.

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

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FOR MORE INFORMATION

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

THE EPISCOPAL CHURCH MEDICAL TRUST

www.cpg.org
(800) 480-9967
e-mail: mtcustserv@cpg.org
Monday through Friday, except holidays, 8:30AM–8:00PM ET

Anthem Blue Cross and Blue Shield

www.anthem.com
(844) 812-9207
Monday through Friday, 8:30AM–8:00PM ET

Cigna Behavioral Health

www.mycigna.com
(866) 395-7794
24 hours a day, seven days a week

Express Scripts

www.express-scripts.com
(800) 841-3361
24 hours a day, seven days a week

EyeMed Vision Care

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

Health Advocate

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

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 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 contains only a partial description of the Plans and is intended for informational purposes only. It should not be viewed as a contract, an offer of coverage, or investment, tax, medical, or other advice.

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 Plans, as well as any post-retirement health subsidy, at any time, for any reason and unless required by law, without notice.

The Plans are church plans within the meaning of section 3(33) of the Employee Retirement Income Security Act and section 414(e) of the Internal Revenue Code. Not all Plans are available in all areas of the United States, and not all Plans are available on both a self-funded and fully insured basis. The Plans do not cover all healthcare expenses, and Members should read the Plan Document Handbook 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. 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.