Plan Document Handbook

Anthem Blue Cross and Blue Shield

PPO 75/50 Plan

Benefits effective as of January 2016

Anthem BlueCross BlueShield

EPISCOPAL CHURCH MEDICAL TRUST

Introduction

The Episcopal Church Medical Trust* (Medical Trust) maintains a series of benefit plans (referred to herein as "Plan" or 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 22,000 active employees and dependents; and over 9,000 retirees and their dependents. The plans are intended to qualify as "church plans" within the meaning of Section 414(e) of the Internal Revenue Code, and are exempt from the requirements of the Employee Retirement Income Security Act of 1974, as amended (ERISA).

The Medical Trust funds certain of its benefit plans through a trust fund known as the Episcopal Church Clergy and Employees' Benefit Trust (ECCEBT)*. The ECCEBT is intended to qualify as a voluntary employees' beneficiary association (VEBA) under Section 501(c)(9) of the Internal Revenue Code. The purpose of the ECCEBT is to provide benefits to eligible employees, former employees, and their dependents in the event of illness or expenses for various types of medical care and treatment.

The mission of the Medical Trust is to "balance compassionate care 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.

** Church Pension Group Services Corporation is the sponsor of this program and is doing business under the name "The Episcopal Church Medical Trust."*

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EPISCOPAL CHURCH MEDICAL TRUST

Anthem Blue Cross and Blue Shield 75/50 PPO Plan Coverage Period: 01/01/2016—12/31/2016

Summary of Benefits and Coverage: What this Plan Covers & What it Costs **Coverage for:** All Tiers | **Plan Type:** PPO

This is only a summary. If you want more detail about your coverage and costs, you can get the complete terms in the policy or plan document at www.cpg.org or by calling 1-800-480-9967.

Important Questions	Answers	Why this Matters:
What is the overall deductible?	**$900** Individual/**$1,800** Family network **$1,800** Individual/**$3,600** Family out-of-network **Network deductible** does not apply to preventive care or emergency care	You must pay all the costs up to the **deductible** amount before this plan begins to pay for covered services you use. Check your policy or plan document to see when the **deductible** starts over (usually, but not always, January 1st). See the chart starting on page 2 for how much you pay for covered services after you meet the deductible.
Are there other deductibles for specific services?	Yes, **$50** deductible for prescription drug coverage when using a retail pharmacy	You must pay all of the costs for these services up to the specific **deductible** amount before this plan begins to pay for these services. Prescription drug benefits are through Express Scripts
Is there an out–of–pocket limit on my medical expenses?	Yes, **$4,100** Individual/**$8,200** Family network (includes deductible) **$8,200** Individual/**$16,400** Family out-of-network (includes deductible)	The **out-of-pocket limit** is the most you could pay during a coverage period (usually one year) for your share of the cost of covered services. This limit helps you plan for health care expenses. See page 5 for the out-of-pocket limits for your pharmacy benefit.
What is not included in the out–of–pocket limit?	Contributions (premiums), balance-billed charges, health care this plan doesn't cover, and penalties.	Even though you pay these expenses, they don't count toward the **out-of-pocket limit**.
Does this plan use a network of providers?	Yes. For a list of network providers, see www.anthem.com or call 1-844-812-9207.	If you use a network doctor or other health care **provider**, this plan will pay some or all of the costs of covered services. Be aware, your network doctor or hospital may use an out-of-network **provider** for some services. Plans use the term in-network, **preferred**, or participating for **providers** in their **network**. See the chart starting on page 2 for how this plan pays different kinds of **providers**.
Do I need a referral to see a specialist?	No	You can see the **specialist** you choose without permission from this plan.
Are there services this plan doesn't cover?	Yes	Some of the services this plan doesn't cover are listed on page 5. See your policy or plan document for additional information about **excluded services**.

- **Copayments** are fixed dollar amounts (for example, $15) you pay for covered health care, usually when you receive the service.
- **Coinsurance** is *your* share of the costs of a covered service, calculated as a percent of the **allowed amount** for the service. For example, if the plan's **allowed amount** for an overnight hospital stay is $1,000, your **coinsurance** payment of 20% would be $200. This may change if you haven't met your **deductible**.
- The amount the plan pays for covered services is based on the **allowed amount**. If an out-of-network **provider** charges more than the **allowed amount**, you may have to pay the difference. For example, if an out-of-network hospital charges $1,500 for an overnight stay and the **allowed amount** is $1,000, you may have to pay the $500 difference. (This is called **balance billing**.)
- This plan may encourage you to use **network providers** by charging you lower **deductibles**, **copayments** and **coinsurance** amounts.

Common Medical Event	Services You May Need	Your cost if you use a Network Provider	Your cost if you use a Out-of-network Provider	Limitations & Exceptions
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	$35 copay/visit	50% coinsurance	None.
	Specialist visit	$45 copay/visit	50% coinsurance	None.
	Other practitioner office visit	$45 copay/visit for chiropractor, 50% coinsurance for acupuncture	50% coinsurance for chiropractor, 50% coinsurance for acupuncture	Limited to 20 visits per year for chiropractor services, 12 visits per year for acupuncture.
	Preventive care/screening/immunization	No charge	50%	Preventive care is based on guidelines from the U.S. Preventive Services Task Force, American Cancer Society, The Advisory Committee on Immunization Practices (ACIP), and the American Academy of Pediatrics. Coverage for child immunizations is based on the published guidelines of the American Academy of Pediatrics.
If you have a test	Diagnostic test (x-ray, blood work)	25% coinsurance	25% coinsurance	None
	Imaging (CT/PET scans, MRIs)	25% coinsurance	25% coinsurance	None
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	25% coinsurance	50% coinsurance	None
	Physician/surgeon fees	25% coinsurance	50% coinsurance	None

Common Medical Event	Services You May Need	Your cost if you use a Network Provider	Your cost if you use a Out-of-network Provider	Limitations & Exceptions
If you need immediate medical attention	Emergency room services	$100 copay/visit	$100/visit	The $100 copay will be waived if you are admitted to the hospital as an inpatient within 24 hours.
	Emergency medical transportation	25% coinsurance	25% coinsurance	None
	Urgent care	25% coinsurance	50% coinsurance	None
If you have a hospital stay	Facility fee (e.g., hospital room)	$100 per day copay to a maximum of $600, then 25% coinsurance	50% coinsurance	Prior authorization is required.
	Physician/surgeon fee	25% coinsurance	50% coinsurance	
If you have mental health, behavioral health, or substance abuse needs. Your mental health/ substance abuse benefits are provided through Cigna Behavioral Health. For more information, visit cignabehavorial.com or call 1-866-395-7794	Mental/Behavioral health outpatient services	$20 copay/visit	30% coinsurance	None**. Benefits are provided through Cigna, NOT Anthem.**
	Substance use disorder outpatient services	$20 copay/visit	30% coinsurance	None. **Benefits are provided through Cigna, NOT Anthem.**
	Mental/Behavioral health inpatient services	$100 per day copay to a maximum of $600	30% coinsurance	Prior authorization is required. **Benefits are through Cigna, NOT Anthem.**
	Substance use disorder inpatient services	$100 per day copay to a maximum of $600	30% coinsurance	Prior authorization is required. **Benefits are provided through Cigna, NOT Anthem.**
	Colleague group	30% coinsurance	30% coinsurance	The plan will reimburse 70% up to a maximum reimbursable fee (MRF) of $40. The member is responsible for all costs above that amount. **Benefits are provided through Cigna, NOT Anthem.**

Common Medical Event	Services You May Need	Your cost if you use a		Limitations & Exceptions
		Network Provider	Out-of-network Provider	
If you are pregnant	Prenatal and postnatal care	$35 copay PCP / $45 copay specialist	50% coinsurance	The copay applies only to the visit to confirm pregnancy
	Delivery and all inpatient services	$100 per day copay, to a maximum of $600, then 25% coinsurance	50% coinsurance	The Plan's coinsurance for hospital expenses will be reduced to 50% if you do not follow the procedures required by the Medical Management Program. This penalty does not apply to the out-of-pocket maximum. Well-newborn care is also covered, but is not subject to the inpatient hospital deductible.
If you need help recovering or have other special health needs	Home health care	25% coinsurance	50% coinsurance	Limited to 210 visits per plan year. Precertification is required.
	Rehabilitation services	$35 copay/PCP $45 copay/ Specialist per visit	50% coinsurance	Benefits include hearing/speech, physical, and occupational therapy. Limited to 60 visits per Plan year, combined facility and office, per each of the three therapies.
	Habilitation services	$35 copay/PCP $45 copay/ Specialist per visit	50% coinsurance	
	Skilled nursing care (facility)	25% coinsurance	50% coinsurance	Limited to 60 days per Plan year.
	Durable medical equipment	25% coinsurance	25% coinsurance	
	Hospice service	25% coinsurance	50% coinsurance	Limited to 210 days per lifetime. Precertification is required.
If your child needs dental or eye care	Eye exam	Not Covered	Not Covered	Vision benefits are available through EyeMed Vision Care.
	Glasses	Not Covered	Not Covered	
	Dental check-up	Not Covered	Not Covered	

Common Medical Event	Services You May Need	Your cost if you have				Limitations & Exceptions
		Standard Prescription Plan		Premium Prescription Plan		
		Retail	Mail Order	Retail	Mail Order	
If you need drugs to treat your illness or condition **More information about prescription drug coverage is available at express-scripts.com**	Generic Drugs	Up to $10	Up to $25	Up to $5	Up to $12	You may get up to a 30-day supply when using a retail pharmacy, and up to a 90-day supply when using home delivery. There is a $50 deductible when using a retail pharmacy.
	Preferred brand drugs	Up to $35	Up to $90	Up to $25	Up to $70	
	Non-preferred brand drugs	Up to $60	Up to $150	Up to $45	Up to $110	
	Specialty drugs	Your cost is based on whether the specialty drug is a preferred brand or non-preferred brand drug.				
	The annual out-of-pocket limit for pharmacy benefits, which is separate from your medical out-of-pocket limit, is $2,500 individual/$5,000 family in-network. Prescription drugs received out-of-network or over-the-counter are not included in the out-of-pocket limit.					

Excluded Services & Other Covered Services:

Services Your Plan Does NOT Cover (This isn't a complete list. Check your policy or plan document for other excluded services.)

- Cosmetic Surgery
- Dental Care (Adult)
- Hearing Aids
- Long-term care
- Routine eye care (adult)
- Routine foot care
- Weight loss programs

Other Covered Services (This isn't a complete list. Check your policy or plan document for other covered services and your costs for these services.)

- Acupuncture
- Bariatric surgery
- Chiropractic care
- Infertility treatment
- Non-emergency care when traveling outside the United States*
- Private duty nursing

** Applies only to services covered by Anthem Blue Cross and Blue Shield. Coverage for non-emergency care and services outside of the United States is not available through Cigna Behavioral Health or Express Scripts.*

Your Rights to Continue Coverage:

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[1]. 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 health plan would otherwise cease. Individuals who elect to continue coverage must pay for the coverage. Call 1-800-480-9967 for more information.

Your Grievance and Appeals Rights:

If you have a complaint or are dissatisfied with a denial of coverage for claims under your plan, you may be able to **appeal** or file a **grievance**. For questions about your rights, this notice, or assistance, you can contact Anthem Blue Cross and Blue Shield at 1-844-812-9207.

Does this Coverage Provide Minimum Essential Coverage?

The Affordable Care Act requires most people to have health care coverage that qualifies as "minimum essential coverage." This plan or policy does provide minimum essential coverage.

Does this Coverage Meet the Minimum Value Standard?

The Affordable Care Act establishes a minimum value standard of benefits of a health plan. The minimum value standard is 60% (actuarial value). **This health coverage does meet the minimum value standard for the benefits it provides.**

Language Access Services:

Spanish (Español): Para obtener asistencia en Español, llame al 1-800-480-9967
Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-800-480-9967
Chinese (中文): 如果需要中文的帮助，**请拨打这个号码** 1-800-480-9967
Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' 1-800-480-9967

To see examples of how this plan might cover costs for a sample medical situation, see the next page.

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

About these Coverage Examples:

These examples show how this plan might cover medical care in given situations. Use these examples to see, in general, how much financial protection a sample patient might get if they are covered under different plans.

This is not a cost estimator.

Don't use these examples to estimate your actual costs under this plan. The actual care you receive will be different from these examples, and the cost of that care will also be different.

See the next page for important information about these examples.

Having a baby
(normal delivery)

- **Amount owed to providers:** $7,540
- **Plan pays** $6,270
- **Patient pays** $1,270

Sample care costs:

Hospital charges (mother)	$2,700
Routine obstetric care	$2,100
Hospital charges (baby)	$900
Anesthesia	$900
Laboratory tests	$500
Prescriptions	$200
Radiology	$200
Vaccines, other preventive	$40
Total	**$7,540**

Patient pays:

Deductibles	$900
Copays	$220
Coinsurance	$0
Limits or exclusions	$150
Total	**$1,270**

These numbers assume the patient has given notice of her pregnancy to the Plan. If you are pregnant and have not given notice of your pregnancy, your costs may be higher. For more information please contact Anthem Blue Cross and Blue Shield at 1-844-812-9207.

Managing type 2 diabetes
(routine maintenance of a well-controlled condition)

- **Amount owed to providers:** $5,400
- **Plan pays** $3,510
- **Patient pays** $1,890

Sample care costs:

Prescriptions	$2,900
Medical Equipment and Supplies	$1,300
Office Visits and Procedures	$700
Education	$300
Laboratory tests	$100
Vaccines, other preventive	$100
Total	**$5,400**

Patient pays:

Deductibles	$900
Copays	$640
Coinsurance	$270
Limits or exclusions	$80
Total	**$1,890**

Questions and answers about the Coverage Examples:

What are some of the assumptions behind the Coverage Examples?

- Costs don't include **premiums**.
- Sample care costs are based on national averages supplied by the U.S. Department of Health and Human Services, and aren't specific to a particular geographic area or health plan.
- The patient's condition was not an excluded or preexisting condition.
- All services and treatments started and ended in the same coverage period.
- There are no other medical expenses for any member covered under this plan.
- Out-of-pocket expenses are based only on treating the condition in the example.
- The patient received all care from in-network **providers**. If the patient had received care from out-of-network **providers**, costs would have been higher.

What does a Coverage Example show?

For each treatment situation, the Coverage Example helps you see how **deductibles**, **copayments**, and **coinsurance** can add up. It also helps you see what expenses might be left up to you to pay because the service or treatment isn't covered or payment is limited.

Does the Coverage Example predict my own care needs?

✘ **No.** Treatments shown are just examples. The care you would receive for this condition could be different based on your doctor's advice, your age, how serious your condition is, and many other factors.

Does the Coverage Example predict my future expenses?

✘ **No.** Coverage Examples are **not** cost estimators. You can't use the examples to estimate costs for an actual condition. They are for comparative purposes only. Your own costs will be different depending on the care you receive, the prices your **providers** charge, and the reimbursement your health plan allows.

Can I use Coverage Examples to compare plans?

✓ **Yes.** When you look at the Summary of Benefits and Coverage for other plans, you'll find the same Coverage Examples. When you compare plans, check the "Patient Pays" box in each example. The smaller that number, the more coverage the plan provides.

Are there other costs I should consider when comparing plans?

✓ **Yes.** An important cost is the **premium** you pay. Generally, the lower your **premium**, the more you'll pay in out-of-pocket costs, such as **copayments**, **deductibles**, and **coinsurance**. You should also consider contributions to accounts such as health savings accounts (HSAs), flexible spending arrangements (FSAs) or health reimbursement accounts (HRAs) that help you pay out-of-pocket expenses.

Chapter 1
IMPORTANT NOTICES

PLAN SPONSOR

We maintain contractual relationships with various third-party administrators and local managed care plans on your behalf. The Episcopal Church Medical Trust (the Medical Trust) is the plan sponsor and plan administrator of all plans except for a) Health Savings Accounts under the High Deductible 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.

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

If you have had or are going to have a mastectomy, you may be entitled to certain benefits under the Women's Health and Cancer Rights Acts of 1998 (WHCRA). For individuals receiving mastectomy-related benefits, coverage will be provided in a manner determined in consultation with the attending physician and the patient, for:

- All stages of reconstruction of the breast on which the mastectomy was performed
- Surgery and reconstruction of the other breast to produce a symmetrical appearance
- Prosthesis and;
- Treatment of physical complications of the mastectomy, including lymphedema.

These benefits will be provided subject to the same deductible and coinsurance applicable to other medical and surgical benefit provided under this plan.

If you would like more information on WHCRA benefits, call your Plan Administrator or the Episcopal Church Medical Trust at (800) 480-9967.

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

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

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

Chapter 2
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). 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. This includes doctors, hospitals, laboratories, and other medical facilities that provide healthcare services—that's what is meant by healthcare "providers".

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. Network providers include hospitals, physicians, outpatient facilities, and other ancillary healthcare providers. Your out-of-pocket costs will generally be higher if you use an out-of-pocket provider. It is your responsibility to know whether a provider is in-network or out-of-network.

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
- Minimal out-of-pocket costs for 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, simply choose the 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.

ASK QUESTIONS ABOUT YOUR HEALTHCARE OPTIONS AND COVERAGE.

To find answers, you can:

- Read this handbook
- Call Anthem's Member Services 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.

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.
Low Cost—Benefits are paid in full after a small copayment for office visits when receiving eligible services.
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 emergency out-of-network services, you may need to file a claim for reimbursement.

Chapter 3
ELIGIBILITY AND ENROLLMENT

Eligibility for the Episcopal Health Plan (EHP)

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.

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

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 31st of the current year**
- A Disabled Child, 30 years of age or older on December 31st 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

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

Coverage and Eligibility Exceptions

There may be certain circumstances where an individual who does not meet the eligibility requirements listed above may choose to request a special eligibility determination from the Plan. The Bishop or Ecclesiastical Authority with authority over the Participating Group must submit the Coverage and Eligibility Exception Request Form to the Plan in these circumstances. The Plan will review the case presented and provide an individual eligibility determination within 30 days after receipt of the form. If eligibility is granted, the effective date of coverage will be the 1st 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.

Pre-Existing Medical Conditions

Eligibility will not be denied due to an individual's health status.

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 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 Benefits Under the Clergy Pension Plan* at www.cpg.org/clergyguide.

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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 Disabled

Eligible Dependents

- A Spouse or Surviving Spouse*
- A Domestic Partner or Surviving Domestic Partner
- A Disabled Dependent Child or Surviving Disabled Dependent 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

Pre-Existing Medical Conditions

Eligibility will not be denied due to an individual's health status.

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, 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 in-network providers. The Member will usually pay less for services from in-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 Plan's rules and requirements related to enrollment and election changes. Topics include effective dates, termination procedures, Significant Life Events, Open Enrollment and other procedures.

Subscriber Responsibilities

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

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

Plan Elections and Changes

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

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

Important Note: the Plan does not allow a member to terminate dental coverage mid-year.

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, 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 HMO and PPO are available, the Subscriber may elect a new Plan. Conversely, if a Subscriber moved out of the

HMO service area, and was therefore no longer eligible for the HMO, the Subscriber may elect a new Plan.

- Significant change in cost or a significant curtailment of medical coverage during a plan year for a Subscriber or Dependent
- Medicare entitlement (or loss of such entitlement)
- 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 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 an SBC 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 Open 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 within 90 days of enrollment resulting from a HIPAA Special Enrollment Event.

Reporting Eligibility and Enrollment Changes

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

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

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

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

The following additional requirements also apply:

- Health Plan choice may be restricted if a Subscriber or an Eligible Individual has Eligible Dependents living outside the service area of a particular Plan.
- If a local managed care plan is elected, additional paper enrollment forms from the local plan option must be submitted to the Plan.
- Seminary Group Administrators must submit paper Enrollment Forms to the Plan instead of using the MLPS website. Forms should be mailed or faxed to Client Services.
- Pre-65 Retired Employees and Post-65 Retired Employees who do not receive any contribution assistance from the Participating Group may submit enrollment forms directly to the Plan.
- It should be noted that with Express Scripts Medicare — the Part D prescription drug coverage under the MSHP—that CMS has certain requirements, such as a 21 day opt out period, that need to be taken into consideration in the processing of enrollment paperwork. Therefore, to ensure timely access to prescription drug coverage, the enrollment form and all required materials must be received at least 3 months prior to your desired coverage effective date.

Other changes such as a change of address or phone number can and should be reported to the Plan when they occur.

Required Information and Documentation

All of the information requested on MLPS or the enrollment form (such as social security number and date of birth) is required in order for a plan election or other change to be processed.

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

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

Open Enrollment

Open Enrollment is the annual period during which Subscribers of the EHP, the EHP/SEE and MSHP 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 Open Enrollment website, as appropriate. Generally, Open Enrollment occurs during the fall with changes becoming effective on January 1st of the following plan year.

At the beginning of Open 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 Open Enrollment website, instructions, a personal login and password, and the dates the Open Enrollment website will be available.

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

The Open 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 Open Enrollment

Open Enrollment for Seminarians is held during the summer preceding the plan year that runs from August 1st through July 31st. 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 the Plan.

Important note for the Association of Episcopal Seminaries: the medical Plans run on an academic year and the dental and vision plans on a calendar year basis.

[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 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 Open 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 Open 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. Paper enrollment forms must be submitted by the Seminary Group Administrator to Client Services.

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 Open 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 Retired 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) Are joining the EHP as part of a new Participating Group

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 open 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 Disabled 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.

Post-65 Retired Employees

The effective date of coverage for the MSHP for a Post-65 Retired Employee is the first day of the month in which he or she turns age 65, provided that he or she is enrolled in Medicare Parts A and B and meets the eligibility requirements of the Plan.

If the Post-65 Retired Employee 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 until the next Open Enrollment period.

Dependents

The effective date of coverage for an Eligible Dependent is the same date as the Subscriber's effective date. If the Subscriber does not enroll all Eligible Dependents within 30 days of a Significant Life Event or HIPAA Special Enrollment Event, then the Eligible Dependents may not enroll until the next Open 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 in order for coverage to continue beyond the 30-day period and to ensure claims incurred during the first 30 days are covered. 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 Open 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 Open 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 Open 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 Disabled may continue to participate in the EHP until the end of the year in which they reach age 30.

Disabled Children

If the Dependent Child is Disabled prior to his/her 25th birthday and continues to be Disabled 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.

Satisfactory proof of disability must be submitted to the Plan within 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 physical or mental disability.

Children of Surviving Spouses of Limited Means

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

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

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

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

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

- The order recognizes or creates a Child's right to receive group health benefits for which the Subscriber is eligible
- The order specifies the Subscriber's name and last known address and the Child's name and

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

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 Benefit and increase it again upon return from leave. It is necessary to notify the Participating Group and the Plan within 30 days of the start date of the leave to decrease the Coverage Tier and also within 30 days of the end date of the leave to increase the Coverage Tier once the Subscriber returns to work.

If the leave of absence is paid leave, 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, 2012

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 Disabled 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

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

Post-65 Retired Employee or Disabled Pre-65 Retired Employee

When a Post-65 Retired Employee or a Disabled Pre-65 Retired Employee with Medicare enrolled in MSHP dies, Surviving Spouses and Surviving Domestic Partners enrolled in the MSHP at the time of 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 Disabled 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 Disabled Pre-65 Retired Employee

When a Pre-65 Retired Employee or a Disabled Pre-65 Retired Employee enrolled in the EHP 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 Disabled 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.

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 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.

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 last day of the month in which the relationship was officially terminated.

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 Open 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 Open 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.

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. Responses must include a payment to cover the contributions that are due. Otherwise, enrollment in the extension is considered declined.
Coverage in effect at the time of separation continues until the last day of the month in which the event occurs. Coverage under the Extension of Benefits program is effective the first of the month following the separation event so that there is no coverage gap between the termination date and enrollment in the extension of benefits.

The Plan will maintain the coverage and invoice the individual directly, without the involvement of the Group Administrator. No conversion option is available at the end of the extension of benefits. If the

[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.

Participating Group ceases to offer the plan at the annual renewal, the member will be notified during Open 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 Benefit period
- The last day of the month after the individual submits a written notice to terminate coverage for medical, dental or both (30 days-notice required)
- The date a Participating Group's participation in the Plan is terminated (whether by the Participating Group or the Medical Trust) and the Participating Group enrolls in another group health plan. (The Group Administrator will be notified by the Plan of all individuals participating in the Extension of Benefits program)
- Upon death of the Member
- 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).

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 that procedures are performed. Your Plan requires that covered services be Medically Necessary for benefits to be provided. The Plan does not cover Experimental or Investigational 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 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 on your ID card 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 physician must notify the Claims Administrator within 2 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 in 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 LOS (including newborn stays beyond the mother's stay)
- Emergency Admissions (Requires Plan notification no later than 2 business days after admission)

Outpatient Services

- Ablative Techniques as a Treatment for Barrett's Esophagus
- Air Ambulance (excludes 911 initiated emergency transport)
- Artificial Intervertebral Discs
- Balloon Sinuplasty
- Bariatric Surgery
- Breast Procedures; including Reconstructive Surgery, Implants, Reduction , Mastectomy for Gynecomastia and other Breast Procedures
- Canaloplasty
- 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
- Cochlear Implants and Auditory Brainstem Implants
- Computer-Assisted Musculoskeletal Surgical Navigational Orthopedic Procedures
- Cryoablation for Plantar Fasciitis and Plantar Fibroma
- Cryopreservation of Oocytes or Ovarian Tissue
- Cryosurgical Ablation of Solid Tumors Outside the Liver
- Deep Brain Stimulation
- Diagnostic Testing
    - Diagnosis of Sleep Disorders
    - Gene Expression Profiling for Managing Breast Cancer Treatment
    - Genetic Testing for Cancer Susceptibility
- DME/Prosthetics
    - Bone Growth Stimulator: Electrical or Ultrasound
    - Communication Assisting / Speech Generating Devices
    - External (Portable) Continuous Insulin Infusion 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 Device with Calibrated Pressure
    - Power Wheeled Mobility Devices
    - 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
- Functional Endoscopic Sinus Surgery
- Gastric Electrical Stimulation
- Gender Reassignment Surgery
- Implantable or Wearable Cardioverter-Defibrillator
- Implantable Infusion Pumps
- Implanted Devices for Spinal Stenosis
- Implanted Spinal Cord Stimulators
- Intraocular Anterior Segment Aqueous Drainage Devices (without extraocular reservoir)
- Locally Ablative Techniques for Treating Primary and Metastatic Liver Malignancies
- Lumbar spinal surgeries
- Lung Volume Reduction Surgery
- Lysis of Epidural Adhesions
- Manipulation Under Anesthesia of the Spine and Joints other than the Knee
- Maze Procedure
- MRI Guided High Intensity Focused Ultrasound Ablation of Uterine Fibroids
- Oral, Pharyngeal & Maxillofacial Surgical Treatment for Obstructive Sleep Apnea
- Surgical Treatment of Migraine Headaches
- Occiptal nerve stimulation
- Orthognathic Surgery
- Ovarian and Internal Iliac Vein Embolization as a Treatment of Pelvic Congestion Syndrome
- Partial Left Ventriculectomy
- Penile Prosthesis Implantation
- Percutaneous Neurolysis for Chronic Back Pain
- Photocoagulation of Macular Drusen
- Physician Attendance and Supervision of Hyperbaric Oxygen Therapy
- 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, scar revision)
    - Procedures Performed on the Trunk and Groin
    - Repair of Pectus Excavatum / Carinatum
    - Rhinoplasty

    - Skin-Related Procedures
- Percutaneous Spinal Procedures
- Private Duty Nursing
- Presbyopia and Astigmatism-Correcting Intraocular Lenses
- Radiation therapy
    - Intensity Modulated Radiation Therapy (IMRT)
    - Proton Beam Therapy
- Radiofrequency Ablation to Treat Tumors Outside the Liver
- Real-Time Remote Heart Monitors
- Sacral Nerve Stimulation as a Treatment of Neurogenic Bladder Secondary to Spinal Cord Injury
- Sacroiliac Joint Fusion
- Septoplasty
- Stereotactic Radiosurgery (SRS) and Stereotactic Body Radiotherapy (SBRT)
- Subtalar Arthroereisis
- Suprachoroidal Injection of a Pharmacologic Agent
- Surgical and Minimally Invasive Treatments for Benign Prostatic Hyperplasia (BPH) and Other GU Conditions
- Thoracoscopy for Treatment of Hyperhidrosis
- Tonsillectomy in Children
- Total Ankle Replacement
- Transcatheter Closure of Cardiac Defects
- Transcatheter Uterine Artery Embolization
- Transmyocardial Preventicular Device
- Transtympanic Micropressure for the Treatment of Ménière's Disease
- Treatment of Obstructive Sleep Apnea, UPPP
- Treatment of Osteochondral Defects of the Knee and Ankle
- Treatment of Temporomandibular Disorders
- Vagus Nerve Stimulation
- Varicose Vein Treatment

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 Specialty Health Program

The AIM Specialty Health Program for Imaging is an innovative program that has a focus on cost & 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.

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

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 or extended care illness or injury, 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.

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

CHAPTER 5
COVERAGE

OUTPATIENT CARE

When you need to visit your healthcare provider, the Plan makes it easy. You pay a copayment for the office visit when you use a network provider, except for preventive care, which has no copay. 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 medical services are covered:

- Physician home and office visits
- X-rays, laboratory services, ultrasounds (including routine pregnancy-related ultrasounds), Magnetic Resonance Imaging (MRI), including Magnetic Resonance Angiography (MRA), Computerized Axial Tomography (CAT) scan
- Dental services received after an accidental injury to teeth, including replacement of teeth (does not include teeth implants) and any related x-rays
- Chiropractic services (limited as outlined on the Summary of Benefits and Coverage)
- Radiation therapy
- Chemotherapy
- Dialysis
- Cardiac therapy
- Pulmonary therapy
- Acupuncture (limited as outlined on the Summary of Benefits and Coverage)
- Nutritional counseling (limited to six visits per Plan Year)
- Smoking cessation, including counseling
- Hypnosis
- Consultation requested by the attending physician for advice on an illness or injury
- 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
- 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.
- Medically necessary treatment of the feet, including treatment of metabolic or peripheral-vascular disease
- Genetic testing when Medically Necessary
- Allergy testing
- Lymphedema treatment
- Podiatric surgery when Medically Necessary
- Diagnosis and treatment of obtrusive sleep apnea
- Termination of pregnancy

- Transgender services and related therapies
- 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

Tips for Visiting Your Doctor

- When you make your appointment, confirm that the doctor is a 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 provider is a 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.

The Episcopal Church Medical Trust takes the importance of preventive care very seriously. That is why your Plan covers preventive care at 100% when you use network providers. There is no co-payment, coinsurance, deductible, or facility charge.

Screenings and others 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 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

- Age-appropriate preventive medical examination
- Discussion with primary care physician regarding alcohol misuse
- Discussion with primary care physician about tobacco cessation
- Discussion with primary care physician regarding obesity and weight management
- Abdominal aortic aneurysm – one-time screening by ultrasonography in men age 65 to 75 who have ever smoked
- Blood pressure screening for all adults
- Cholesterol screening for adults at higher risk of cardiovascular disease
- Colorectal cancer screening for adults age 50 to 75
- Hepatitis C screening for adults born between 1945 and 1965
- Discussion with primary care physician regarding risks and benefits of Prostate cancer screening in men age 50 or over
- Depression screening for adults
- Type 2 diabetes screening for adults with high blood pressure
- Discussion with physician regarding aspirin for adults at higher risk of cardiovascular disease
- Discussion with physician regarding diet counseling for adults at higher risk for chronic disease
- 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
    - Varicella
- Screening for all adults at higher risk for sexually transmitted infections and counseling for prevention of sexually transmitted infections, including:
    - Chlamydia
    - Gonorrhea
    - HIV

- Syphilis

Preventive Services for Women, Including Pregnant Women

- Age-appropriate preventive medical examination
- Discussion with physician regarding chemoprevention in women at higher risk for breast cancer
- Discussion with physician regarding inherited susceptibility to breast and/or ovarian cancer
- Mammography screening for breast cancer for women
- Mammography screening for breast cancer in other age groups as jointly determined by patient and physician
- Cervical cancer screening in women age 21 to 65
- Osteoporosis screening for women age 65 or older and women at higher risk
- Chlamydia infection screening for sexually active women at higher risk
- Gonorrhea screening for all women at higher risk
- Syphilis screening for all pregnant women and other women at higher risk
- Anemia screening for pregnant women
- Urinary tract or other infection screening for pregnant women
- Hepatitis B screening for pregnant women at their first prenatal visit
- Discussion with physician about folic acid supplements for women who may become pregnant
- Rh incompatibility screening for pregnant women and follow-up testing for women at higher risk
- Routine prenatal care visits
- Discussion with physician regarding preconception care
- Discussion with physician about interventions to promote and support breastfeeding and comprehensive lactation support and counseling
- Costs for renting breastfeeding equipment
- 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
- Discussion with physician about interpersonal and domestic violence
- Prescribed, FDA-approved, contraceptive devices and contraceptive drugs; discussion with primary care physician about contraceptive methods

Preventive Services for Children

- Age-appropriate preventive medical examination
- Medical history for all children throughout development
- Height, weight, and body mass index measurements for children
- Behavioral assessments for children of all ages by primary care physician
- Developmental screening for children under 3 years and surveillance throughout childhood by primary care physician
- Discussion with physician regarding alcohol and drug use assessments for adolescents
- Autism screening for children at age 18 months and 24 months by physician
- Cervical dysplasia screening for sexually active females
- Congenital hypothyroidism screening for newborns
- Phenylketonuria (PKU) screening at higher risk of lipid disorders
- Oral health risk assessment for young children by primary care physician
- Lead screening for children at risk of exposure
- Discussion with primary care physician regarding obesity screening and counseling
- Gonorrhea prevention medication for the eyes of all newborns
- Hearing screening for all newborns
- Vision screening for all children
- Hematocrit or hemoglobin screening for children

- Hemoglobinopathies or sickle cell screening for newborns
- Tuberculin testing for children at higher risk of tuberculosis
- HIV screening for adolescents at higher risk
- Sexually transmitted infection (STI) prevention counseling for adolescents at higher risk
- Discussion with physician regarding fluoride supplements for children who have no fluoride in their water source
- Discussion with physician regarding iron supplements for children age 6 months to 12 months who are at risk for anemia
- 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
    - Inactivated poliovirus
    - Influenza
    - Measles, mumps, rubella
    - Meningococcal
    - Pneumococcal
    - Rotavirus
    - Varicella

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.

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 48 hours. 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 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 on 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:

- Preadmission testing (PAT)
- Room and board in a semiprivate room with general nursing services
- Laboratory services, x-rays, MRI, MRA, PET scan, CAT scan, ultrasounds
- Physician charges

- Anesthesiology services, including consultation before surgery
- Administration of blood and/or blood products, except the collection or storage of blood plasma; blood banking (including the collection, testing, and storage of cord blood); the cost of receiving the services of professional blood donors; aphaeresis; or plasmapheresis, with the exception of any of these services that might be required as part of a Plan participant's stem cell or bone marrow transplant
- Surgeon's charges for the performance of a surgical procedure
- Assistant surgeon's expenses
- Two or more surgical procedures performed during the session
- 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 Blue Cross and Blue Shield
- Specialty care units (e.g. intensive care unit, cardiac care unit)
- Operating rooms, recovery room, treatment rooms
- Hospital charges for dental services if hospitalization is necessary to safeguard the health of the patient
- Related Medically Necessary ancillary services (e.g. supplies, equipment, social services, therapy services)
- 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
- Oral surgery, limited to:
    - Extraction of impacted wisdom teeth
    - Treatment of an injury to sound and natural teeth if treatment is finished within 12 months of the date of injury
- 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
- Medically necessary removal of breast or other prosthetic implants
- Surgical treatment of morbid obesity (limited to one procedure per lifetime)
- Gender reassignment surgery
- Surgical reproductive sterilization
- Human organ and tissue transplants. Please refer to the “Transplant Care” section of this handbook for further information.
- Circumcision for newborns or when Medically Necessary
- Outpatient surgery
- Podiatry surgery when Medically Necessary
- 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.
- 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
- Diabetic nutritional counseling

TIPS FOR GETTING HOSPITAL CARE

- If your doctor prescribes presurgical testing, have your tests done 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

Should you need emergency care, your Plan is there to cover you. 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 copayment under the Plan for emergency care is higher than the co-payment for a doctor's visit (see the Summary of Benefits and Coverage for copayment 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 a copayment for a visit to an emergency room. This copayment is waived if you are admitted to the hospital as an inpatient within 48 hours. You must notify Anthem's Medical Management Program at (844) 812-9207 within 48 hours of the admission. If you make an emergency visit to your doctor's office, you pay the same copayment 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

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 ((877) 825-5276) for advice, 24 hours a day, 7 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.

Tips for Emergency and Urgent Care

- 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 48 hours of admission. If the hospital does not participate in the 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 BlueCard Worldwide Program, show your ID card and call the BlueCard Worldwide Service Center collect at (804) 673-1177. The hospital will submit its bill through the BlueCard Worldwide Program. If the hospital does not participate in the BlueCard Worldwide Program, you will need to file a claim.

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).

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.

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.

There are no out-of-pocket expenses for office visits, except the initial office visit copayment for maternity and newborn care, when you use providers participating in the BlueCard PPO Network.

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. The following are additional covered services and limitations:

- 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.
- Screening and counseling for alcohol misuse, smoking, bacteriuria, iron deficiency, and sexually transmitted diseases, including HIV
- RH (D) bloody typing and antibody testing at first pregnancy-related visit
- Parent education, and assistance and training in breast or bottle feeding, if available
- Amniocentesis, including the associated genetic counseling and genetic testing
- Ultrasounds
- Circumcision of newborn males prior to discharge (after discharge, circumcision must be Medically Necessary)
- 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.
- Semiprivate room and board

- Home care with precertification

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 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.
- Must be 44 years of age or younger (if female)
- 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.

Benefits include:

- Ovulation induction
- Insemination procedures (artificial insemination (AI) and intrauterine insemination (IUI))
- Assisted Reproductive Technologies, including (but not limited to):
    - In vitro fertilization
    - Gamete Intrafallopian Transfer
    - Zygote Intrafallopian Transfer
    - Uterine Embryo Lavage
    - Embryo transfer

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, 7 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.

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 transplant facilities. 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.

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
- Heart
- Heart/lung
- Lung
- Double lung
- Liver
- Kidney
- Kidney/pancreas
- Small bowel

The following services are covered:

- Pre-transplant evaluation
- Organ procurement (bone marrow donor search is not covered)
- Transplant procedures and associated hospitalization
- Transplant-related follow-up care provided by the designated transplant facility for up to one year
- Pharmacy supplies and services provided by the BCBS National Transplant Program facility for immunosuppressant and other transplant-related medications while hospitalized
- Donor expenses, if not covered under any other plan

- 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
- Physician services related to the transplant events listed in this section
- 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
- 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.

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 or travel, lodging, and meal expenses.

If you choose not to have a transplant performed at a BCBS National Transplant Program facility, 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.

Durable Medical Equipment is defined as medical equipment that:

- Can withstand repeated use
- Is not disposable
- Is used to serve a medical purpose with respect to treatment of a sickness, injury, or the symptoms of a sickness or injury
- Is generally not useful to a person in the absence of a sickness, injury, or the symptoms of a sickness or injury
- Is appropriate for use in the home

Durable Medical Equipment is covered when it meets each of the following criteria:

- Ordered or provided by a physician for out-patient use
- Used for medical purposes
- Not consumable
- Not of use to a person in the absence of a disease or disability

Anthem's medical management program

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

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.

The following supplies and services are covered:

- Durable medical equipment, 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. Replacement equipment will be covered if the replacement equipment is required due to a change in the patient's physical condition or if purchase of new equipment will be less expensive than repair of existing equipment.
- 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
- 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
- Oxygen and rental of equipment required for its use, not to exceed the purchase price of such equipment
- Blood and/or plasma and the equipment for its administration
- Allergy injections, including the serum

- Contraceptive devices, including diaphragms, IUDs, and Norplant implants
- Depo-Provera injections. Contraceptive injectables dispensed at a pharmacy may be available through the Prescription Drug Program.
- Insulin infusion pumps
- Initial prescription contact lenses or eyeglasses, including the examination and fitting of the lenses, to replace the human lens lost through intraocular surgery
- Wigs and artificial hairpieces, only after chemotherapy or radiation therapy
- Sterile surgical supplies after surgery
- Compression garments.

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

Examples of durable medical equipment include:

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

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 for Care in a Skilled Nursing Facility

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 done 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 health care 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 registered nurse (RN) or a licensed practical nurse (LPN). 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 healthcare provider is equal to one visit.

HOME INFUSION SERVICES

Home infusion therapy is the administration of drugs in your home using intravenous (into the blood-stream), subcutaneous (into the membranes surrounding the spinal cord), and epidural (under the skin) 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 is an integrated program that provides comfort and support services for the terminally ill and their families. Hospice care includes physical, psychological, social, and spiritual care. Hospice can be provided at home, in a hospice facility, or in the hospice area of a hospital. You may change your decision to receive hospice care at any time. Covered services may continue if the member lives longer than six months, the traditional maximum for hospice care.

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 for Hospice Care

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; and
- Items and services provided by the research sponsors free of charge for any person enrolled in the trial.

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 meets any of the following:

- 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)*. (Includes *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 *Veterans Administration (VA);*
- A qualified non-governmental research entity identified in the guidelines issued by the *National Institutes of Health* for center support grants; or
- 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 review 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; and*
    - Ensures unbiased review of the highest scientific standards by qualified individuals who have no interest in the outcome of the review.

- The study or investigation is conducted under an investigational new drug application reviewed by the *U.S. Food and Drug Administration*
- The study or investigation is a drug trial that is exempt from having such an investigational new drug application; or
- The clinical trial must have a written protocol that describes a scientifically sound study and have been approved by all relevant institutional review boards (*IRBs*) before participants are enrolled in the clinical trial. We may, at any time, request documentation about the clinical trial.

CHAPTER 6
MEDICAL EXCLUSIONS AND LIMITATIONS

The Medical Plan 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 provider. This list is intended to give you a description of services and supplies not covered by the Medical Plan. This section uses headings to help you find specific exclusions more easily. Some of the services not covered by your Medical Plan may be covered by your pharmacy, mental health, or vision plans.

ALTERNATIVE TREATMENTS

- Acupressure
- Aromatherapy
- Massage therapy
- Rolfing
- Other forms of alternative treatment as defined by the Office of Alternative Medicine of the National Institutes of Health
- Services received by a naturopath or a naturalist
- Holistic or homeopathic care, except for covered services listed in the Summary of Benefits and Coverage

COMFORT OR CONVENIENCE

- Television
- Telephone
- Beauty/barber service
- Guest service
- 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
- Devices and computers to assist in communication and speech
- Home remodeling to accommodate a health need (such as, but not limited to, ramps, electric chairlifts, and swimming pools)

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 super numerary teeth, except as part of a congenital anomaly
- Surgical treatment of temporomandibular joint (TMJ) dysfunction
- Excision of maxillary or mandibular cysts for the diagnoses of odentogenic, dentigerous, or radicular cysts

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

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

Durable Medical Equipment, Medical Supplies and Appliances

- False teeth
- Hearing aids
- Devices used specifically as safety items or to affect performance in sports-related activities
- Elastic stocking exceeding two pairs per calendar year
- Prescribed or non-prescribed medical supplies. Examples include:
    - Ace bandages
    - Gauzes and dressings
- Orthotic appliances that straighten or reshape a body part (including some types of braces)
- Foot orthotics except in the treatment of diabetes
- Tubings, nasal cannulas, connectors, and masks are not covered except when used with Durable Medical Equipment as described in the coverage section
- Services provided by a doula (labor aide)

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 or Investigational Services or Unproven Services

Experimental or Investigational Services and unproven services are excluded. The fact that an Experimental or Investigational Service or an unproven 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 Experimental, Investigational, or unproven in the treatment of that particular condition.

Foot Care

- Except when needed for severe systemic disease:
    - Routine foot care (including the cutting or removal of corns and calluses)

    - Nail trimming, cutting, or debriding
- 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
- Symptomatic complaints of the feet, except capsular or bone surgery related to bunions and hammertoes
- Treatment of flat feet
- Shoe orthotics except for custom molded shoe inserts prescribed to treat a disease or illness of the foot when Medically Necessary

HOME HEALTH CARE

- Custodial services, including bathing, feeding, changing, or other services that do not require skilled care
- 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
- Services of a social worker

HOSPITAL CARE – INPATIENT

- 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.
- 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
- Services performed in the following:
    - Nursing or convalescent homes
    - Institutions primarily for rest or for the aged
    - Rehabilitation facilities (except for physical therapy)
    - Spas
    - Sanitariums
    - Infirmaries at schools, colleges, or camps
- Any part of a hospital stay that is primarily custodial
- Elective cosmetic surgery
- Hospital services received in clinic settings that do not meet the Plan's definition of a hospital or other covered facility

HOSPITAL CARE – OUTPATIENT

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

MATERNITY

- Days in the hospital that are not Medically Necessary (beyond the 48-hour/96-hour limits)
- Services that are not Medically Necessary

- Private room charges in excess of the cost of a semiprivate room
- Out-of-network birthing center facilities (may be covered at the out-of-network level—contact your health Plan for more information)
- Private-duty nursing
- Cold blood storage
- Parenting, prenatal, or birthing classes

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 sole source of nutrition or except when a certain nutritional formula treats a specific inborn error of metabolism

Outpatient Care

- Treatment of or related to sleep disorders
- Services such as laboratory x-ray and imaging, and 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
- Nonsurgical treatment for, or prevention of, temporomandibular joint (TMJ) dysfunction, craniomandibular disorder, and other conditions of the joint linking the jawbone and skull, and the muscles, nerves, and other tissues related to that joint
- Screening tests done at your place of work at no cost to you
- Free screening services offered by a government health department.
- Tests done by a mobile screening unit, unless a doctor not affiliated with the mobile unit prescribes the tests
- Flu vaccines supplied by a government agency, or otherwise provided at no cost to you
- Nonsurgical treatment of morbid obesity

Physical Appearance

- Cosmetic surgery and therapies. Cosmetic surgery or therapy is defined as surgery or therapy performed to improve or alter appearance or self-esteem or to treat psychological symptomatology or psychosocial complaints related to one's appearance.
- Redundant skin surgery, removal of skin tags, acupressure, craniosacral/cranial therapy, dance therapy, movement therapy, applied kinesiology, prolotherapy, and extracorporeal shock wave lithotripsy (ESWL) for musculoskeletal and orthopedic conditions
- 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.
- Physical conditioning programs such as athletic training, body-building, exercise, fitness, flexibility, and diversion or general motivation
- Weight loss programs whether or not they are under medical supervision. Weight loss programs for medical reasons are also excluded.
- Wigs regardless of the reason for the hair loss except for loss of hair resulting from treatment of a malignancy
- Services received from a personal trainer
- Liposuction

- Salabrasion, chemosurgery and other such skin abrasion procedures associated with the removal of scard, tattoos, actinic changes and/or which are performed as a treatment for acne

Providers

- Treatment not prescribed or recommended by a healthcare provider
- Services given by an unlicensed healthcare provider 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
- 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

Reproduction

- Surrogate parenting
- The reversal of voluntary sterilization
- Fees or direct payment to a donor for sperm or ovum donations
- Monthly fees for maintenance and/or storage of frozen embryos
- Oral contraceptives
- Genetic counseling, except when associated with amniocentesis

Services Provided Under Another Plan

- 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.
- 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

Skilled Nursing and Hospice Care

- Assistance with daily living activities
- Treatment for drug addiction or alcoholism
- Convalescent care
- Sanitarium-type care
- Rest cures
- Funeral arrangements
- Financial or legal counseling

Smoking Cessation

- Transdermal patches or nicotine gum

Transplants

- 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
- 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

Vision and Hearing (check the vision care document to see what's covered under the vision plan)

- Purchase cost of eyeglasses, contact lenses, or hearing aids
- Fitting charge for hearing aids
- Eyeglasses or contact lenses, and related fitting charges, unless following cataract surgery
- Eye examinations for the diagnosis or treatment of a refractive error
- Surgery and other related treatment that is intended to correct nearsightedness, farsightedness, presbyopia, and astigmatism including, but not limited to, procedures such as radial keratotomy, laser, and other refractive eye surgery

All Other Exclusions

- Educational, vocational, or training services and supplies
- Expenses for copying or preparing medical reports, itemized bills, or claim forms
- Mailing and/or shipping and handling expenses (there may be certain exceptions—contact your health Plan for more information)
- Expenses for failure to keep an appointment
- Telephone calls or telephone consultations
- Charges in connection with telephonic or other electronic consultations
- Maintenance care
- Sales tax (there may be certain exceptions—contact your health Plan for more information)
- Expenses relating to, or incurred in connection with, autologous hematopoietic support (e.g., autologous bone marrow transplantation or stem cell rescue), including expenses for high-dose chemotherapy or radiotherapy, for any symptom, disease, or condition, except as specified in the Transplant section of this document
- Biofeedback
- Cost of biologicals that are immunizations or medications for the purpose of travel, or to protect against occupational hazards and risks
- Services usually given without charge, even if charges are billed
- Any disease or injury resulting from a war, declared or not, or any military duty or any release of nuclear energy. Also excluded are charges for services directly related to military service provided or available from the Veterans' Administration or military facilities except as required by law

CHAPTER 7
MENTAL HEALTH AND SUBSTANCE ABUSE BENEFITS

Cigna Behavioral Health administers the inpatient and outpatient mental health benefits for members enrolled in this Plan. Cigna Behavioral Health's nationwide network of providers includes more than 80,500 independent psychiatrists, psychologists, pastoral counselors and clinical social work-ers and more than 10,200 facilities and clinics.

OUTPATIENT BENEFITS

The following outpatient services are covered based on Medical Necessity:

- Individual therapy
- Family therapy
- Couples therapy (including pre-marital therapy)
- Group therapy
- Medical management
- Applied Behavior Analysis (ABA), 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). Member will be responsible for the remaining charges.

INPATIENT BENEFITS

To find a network facility, contact Cigna Behavioral Health at (866) 395-7794 24 hours a day, 7 days a week. 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

The following inpatient services are NOT covered:

- Sanitarium, rest, or custodial care
- Vocational or occupational training

PREAUTHORIZATION

Preauthorization is required for inpatient, partial hospitalization, residential care, transcranial magnetic stimulation, intensive outpatient, 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

- Treatment that is Experimental, Investigational, 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
- Regressive therapy
- Educational, vocational or employment testing, training or services
- Educational therapy or services for learning disabilities or mental retardation
- Pervasive developmental disorders, except for behavioral therapy provided by eligible behavioral providers as listed in the Plan Description
- 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
- Testing for ADD/ADHD
- Psychological Testing unless completed while in-patient for diagnosis or treatment planning
- Telephonic, e-mail or internet consultations, therapy, or telemedicine
- Neuro-psych testing (see Medical Benefit)
- Aversion therapy
- Bio-feedback, neuro-bio-feedback, hypnotherapy
- Acupuncture, acupressure, aroma therapy, 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
- 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) is managed by Cigna Behavioral Health and covers a vast array of family and personal services. The program is designed to assist our members with information, educational materials, resources, referrals, and ongoing support.
EAP services are available 24 hours a day, 7 days a week through the CIGNA Behavioral Health website or by phone. All services are free and confidential. Equipped with many tools, the EAP staff members are trained to provide you with a multitude of services including: help finding daycare ser-

vices for your children, support for managing stress, information on adoption, assistance in researching nursing homes, and much more.
To access the Cigna EAP services, visit the EAP website at www.cignabehavioral.com, login: episcopal or call (866) 395-7794.

Filing a Claim With Cigna Behavioral Health

See Chapter 9 for claims and appeals information.

CHAPTER 8
PHARMACY BENEFITS

The pharmacy benefit is administered separately from the other components of your Medical Plan. There are three ways to fill your prescriptions. You can use one of the 69,000 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 the 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 (Tier 1) when available.

DRUG FORMULARY

Express Scripts includes a Formulary Management Program designed to control costs for you and the Plan. The formulary includes 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 formulary brand-name drugs; and Tier 3 includes nonformulary 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 Tier 1 or Tier 2 drug if possible. By choosing Tier 1 generic or Tier 2 formulary 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 the provisions of your Plan for specific drug exclusions. See “What’s Covered” and “What’s Not Covered” in this section for further information.

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-formulary brand-name drugs and pay a higher copayment.

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:

- Federal legend drugs: drugs approved by the FDA and that require a prescription (not all FDA-approved drugs are covered by this Plan)
- State-restricted drugs
- Insulin
- Needles and syringes
- Diabetic supplies
- Legend contraceptive medications—oral, injectable, patch, ring
- Over-the-counter and legend prenatal vitamins
- Legend smoking cessation treatment

Brand non-sedating antihistamine drugs will be paid as Tier 3, 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 RulesTM, is automatically implemented to determine if the medication qualifies for coverage.
- By applying factors that are on file with Express Scripts, such as the member's medical history, drug history, age, or sex, Smart Rules can often eliminate the need for a coverage review. If the claim is rejected, a coverage review can be initiated.
- *Step Therapy*—Step Therapy rules encourage appropriate use of medications.
- *Dose and Quantity Duration*—Encourage appropriate dosing over the course of therapy.
- Coverage is determined based on drug history. Quantity duration rules limit coverage for certain quantities of medications within a defined time period. A prescription that exceeds the dosage or quantity allowed will require coverage review.
- *Dispensing quantity*—The quantity of drug covered for each copayment is based primarily on the common uses of a drug and how frequently the drug is administered (e.g. episodic use (migraine therapy); chronic use (antihypertensive therapy); or defined course of therapy use (anti-infective therapy).
- *Dose optimization*—Rules focus on switching those members currently taking two tablets or capsules a day to taking one a day of the higher strength. The medications in this program are generally dosed once daily and are priced similarly across most strengths by the manufacturer. This voluntary program notifies the member that a single strength is available.

If your prescription requires review or authorization, Express Scripts will work with you, your pharmacist, and your physician to determine if the medication, as prescribed by your physician, is covered under the Prescription Drug Program. If you have any questions regarding coverage of a specific drug, please check the Express Scripts website or call the member services department at (800) 841-3361.

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:

- Non-federal legend drugs
- Medication for which the cost is recoverable under any Workers' Compensation or occupational disease law, or from any state or governmental agency
- Compounded medications
- 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
- 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
- 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 receives a prescription for a maintenance medication and you do not use home delivery, your prescriptions may not be covered.

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

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

- Anti-infectives, including antibiotics (Amoxicillin, Biaxin), antivirals (Zovirax, Famvir), antifungals (Diflucan), and drops used in the eyes and ears (Polsporin Opth, 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 (DUR)

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 Pharmacy 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 provider should file claims for you. However, if you receive out-of-network services, you may have to file claims yourself. Electronically submitted claims are processed most efficiently. If unable to file electronically, you or your healthcare provider may submit the following:

- HCFA-1500 (revision 12/90 and later) or UB-92 forms for medical expenses
- Prescription drug submittal forms and vision care submittal forms

These are the only appropriate forms for requesting Plan payment. If your healthcare provider is unable to file one of these forms for you, you are responsible for completing and submitting it. These forms are available from either your healthcare provider or your health Plan, as well as on our website at *www.cpg.org*. Include the following information:

- 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 payor

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 provider will be notified.

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

Send complete information to the appropriate Plan.

Send claims for medical services to:

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

Send claims for mental health and substance abuse services to:

Cigna Behavioral Health
P.O. Box 188022
Chattanooga, TN 37422

Send claims for pharmacy services to:

Express Scripts,
PO Box 14711
Lexington, KY 40512

If you have any questions regarding your claim, please call the appropriate number, listed on the last page of this handbook.

ALL CLAIMS MUST BE RECEIVED WITHIN 180 DAYS FOLLOWING THE DATE SERVICES WERE RECEIVED.

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. An assignment of benefits does not constitute designation of an Authorized Representative. 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, 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 Investigational treatment, 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 two mandatory levels of appeal and an additional voluntary level of appeal which will be performed by an independent external review organization. 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 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 80.

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 mental health and substance abuse 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 claimant
- 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 Experimental or Investigational, 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. This healthcare professional will not be one who was consulted in making an earlier determination or who works for one who was consulted in making an earlier determination.

NOTIFICATION OF THE OUTCOME OF THE NON-URGENT APPEAL

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

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

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

APPEAL DENIAL

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

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

If you are dissatisfied with the Claims Administrator's first level appeal decision, a 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 or Cigna Behavioral Health, send your second level appeal to:

VP, Plan Administration
CPG Benefits Policy Department

PO Box 2745
New York, NY 10163

For a post-service appeals involving Express Scripts, send your second level appeal to:

Express Scripts
P.O. Box 631850
Irving, TX 75063-0030
Attn: Appeals

For a pre-service appeal involving Anthem, send your second level appeal to:

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

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 second level appeal is denied, you 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.

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 all of the levels of standard appeal for the Plan involved before you can request External Review, other than in a case where the Plan or its designee, does not strictly adhere to all claim determination and appeal requirements under federal law (*Deemed Exhaustion*). Subject to verification procedures that the Plan may establish, your Authorized Representative may act on your behalf in filing and pursuing this voluntary appeal. You may file a voluntary appeal for External Review of any Adverse Benefit Determination that qualifies as set forth below.

The notice of Adverse Benefit Determination that you receive from the Plan or its designee will describe the process to follow if you wish to pursue an External Review, and will include a copy of the *Request for External Review Form*. *You must submit the Request for External Review Form within four (4) months of the date you received the Adverse Benefit Determination notice*. If the last filing date would fall on a Saturday, Sunday or Federal holiday, the last filing date is extended to the next

day that is not a Saturday, Sunday or Federal holiday. You also must include a copy of the notice and all other pertinent information that supports your request.

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

- The Plan or its designee, does not strictly adhere to all claim determination and appeal requirements under federal law;
- The standard levels of appeal have been exhausted
- 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

If you file a voluntary 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 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) is based upon your eligibility.

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 administer 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 5 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 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 timely 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 timely received. 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 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 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 internal Appeals Procedure but 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 of the State of New York. Therefore any civil action must be filed 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

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 employers in the previous year, you may be eligible to choose a plan that participates in this program.

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 Episcopal Health Plan 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 Episcopal Health 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 Anthem 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 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 2016, 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 Anthem Blue Cross and Blue Shield Plan (Anthem).

HOW IT WORKS

If you have an inpatient hospitalization in 2016, 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 Anthem who will process the portion not paid by Medicare, minus the plan's deductible and your cost share. The chart below shows how this will work.

Part A Billed Charges	$10,000.00
Medicare Allowed	$5,000.00
Medicare's Payment	
Medicare Paid	$3,784.00
Medicare's Deductible*	$1,216.00
PPO 90/70 Plan Payment	
Plan Allowed (amount not paid by Medicare)	$1,216.00
Plan's Maximum Liability minus copayment* times coinsurance	$1,216.00 -600 $616.00 X 90% $554.40
Plan Pays	**$554.40**
Member Pays ($600 copayment* + 10% coinsurance)	**$661.60**

* This chart assumes you have not yet met your deductibles and you have a hospital stay of 6 days.

As the secondary payer of claims, Anthem does not look at the provider status to determine the benefits. All claims are processed at the in-network level, regardless of whether the facility is in Anthem's network.

You must pay all the costs up to the deductible amount before Anthem begins to pay for covered services you use. Your copayments and coinsurance, as well as your deductible, are applied to your out-of-pocket limit.

If you receive services that are not covered by Medicare but are covered by Anthem, 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 Anthem plan, Anthem 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 – 8:00pm ET, or email mtcustserv@cpg.org.

Chapter 12
Other Important Plan Provisions

Assignment of Benefits

All benefits payable by the Plan are automatically assigned to the provider of services or supplies, unless evidence of previous payment is submitted with the claim. All other benefits payable by the Plan may be assigned to the provider of services or suppliers at the Member's option. Payments made in accordance with an assignment are made in good faith and release the Plan's obligation to the extent of the payment. Payments will also be made in accordance with any assignment of rights required by a state Medicaid plan.

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. If coverage remains under the Plan, the Plan will be the primary payor of benefits, and Medicare will be secondary.

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.

Alternate Payee Provision

Benefits are generally payable to the provider of services or supplies. Any other benefits that are payable to a Member can only be paid directly to another party upon signed authorization from the Member. If conditions exist under which a valid release or assignment cannot be obtained, the Plan may make payment to any individual or organization that has assumed the care or principal support for the Member and is equitably entitled to payment. 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.

The Plan may also honor benefit assignments made prior to a Member's death in relation to remaining benefits payable by the Plan.

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 "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 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 Information and Rights

The Plan(s) described in this 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 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 the Summary of Benefits and Coverage and this Plan 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.

Chapter 13
Privacy

Joint Notice of Privacy Practices

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

Introduction

Church Pension Group Services Corporation, doing business as The Episcopal Church Medical Trust (Medical Trust), is the plan sponsor of certain group health plans (each a Plan and together the Plans) that are subject to the Health Insurance Portability and Accountability Act of 1996 and the regulations enacted thereunder (HIPAA). HIPAA places certain restrictions on the use and disclosure of Protected Health Information (PHI) and requires the Medical Trust to provide this Joint Notice of Privacy Practices (the Notice) to you. PHI is your individually identifiable health information that is created, received, transmitted or maintained by the Plans or its business associates, regardless of the form of the information. It does not include employment records held by your employer in its role as an employer. This chapter 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 associ-

ates for plan administration if the business associate agrees in writing to protect the privacy of your information.

- Plan Sponsor. ECMT, as sponsor of the Plans, will have access to your PHI for plan administration purposes. Unless you authorize the Plans otherwise in writing (or your individual identifying data is deleted from the information), your PHI will be available only to the individuals who need this information to conduct these plan administration activities, but this release of your PHI will be limited to the minimum disclosure required, unless otherwise permitted or required by law.

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

- Most uses and disclosures of psychotherapy notes
- Uses and disclosures of PHI for marketing purposes
- Uses and disclosures that constitute a sale of PHI

Any other use or disclosure of your PHI not identified in this chapter 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 chapter.

Fundraising

The Plans may contact you to support its 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
- Is accurate and complete

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 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 24, 2015.

Changes

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

CHAPTER 14
GLOSSARY

ANNUAL DEDUCTIBLES

A deductible is the amount of covered expenses each covered individual must pay during each year before the Plan will consider expenses for reimbursement. The individual deductible applies separately to each covered person. 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, except in the case of an inpatient hospital deductible. The annual individual and family out-of-network deductible amounts, and the inpatient hospital deductibles, are shown on the Summary of Benefits and Coverage. The deductible is included in your out-of-pocket maximum.

BENEFITS

Your right to payment for Covered Health Services that is available under the Plan. Your right to benefits is subject to the terms, conditions, limitations and exclusions of the Plan, including this handbook and any applicable riders and amendments.

BENEFIT MAXIMUMS

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 annual 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 portion 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.

CONGENITAL ANOMALY

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

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. Monthly 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 abuse, 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 Experimental or Investigational and unproven services.

Covered Health Services must be provided:

- When the Plan is in effect
- Prior to the effective date of any of the individual termination conditions set forth in this 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.

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.

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.

DENOMINATIONAL HEALTH PLAN

Created in 2009 by an Act of General convention, the Denominational Health Plan is a program that provides healthcare benefits to eligible employees of The Episcopal Church. The associated Resolution A177 requires that all domestic dioceses, parishes, missions, and other ecclesiastical organizations or bodies subject to the authority of The Episcopal Church join the program and enroll clergy and lay employees who are scheduled to work and are compensated for 1,500 hours or more annu-

ally. The Trustees and Officers of the Church Pension Fund administer the program. Benefits are provided through the Episcopal Church Medical Trust, which is the sole plan sponsor of such benefits. All affected groups were required to provide healthcare benefits through the Medical Trust no later than January 1, 2013.

DEPENDENT

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

Child
A natural child, stepchild, foster child, legally adopted child or child who has been placed with the Subscriber for adoption, and if Domestic Partner benefits are permitted by the Participating Group, a domestic Partner's Child. A foster child is an individual who is placed with the Subscriber by an authorized placement agency or by judgment, decree, or other order of any court of competent jurisdiction.

Domestic Partner
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 section and is enrolled in the Plan at the time of the Subscriber's death. A Surviving Child shall include a Child of a Subscriber born within 12 months of the Subscriber's death.

Surviving Spouse
A Spouse of a Subscriber who meets the qualifications listed in the eligibility chapter and is enrolled in the Plan at the time of the Subscriber's death.

DISABLED

A medically determinable physical or mental condition, which prevents an individual from engaging in substantial gainful activity and which can be of long-continued or indefinite duration.

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

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, 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.

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 source or determination that the Claims Administrator accepts

ELIGIBLE INDIVIDUAL

An Exempt Employee, a Non-Exempt Employee normally scheduled to work 1,000 or more compensated hours per Plan Year, a Seminarian who is a full-time student enrolled at a participating seminary of the Association of Episcopal Seminaries, a postulant, novice or professed member of Episcopal Religious Orders who has been accepted or received by the Religious Order, a Pre-65 Retired Employee, not eligible for Medicare, as long as his/her former employer is participating in the Episcopal Health Plan.

EMERGENCY

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

- 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 an 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 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 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, **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 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 5 years **AND** either (1) Participated in a pension plan sponsored by The Church Pension Fund for a minimum of 5 years **OR** (2) is a former Employee of a Participating Group of the EHP.

Member of Religious Order who:

a) Is age 65 or older **and**

(b) either (1) Participated in a pension plan sponsored by The Church Pension Fund for a minimum of 5 years **OR** (2) is a former Member of a Religious Order that is a Participating Group of the EHP.

Seasonal Employee

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

Temporary Employee

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

EPISCOPAL CHURCH CLERGY AND EMPLOYEE'S BENEFIT TRUST (ECCEBT)

The Plan funds certain of its benefit plans through this trust that is intended to qualify as a voluntary employees' beneficiary association (VEBA) under Section 501(c)(9) of the Internal Revenue Code. The main purpose of the ECCEBT is to provide health benefits to eligible Employees, former Employees and/or their dependents.

EXPERIMENTAL OR INVESTIGATIONAL

Medical, surgical, diagnostic, psychiatric, substance abuse or other healthcare services, technologies, supplies, treatments, procedures, drug therapies or devices that, at the time the Plan makes a determination regarding coverage in a particular case, are determined to be any of the following:

- Not approved by the U.S. Food and Drug Administration (FDA) to be lawfully marketed for the proposed use and not identified in the American Hospital Formulary Service or the United States Pharmacopoeia Dispensing Information as appropriate for the proposed use
- Subject to review and approval by any institutional review board for the proposed use
- The subject of an ongoing clinical trial that meets the definition of a Phase 1, 2 or 3 clinical trial set forth in the FDA regulations, regardless of whether the trial is actually subject to FDA oversight

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 there under. 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.

LEGEND DRUG

A drug that is approved by the U.S. Food and Drug Administration and that is required by federal or state law to be dispensed to the public only on prescription of a licensed physician or other licensed provider.

MEDICARE

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

MEDICARE SECONDARY PAYER (MSP) - 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.

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 allow Group Administrators to view bills and payment histories, create reports, and generate mailing lists.

MEDICAL NECESSITY

“Medically Necessary” or “Medical Necessity” shall mean healthcare services that a Physician, exercising prudent clinical judgment, would provide to a patient for the purpose of preventing, evaluating, diagnosing or treating an illness, injury, disease or its symptoms, and that are: (a) in accordance with generally accepted standards of medical practice; (b) clinically appropriate, in terms of type, frequency, extent, site and duration, and considered effective for the patient’s illness, injury or disease; (c) not primarily for the convenience of the patient, physician, or other healthcare provider, and not more costly 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 patient’s illness, injury or disease and (d) not Experimental or Investigational. 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, Physician Specialty Society recommendations and the views of Physicians practicing in relevant clinical areas and any other relevant factors.

MEMBER

A Subscriber or Dependent

MEMBER OF A RELIGIOUS ORDER

A postulant, novice or professed member of Episcopal Religious Orders, as defined in Title III, Canon 14.1[6] 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 provider of healthcare services, this means a 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 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 provider will be a network provider for the Covered Health Services and products included in the participation agreement, and an out-of-network provider for other Covered 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 provider's office or at a network or out-of-network facility.

OPEN ENROLLMENT

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

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

Passive Open Enrollment
During a Passive Open Enrollment, a Subscriber or Eligible Individual is not required by the Plan to take any action. However, the Plan encourages Subscribers and Eligible Individuals to log on to the Open Enrollment website to update demographic information and verify the existing coverage.

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.

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

NON-PPO DEDUCTIBLES, NON-POS DEDUCTIBLES

A non-PPO or non-POS deductible is the amount of covered expenses each covered individual must pay during each year before the Plan will consider expenses for reimbursement. The individual deductible applies separately to each covered person. 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.

OUT-OF-POCKET MAXIMUM

An out-of-pocket maximum is the maximum amount of covered expenses you must pay during a year, including the deductible, before the coinsurance percentage of the Plan increases. 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 year.

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 expenses for any covered family member during the remainder of that year.

The following costs will never apply to the out-of-pocket maximum:

- Any charges for non-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

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 The Episcopal Church, which has elected to participate in the Plan.

PLAN(S)

The medical and dental plans (i.e. 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 Plans through which Eligible Individuals and Eligible Dependents of the Episcopal Church are provided health benefits. Benefits are provided through the Medical Trust.

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.

Medicare Supplement Health Plan (MSHP)

A program of supplemental medical and dental Plans through which Eligible Individuals and Eligible Dependents of the Episcopal Church are provided health benefits. Benefits are provided through the Medical Trust. A Medicare supplement health plan provides coverage for medical expenses not covered or partially covered by the Original Medicare Plan (Part A and B).

It may also provide benefits for expenses not covered by the Original Medicare Plan such as pharmacy benefits and vision care. A Medicare supplement health plan only works with the Original Medicare Plan, where Medicare pays first (primary) for a medical claim, and the Medicare supplement plan pays for the medical claim after the Original Medicare Plan (secondary). The Original Medicare Plan and the MSHP only pay claims for services that are provided in the United States.

Plan Year

Refers to the plan year which is the 12-month period beginning January 1 and ending December 31. All benefit maximums and annual deductibles accumulate during the plan year.

Preventive Care

Medical services aimed at early detection and intervention as determined by the plan administrator and described in Chapter 4. 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 that makes the Subscriber eligible to make a mid-year election change that is consistent with the change.

Subscriber

An individual who meets the qualifications listed in the eligibility chapter and is enrolled in the Plan.

Substance Abuse Services

Covered Health Services for the diagnosis and treatment of alcoholism and substance abuse disorders that are listed in the current Diagnostic and Statistical Manual of the American Psychiatric Association, unless those services are specifically excluded. The fact that a disorder is listed in the Diagnostic and Statistical Manual of the American Psychiatric Association does not mean that treatment of the disorder is a Covered Health Service.

Maximum Allowed Amount

The Plan provides benefits only for covered expenses that are equal to or less than the maximum allowed amount in the geographic area where services or supplies are provided. Any amounts that exceed the maximum allowed amount are not recognized by the Plan for any purpose.

In determining the reasonable charge for a service or supply that is:

- Unusual
- Not often provided in the area
- Provided by only a small number of providers in the area

The Claims Administrator may take into account factors such as:

- The complexity
- The degree of skill needed
- The type of specialty of the provider
- The prevailing charge in other areas

In some circumstances, the Claims Administrator may have an agreement with a provider (either directly, or indirectly through a third party) that sets the rate that will be paid for a service or supply. In these instances, in spite of the methodology described above, the maximum allowed amount is the rate established in such an agreement.

For covered individuals participating in a PPO plan option, maximum allowed amounts do not apply to PPO healthcare providers, or any non-PPO anesthesiology, diagnostic testing, x-ray, and laboratory services.

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.

Premium Assistance Under Medicaid and the Children's Health Insurance Program (CHIP)

If you or your children are eligible for Medicaid or CHIP and you're eligible for health coverage from your employer, your state may have a premium assistance program that can help pay for coverage, using funds from their Medicaid or CHIP programs. If you or your children aren't eligible for Medicaid or CHIP, you won't be eligible for these premium assistance programs but you may be able to buy individual insurance coverage through the Health Insurance Marketplace. For more information, visit **www.healthcare.gov**.

If you or your dependents are already enrolled in Medicaid or CHIP and you live in a State listed below, contact your State Medicaid or CHIP office to find out if premium assistance is available.

If you or your dependents are NOT currently enrolled in Medicaid or CHIP, and you think you or any of your dependents might be eligible for either of these programs, contact your State Medicaid or CHIP office or dial **1-877-KIDS NOW** or **www.insurekidsnow.gov** to find out how to apply. If you qualify, ask your state if it has a program that might help you pay the premiums for an employer-sponsored plan.

If you or your dependents are eligible for premium assistance under Medicaid or CHIP, as well as eligible under your employer plan, your employer must allow you to enroll in your employer plan if you aren't already enrolled. This is called a "special enrollment" opportunity, and **you must request coverage within 60 days of being determined eligible for premium assistance**. If you have questions about enrolling in your employer plan, contact the Department of Labor at **www.askebsa.dol.gov** or call **1-866-444-EBSA (3272)**.

If you live in one of the following states, you may be eligible for assistance paying your employer health plan premiums. The following list of states is current as of July 31, 2015. Contact your State for more information on eligibility –

ALABAMA – Medicaid	GEORGIA – Medicaid
Website: www.myalhipp.com Phone: 1-855-692-5447	Website: http://dch.georgia.gov/ - Click on Programs, then Medicaid, then Health Insurance Premium Payment (HIPP) Phone: 404-656-4507
ALASKA – Medicaid	**INDIANA – Medicaid**
Website: http://health.hss.state.ak.us/dpa/programs/medicaid/ Phone (Outside of Anchorage): 1-888-318-8890 Phone (Anchorage): 907-269-6529	Website: http://www.in.gov/fssa Phone: 1-800-889-9949
COLORADO – Medicaid	**IOWA – Medicaid**
Medicaid Website: http://www.colorado.gov/hcpf Medicaid Customer Contact Center: 1-800-221-3943	Website: www.dhs.state.ia.us/hipp/ Phone: 1-888-346-9562
FLORIDA – Medicaid	**KANSAS – Medicaid**
Website: https://www.flmedicaidtplrecovery.com/ Phone: 1-877-357-3268	Website: http://www.kdheks.gov/hcf/ Phone: 1-800-792-4884

KENTUCKY – Medicaid	NEW HAMPSHIRE – Medicaid
Website: http://chfs.ky.gov/dms/default.htm Phone: 1-800-635-2570	Website: http://www.dhhs.nh.gov/oii/documents/hippapp.pdf Phone: 603-271-5218
LOUISIANA – Medicaid	**NEW JERSEY – Medicaid and CHIP**
Website: http://dhh.louisiana.gov/index.cfm/subhome/1/n/331 Phone: 1-888-695-2447	Medicaid Website: http://www.state.nj.us/humanservices/ dmahs/clients/medicaid/ Medicaid Phone: 609-631-2392 CHIP Website: http://www.njfamilycare.org/index.html CHIP Phone: 1-800-701-0710
MAINE – Medicaid	**NEW YORK – Medicaid**
Website: http://www.maine.gov/dhhs/ofi/public-assistance/index.html Phone: 1-800-977-6740 TTY 1-800-977-6741	Website: http://www.nyhealth.gov/health_care/medicaid/ Phone: 1-800-541-2831
MASSACHUSETTS – Medicaid and CHIP	**NORTH CAROLINA – Medicaid**
Website: http://www.mass.gov/MassHealth Phone: 1-800-462-1120	Website: http://www.ncdhhs.gov/dma Phone: 919-855-4100
MINNESOTA – Medicaid	**NORTH DAKOTA – Medicaid**
Website: http://www.dhs.state.mn.us/id_006254 Click on Health Care, then Medical Assistance Phone: 1-800-657-3739	Website: http://www.nd.gov/dhs/services/medicalserv/medicaid/ Phone: 1-800-755-2604
MISSOURI – Medicaid	**OKLAHOMA – Medicaid and CHIP**
Website: http://www.dss.mo.gov/mhd/participants/pages/hipp.htm Phone: 573-751-2005	Website: http://www.insureoklahoma.org Phone: 1-888-365-3742
MONTANA – Medicaid	**OREGON – Medicaid**
Website: http://medicaid.mt.gov/member Phone: 1-800-694-3084	Website: http://www.oregonhealthykids.gov http://www.hijossaludablesoregon.gov Phone: 1-800-699-9075
NEBRASKA – Medicaid	**PENNSYLVANIA – Medicaid**
Website: www.ACCESSNebraska.ne.gov Phone: 1-855-632-7633	Website: http://www.dhs.state.pa.us/hipp Phone: 1-800-692-7462
NEVADA – Medicaid	**RHODE ISLAND – Medicaid**
Medicaid Website: http://dwss.nv.gov/ Medicaid Phone: 1-800-992-0900	Website: http://www.eohhs.ri.gov/ Phone: 401-462-5300

SOUTH CAROLINA – Medicaid	VIRGINIA – Medicaid and CHIP
Website: http://www.scdhhs.gov Phone: 1-888-549-0820	Medicaid Website: http://www.coverva.org/programs_premium_assistance.cfm Medicaid Phone: 1-800-432-5924 CHIP Website: http://www.coverva.org/programs_premium_assistance.cfm CHIP Phone: 1-855-242-8282
SOUTH DAKOTA - Medicaid	**WASHINGTON – Medicaid**
Website: http://dss.sd.gov Phone: 1-888-828-0059	Website: http://www.hca.wa.gov/medicaid/premiumpymt/pages/index.aspx Phone: 1-800-562-3022 ext. 15473
TEXAS – Medicaid	**WEST VIRGINIA – Medicaid**
Website: http://gethipptexas.com/ Phone: 1-800-440-0493	Website: http://www.dhhr.wv.gov/bms/Medicaid%20Expansion/Pages/default.aspx Phone: 1-877-598-5820, HMS Third Party Liability
UTAH – Medicaid and CHIP	**WISCONSIN – Medicaid and CHIP**
Website: Medicaid: http://health.utah.gov/medicaid CHIP: http://health.utah.gov/chip Phone: 1-866-435-7414	Website: https://www.dhs.wisconsin.gov/badgercareplus/p-10095.htm Phone: 1-800-362-3002
VERMONT– Medicaid	**WYOMING – Medicaid**
Website: http://www.greenmountaincare.org/ Phone: 1-800-250-8427	Website: https://wyequalitycare.acs-inc.com/ Phone: 307-777-7531

To see if any other states have added a premium assistance program since July 31, 2015, or for more information on special enrollment rights, contact either:

U.S. Department of Labor
Employee Benefits Security Administration
www.dol.gov/ebsa
1-866-444-EBSA (3272)

U.S. Department of Health and Human Services
Centers for Medicare & Medicaid Services
www.cms.hhs.gov
1-877-267-2323, Menu Option 4, Ext. 61565

OMB Control Number 1210-0137 (expires 10/31/2016)

FOR MORE INFORMATION

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

THE EPISCOPAL CHURCH MEDICAL TRUST

www.cpg.org

(800) 480-9967
e-mail: mtcustserv@cpg.org

Monday through Friday, except holidays,
8:30 a.m.– 8:00 p.m. ET

Anthem Blue Cross and Blue Shield

www.anthem.com
(844) 812-9207
Monday through Friday, 8:30 a.m. - 8:00 p.m. EST

MENTAL HEALTH BENEFIT PROGRAM

www.cignabehavioral.com
(866) 395-7794
24 hours a day, 7 days a week

Express Scripts

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

EYEMED VISION CARE

www.eyemedvisioncare.com
(866) 723-0513
Monday through Saturday, 8:00 a.m. – 11:00 p.m. EST, and Sunday, 11:00 a.m. – 8:00 p.m. EST

The Plan(s) described in this 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 handbook contains only a partial description of the Plans intended for informational purposes only. It should be 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 official Plan 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.