Anthem BlueCross BlueShield

2023 Plan Handbook

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Benefits effective as of January 1, 2023

EPISCOPAL CHURCH MEDICAL TRUST

Introduction

The Episcopal Church Medical Trust (the "Medical Trust") maintains a series of benefit Plans (each a "Plan" and collectively, the "Plans") for the eligible Employees (and their Eligible Dependents) of The Episcopal Church. Since 1978, the Plans sponsored by the Medical Trust have served the dioceses, parishes, schools, missionary districts, seminaries, and other institutions subject to the authority of The Episcopal Church. The Medical Trust serves thousands of active Employees, retirees, and their Eligible Dependents. The Plans are intended to qualify as "church plans" within the meaning of section 414(e) of the Internal Revenue Code (the "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 (the "ECCEBT"). The ECCEBT is intended to qualify as a Voluntary Employees' Beneficiary Association (a "VEBA") under section 501(c)(9) of the 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 administer a comprehensive benefit plan while balancing compassion with financial stewardship. This is a unique mission in the world of healthcare benefits, and we believe that our experience and mission to serve The Episcopal Church offers a level of expertise that is unparalleled.

If you have questions about any of our Plans, please don't hesitate to contact us. We're looking forward to serving you. For more information, please visit our website at *cpg.org*; or call Client Services at 800-480-9967.

Benefits described in this Plan Document Handbook are effective as of January 1, 2023. Please note that capitalized terms used in this section but not defined here have the meanings ascribed to such terms in the body of the Plan Document Handbook below.

A Note about How This Plan Document Handbook is Organized

In order to provide a more seamless experience to Members choosing between Plans administered by two of our Claims Administrators, Anthem BCBS and Cigna, this Plan Document Handbook is split into two parts:

- **Part I** addresses topics that are consistent between the Plans administered by Anthem BCBS and Cigna – for example, eligibility and basic coverage terms.
    - Chapters ending in "A" contain Claims-Administrator-specific supplements to topics addressed in the corresponding chapter – for example, *Chapter 3* addresses basic coverage terms, and *Chapter 3A* contains Anthem-BCBS-specific or Cigna-specific modifications to those terms.
- **Part II** addresses topics handled differently by these two Claims Administrators – for example, how their respective Networks are maintained and their "Precertification" / "Prior-Authorization" requirements work.

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Part I—Episcopal Church Medical Trust Plan Provisions

Chapter 1: Important Notices

Newborns' and Mothers' Health Protection Act of 1996

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

Women's Health and Cancer Rights Act of 1998

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

For more information, contact the Plan Administrator.

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

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

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

Chapter 2: Eligibility and Enrollment

Eligibility for the Episcopal Health Plan (EHP)

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

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

Eligible Individuals

- An Employee normally scheduled to work 1,000 or more compensated hours per Plan Year or who is treated as a full-time Employee under the Employer Shared Responsibility Provisions under the Affordable Care Act (Pay or Play Rules), but only for the applicable stability period
- A Seminarian who is a full-time student enrolled at a participating seminary of the Association of Episcopal Seminaries
- A Member of a Religious Order
- A Pre-65 Former Employee, not eligible for Medicare, as long as their former employer is participating in the EHP
- A cleric, not eligible for Medicare, who is eligible for benefits under The Church Pension Fund Clergy Short-Term Disability Plan, or The Church Pension Fund Clergy Long-Term Disability Plan who was (i) enrolled in the EHP or SEE Plan as of the date of their disability or (ii) who was eligible for enrollment in the EHP or SEE Plan as of the date of their disability and who subsequently experiences a Significant Life Event that entitles them to subsidized medical coverage under The Church Pension Fund Clergy Long-Term Disability Plan

Eligible Dependents

- A Spouse of an Eligible Individual enrolled in a Plan sponsored by the Medical Trust*
- A Domestic Partner of an Eligible Individual enrolled in a Plan sponsored by the Medical Trust, if Domestic Partner benefits are elected by the Participating Group
- A Child of an Eligible Individual enrolled in a Plan sponsored by the Medical Trust, who is 30[1] years of age or younger on December 31 of the Plan Year**
- A Disabled Child of an Eligible Individual enrolled in a Plan sponsored by the Medical Trust, who is older than 30[1] years of age on December 31 of the Plan Year, provided the disability began before the age of 25**
- A pre-65 Dependent, not eligible for Medicare, of a Post-65 Former Employee enrolled in the Group Medicare Advantage Plan (the "GMAP")***
- A pre-65 Surviving Dependent, not eligible for Medicare, of a deceased Post-65 Former Employee or Pre-65 Former Employee who, in each case, was enrolled in a Plan sponsored by the Medical Trust at the time of their death***
- A pre-65 Dependent, of a Pre-65 Former Employee enrolled in the GMAP****

**For information on the eligibility of a former Spouse refer to the Termination of Individual Coverage, under Divorce*
***The Dependent must be enrolled under the Eligible Individual's Plan.*
****The Dependent will be enrolled as a "subscriber" (i.e., as if they were themselves an Eligible Individual); however, eligibility is based on the Post-65 Former Employee's status.*
*****The Dependent will be enrolled as a "subscriber" (i.e., as if they were themselves an Eligible Individual); however, eligibility is based on the Pre-65 Former Employee's status.*

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

Ineligible Individuals

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

- A part-time Employee who is scheduled to work and be compensated for less than 1,000 hours per Plan Year unless such Employee is required to be treated as a full-time Employee under the Pay or Play Rules
- A Temporary Employee unless such Employee is required to be treated as a full-time Employee under the Pay or Play Rules
- A Seasonal Employee unless such Employee is required to be treated as a full-time Employee under the Pay or Play Rules
- A Seminarian who is not a full-time student or not enrolled at a participating seminary of the Association of Episcopal Seminaries
- A parent or other relative of an Eligible Individual, including grandchildren and in-laws, not listed in the Eligible Dependents section above
- A Post-65 Former Employee or Pre-65 Former Employee (or Spouse/Domestic Partner) eligible for Medicare, regardless of whether they are actually enrolled in Medicare
- A volunteer
- Any Employee who does not meet local jurisdiction's employment requirements (e.g., age requirements or work visa requirements)
- A person who would otherwise be 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 of, foster child of, legally adopted by or who has not been placed for adoption with, in each case, the Eligible Individual, Eligible Individual's Spouse, or, if Domestic Partner benefits are provided by the Participating Group, the Eligible Individual's Domestic Partner
- A person who would otherwise be an Eligible Individual or Eligible Dependent who is on long-term disability and eligible to enroll in Medicare Part A and Part B
- A person who would otherwise be an Eligible Individual or Eligible Dependent who has been barred from enrolling because their eligibility has been terminated for cause due to such individual's actions
- A person who would otherwise be an Eligible Individual or Eligible Dependent whose coverage by the Plan would be illegal under applicable law

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 individual with requisite authority to make benefits decisions on behalf of the Participating Group must submit the Coverage and Eligibility Exception Request Form to the Plan in these circumstances. The Plan will review the case presented and provide an individual eligibility determination within approximately 30 days after receipt of the form. If eligibility is granted, the effective date of coverage will be the first of the month following the receipt of the enrollment form. The Coverage and Eligibility Exception Request Form is provided in the Appendix section of the *Administrative Policy Manual*.

Standalone Employee Assistance Program (EAP) Plan

The Plan offers the Employee Assistance Program (EAP) with Cigna as a standalone Plan that Participating Groups may offer to Employees who waived EHP coverage as a qualified opt out.

Please note that Eligible Individuals who enroll in Medical Trust health coverage are automatically enrolled in the Cigna EAP and should not be enrolled in the Standalone EAP Plan.

If the Standalone EAP Plan is offered by a Participating Group, Billed Groups that elect to enroll Employees who waived EHP coverage as qualified opt outs must pay for the Standalone EAP Plan coverage. Requiring Employees to contribute toward the cost of the Standalone EAP Plan would violate the Affordable Care Act and subject the Billed Group to significant penalties.

Eligibility for the Standalone EAP Plan is limited to Employees who waived EHP coverage as a qualified

opt out. All Employees of a Billed Group that offers the Standalone EAP Plan who waived EHP coverage as a qualified opt out must be enrolled in the Standalone EAP Plan.

Since Eligible Individuals do not have the ability to enroll in the Standalone EAP Plan during Annual Enrollment, enrollments must be completed by the employer or Participating Group.

Important Notes

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

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

Medicare/Medicaid
Except as noted above, eligibility for Medicare/Medicaid or the receipt of Medicare/Medicaid benefits will not be taken into account in determining eligibility for participation in the EHP. For participation in the SEE Plan, eligibility for Medicare will be taken into account in determining eligibility.

Eligibility for the Small Employer Exception (SEE) Plan

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

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

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

If the Member is approved and enrolled, Medicare would become the primary payer of claims covered under Medicare Part A only. Part A is hospitalization insurance that helps cover inpatient care in hospitals, skilled nursing facilities, hospices, and home healthcare situations. The SEE 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 EHP.

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

Determining Eligibility for the SEE Plan

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

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

In addition to the eligibility criteria set forth below, the following requirements must be met in order for participation in the SEE Plan to be permitted:

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

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

Eligible Individuals

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

Eligible Dependents

- A Spouse of an enrolled Eligible Individual*
- A Domestic Partner of an enrolled Eligible Individual, if Domestic Partner benefits are elected by the Participating Group
- A Child of an enrolled Eligible Individual, who is 30[2] years of age or younger on December 31 of the Plan Year
- A Disabled Child of an enrolled Eligible Individual, who is older than 30[2] years of age on December 31 of the Plan Year, provided the disability began before the age of 25**

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

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

Ineligible Individuals

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

- Any Employee working for an employer that does not meet the criteria for the SEE
- A part-time Employee who is scheduled to work and be compensated for less than 1,000 hours per year unless such Employee is required to be treated as a full-time Employee under the Pay or Play Rules
- A Temporary Employee unless such Employee is required to be treated as a full-time Employee under the Pay or Play Rules
- A Seasonal Employee unless such Employee is required to be treated as a full-time Employee under the Pay or Play Rules
- A Seminarian
- A parent or other relative of an Eligible Individual, including grandchildren and in-laws, not listed in the Eligible Dependents section above
- A volunteer
- Any Employee who does not meet local jurisdiction's employment requirements (e.g., age requirements or work visa requirements)
- A person who would otherwise be 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 of, foster child of, legally adopted by or who has not been placed for adoption with, in each case, the Eligible Individual, Eligible Individual's Spouse, or, if Domestic Partner benefits are provided by the Participating Group, the Eligible Individual's Domestic Partner
- A person who would otherwise be an Eligible Individual or Eligible Dependent who has been barred from enrolling because their eligibility has been terminated for cause due to such individual's actions
- A person who would otherwise be an Eligible Individual or Eligible Dependent whose coverage by the Plan would be illegal under applicable law

Important Notes

Medicare Secondary Payer (MSP)

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

Each employer must determine which Employees are eligible for employer-provided health benefits. The employer must comply with the Age Discrimination in Employment Act (ADEA), if applicable, which requires employers to offer to their over age 65 Employees and Spouses the same coverage that is offered to Employees and Spouses under age 65, regardless of their Medicare eligibility. In addition, this equal benefit rule applies to coverage offered to full-time and part-time Employees. Those Employees over age 65 who are qualified for employer-provided health benefits and meet the Plan's eligibility rules described in this section must be offered the EHP or SEE Plan, if eligible.

Medicare beneficiaries are free to reject employer plan coverage and retain Medicare as their primary coverage. However, when Medicare is the primary payer, employers cannot offer such Employees (or their Spouses) secondary coverage for items and services covered by Medicare. Medicare states that an employer cannot sponsor or contribute to individual Medicare supplement health plans, Medicare HMOs, or Group Medicare Advantage plans for Medicare beneficiaries who are otherwise eligible for active group health coverage. Therefore, the Plan does not offer group Medicare supplement health plans, group Medicare HMOs or Group Medicare Advantage plans to Employees and their Spouses over age 65 who are Medicare beneficiaries, and the Employee and their eligible Spouse can no longer

receive a subsidy under The Church Pension Fund Post-Retirement Medical Assistance Plan. Failure to comply with the MSP rules can result in penalties assessed against the employer. It is the employer's responsibility to comply with the MSP rules and by participating in the Plans the employer agrees to indemnify and hold the Medical Trust harmless from any claims resulting from the failure to comply with the MSP rules.

Small Employer Exception

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

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

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

Because Medicare will become the primary payer of claims covered under Medicare Part A, to participate in the SEE Plan, 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.

Individuals who are enrolled in the SEE Plan will continue to have access to the additional benefits included in the Medical Trust plans, such as

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

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

Working for the Church after Retirement

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

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

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

Plan Election and Enrollment Guidelines

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

Eligible Individual Responsibilities

The Plan and its administrators rely on information provided by Eligible Individuals when evaluating the coverage and benefits under the Plan. Eligible Individuals must provide all required information (including their and their enrolled Eligible Dependent's Social Security Number or Individual Taxpayer Identification Number) through a MyCPG Accounts submission or with an enrollment form to the Participating Group.

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. An Eligible Individual may not change their elected Plan or Coverage Tier except during Annual Enrollment, unless there is a Significant Life Event.

Important Note: An Eligible Individual (and their Eligible Dependents) may not enroll in or terminate a medical or dental Plan mid-year (i.e., outside of Annual Enrollment) without a Significant Life Event.

Significant Life Events

A Significant Life Event gives an Eligible Individual the opportunity to make a change to enrollment (or to enroll themselves and/or Eligible Dependents). The enrollment change must be requested in writing by the Eligible Individual within 30 days following the event and must be consistent with the event. Significant Life Events may[3] include:

- Marital status change (e.g., marriage, divorce, legal separation or annulment of marriage)
- Establishment or termination of a Domestic Partnership (in Participating Groups offering Domestic Partner coverage)
- Change in the number of Eligible Dependents (e.g., an increase through marriage, birth, adoption or placement for adoption, or a decrease through death or Dependent gaining own health benefits)

[3] Note: The employer is responsible for designating, in its Cafeteria Plan, which Significant Life Events will permit enrollment changes. Employers are not required to permit changes for all possible Significant Life Events. Please note, however, that employers are required to permit enrollment changes following a HIPAA Special Enrollment Event.

- Change in Dependent status (e.g., becoming ineligible by reaching a limiting age)
- Change in employment status of an Eligible Individual or Eligible Dependent, that affects Plan eligibility (e.g., termination or commencement of employment, change in normally scheduled and compensated hours in a plan year affecting Plan eligibility, significant change in the employer contribution or eligibility for contribution, commencement of or return from an unpaid leave of absence, changing from an Employee to a Pre-65 Former Employee or a Post-65 Former Employee)
- Judgment, decree or order (e.g., a Qualified Medical Child Support Order (QMCSO))
- Change in residence or work site for an Eligible Individual or Eligible Dependent that affects network access to the current Plan
    - For example, if an Eligible Individual previously resided in an area in which only the PPO was available and then moved into an area where the EPO and PPO are available, the Eligible Individual may elect a new Plan. Conversely, if an Eligible Individual moved out of the EPO service area, and was therefore no longer eligible for the EPO, the Eligible Individual may elect a new Plan.
- Significant change in the cost of the Plan or a significant curtailment of medical coverage during a Plan Year for an Eligible Individual or Eligible Dependent
- Medicare or Medicaid entitlement (or loss of such entitlement)
- HIPAA Special Enrollment Event (see below)
- Enrollment in or termination of a Medicare Part D plan
- Change in employment or insurance status of Spouse
- Qualification change of a post-65 actively working Eligible Individual or Eligible Individual's Spouse to participate in the SEE Plan or GMAP
- Enrollment in a "qualified health plan" through a health insurance exchange in the individual market
- Any other Significant Life Events provided under the applicable regulations and provided for under the employer's Cafeteria Plan

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

The effective date of coverage for an election change due to a Significant Life Event is the first day of the month coincident with or following the Significant Life Event (except in the case of birth, adoption or placement for adoption of a Child, in which case coverage will be effective retroactive to the date of the event). The Eligible Individual must notify the Group Administrator of election changes no later than 30 days after the Significant Life Event (60 days if the change relates to loss or eligibility for Medicaid or a state child healthcare program – see below under *HIPAA Special Enrollment Events*) and are valid for the remainder of the current Plan Year.

The Participating Group must submit notice of the Significant Life Event and the request for an enrollment change or new enrollment, as applicable, to the Medical Trust through MAP within 60 days following the Significant Life Event. If a Significant Life Event occurs and notice of the event and a request for an enrollment change or new enrollment, as applicable, is submitted to the Medical Trust more than 60 days after the occurrence of the event, the Medical Trust will only consider the request if extenuating circumstances prevented the Group Administrator from notifying the Medical Trust of the Eligible Individual's election change. A description of such extenuating circumstances should be submitted to the Medical Trust together with the request for enrollment change or new enrollment, as applicable. The Medical Trust reserves the right to require the Group Administrator to provide additional information regarding the late request. The Medical Trust will make a determination, in its sole discretion, of whether the late request will be accepted.

Please note that, in all instances, the Eligible Individual must have informed their employer or Group Administrator of the Significant Life Event and the requested enrollment change or new enrollment within 30 days (or 60 days in the case of loss of eligibility for coverage under a Medicaid program or a state child healthcare program, or eligibility for assistance with coverage under the Plan through Medicaid or a state child healthcare program) following the Significant Life Event. In other words, the "extenuating circumstances" can only relate to the delay in the Group Administrator submitting the required information to the Medical Trust. The Medical Trust cannot consider extenuating circumstances

that led to the Eligible Individual failing to provide timely notice of the Significant Life Event and of their new election. In no event will the Medical Trust consider a request for an enrollment change or new enrollment submitted to the Medical Trust more than 180 days after the occurrence of the Significant Life Event.

If a Significant Life Event is expected to occur (e.g., an institution hires a new Employee, who will be an Eligible Individual after their start date), notice of the event and a request for the enrollment change or new enrollment, as applicable, may be submitted to the Medical Trust up to 90 days in advance. If the Significant Life Event does not occur, or does not occur on the date indicated in the notice submitted to the Medical Trust, the Participating Group must notify the Medical Trust as soon as possible. If the Participating Group fails to notify the Medical Trust in a timely manner, the termination of the requested coverage will be handled as described under "Retroactive Terminations" in the "Billing" section of the *Administrative Policy Manual*. For purposes of determining the effective date of coverage, any request submitted in advance will be deemed to have been submitted on the date the Significant Life Event actually occurs.

The employer is responsible for providing the Member a Summary of Benefits and Coverage (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 HIPAA Special Enrollment Events. HIPAA Special Enrollment Events include:

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

Eligible Individuals will generally have 30 days to elect to enroll in the Plan after a HIPAA Special Enrollment Event, but will have 60 days to elect to enroll in the Plan as a result of a HIPAA Special Enrollment Event that is a loss of eligibility for coverage under a Medicaid program or a state child healthcare program or eligibility for assistance with coverage under the Plan through Medicaid or a state child healthcare program. In the case of birth, adoption or placement for adoption of a Child, coverage will be effective retroactive to the date of the event. For all other HIPAA Special Enrollment Events, coverage will be effective as of the first day of the month following the month in which the coverage is requested in writing, or, if earlier, the date described under *Significant Life Events,* above, provided that the request is submitted to the Medical Trust within 60 days following the occurrence of the HIPAA Special Enrollment Event (or that the request was submitted to the Medical Trust more than 60 days but within 180 days following the occurrence of the HIPAA Special Enrollment Event and the Medical Trust accepted such late request).

The deadline to enroll in a group health plan sponsored by the Episcopal Church Medical Trust under the special enrollment provisions of the Health Insurance Portability and Accountability Act (HIPAA) has been temporarily extended as a result of the COVID-19 pandemic. Guidance was issued on April 28, 2020, directing plan sponsors to disregard the "Outbreak Period" when calculating these deadlines. The Outbreak Period is the period from March 1, 2020 until sixty (60) days after the announced end of the

COVID-19 National Emergency (or other date announced through future guidance).[4] If there are different Outbreak Periods in different parts of the country, additional guidance will be issued. Please see the example below, and, for complete details, please review the HIPAA Special Enrollment Rights Notice.

> *Example: For purposes of this example, assume the National Emergency ends on May 11, 2023, and accordingly the Outbreak Period ends on July 10, 2023 (i.e., the 60th day after the end of National Emergency). The Outbreak Period must be disregarded for purposes of determining the special enrollment period.*
>
> *If an Eligible Individual gives birth on March 31, 2023, the Eligible Individual has until August 9, 2023 (30 days after July 10, 2023, the end of the Outbreak Period), to enroll themselves and their newborn in the group health plan.*

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

Reporting Eligibility and Enrollment Changes

The Group Administrator must report all changes that affect Member benefit coverage and Plan elections to the Plan when they occur, but no later than 60 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 (including an enrolled Dependent)
- Retirement of an Employee
- Billing information change
- Disability of a Child
- Change of gender

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

The Group Administrator must then notify the Medical Trust through a MAP submission within 60 days after the event. Failure by the Group Administrator to perform this task could jeopardize the Eligible Individual's/Eligible Dependent's enrollment.

The following additional requirements also apply:

- Health Plan choice may be restricted if an Eligible Individual has Eligible Dependents living outside the service area of a particular Plan.
- If a local managed care plan is elected, additional enrollment forms from the local plan option may be required.
- Pre-65 Former Employees and Post-65 Former Employees who do not receive any contribution assistance from the Participating Group may submit enrollment forms directly to the Plan.
- Certain additional requirements may apply under the GMAP that should be taken into consideration in the processing of enrollment paperwork. Therefore, to ensure timely access to

[4] On January 30, 2023, the Biden Administration announced its intent to end the national emergency and public health emergency declarations on May 11, 2023.

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 through a MAP or MyCPG Accounts submission.

Required Information and Documentation

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

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

- Birth certificate
- Social Security card
- Individual Taxpayer Identification Number (ITIN) card
- Marriage certificate
- Divorce decree
- Domestic Partnership Affidavit
- Statement of Dissolution of Domestic Partnership
- Child Affidavit
- Placement or custody order from social services, a welfare agency or court of competent jurisdiction
- Adoption petition or decree
- Medicare card
- Driver's license

Annual Enrollment

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

At the beginning of Annual Enrollment, enrolled Eligible Individuals receive a personalized letter outlining the steps required to make Plan election(s) or other changes for the upcoming Plan Year. The letter contains information about the Annual Enrollment website, instructions, and the dates the Annual Enrollment website will be available. The Medical Trust provides Participating Groups with customizable templates to help them communicate with non-enrolled Eligible Individuals and Eligible Individuals who recently met the eligibility for the Plans.

The Annual Enrollment website, which is accessed through MyCPG Accounts, contains:

- Current demographic and coverage information
- Available medical and/or dental Plans
- Full contribution rates for each Plan and Coverage Tier[5]
- Options to add or remove Eligible Dependents
- The deadline for submitting Plan elections
- Links to Summaries of Benefits and Coverage (SBCs)
- Reference material and other helpful resources

Seminarian Annual Enrollment

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

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

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

Specific Guidelines and Effective Dates of Coverage for Eligible Individuals

Coverage is generally effective on the first day of the month coincident with or following the date an Eligible Individual first becomes eligible to participate in the Plan, provided that they are timely enrolled in the Plan. **Completed MAP submissions must be received by the Plan within 60 days of the event**. See the *Significant Life Events* and *HIPAA Special Enrollment Events* sections above for coverage effective date guidelines.

New Employees and Newly Eligible Employees

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

However, if an Employee's date of hire is the first calendar day of the month (e.g., Monday, June 1), coverage for the Employee will commence on the first day of that month (i.e., Monday, June 1), provided that the Plan receives a MAP submission within 60 days of that date.

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

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

Plan elections, once made, cannot be changed for the remainder of the current Plan Year, unless the Eligible Individual experiences a Significant Life 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.

Religious Orders

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

However, if a postulant, novice or member is received or accepted by the Religious Order on the first working day of the month and the first calendar day of the month (e.g., Monday, June 1), coverage for the postulant, novice or member will commence on the first day of that month (i.e., Monday, June 1), provided that the Plan receives a MAP submission within 60 days of that date.

If the postulant, novice or member does not enroll when initially eligible, then they must wait for an applicable Significant Life Event to occur or until the next Annual Enrollment period.

Seminarians

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

The Seminarian must make any elections no later than 30 days after the seminary's published registration deadline for that semester.

If the Seminarian does not elect to enroll during the 30-day period described above, then they must wait for an applicable Significant Life 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), or they must wait for an applicable Significant Life Event or Annual Enrollment.

Pre-65 Former Employees

A Pre-65 Former Employee from a Participating Group who terminates employment (e.g., due to retirement) but is not Medicare-eligible, may continue coverage through the Episcopal Health Plan (EHP), provided an enrollment form is received by the Plan no later than 30 days after the termination date.

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

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

Once the Pre-65 Former Employee becomes Medicare-eligible, they are no longer eligible for the EHP and must actively switch enrollment to the Group Medicare Advantage Plan (GMAP). If the enrolled Spouse/Domestic Partner is not Medicare-eligible at that time, then the enrolled Spouse/Domestic Partner may remain in the EHP until becoming Medicare-eligible, at which time they too are no longer eligible for the EHP and must actively switch enrollment to the GMAP. The enrolled Children who are not Disabled Children may remain in the EHP until the end of the year in which they reach age 30.[6]

If the Pre-65 Former Employee has a Spouse who becomes age 65, the post-65 Spouse of the Pre-65 Former Employee is allowed to enroll in the GMAP provided they are enrolled in Medicare Parts A and B. The Pre-65 Former Employee remains in the EHP. This reverse split is allowed because the enrolled Eligible Individual is a Pre-65 Former Employee.

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

Important Notes:

- An Employee who terminates their employment with a Participating Group who does not meet the eligibility requirements for a Pre-65 Former Employee will be offered an Extension of Benefits (as described in the *Extension of Benefits* section below).
- By definition, a Pre-65 Former Employee who returns to active employment with a Participating Group and becomes eligible for the EHP as an Employee is no longer a Pre-65 Former Employee.
- A Pre-65 Former Employee who returns to active employment with a Participating Group, becomes eligible for the EHP as an Employee, subsequently terminates the new active employment, and once again meets the definition of a Pre-65 Former Employee will be considered a Pre-65 Former Employee who has terminated from the most recent Participating Group.
    - For example, assume that Father Smith works for Diocese A and is enrolled in the EHP. Father Smith's employment with Diocese A ends. If he is eligible to continue to participate in the EHP as a Pre-65 Former Employee, he may choose from the plan options offered by Diocese A. If Father Smith is subsequently employed by Diocese B and becomes eligible to enroll in the EHP by virtue of this new employment, Father Smith will no longer be a Pre-65 Former Employee and will now only be able to choose from the plan options offered by Diocese B. If Father Smith's employment with Diocese B subsequently ends, and he continues to meet the requirements to qualify as a Pre-65 Former Employee, he can choose from the plan options offered by Diocese B. Father Smith will no longer be able to choose from the plan options offered by Diocese A, because he is now a Pre-65 Former Employee of Diocese B.

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

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

a) Waived EHP coverage as a qualified opt out and either (i) have subsequently experienced a Significant Life Event or (ii) enroll during Annual Enrollment, or
b) Join the EHP as part of a new Participating Group during their initial enrollment period, provided they were covered under that group's plan and included in the group census

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

Enrolled Children of such a Pre-65 Former Employee may also remain enrolled in the EHP for so long as they remain an Eligible Dependent.[7]

See the *HIPAA Special Enrollment Events* section for information on HIPAA Special Enrollment extensions due to COVID-19.

Post-65 Former Employees

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

If the Post-65 Former Employee does not enroll when initially eligible, then they must wait for an

[7] Fully insured plans may not cover children up to age 30; as the eligibility rules of the regional or local plans vary and will apply, please confirm your chosen plan's eligibility rules prior to enrollment.

applicable Significant Life Event to occur, or wait until the next Annual Enrollment period. See the *HIPAA Special Enrollment Events* section for information on HIPAA Special Enrollment extensions due to COVID-19.

Dependents

The effective date of coverage for an Eligible Dependent is the same date as the enrolled Eligible Individual's effective date. If the Eligible Individual does not elect to enroll all Eligible Dependents within 30 days of the Eligible Individual's initial eligibility or a subsequent Significant Life Event, then the Eligible Dependents may not enroll until the next Annual Enrollment period or until another Significant Life Event occurs. See the *HIPAA Special Enrollment Events* section for information on HIPAA Special Enrollment extensions due to COVID-19.

New Children

An Eligible Individual's newborn Child is covered under the Plan for the first 30 days immediately following birth only if the newborn Child is enrolled in the Plan. The Eligible Individual must elect to enroll the new Child for coverage within 30 days of the birth to ensure that claims incurred during the first 30 days are covered and for coverage to continue beyond the 30-day period. The coverage effective date will be the date of birth. If applicable, monthly contribution rates will change to reflect the new Coverage Tier on the first day of the month following the date of birth. If the Eligible Individual does not elect to enroll the Child within the 30-day period, the Child may not be enrolled in the Plan until the next Annual Enrollment period or the occurrence of a subsequent Significant Life Event. See the *HIPAA Special Enrollment Events* section for information on HIPAA Special Enrollment extensions due to COVID-19.

Important Notes:

- The birth of a newborn Child constitutes a Significant Life Event that allows an Eligible Individual or an Eligible Individual's Spouse/Domestic Partner who is not enrolled in the Plan to enroll as of the date of birth of the newborn Child.
- A newborn Child may not enroll in the Plan if the Eligible Individual is not enrolled in the Plan.
- 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 by, or is a legal ward or foster child of, the Eligible Individual or Eligible Individual'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, in each case, by an Eligible Individual or an Eligible Individual's Spouse/Domestic Partner. If the Eligible Individual does not elect to enroll the Child within 30 days of that date, then the Child may not enroll until the next Annual Enrollment period or until a subsequent Significant Life Event 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.

Spouses

An enrolled Eligible Individual may enroll their eligible Spouse for coverage under the Plan. If the Eligible Individual does not elect to enroll their eligible Spouse within 30 days after marriage, then the eligible Spouse may not enroll until the next Annual Enrollment period or until a Significant Life Event occurs.

Domestic Partners

An enrolled Eligible Individual may enroll their eligible Domestic Partner for coverage under the Plan 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 Eligible Individual does not elect to enroll their eligible Domestic Partner within 30 days after the establishment of a valid Domestic Partnership as

certified by a Domestic Partnership Affidavit, then the eligible Domestic Partner may not enroll until the next Annual Enrollment period or until a Significant Life Event occurs.

Non-Medicare-eligible Dependents

A Post-65 Former Employee and the Employee's Eligible Dependents may split enrollment between the EHP and the GMAP in cases where the Post-65 Former Employee is eligible for Medicare and the Dependents are not eligible for Medicare and are under age 65. Eligibility in the EHP will end once the Spouse/Domestic Partner becomes Medicare eligible and/or reaches age 65, at which time, the Spouse/Domestic Partner must actively switch enrollment to the GMAP. The enrolled Eligible Individual's enrolled Children who are not a Disabled Child may continue to participate in the EHP until the end of the year in which they reach age 30.[8]

Disabled Child

If the Dependent Child is a Disabled Child prior to their 25th birthday and continues to be a Disabled Child on the last day of the year in which the Child reaches age 30, the Child's eligibility will be extended for as long as the parent is an Eligible Individual enrolled in the EHP, SEE Plan, or GMAP, and the Child continues to meet the Plan's eligibility requirements in all aspects other than age.[8]

In order for the Plan to confirm the status of a Disabled Child, the Eligible Individual must contact Client Services, who will initiate the confirmation process with the Medical Board. The Medical Board will review satisfactory proof of disability and determine the status of the Disabled Child. In connection with this review, the Medical Board will contact the Eligible Individual with the request for documentation. The Plan may require, at any time, a physician's statement certifying the ongoing physical or mental disability.

Children of Surviving Spouses of Limited Means

The Children's Health Insurance Program (CHIP) is a federal program through which the government assists states in providing affordable health insurance to families with children. The program was designed 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 to cover their 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 Events* 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 enrolled Eligible Individual to provide coverage for any Children named in the QMCSO.

[8] Fully insured plans may not cover children up to age 30; as the eligibility rules of the regional or local plans vary and will apply, please confirm your chosen plan's eligibility rules prior to enrollment.

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 Eligible Individual is eligible
- The order specifies the Eligible Individual'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 an enrolled Eligible Individual 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 Eligible Individual provide health coverage for the Eligible Individual's Children and the Eligible Individual does not enroll the Children, the Participating Group will enroll the Children upon application from the Eligible Individual's separated or divorced Spouse, the state child support agency or Medicaid agency, provided it is required to do so by law. If the Eligible Individual is not enrolled in the Plan, the Participating Group will also enroll the Eligible Individual, because Children may not be enrolled in the Plan without the Eligible Individual also being enrolled. The Participating Group will withhold from the Eligible Individual's pay their share of the cost of such coverage.

If a QMCSO requires a separated or divorced ex-Spouse of an Eligible Individual to cover a Child, the Eligible Individual may change elections and drop coverage for the Child. However, the Eligible Individual may not drop coverage for the Child until the other plan's coverage begins.

Eligible Individuals 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.[9]

If the leave of absence is paid leave, or a legally mandated unpaid leave, the Member(s) can retain their active coverage. If the leave of absence is unpaid, and otherwise not legally mandated, then the Member(s) will be terminated and a letter will be sent offering an Extension of Benefits. Upon the enrolled Eligible Individual's return, the employer can reinstate the Member(s). Note that a change to employer premium cost sharing as a result of a leave of absence may constitute a Significant Life Event.

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

Termination of Individual Coverage

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

Coverage ends the earliest of:

- The last day of the month in which:
    - The enrolled Eligible Individual no longer meets the eligibility requirements (e.g., an Employee's employment ends, or a Seminarian graduates from seminary)
    - The Dependent no longer meets the eligibility requirements for any reasons other than death or turning age 30[10] (e.g., a Spouse is no longer eligible due to divorce from an enrolled Eligible Individual, or an enrolled Eligible Individual ceases to be a Dependent's legal guardian)
    - The Participating Group's participation with the Plan terminates
- The last day of the year in which an enrolled Dependent Child reaches age 30[10] (except if the Child is a Disabled Child in accordance with the terms of the Plan)
- The date on which monthly contributions are deemed delinquent, as determined by the Plan in its sole discretion
- The date the Plan ceases to exist

When a termination event occurs that relates to the enrolled Eligible Individual's or a Dependent's eligibility, the enrolled Eligible Individual must notify the Group Administrator as soon as possible. The Group Administrator should request supporting documentation regarding such event.

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

For Cause

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

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

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

Persons Barred from Enrolling

A person who would otherwise be an Eligible Individual or Eligible Dependent cannot enroll if such

[10] Fully insured plans may not cover children up to age 30; as the eligibility rules of the regional or local plans vary and will apply, please confirm your chosen plan's eligibility rules prior to enrollment.

individual has had their eligibility terminated for cause due to their actions.

Death and Surviving Dependents

Except as otherwise stated below, Surviving Dependents are not eligible to remain covered by the EHP, SEE Plan, or GMAP. Coverage will be terminated following the Eligible Individual's death, and Surviving Dependents who were covered under the EHP or SEE Plan on the date the Eligible Individual died will be offered coverage under the Extension of Benefits program. The coverage termination date will be the last day of the month in which the Eligible Individual's death occurred. The new coverage effective date for the Surviving Dependents who enroll in the Extension of Benefits program will be the first day of the month following the Eligible Individual's death date. Surviving Dependents who are or who subsequently become an Eligible Individual in their own right (e.g., through their own employment at an Episcopal institution) are no longer eligible for coverage under the Extension of Benefits program.

Remarriage / Subsequent Domestic Partnership

If a Surviving Spouse remarries (or enters into a Domestic Partnership), any new Dependents acquired after the Eligible Individual's death are ineligible for coverage under the Plan, unless the Dependent is a Child of the Eligible Individual born or adopted up to 12 months after the Eligible Individual's death. The same rules apply to Surviving Domestic Partners who engage in a new Domestic Partnership (or who subsequently marry).

Employee/Seminarian

When an Employee or Seminarian enrolled in the EHP or SEE Plan dies, and they would not have met the definition of a Pre-65 Former Employee or a Post-65 Former Employee if their status as an Employee or Seminarian had terminated immediately prior to the time of their death, their Surviving Dependents who are also enrolled in the EHP or SEE Plan at that time are offered an Extension of Benefits. The coverage termination date will be the last day of the month in which the Eligible Individual'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 Eligible Individual's date of death.

When an Employee or Seminarian enrolled in the EHP or SEE Plan dies, and they would have met the definition of a Post-65 Former Employee or a Pre-65 Former Employee, in each case, if their status as an Employee or Seminarian had terminated immediately prior to the time of their death, their Surviving Dependents who are also enrolled in the EHP or SEE Plan at that time can remain covered in the EHP until becoming Medicare-eligible, at which time the individual will no longer be eligible for the EHP and must actively enroll in the GMAP, if eligible. Enrolled Children may remain in the EHP until the last day of the year in which they turn 30[11] or later if the Child is a Disabled Child in accordance with the terms of the Plan. If the Surviving Dependents leave the EHP, they may not return to the Plan, unless they are eligible to enroll in and elect to enroll in the GMAP.

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

When a Pre-65 Former Employee, Post-65 Former Employee, or a Cleric receiving benefits under The Church Pension Fund Clergy Long-Term Disability Plan enrolled in the EHP or GMAP dies, Surviving Spouses and Surviving Domestic Partners enrolled in the EHP can remain covered in the EHP until becoming Medicare-eligible, at which time the individual will no longer be eligible for the EHP and must actively enroll in the GMAP, if eligible. Surviving Spouses and Surviving Domestic Partners enrolled in the GMAP at the time of the enrolled Eligible Individual's death can remain covered in the GMAP.

[11] Fully insured plans may not cover children up to age 30; as the eligibility rules of the regional or local plans vary and will apply, please confirm your chosen plan's eligibility rules prior to enrollment.

Children enrolled in the EHP may remain in the EHP until the last day of the year in which they turn 30[12] or later if the Child is a Disabled Child in accordance with the terms of the Plan. If the Surviving Dependents leave the EHP, they may not return to the Plan, unless they are eligible to enroll in and elect to enroll in the GMAP.

Dependents

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

Divorce or Dissolution of a Domestic Partnership

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

Employees and Seminarians

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

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

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

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

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

Extension of Benefits Program for the EHP

The Plan's Extension of Benefits program is similar, but not identical, to the healthcare continuation coverage provided under federal law (known as "COBRA") for non-church plans. Because the Plan is a church plan as described under section 3(33) of ERISA, the Plan is exempt from COBRA requirements.[13] Nonetheless, enrolled Eligible Individuals and/or their enrolled Eligible 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 full cost of their coverage.

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

- Employees who no longer meet the Plan's eligibility requirements for the EHP or SEE Plan

[12] Fully insured plans may not cover children up to age 30; as the eligibility rules of the regional or local plans vary and will apply, please confirm your chosen plan's eligibility rules prior to enrollment.

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

(e.g., as the result of a termination of employment or reduction of scheduled hours) are offered an extension of 36 months[14] starting on the first day of the month following the termination event.
    - Note that, because the SEE Plan requires that the Eligible Individual be actively working for an Eligible Small Employer, Eligible Individuals enrolled in the SEE Plan who terminate employment will be offered continuation of coverage under the EHP in the Extension of Benefits program.
- Spouses and Domestic Partners whose coverage is terminated as a result of the Employee no longer meeting the Plan's eligibility requirements for the EHP or SEE Plan (e.g., as the result of a termination of employment or reduction of scheduled hours), 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 (or dissolves their Domestic Partnership) while on an Extension of Benefits, the divorced Spouse (or former Domestic Partner) of the former Employee may choose to remain on their own extension for the remaining period of the current extension.
    - Note that, with respect to former Domestic Partners, an Extension of Benefits will only be available if the Participating Group offers coverage to Domestic Partners generally.
- Dependent Children whose coverage is terminated (including as a result of reaching age 30) are offered an extension of up to 36 months starting on the first day of the month following the termination event.
- Seminarians who cease to be a Seminarian are offered an extension of 36 months starting on the first day of the month following graduation or other separation event.
- Employees whose Medical Trust coverage terminates under the terms of The Church Pension Fund Clergy Long-Term Disability Plan are offered an extension of 36 months starting on the first day of the month following the termination under The Church Pension Fund Clergy Long-Term Disability Plan.

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

The Plan will make an assessment of whether an individual to be offered an Extension of Benefits is otherwise an Eligible Individual (e.g., a Pre-65 Former Employee). If the Plan determines that they are an Eligible Individual, the Plan will make an offer of coverage consistent with that eligibility.

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

The Plan notifies individuals regarding their eligibility for an Extension of Benefits within five business days of receiving a termination notice from the Group Administrator. Such notification from the Plan may be by physical mail or by electronic means. 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.

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

Coverage in effect at the time of the applicable event 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 applicable event so that there is no coverage gap between the termination date and

[14] The duration of any continuation of coverage under fully insured plans offered by the Medical Trust may vary; please confirm your chosen plan's eligibility rules prior to enrollment.

enrollment in the Extension of Benefits.

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

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

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

- The date that required monthly contributions to the Plan are deemed delinquent, as determined by the Plan in its sole discretion
- The date the Member becomes a Post-65 Former Employee, is enrolled in Medicare Parts A and B and is not an Eligible Individual for the EHP or SEE Plan
- The first of the month following the date the Member is hired by another Participating Group, becomes a Seminarian, or becomes a Member of a Religious Order, and, in each case, is an Eligible Individual for the EHP or SEE Plan
- The last day of the last month of the Extension of Benefits period
- The last day of the month after the individual submits a written notice to terminate coverage for medical, dental or both (30-day notice is 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.)
    - **Important Note:** The merger of a Participating Group with or into, or the acquisition of a Participating Group by, another Participating Group, or another transaction of similar effect, shall not result in the cessation of coverage under the Extension of Benefits program, so long as the surviving Participating Group continues to participate in the Plan.
- The last day of the month in which the death of the Member occurred (surviving Dependents may continue coverage under the remaining period of the Extension of Benefits)
- The date the Member's eligibility has been terminated for cause due to such individual's actions
- The date the Member's coverage by the Plan would be illegal under applicable law
- The date the Plan ceases to exist

Important Notes

Required Monthly Contributions

The Plan does not prorate 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 Eligible Individuals who are Members from covering each other as a Dependent in the same Plan (EHP, SEE Plan or GMAP). Therefore, an Eligible Individual who participates in the Plan based on their own eligibility may not be a Dependent in the same Plan.

A Child of two Members who both work for The Episcopal Church in Participating Groups and are enrolled Eligible Individuals may not be covered as an enrolled Eligible Dependent by virtue of their relationship with both enrolled Eligible Individuals in the same Plan (EHP, SEE Plan, or GMAP) at the same time.

If two Members who are Spouses (or Domestic Partners, if their Participating Groups offer Domestic Partner benefits) both work for The Episcopal Church in Participating Groups, one of which offers dental benefits and one of which does not, an individual may enroll as an Eligible Individual in a medical Plan and as an Eligible Dependent in a dental Plan, or vice versa.

Plan Sponsor

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

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

Fully Insured Plans

Under certain limited circumstances, the Medical Trust offers fully insured plans to certain Participating Groups or to former employees of certain Participating Groups. These fully insured plans are not sponsored or administered by the Medical Trust; instead, an insurance company not affiliated with the Medical Trust issues and administers these plans. Accordingly, the terms of these plans, including the eligibility criteria applicable to employees, former employees and their dependents, as well as the availability and duration of any continuation coverage following a loss of eligibility, may vary from the terms of the Medical Trust's self-funded Plans. In addition, separate eligibility rules apply for the subsidy under The Church Pension Fund Clergy Post-Retirement Medical Assistance Plan. Additional details can be found in *A Guide to Clergy Benefits* at *cpg.org/clergyguide.*

Chapter 3: Coverage

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

Acupuncture

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

Allergy Services

Allergy testing and treatment.

Ambulance Service

Medically Necessary Ambulance Services are a Covered Health Service when:

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

Additionally, one or more of the following criteria must be met:

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

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

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

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

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

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

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

- a Physician's office or clinic, or
- a morgue or funeral home.

Important Notes on Air Ambulance Benefits

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

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

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

Applied Behavioral Analysis (ABA)

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

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

Assistant Surgery

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

Bariatric Surgery (for Clinically Severe Obesity)

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

Breast Cancer Care

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

Breast Reconstructive Surgery

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

Chiropractic Care

Covered Health Services are provided for the conservative management of neuromusculoskeletal conditions through manipulation and ancillary physiological treatment rendered to specific joints to restore motion, reduce pain, and improve function. Limited to 20 visits per Plan Year (for Members enrolled in a Plan administered by Anthem BCBS) or 20 days per Plan Year (for Members enrolled in a Plan administered by Cigna). Visit maximum is combined for Network Providers and Out-of-Network Providers.

Clinical Trials

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

Benefits are limited to the following trials:

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

2. Studies or investigations done as part of an investigational new drug application reviewed by the Food and Drug Administration

3. Studies or investigations done for drug trials that are exempt from the investigational new drug application

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

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

All other requests for clinical trials services, including requests that are not part of approved clinical trials, will be reviewed according to the Claims Administrator's Clinical Coverage Guidelines, related policies and procedures.

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

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

Consultation Services

Covered when the special skill and knowledge of a consulting Physician is required for the diagnosis or treatment of an illness or Injury. Second surgical opinion consultations are covered.
Staff consultations required by Hospital rules are excluded. Referrals (the transfer of a patient from one Physician to another for treatment) are not consultations under this Plan.

Dental Services

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

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

Other Dental Services

Your Plan also includes Benefits for (1) Hospital Charges and anesthetics provided for dental care if the Member meets Medical Necessity, as determined by the Claims Administrator, and (2) certain Medically Necessary non-surgical treatment of temporomandibular joint (TMJ) dysfunction. See *Oral Surgery* below for information on coverage of surgical treatment of TMJ dysfunction.

Diabetes

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

Dialysis Outpatient Treatment

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

Durable Medical Equipment, Medical Devices and Supplies

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

Examples of Durable Medical Equipment include:

- Crutches
- Dialysis machines
- Braces that stabilize an injured body part and braces to treat curvature of the spine
- Diabetic and ostomy supplies
- Mechanical equipment necessary for the treatment of chronic or acute respiratory failure
- Oxygen and the purchase or rental of equipment for its use
- Standard wheelchair, walker, or cane

- Standard Hospital bed

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

Coverage for Durable Medical Equipment is limited to the lowest-cost alternative as determined by Anthem's Medical Management Program (for Members enrolled in a Plan administered by Anthem BCBS) or the utilization review Physician (for Members enrolled in a Plan administered by Cigna).

Contact the Claims Administrator for more information about covered medical services and supplies.

Please see *Supplies or Equipment (Including Durable Medical Equipment) Not Medically Necessary* in *Chapter 4: Exclusions and Limitations* for medical services and supplies that are NOT covered.

Emergency Services

LIFE-THREATENING MEDICAL EMERGENCY OR SERIOUS ACCIDENTAL INJURY

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

Coverage is provided for Hospital emergency room or emergency Freestanding Ambulatory Facility care, including a medical or mental health screening examination that is within the capability of the emergency department of a Hospital, including ancillary services routinely available to the emergency department to evaluate an Emergency Medical Condition, and within the capabilities of the staff and Facilities available at the Hospital, such further medical or mental health examination and treatment as are required to Stabilize the patient. Emergency Service care does not require any Prior Authorization from the Plan. Services provided for conditions that do not meet the definition of an Emergency Medical Condition will not be covered.

Medically Necessary services will be covered whether you get care from a Network or Out-of-Network Provider. Emergency health services you get from an Out-of-Network Provider will be covered as a Network service and will not require Precertification/Prior-Authorization. The Out-of-Network Provider can only charge you any applicable Deductible, Coinsurance, and/or Copayment and cannot bill you for the difference between the Maximum Allowed Amount / Maximum Reimbursable Charge and their billed charges until your condition is stable as described under *Surprise Billing Claims* in *Chapter 10: Other Important Plan Provisions*. Your cost shares will be based on the Maximum Allowed Amount / Maximum Reimbursable Charge and will be applied to your Network Deductible and Network Out-of-Pocket Limit.

Treatment you get after your condition has Stabilized are not emergency health services. If you receive such services from an Out-of-Network Provider, please refer to the information under *Out-Of-Network Services* in *Chapter 16* of this Plan Document Handbook for more details on how this will impact your benefits.

For the definitions of Emergency Medical Condition and Stabilize, please refer to *Chapter 13: Glossary*.

In an emergency, call 911 for an ambulance or go directly to the nearest emergency room. You pay only your cost share for a covered visit to an emergency room. If you make an emergency visit to your Physician's office, you pay the same cost share as for an office visit.

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

These emergency services are covered:

- Treatment in a Hospital emergency room or other emergency care Facility for a condition that can be classified as an Emergency Medical Condition or Injuries received in an accident

- Outpatient professional services, X-ray and/or lab services performed at the emergency room and billed by the Facility as part of the emergency room visit
- Advanced radiological imaging (MRIs, MRAs, CAT Scans, PET Scans, etc.) billed by the Facility as part of the emergency room visit
- Ambulance Services

If time permits, speak to your Physician to direct you to the best place for treatment. Be sure to show your ID Card at the emergency room, and if you are admitted, notify the Claims Administrator as soon as you are Stabilized.

Additionally, Anthem BCBS provides Benefits in certain emergency situations outside of the United States. For more information, see *Chapter 3A*, which describes how these Benefits are provided through Anthem BCBS.

Erectile Dysfunction

The Plan covers medical diagnostic services to determine the cause of erectile dysfunction. Penile implants are covered for an established medical condition that clearly is the cause of erectile dysfunction, such as postoperative prostatectomy and diabetes. Penile implants are not covered as treatment of psychogenic erectile dysfunction. The Claims Administrator may also impose additional requirements prior to coverage of penile implants, such as a minimum duration of erectile dysfunction and/or having experienced failure of or having a contraindication to less invasive treatment methods, and may also impose additional clinical criteria or exclusions on coverage. Please contact the Claims Administrator for more information.

Foot Care

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

Gender Affirmation Surgery and Services

This Plan provides Benefits for many of the Charges for gender-affirming surgery and services for Members diagnosed with gender dysphoria. Gender-affirming surgery and services must be approved by the Claims Administrator for the type of procedure requested and requires Precertification/Prior-Authorization. Charges for services that are not authorized for the gender-affirming surgery and services requested will not be considered Covered Health Services. Some conditions apply, and all services must be authorized by the Claims Administrator as outlined in *Chapter 17*.

General Anesthesia Services

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

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

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

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

Genetic Testing

Genetic testing is covered when Medically Necessary and not Experimental/Investigative/Unproven.

Gene Therapy Services

Gene Therapy Services is covered when Medically Necessary and not Experimental/Investigative/Unproven. For coverage information, see *Chapter 5: Pharmacy Benefits*.

Habilitative Services

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

Hearing Aids

Limited to $3,000 every three years. Limit applies to hearing aid device only. Replacement parts, batteries, and repairs are not covered. Audiologist office visits are billed separately and not applied to the $3,000 maximum.

Home Health Care Services

Home Health Care provides a program for the Member's care and treatment in the home. The program consists of required intermittent skilled care, which may include observation, evaluation, teaching, and nursing services consistent with the diagnosis, established and approved in writing by the Member's attending Physician. Services may be performed by either Network Providers or Out-of-Network Providers. Limited to 210 visits per Plan Year (for Members enrolled in a Plan administered by Anthem BCBS) or 210 days per Plan Year (for Members enrolled in a Plan administered by Cigna). Visit maximum is combined for Network and Out-of-Network services. This limit does not apply to visits related to Mental Health and Substance Use Disorder Treatment or home infusion services. The Physician's statement and recommended program may require Precertification/Prior-Authorization. Please refer to *Chapter 17* for details.

Covered Health Services:

- Visits by an RN or LPN. Benefits cannot be provided for services if the nurse is a Member's family member.
- Visits by a qualified physiotherapist or speech therapist and by an inhalation therapist certified by the National Board of Respiratory Therapy.
- Visits to render services and/or supplies of a licensed Medical Social Services Worker when Medically Necessary to enable the Member to understand the emotional, social, and environmental factors resulting from or affecting the Member's illness.
- Visits by a home health nursing aide when rendered under the direct supervision of an RN.
- Nutritional guidance when Medically Necessary.
- Oxygen and its administration.
- Dialysis treatment
- Home infusion therapy (see *Home Infusion Services* below)
- Purchase or rental of dialysis equipment (see *Durable Medical Equipment* above)
- Private duty nursing

Covered Health Services for Home Health Care do not include:

- Food, housing, homemaker services, sitters, or home-delivered meals
- Home Health Care services which are not Medically Necessary or of a non-skilled level of care
- Services and/or supplies which are not included in the Home Health Care plan
- Services of a person who ordinarily resides in the Member's home or is a member of the family of either the Member or Member's Spouse
- Any services for any period during which the Member is not under the continuing care of a Physician

- Convalescent or Custodial Care where the Member has spent a period of time for recovery of an illness or surgery and where skilled care is not required or the services being rendered are only for aid in daily living, i.e., for the convenience of the Member
- Maintenance therapy
- Acupuncture Services
- Chiropractic Services

Home Infusion Services

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

Hospice Care Services

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

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

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

Your Physician must agree to care by the Hospice and must be consulted in the development of the care plan. The Hospice must keep a written care plan on file and give it to the Claims Administrator upon request.

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

Hospital Services

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

Inpatient Services

- Inpatient room Charges. Covered Health Services include Semiprivate Room and board, general nursing care and intensive or cardiac care. Stays in private rooms are generally excluded, except in Hospitals that only have private rooms. See the Exclusion for *Private Rooms* in *Chapter 4: Exclusions and Limitations* for more information.

Service and Supplies

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

Remember to call the Medical Management Program at 844-812-9207 (for Members enrolled in a Plan administered by Anthem BCBS) or the Review Organization at 800-244-6224 (for Members enrolled in a Plan administered by Cigna), in each case, at least two weeks prior to any planned surgery or Hospital admission. For an emergency admission, call the Medical Management Program / the Review Organization as soon as you are Stabilized. Otherwise, your Benefits may be denied for each Hospital admission or surgery that is not granted Precertification/Prior-Authorization.

The Medical Necessity and length of any Hospital stay are subject to the Medical Management Program's / the Review Organization's guidelines. If the Medical Management Program / the Review Organization determines that the admission or surgery is not Medically Necessary, no Benefits will be paid. See *Chapter 17* of this Plan Document Handbook for additional information.

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

If you follow the notification and Precertification/Prior-Authorization 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 Precertification/Prior-Authorization requirements and subsequently the Medical Management Program / the Review Organization retrospectively reviews the treatment and/or services you received and determines they were not Medically Necessary, Benefits may be denied, and you may be responsible for all non-covered expenses.

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

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

Human Organ and Tissue Transplant Services

Anthem BCBS and Cigna both cover Human Organ and Tissue Transplant Services but manage these Benefits differently. For more information, see *Chapter 3A*, which describes how these Benefits are provided through the applicable Claims Administrator.

Hypnosis

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

Maternity Care

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

Routine newborn nursery care is part of the mother's maternity Benefits. Benefits are provided for well-baby pediatrician visits performed in the Hospital. Should the newborn require other than routine nursery care, the baby will be admitted to the Hospital in his or her own name. (Please see *Chapter 2: Eligibility and Enrollment*, for information on how to add your newborn to your coverage under the Plan.)

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

In addition, both Anthem BCBS and Cigna offer supplemental programs to assist expectant mothers. For more information, see *Chapter 3A*, which describes the programs provided through the applicable Claims Administrator.

Mental Health and Substance Use Disorder Treatment

Anthem BCBS and Cigna both cover Mental Health and Substance Use Disorder Treatment but manage these Benefits differently. For more information, see *Chapter 3A*, which describes how these Benefits are provided through the applicable Claims Administrator. In addition, the Benefits listed below are provided to Members in Plans administered by both Claims Administrators.

Colleague Group Benefits

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

Nutritional Counseling

Nutritional counseling is covered, but is limited to six (6) visits per Plan Year (limit applies to office/Outpatient setting only). Visit maximum is combined for Network Providers and Out-of-Network Providers.
This Benefit is unlimited if related to a diagnosis of diabetes.

Online Visits

Anthem BCBS and Cigna both cover certain Online Visits but manage these Benefits differently. For more information, see *Chapter 3A*, which describes how these Benefits are provided through the applicable Claims Administrator.

Oral Surgery

Covered Health Services include the following:

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

Covered Health Services do not include fixed or removable appliances that involve movement or repositioning of the teeth, or operative restoration of teeth (fillings), or prosthetics (crowns, bridges, dentures).

Orthognathic Surgery

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

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

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

Other Covered Health Services

Your Plan provides the following services when Medically Necessary:

- Chemotherapy and radioisotope, radiation, and nuclear medicine therapy
- Diagnostic X-ray and laboratory procedures
- Dressings, splints, and casts when provided by a Physician
- Lymphedema treatment
- Obstructive sleep apnea diagnosis and treatment
- Oxygen, blood and components, and administration
- Naturopathy services received in a Provider's office
- Pacemakers and electrodes
- Use of operating and treatment rooms and equipment

Out-of-Network Freestanding Ambulatory Facility

Any services rendered or supplies provided while you are a patient or receiving services at or from an Out-of-Network Freestanding Ambulatory Facility will be payable at the Maximum Allowed Amount / Maximum Reimbursable Charge and are subject to any required Copayments, Coinsurance or Deductibles.

Outpatient Laboratory Services, CT Scans, and MRIs

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

Outpatient Hospital Services

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

Outpatient Short-Term Rehabilitation

- Physical Therapy, Speech and Hearing Therapy, Cognitive Therapy and Occupational Therapy are covered at 60 visits per Plan Year (for Members enrolled in a Plan administered by Anthem BCBS) or 60 days per Plan Year (for Members enrolled in a Plan administered by Cigna), in each case, per type of therapy, and not combined with any other therapy. Includes Speech, Physical and Occupational therapy for Autism Spectrum Disorders and Developmental Delays.
- Pulmonary rehabilitation/respiratory therapy limited to 18 visits per Plan Year (for Members enrolled in a Plan administered by Anthem BCBS) or 18 days per Plan Year (for Members enrolled in a Plan administered by Cigna), in each case, not combined with any other therapy.
- Cardiac rehabilitation limited to 36 visits per Plan Year (for Members enrolled in a Plan administered by Anthem BCBS) or 36 days per Plan Year (for Members enrolled in a Plan administered by Cigna), in each case, not combined with any other therapy.
- Vision therapy, limited to 16 visits per Plan Year, not combined with any other therapy.

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

Physician Services

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

Prescription Drugs

For coverage information, see *Chapter 5: Pharmacy Benefits*.

Preventive Services

Preventive Services include screenings and other services for adults and Children. All recommended preventive services will be covered as required by the Affordable Care Act (ACA). This means many Preventive Care services are covered with no Deductible, Copayments, or Coinsurance when you use a Network Provider.

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

Covered Health Services fall under the following broad groups:

- Services with an “A” or “B” rating from the United States Preventive Services Task Force. Examples of these services are screenings for:
  - Breast cancer
  - Cervical cancer
  - Colorectal cancer
  - High blood pressure

    - Type 2 Diabetes Mellitus
    - Cholesterol
    - Child and adult obesity
- Immunizations for Children, adolescents, and adults recommended by the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention
- Preventive Care and screenings for infants, Children, and adolescents as provided for in the comprehensive guidelines supported by the Health Resources and Services Administration
- Preventive Care and screening for women as listed in the guidelines supported by the Health Resources and Services Administration, including the following:
    - Women's contraceptives (including contraceptive devices such as diaphragms, intrauterine devices (IUDs), and implants), sterilization procedures, and counseling
    - Breastfeeding support, supplies (benefits for breast pumps limited to one pump per pregnancy), and counseling
    - Gestational diabetes screening
- Preventive Care services for smoking cessation and tobacco cessation for Members age 18 and older as recommended by the United States Preventive Services Task Force, including counseling

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

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

Prosthetic Appliances

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

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

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

Wigs and artificial hairpieces are covered, but only after chemotherapy or radiation therapy (limited to $700 per Plan Year).

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

Reconstructive Surgery

Anthem BCBS and Cigna both cover Reconstructive Surgery but manage these Benefits differently. For more information, see *Chapter 3A*, which describes how these Benefits are provided through the applicable Claims Administrator.

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

Reproductive Health Services

Contraceptive Benefits

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

Sterilization Services

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

Termination of Pregnancy

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

Infertility Coverage

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

There is a lifetime Benefit Maximum of $50,000 combined for services covered under your health Plan and your prescription drug Plan. Your cost shares and Deductibles do not count against your Benefit Maximums.

Infertility Prescription Drugs

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

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

Retail Health Clinic

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

Skilled Nursing Facility Care/Rehabilitation Hospital

Benefits are provided as outlined in the Summary of Benefits and Coverage. This care must be ordered by the attending Physician. All Skilled Nursing Facility and rehabilitation Hospital admissions require Precertification/Prior-Authorization. Claims will be reviewed to verify that services consist of Skilled Convalescent Care that is medically consistent with the diagnosis.

Skilled Convalescent Care during a period of recovery is characterized by:

- A favorable prognosis
- A reasonably predictable recovery time
- Services and/or Facilities less intense than those of the acute general Hospital, but greater than those normally available at the Member’s residence.

Covered Health Services include:

- Semiprivate Room or wardroom Charges, including general nursing service, meals, and special diets. If a Member stays in a private room, this Plan pays the Semiprivate Room rate toward the Charge for the private room
- Use of special care rooms
- Pathology and radiology
- Physical or speech therapy
- Oxygen and other gas therapy
- Drugs and solutions used while a patient
- Gauze, cotton, fabrics, solutions, plaster, and other materials used in dressings, bandages, and casts.

This Benefit is available only if the patient requires a Physician's continuous care and 24 hour-a-day nursing care

Benefits will not be provided when:

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

Smoking Cessation

Smoking cessation services are covered, including counseling.

Surgical Care

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

Urgent Care

Urgent Care services are covered.

Sometimes, you have a need for medical care that is not an emergency (e.g., bronchitis, high fever, sprained ankle), but you can't wait for a regular appointment. If you need Urgent Care, try to contact your Physician or your Physician's backup.

Members enrolled in a Plan administered by Anthem BCBS can also call the Anthem 24/7 NurseLine® at 877-TALK-2-RN (877-825-5276) for advice, 24 hours a day, seven days a week.

Members enrolled in a Plan administered by Cigna can also call Cigna at the number on their ID Card for advice, 24 hours a day, seven days a week.

Chapter 3A: Coverage – Claims-Administrator-Specific Modifications

Anthem BCBS

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

Emergency Services

Blue Cross Blue Shield Global Core

If you have an emergency outside of the United States and need to visit a Hospital that participates in the Blue Cross Blue Shield Global Core, show your ID Card and call the Blue Cross Blue Shield Global Core Service Center at +1 (800) 810-2583, or call collect at +1 (804) 673-1177. The Hospital will submit its bill through the Blue Cross Blue Shield Global Core. If the Hospital does not participate, you will need to file a claim.

Human Organ and Tissue Transplant Services

Notification

To maximize your benefits, you must call the Claims Administrator's transplant department to discuss benefit coverage when it is determined a transplant may be needed. You must do this before you have an evaluation and/or work-up for a transplant. Your evaluation and work-up services must be provided by a Network Transplant Provider that the Claims Administrator has chosen as a Center of Medical Excellence for Transplant Provider and/or a Provider designated as a Network Transplant Provider by the Blue Cross and Blue Shield Association. Even if a Hospital is a Network Provider for other services, it may not be a Network Transplant Provider for certain transplant services. Please call Anthem to find out which Hospitals are Network Transplant Providers.

Centers of Medical Excellence (CME) Transplant Providers

Blue Distinction Center Facility: Blue Distinction Facilities have met or exceeded national quality standards for care delivery.

Centers of Medical Excellence (CME): Centers of Medical Excellence Facilities have met or exceeded quality standards for care delivery.

Network Transplant Provider: Providers who have achieved designation as a Center of Medical Excellence for Transplant and/or Blue Distinction Centers + or Blue Distinction Centers for Transplant. The Provider has entered into a Transplant Provider Agreement to give Covered Transplant Procedures to you and take care of certain administrative duties for the Transplant Network. A Provider may be a Network Transplant Provider for certain Covered Transplant Procedures or all Covered Transplant Procedures.

Out-of-Network (PAR) Transplant Provider: Providers participating in the Plan's networks but not designated as a Centers of Medical Excellence for Transplant or Blue Distinction Center + or Blue Distinction Center for Transplant.

Please note that because transplantation is a highly specialized area, not all BlueCard PPO Network Hospitals are Network Transplant Providers.

If you receive your transplant services at a Network Transplant Provider Facility, the Plan will pay 100% of eligible costs (after your Deductible, if you are enrolled in a Consumer-Directed Health Plan (CDHP)). Your usual cost shares will apply if you receive your services at any other BlueCard PPO Network Hospital. Transplant services received Out-of-Network are not covered.

Contact the Member Services telephone number on your ID Card and ask for the transplant coordinator. The Claims Administrator will then assist you in maximizing your benefits by providing coverage information including details regarding what is covered and whether any medical policies, network requirements or Plan Document Handbook exclusions are applicable. Failure to obtain this information prior to receiving services could result in increased financial responsibility for the Member.

Covered Transplant Benefit Period

At a Network Transplant Provider Facility, the Transplant Benefit Period starts one day before a covered Solid Organ Transplant Procedure and one day before high dose chemotherapy or preparative regimen for a covered Bone Marrow/Stem Cell Transplant Procedure and lasts for the applicable case rate/global time period. The number of days will vary depending on the type of transplant received and the Network Transplant Provider agreement. Call the Claims Administrator for specific Network Transplant Provider details for services received at or coordinated by a Network Transplant Provider Facility.

At an Out-of-Network (PAR) Transplant Provider Facility, the Transplant Benefit Period starts the day of a Covered Transplant Procedure and lasts until the date of discharge.

Prior Approval and Precertification

You must contact Anthem's Medical Management Program at 844-812-9207 to discuss benefit coverage when it is determined a transplant may be needed. You must do this before you have an evaluation and/or work-up for a transplant. Anthem will assist you in maximizing your benefits by providing coverage information, including details regarding what is covered and whether any clinical coverage guidelines, medical policies, Network Transplant Provider requirements, or exclusions are applicable. Contact the Member Services telephone number on the back of your ID Card and ask for the transplant coordinator. Even if the Claims Administrator issues a prior approval for the Covered Transplant Procedure, you or your Provider must call the Claims Administrator's Transplant Department for Precertification prior to the transplant whether this is performed in an Inpatient or outpatient setting.

Please note that there are instances where your Provider requests approval for Human Leukocyte Antigen (HLA) testing, donor searches and/or a collection and storage of stem cells prior to the final determination as to what transplant procedure will be requested. Under these circumstances, the HLA testing and donor search charges are covered as routine diagnostic testing. The collection and storage request will be reviewed for Medical Necessity and may be approved. However, such an approval for HLA testing, donor search and/or a collection and storage is NOT an approval for the subsequent requested transplant. A separate Medical Necessity determination will be made for the transplant procedure.

Transportation and Lodging

The Plan will provide assistance with reasonable and necessary travel expenses as determined by the Claims Administrator when you obtain prior approval and are required to travel more than 100 miles from your residence to reach the Facility where your Covered Transplant Procedure will be performed. The Plan's assistance with travel expenses includes transportation to and from the Facility, and lodging for the transplant recipient Member and one companion for an adult Member, or two companions for a child patient. The Member must submit itemized receipts for transportation and lodging expenses in a form satisfactory to the Claims Administrator when claims are filed.

Contact the Claims Administrator for detailed information. The Claims Administrator will follow Internal Revenue Service (IRS) guidelines in determining what expenses can be paid.

Travel and lodging expenses are limited to $10,000 per lifetime. Certain expenses are not covered, such as gratuities, valet parking, furnishings and entertainment. Additionally, coverage for travel and lodging expenses is subject to applicable IRS limits. Contact Anthem's Medical Management Program at 844-812-9207 for further information on eligible travel and lodging expenses.

When the required Medical Management Program procedures 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 Network Transplant Provider Facility, the Plan will not cover travel and lodging expenses.

If you choose not to have a transplant performed at a Network Transplant Provider Facility, you must still follow the Medical Management Program prior notification and Precertification 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 Precertification procedures required by the Plan does not apply toward your Out-of-Pocket Limit.

Maternity Care

Building Healthy Families

This digital program can help support your family from preconception through the stages of pregnancy, childbirth, and early childhood (to age 5 and beyond). It is available 24/7 through Anthem BCBS's Sydney Health Engage mobile app and at *anthem.com*, and features an extensive content library covering topics to support diverse families, including single parents and same-sex or multicultural couples. In addition, the app features many tools including fertility, diaper change and feeding trackers, due date calculators, and blood pressure monitoring. Visit the Sydney Health Engage mobile app or *anthem.com* to enroll today.

Mental Health and Substance Use Disorder Treatment

Please refer to the Summary of Benefits and Coverage for any applicable Deductible, Coinsurance, and Copayment information. Coverage for the diagnosis and treatment of Mental Healthcare and substance use disorder on an Inpatient or outpatient basis will not be subject to Deductibles, Coinsurance, or Copayment provisions that are less favorable than the Deductible, Coinsurance, or Copayment provisions that apply to a physical illness as covered under this Plan Document Handbook.

Covered Health Services include the following:

- Applied Behavioral Analysis (ABA) treatment when Medically Necessary
- Inpatient services, including psychotherapy, psychological testing, electroconvulsive therapy, and Detoxification
- Residential treatment in a licensed Residential Treatment Center that offers individualized and intensive treatment
- Outpatient services including:
    - Office visits
    - Therapy and treatment
    - Partial Hospitalization/Day Treatment Programs
    - Intensive Outpatient Programs
- Behavioral Health In-Home Programs (see the *Home Health Care Services* section above for further information)
- Online visits through LiveHealth Online when available in your area (see the *Online Visits* section below for further information)

Examples of Providers from whom you can receive Covered Health Services include:

- Psychiatrist
- Psychologist
- Licensed Clinical Social Worker (L.C.S.W.)
- Mental Health Clinical Nurse Specialist
- Licensed Marriage and Family Therapist (L.M.F.T.)
- Licensed Professional Counselor (L.P.C.)
- Any agency licensed by the state to give these services, when they have to be covered by law

Precertification is required for Inpatient care, Partial Hospitalization/Day Treatment Programs, residential care, transcranial magnetic stimulation, intensive outpatient care, and Applied Behavioral Analysis services. Failure to obtain Precertification may result in a denial of covered Benefits paid by the Plan.

For a list of exclusions, please refer to *Chapter 4: Exclusions and Limitations*.

Online Visits

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

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

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

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

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

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

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

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

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

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

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

Your coverage includes online visits from a LiveHealth Online Provider. Covered Health Services include a medical consultation using the internet via a webcam, chat, or voice. For Mental Health and Substance Use

Disorder Treatment online visits, see the *Mental Health and Substance Use Disorder Treatment* section.

Non-Covered Health Services include, but are not limited to, communications used for:

- Reporting normal lab or other test results
- Office appointment requests
- Billing, insurance coverage or payment questions
- Requests for referrals to Physicians outside of the online care panel
- Benefit Precertification
- Physician-to-Physician consultation

The Plan also covers online visits with non-LiveHealth Online Providers (e.g., with your Primary Care Physician). If you have an online visit with a non-LiveHealth Online Provider, you will pay the same cost share as if you visited that Provider in their office.

Reconstructive Surgery

Benefits include reconstructive surgery to correct significant deformities caused by Congenital Anomalies or developmental abnormalities, illness, Injury, or an earlier treatment in order to create a more normal appearance. Benefits include surgery performed to restore symmetry after a mastectomy. Reconstructive services needed as a result of an earlier treatment are covered only if the first treatment would have been a Covered Health Service under this Plan. Precertification is required.

Chapter 4: Exclusions and Limitations

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

Admissions for Non-Inpatient Services

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

Administrative Charges

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

Before Coverage Begins/After Coverage Ends

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

Blood

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

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

Certain Providers

Services you get from a Provider that is not licensed by law to provide Covered Health Services (or that is operating beyond the scope of their license); services that do not require a license to provide; services that consist of supervision by a Provider of a non-licensed person; services from Providers at a facility that does not meet the definition of Facility; Christian Science Practitioners; and separate charges for interns, residents, house Physicians or other healthcare professionals who are employed by the covered Facility. Examples include, but are not limited to, masseurs or masseuses (massage therapists) and physical therapist technicians.

Comfort and Convenience Items

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

Cosmetic Services

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

Court-Ordered Services

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

Crime and Incarceration

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

Custodial Care Services and Rest Care

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

Daily Room Charges

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

Dental Care

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

Educational Services

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

Excessive Expenses

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

Experimental/Investigative/Unproven Services

Treatments, procedures, equipment, drugs, devices, or supplies (hereafter called "services") which are, in the Claims Administrator's judgment, Experimental/Investigative/Unproven (as such term is defined in *Chapter 13: Glossary*) for the diagnosis for which the Member is being treated. An Experimental/Investigative/Unproven service is not made eligible for coverage by the fact that other treatment is considered by a Member's Physician to be ineffective or not as effective as the service or that the service is prescribed as the most likely to prolong life.

Family Members

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

Foot Care

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

Free Services

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

Genetic Screening

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

Government Programs

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

Hair

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

Health Spa

Expenses incurred at a health spa or similar Facility.

Hearing Aid Replacements, Batteries, and Repairs

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

Illegal Services

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

Inpatient Rehabilitation Programs

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

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

Maintenance Care

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

Maternity Care

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

Never Events

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

Not Generally Accepted Services

Services, treatment, or supplies not generally accepted in medical practice for the prevention, diagnosis, or treatment of the relevant illness or Injury, as determined by the Claims Administrator.

Not Medically Necessary Services

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

Nutrition and Weight Loss Treatment and Services

Any services or supplies for the treatment of obesity, including but not limited to weight reduction, medical care or prescription drugs, or dietary control (except as related to covered nutritional counseling); nutritional supplements, services, supplies and/or nutritional sustenance products (food) related to enteral feeding except when it's the sole means of nutrition; food supplements; electrolyte formulas; any services or supplies that involve weight reduction as the main method of treatment, including medical or counseling; weight loss programs including, but not limited to, commercial weight loss programs (Weight Watchers, Jenny Craig, and LA Weight Loss), nutritional supplements, appetite suppressants, and supplies of a similar nature. This exclusion does not apply to bariatric surgery when approved by the Plan.

OIG Excluded Drugs

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

Prescription Drugs

Refer to *Chapter 5: Pharmacy Benefits* for exclusions under the pharmacy Benefit.

Private Duty Nursing

Except when provided through the Home Health Care benefit.

Private Rooms

Reimbursement for private rooms is generally excluded. If you stay in a private room, the Maximum Allowed Amount / Maximum Reimbursable Charge is based on the Facility's prevalent Semiprivate Room rate, and the Facility will be permitted to bill you for the difference between the Maximum Allowed Amount / Maximum Reimbursable Charge and their billed charges, regardless of whether the Facility is a Network Provider or an Out-of-Network Provider. If you are admitted to a Facility that has only private rooms, the Maximum Allowed Amount / Maximum Reimbursable Charge is based on the Facility's prevalent room rate.

Reproductive Services

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

Research Screenings

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

Residential Accommodations

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

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

Routine Examinations

Routine physical examinations, screenings procedures, and immunizations* necessitated by employment, foreign travel, recreational camps, or retreats, or any insurance program which are not called for by known symptoms and illness or Injury, except those which may be specifically listed as covered in this Plan Document Handbook.

*Note, however, that immunizations for personal travel are Covered Health Services.

Safe Surroundings

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

Shoes and Orthotics

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

Spider Veins

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

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

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

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

wheelchair is the individual's primary means of mobility, a second wheeled mobility device specifically for work or school use, car seats); or

6. The item represents a product upgrade to a current piece of equipment that is either fully functional or replacement of a device when the item can be cost-effectively repaired.

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

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

- Bed-related items: bed trays, over-the-bed tables, bed wedges, pillows, custom bedroom equipment, and mattresses, including nonpower mattresses, custom mattresses, and posturepedic mattresses
- Bath-related items: bath lifts, nonportable whirlpools, bathtub rails, toilet rails, raised toilet seats, bath benches, bath stools, handheld showers, paraffin baths, bath mats, and spas
- Fixtures to real property: ceiling lifts and wheelchair ramps
- Car/van Modifications
- Air quality Items: room humidifiers, vaporizers, and air purifiers
- Other equipment: centrifuges, needleless injectors, heat lamps, heating pads, cryo units, cryotherapy machines, ultraviolet cabinets that emit Ultraviolet A (UVA) rays, sheepskin pads and boots, postural drainage board, AC/DC adaptors, scales (baby and adult), stair gliders, elevators, saunas, cervical and lumbar traction devices, exercise equipment and diathermy machines

Therapy Services

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

Transportation

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

Thermograms and Thermography

Thermograms and thermography services.

Vision Care

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

Vision Surgeries

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

Waived Cost Share Out-of-Network

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

Waived Fees

Any portion of a Provider's fee or charge which is ordinarily due from a Member but which has been waived, reduced, forgiven or otherwise not billed to a Member. If a Provider waives (does not require the Member to pay) a Deductible or out-of-pocket expenses, the Claims Administrator reserves the right to calculate the actual Provider fee or charge by the amount waived. If the Claims Administrator determines that this exclusion may apply, the Claims Administrator, in its sole discretion, shall have the right to require a Member and/or any Provider to provide proof satisfactory to the Claims Administrator that the Member made their required cost-share payments prior to the payment of any benefits by the Claims Administrator.

War/Military Duty

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

Workers' Compensation

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

Chapter 4A: Exclusions and Limitations – Claims-Administrator-Specific Modifications

Anthem BCBS

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

No Additional Exclusions

Chapter 5: Pharmacy Benefits (Administered by Express Scripts)

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

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

Drug Formulary

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

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

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

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

Generic Medications

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

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

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

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

What's covered

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

unless specifically excluded under this Plan:

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

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

Coverage Management Programs

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

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

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

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

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

What's Not Covered

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

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

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

Note: Drugs that are legally prohibited in certain states may only be ingested while physically in the state in which the drug is legal. In no event may a member legally obtain a drug through the Plan in one state and ingest it in a state in which the drug is prohibited by law.

Using a Retail Pharmacy

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

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

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

At a nonparticipating pharmacy, you must pay in full for your prescription and submit a claim for reimbursement. If the pharmacy charges you more than the allowed amount (based on pricing at a participating pharmacy), you will

be reimbursed based on the allowed amount minus the Copayment or Coinsurance. 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 or Coinsurance, please refer to the appeal provisions in the *Chapter 7: Claims and Appeals*.

Using Home Delivery

Home delivery should be used for maintenance medications. You can receive up to a 90-day supply of medication for one Copayment or Coinsurance payment. 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 and Coinsurance.

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

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

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

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

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

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

Specialty Drugs – Medical Channel Management (Accredo)

Specialty Prescription Drug Products are drugs that are used to treat complex conditions and illnesses, such as cancer, growth hormone deficiency, hemophilia, hepatitis C, immune deficiency, multiple sclerosis, and rheumatoid arthritis. These drugs usually require special handling, special administration, or intensive patient monitoring. Medications used to treat diabetes are not considered specialty medications. Whether they are administered by a healthcare professional, self-injected, or taken by mouth, specialty medications require an enhanced level of service. Many Specialty Prescription Drug Products are covered by the Plan.

The Plan requires that certain Specialty Prescription Drug Products be accessed through Accredo Health Group,

Inc. (“Accredo”), an Express Scripts specialty pharmacy, effective as of January 1, 2023. Members are no longer covered for those Specialty Prescription Drug Products through their medical Benefit administered by the Claims Administrator. The list of medications subject to the program is available by calling the number on your prescription drug ID Card. If you have been using Specialty Prescription Drug Products affected by the program and you do not obtain them through Accredo, you will be required to transfer those prescriptions to Accredo. If you continue to obtain your medications from your doctor or a pharmacy other than Accredo, you may be responsible for their full cost. When you order a covered Specialty Prescription Drug Product through Accredo, your out-of-pocket cost will be limited to the applicable mail-order Copayment or Coinsurance.

The list of medications subject to this specialty drug program may change, and you should check the list before you fill a prescription for a Specialty Prescription Drug Product.

To confirm whether a medication you take is part of the specialty program, you may review the list of impacted medications on *express-scripts.com* or you may call the number on your prescription drug ID Card.

Express Scripts Special Care Pharmacy (Accredo)

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

- Access to nurses who are trained in specialty medications.
- Answers to your questions about specialty medications from a pharmacist 24 hours a day, 7 days a week.
- Coordination of home care and other healthcare services.

Drug Utilization Review

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

SaveOnSP Copay Assistance Program

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

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

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

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

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

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

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

Emergency Pharmacist Consultation

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

Pharmacy Locator

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

Telecommunications for the Deaf

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

Printed Materials for the Visually Impaired

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

Filing a Claim

See *Chapter 7* for information on claims and appeals.

Chapter 6: Other Programs and Services

Cigna Employee Assistance Program (EAP)

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

EAP services include:

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

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

Pastoral Support Network (PSN)

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

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

The PSN is offered at no cost and is available to all the family members in your household.

For more information or to talk with a PSN specialist, call 866-395-7794.

EyeMed Vision Care

If you enroll in an Anthem BCBS, Cigna or Kaiser Plan offered through the Medical Trust, you will receive vision Benefits through EyeMed Vision Care's Insight Network®.

Vision Benefits include an annual eye exam with no copay when you use a network provider, and prescription eyewear or contact lenses offered through a broad-based network of ophthalmologists, optometrists, and opticians at retail chains and independent provider locations. Certain calendar-year benefit limitations apply.

Review the *EyeMed Summary of Benefits* for information about covered services under this Plan.

If you are already registered on the EyeMed site, visit *eyemedvisioncare.com/ecmt* and use your EyeMed member account credentials to log in for details. Click "Need to register?" to create an EyeMed member account.

Health Advocate

This program is like having your own healthcare navigator at no cost to you! Health Advocate offers help when you have questions about your medical care—from finding a doctor and scheduling an appointment to understanding treatment options for a medical condition to understanding your benefits or resolving a claim.

This service can help you navigate the healthcare system and make the most of your benefits. It is available for you, your dependents, your parents, and your parents-in-law (even if they do not live with you).

Call as often as you need and speak toll-free with a health advocate about your healthcare options. Your information is confidential. Your employer does not receive and does not have access to any of your confidential information. You will be asked to complete and submit forms to protect your privacy.

To access Health Advocate, visit *healthadvocate.com/ecmt* or call 866-695-8622, Monday to Friday, 8:00 AM to 7:00 PM ET.

UHC Global Travel Medical Assistance

When you enroll in a medical Plan offered through the Medical Trust, you have access to UnitedHealthcare Global Assistance®. This travel assistance program can help you with travel needs you encounter while you are outside the United States or 100 or more miles away from home.

The program includes these features:

- Assistance in obtaining medical treatment—whether you need a local referral for treatment or evacuation due to a medical emergency, UnitedHealthcare Global Assistance staff will help make the arrangements
- Assistance with providing insurance information and medical records for treatment
- Assistance with replacement of prescriptions, medical devices, and corrective lenses
- Assistance procuring emergency travel arrangements and replacement of lost or stolen travel documents
- Emergency fund transfers
- Destination profiles, which include health and security risks for more than 170 countries

IMPORTANT NOTE: UnitedHealthcare Global Assistance is **not** travel insurance. It **does not cover** your medical or other costs while you are traveling. If you incur costs, and depending on where you travel, you may be required to pay for your healthcare services. UnitedHealthcare Global Assistance's role is solely to **arrange** for care and other services.

If you have an emergency medical event while traveling, contact your health plan carrier using the number on your member ID card.

For more information about UnitedHealthcare Global Assistance services, please visit *members.uhcglobal.com* or call 800-527-0218.

Hinge Health

Hinge Health is available at no cost to Members enrolled in a Plan administered by Anthem BCBS or by Cigna.

Through the Hinge Health Digital Musculoskeletal (MSK) Clinic, participants have access to personalized MSK care programs depending on their specific MSK needs.

- Prevention – Program designed to increase education with regard to key strengthening and stretching activities around healthy habits. The Prevention program is software-based and offered through the Hinge Health app.
- Chronic – Program designed to address long-term back and joint pain. It includes personalized app-guided exercise therapy sessions, one-on-one access to a personalized health coach, personalized education content, and behavioral health support. Participants in the chronic program may also be offered access to virtual sessions with a licensed physical therapist and/or the non-invasive ENSO High Frequency Impulse Therapy™ pain management device and service, as appropriate, for symptomatic relief.

- Acute – Program designed to address recent injuries. It includes live virtual sessions with a dedicated licensed physical therapist along with software-guided rehabilitation and education.
- Surgery – Program designed to address pre/post-surgery rehab for the most common MSK Surgeries. It includes personalized app-guided exercise therapy sessions, 1:1 access to a personalized health coach and physical therapist, personalized education content, and behavioral health support.
- Expert Medical Opinion – Service offering second opinions for elective MSK procedures.

For applicable programs, a participant may obtain up to six virtual physical therapy sessions per episode (with no cost share to the member) prior to in-person healthcare provider or physical therapy care.

State laws may limit access without a physician's referral.

To get started with Hinge Health, visit *hingehealth.com/ecmt* to enroll. If you have any questions regarding Hinge Health, email *help@hingehealth.com* or call 855-902-2777.

Chapter 7: Claims and Appeals

This chapter describes the claims and appeals procedures for services received through the Claims Administrator or Express Scripts.

Filing a Claim

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

You may get the required claim forms from the website listed on your ID Card or by using the toll-free number on your ID Card. You can also find the claim forms for the Claims Administrator and Express Scripts at *cpg.org/forms-and-publications/forms/health-plans/#Claims*.

Timely Filing of Out-of-Network Claims

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

Claim Reminders

Be sure to follow the instructions listed on the claim form carefully when submitting a claim to the Claims Administrator.

Be sure to include the following information when you file your claim:

- Plan participant's name, social security number, and address
- Patient's name, social security number, and address, if different from the participant's
- Member ID and group number (found on your ID Card)
- Provider's name, tax identification number, address, degree, and signature
- Date(s) of service
- Diagnosis
- Procedure codes (describes the treatment or services rendered)
- Signed assignment of Benefits (if payment is to be made to the Provider)
- Explanation of Benefits (EOB) if another plan is the primary payer

You should submit claims for each individual Member. Please do not attach or staple claims together. If additional information is needed to process your claim, you or your Provider(s) 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 services received through a Plan administered by **Anthem BCBS** to:

Anthem Blue Cross and Blue Shield
PO Box 105187
Atlanta, GA 30348-5187
Fax: 877-286-3030

Send claims for medical services received through a Plan administered by **Cigna** to:

Cigna
PO Box 981106
El Paso, TX 79998-1106

Send claims for behavioral health services received through a Plan administered by **Cigna** to:

Cigna Behavioral Health
PO Box 188022
Chattanooga, TN 37422

Send claims for pharmacy services to:

Express Scripts
Attn: Commercial Claims
PO Box 14711
Lexington, KY 40512-4711
Fax: (608) 741-5475

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

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

Authorized Representative

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

How to Appeal a Denial of Benefits

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

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

If your claim is denied:

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

Notice of Adverse Benefit Determination

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

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

Appeals

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

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

Urgent Pre-Service and Concurrent Appeals (First- and Voluntary Second-Level)

For urgent pre-service and concurrent services, you may obtain an expedited appeal. You or your Authorized Representative may request it orally or in writing. All necessary information, including the Claims Administrator's decision, can be sent between the Claims Administrator and you by telephone,

facsimile (fax), 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 ID Card and provide at least the following information:

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

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

First-Level Appeals (Post-Service and Non-Urgent Pre-Service)

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

You or your Authorized Representative must submit a request for review as follows:

For services under your medical Plan administered by **Anthem BCBS**:

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

For medical services under your medical Plan administered by **Cigna**:

Cigna
PO Box 188011
Chattanooga, TN 37422

For behavioral health services under your medical Plan administered by **Cigna**:

Cigna Behavioral Health Appeals
PO Box 188064
Chattanooga, TN 37422

For prescription drug services:

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

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

- Was relied on in making the Benefit determination;
- Was submitted, considered, or produced in the course of making the Benefit determination;

- Demonstrates compliance with processes and safeguards to ensure that claim determinations are made in accordance with the terms of the Plan, applied consistently for similarly situated claimants; or
- Is a statement of the Plan's policy or guidance about the treatment or benefit relative to your diagnosis.

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

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

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

Notification of the Outcome of the Non-Urgent Appeal

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

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

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

Appeal Denial

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

Voluntary Second-Level Appeals (Post-Service and Non-Urgent Pre-Service)

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

- Your name and the identification number from your ID Card
- The date(s) of medical service(s)
- The Provider's name
- Any other documentation or other information to support the appeal request

For a post-service appeal involving the Claims Administrator or Express Scripts, send your second-level appeal to:

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

For a non-urgent pre-service appeal involving **Anthem BCBS** send your second-level appeal to:

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

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

Cigna
PO Box 188011
Chattanooga, TN 37422

Cigna Behavioral Health Appeals
PO Box 188064
Chattanooga, TN 37422

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

External Review Program

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

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

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

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

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

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

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

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

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

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

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

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

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

If you file a voluntary external appeal, any applicable statute of limitations will be tolled while the appeal is pending. The filing of a claim will have no effect on your rights to any other Benefits under the Plan. However, the appeal is voluntary, and you are not required to undertake it before pursuing legal action. If you choose not to file for an external voluntary review, the Plan will not assert that you have failed to exhaust your administrative remedies because of that choice.

Request for External Review

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

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

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

Preliminary Review

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

- You were covered under the Plan at the time the service was requested or provided,
- The determination does not relate to eligibility,
- You have exhausted the mandatory internal appeals process (unless deemed exhaustion applies), and
- You have provided all paperwork necessary to complete the external review.

Within one (1) business day after completion of the preliminary review, the Plan or its designee must issue to you a notification in writing. If the request is complete but not eligible for external review, such

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

Referral to ERO

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

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

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

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

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

Expedited External Review

The Plan must allow you to request an expedited external review at the time you receive:

(a) an Adverse Benefit Determination if the Adverse Benefit Determination involves a medical condition for which the timeframe for completion of an expedited internal appeal would seriously jeopardize your life or health or would jeopardize your ability to regain maximum function and you have filed a request for an expedited internal appeal; or

(b) an Adverse Benefit Determination that concerns an admission, availability of care, continued

stay, or healthcare item or service regarding an issue for which you received emergency services, but have not been discharged from a Facility.

Immediately upon receipt of the request for expedited external review, the Plan or its designee will determine whether the request meets the reviewability requirements set forth above for standard external review. The Plan or its designee must immediately send you a notice of its eligibility determination.

Referral of Expedited Review to ERO

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

Extensions Due to COVID-19 Pandemic

The timeframe for a claimant to file (1) a benefit claim, (2) an appeal of an adverse benefit determination, (3) a request for an external review after receipt of an adverse benefit determination or final internal adverse benefit determination, and (4) information to perfect a request for external review upon a finding that the request was not complete has been extended. Guidance was issued on April 28, 2020, directing plan sponsors to disregard the “Outbreak Period” when calculating these deadlines. The Outbreak Period is the period from March 1, 2020 until sixty (60) days after the announced end of the COVID-19 National Emergency (or other date announced through future guidance).[15] If there are different Outbreak Periods in different parts of the country, additional guidance will be issued. Please see the example below.

> *Example*: For purposes of this example, assume the National Emergency ends on May 11, 2023, and accordingly the Outbreak Period ends on July 10, 2023 (i.e., the 60th day after the end of National Emergency). On April 15, 2023, a Member received notice of an adverse benefit determination. Under the health plan, the individual has 60 days within which to file an appeal.
>
> In this example, the Outbreak Period is disregarded and the Member’s last day to submit an appeal is 60 days after July 10, 2023, which is September 8, 2023.

Requirements relating to Commencing Legal Action

No legal action of any kind related to a Benefit decision may be commenced by you, unless it is commenced within one (1) year of the Plan's final decision on the claim or other request for Benefits. If the Plan decides an appeal is untimely, the Plan's latest decision on the merits of the underlying claim or Benefit request is the final decision date. You must exhaust the Plan’s mandatory internal appeals procedure, not including any voluntary level of appeal, before taking legal action of any kind against the Plan. As described in more detail in *Chapter 10: Other Important Plan Provisions* legal action may be pursued only and exclusively by submitting the matter to arbitration.

[15] On January 30, 2023, the Biden Administration announced its intent to end the national emergency and public health emergency declarations on May 11, 2023.

Chapter 8: 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:

- The parents are married;
- The parents are not separated (regardless of whether they ever have been married); or
- 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. 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 9: Medicare Secondary Payer (MSP) — Small Employer Exception (SEE)

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

If you are 65 or over (or have an Eligible Dependent who is 65 or over), actively working, and your employer has fewer than 20 employees in the current year and had fewer than 20 employees in the previous year, you may be eligible to choose a Plan that participates in this program.[16]

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 SEE 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 SEE Plan.

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

What Your Employer Needs to Do

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

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

What You Need to Do

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

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

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

How It Works

If you have an Inpatient hospitalization while enrolled in the SEE Plan, 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 the Claims Administrator who will process the portion not paid by Medicare, minus the Plan's Deductible and your cost share.

In administering the Plan's role as the secondary payer of claims, the Claims Administrator does not look at the Provider status to determine the Benefits. All claims are processed at the Network Benefit level,

[16] Please note that the Consumer-Directed Health Plans are not available as SEE Plans.

regardless of whether the Facility is in the Claims Administrator's Network. The Provider must, however, participate with Medicare or accept Medicare assignment in order for Medicare to consider the claim for primary payment.

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

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

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

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

Chapter 10: Other Important Plan Provisions

Assignment of Benefits

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

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

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

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

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

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

Surprise Billing Claims

Surprise Billing Claims – Out-of-Network Charges for Certain Services

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

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

Surprise Billing Claims – Out-of-Network Emergency Services Charges

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

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

Surprise Billing Claims – Out-of-Network Consent

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

An Out-of-Network Consent may not be obtained for ancillary services provided by an Out-of-Network Provider in a Network Facility (e.g., an anesthesiologist, radiologist, assistant surgeon, hospitalist, neonatologist, or laboratory, pathology or diagnostic services) or for unforeseen, urgent medical needs that arise at the time the covered service is provided.

If an Out-of-Network Provider obtains a Member's Out-of-Network Consent, the cost-sharing principles described under *Out-Of-Network Services*, in *Chapter 16*, will apply.

Continuity of Care

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

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

If you are a Continuing Care Patient and wish to continue seeing the same Provider, you should contact the Claims Administrator for details. The Claims Administrator may require the Provider to attest that discontinuing care by the current Provider would worsen your condition or interfere with anticipated outcomes.

Special Election for Employees and Spouses Age 65 and over

If an Eligible Individual remains actively employed after reaching age 65 and is eligible to participate in the Plan, the Eligible Individual and/or eligible Spouse may choose to remain covered under the Plan without reduction for Medicare Benefits. An Eligible Individual and/or Spouse may also choose to end coverage under the Plan and enroll only in Medicare; however, Benefits that are payable under this Plan may not be covered by Medicare, and neither the Eligible Individual nor the Spouse may be enrolled in a Group Medicare Advantage plan or Medicare Supplement plan sponsored by the Medical Trust. If coverage remains under the Plan, the Plan will be the primary payer of Benefits, and Medicare will be the secondary payer (unless the Eligible Individual and/or Spouse qualifies for a SEE Plan).

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

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

Alternative Payee Provision

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

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

Unclaimed Property

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

Reliance on Documents and Information

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

No Waiver

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

No Guarantee of Tax Consequences

Although the Plan intends to offer some Benefits on a tax-favored basis, there is no guarantee that any

particular tax result will apply. Nothing in this Plan Document Handbook constitutes tax, medical, financial or legal advice. If you have questions about the tax, financial, or legal consequences of a Benefit, you should consult your personal tax, legal, or financial advisor.

Physician/Patient Relationship

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

The Plan is Not a Contract of Employment

Nothing contained in the Plan will be construed as a contract or condition of employment between the employer and any employee.

Plan Administration

In administering the Plan(s), the Medical Trust has full discretion and authority to interpret Plan provisions, make factual determinations, and address other issues that may arise. Subject to any right that a Member has to appeal a decision, the Medical Trust determinations are final and binding. To the extent that the Medical Trust delegates administrative authority under the Plan(s) to another party, such as a Claims Administrator, that party shall act with the same discretion and authority as the Medical Trust.

Plan Information and Rights

The Plan(s) described in this Plan Document Handbook are sponsored and administered by the Church Pension Group Services Corporation ("CPGSC"), also known as the Episcopal Church Medical Trust (the "Medical Trust"). The Medical Trust serves only eligible Episcopal employers. The Plans that are self-funded are funded by the Episcopal Church Clergy and Employees' Benefit Trust ("ECCEBT"), a Voluntary Employees' Beneficiary Association within the meaning of section 501(c)(9) of the Code.

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

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

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

The Plan is a church plan within the meaning of section 3(33) of ERISA and section 414(e) of the Code and is exempt from ERISA. Not all Plans are available in all areas of the United States, and not all Plans are available on both a self-funded and fully insured basis. Additionally, the Plan may be exempt from federal and state laws that may otherwise apply to health insurance arrangements. The Plan does not cover all healthcare expenses, and Members should read this document carefully to determine which Benefits are covered, as well as any applicable exclusions, limitations, and procedures.

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

Unauthorized Use of Identification Card

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

Arbitration

Subject to exhaustion of the procedures set forth in *Chapter 7: Claims and Appeals*, a Member who believes that they are entitled to Benefits under the Plan may pursue such claim only and exclusively by submitting the matter to arbitration. Any such arbitration must be commenced no later than one (1) year after the date the procedures set forth in *Chapter 7: Claims and Appeals*, are exhausted.

For any controversy, claim or dispute arising out of or related in any way to the Plan aside from one described in the immediately preceding paragraph, including but not limited to any claims for breach of fiduciary duty, a Member may pursue such controversy, claim or dispute only and exclusively by submitting the matter to arbitration. Any such arbitration must be commenced no later than two (2) years after the date on which the Member knew or should have known the information that forms the basis of such controversy, claim or dispute.

In any such arbitration, the parties shall select an arbitrator from a list of names supplied by JAMS, Inc. ("JAMS") in accordance with JAMS's procedures for selection of arbitrators, and the arbitration shall be conducted in accordance with the JAMS Employment Arbitration Rules and Procedures and subject to the JAMS Policy on Employment Arbitration Minimum Standards of Procedural Fairness. The arbitrator's authority shall be governed by the same principles that would apply to such an action in court, including, to the extent applicable, any deferential standard of review applicable to such actions and appropriate limits on discovery beyond the administrative record. In addition, the arbitrator's decision shall be final and binding on all parties and may be enforced in any court of competent jurisdiction. The arbitrator selected must have substantial familiarity with and knowledge of group health plans, preferably with those that are not subject to ERISA.

Waiver of Class, Collective and Representative Actions

Members must bring any controversy, claim or dispute in arbitration on an individual basis only, and not on a class, collective or representative basis, and must waive the right to commence, be a party to or be an actual or putative class member of any class, collective or representative action arising out of or relating to the Plan, including but not limited to any claims related to the Plan ("class action waiver").

By participating in the Plan or by seeking or receiving any benefit under the Plan, to the fullest extent permitted by law, a Member waives any right to commence, be a party to in any way, recover from and/or be an actual or putative member or representative of any class, collective or representative action arising out of or relating to any claim, dispute or controversy arising out of or relating to the Plan. Notwithstanding anything to the contrary in this Plan, if, for any reason, the waiver of a Member's right to commence, be a party to, recover from or be an actual or putative member or representative of any class, collective or representative action within or outside of an arbitration proceeding is found to be unenforceable by a court of competent jurisdiction, the requirement to arbitrate shall no longer apply, and any class, collective or representative claim shall be filed, litigated and adjudicated in a court of competent jurisdiction and not in arbitration.

In any arbitration, the Member may not seek or receive any remedy that has the purpose or effect of providing additional benefits or monetary relief to any other Member or beneficiary. Notwithstanding anything to the contrary in this Plan, if, for any reason, a court of competent jurisdiction were to find this restriction on the scope of remedies unenforceable or invalid as to a particular controversy, claim or dispute, then the requirement to arbitrate shall no longer apply to such controversy, claim or dispute, and that controversy, claim or dispute shall be filed, litigated and adjudicated in a court of competent jurisdiction and not in arbitration.

Chapter 11: Subrogation and Right of Recovery

Definitions

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

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

For purposes of this provision, a “covered person” includes anyone on whose behalf the Plan pays or provides any Benefit including, but not limited to, the representative of the Plan Member’s estate, heir, descendant, a minor Child or Dependent of any Plan Member or person entitled to receive any Benefits from the Plan. A “covered person” also includes anyone to whom a Plan Member or a Plan Member’s representative transfers or assigns (or purports to transfer or assign) any recovery or right of recovery from a responsible party.

Subrogation

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

The right of subrogation means the Plan is, with or without the covered person’s consent, entitled to pursue any claims that the covered person may have in order to recover the Benefits paid or payable by the Plan.

Reimbursement

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

Constructive Trust

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

Lien Rights

The Plan will automatically have an equitable lien to the extent of Benefits paid by the Plan for treatment of the illness, Injury, or condition for which the responsible party is liable. The lien shall be imposed upon any recovery, whether by settlement, judgment, or otherwise, related to treatment for any illness, Injury, or condition for which the Plan paid Benefits. The lien may be enforced against any party who possesses funds or proceeds representing the amount of Benefits paid by the Plan including, but not limited to, the covered person, the covered person’s representative or agent, the responsible party, the responsible party’s insurer, representative or agent, and/or any other source possessing funds representing the amount of Benefits paid by the Plan. The lien exists at the time the Plan pays Benefits and, therefore, exists prior to any subsequent filing for bankruptcy.

First-Priority Claim

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

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

Applicability to All Settlements and Judgments

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

Cooperation

The covered person shall fully cooperate with the Plan's efforts to recover its Benefits paid. It is the duty of the covered person to notify the Plan within 30 days of the date when any notice is given to any party, including an insurance company or attorney, of the covered person's intention to pursue or investigate a claim to recover damages or obtain compensation due to Injury, illness, or condition sustained by the covered person and as soon as reasonably practicable, but in any event within five days, of learning of any settlement offer, judgment award, or decision regarding such compensation. The covered person and their agents shall provide all information requested by the Plan, the Claims Administrator or its representative including, but not limited to, completing, signing and submitting any applications or other forms or statements as the Plan, the Claims Administrator or its representative may reasonably request and providing all documents related to or filed in personal injury litigation. Failure to provide this information may result in the institution of court proceedings against the covered person. The covered person shall make any court appearances reasonably requested by the Plan.

The covered person will provide the Plan, the Claims Administrator, or its representative notice of any recovery the covered person or their agent obtains prior to their receipt of such recovery or, if the covered person or their agent did not learn of the recovery prior to such receipt, within five days after the recovery. The covered person will refrain from any disbursement of settlement proceeds or any other recovery prior to fully satisfying the Plan's subrogation and reimbursement interest.

The covered person shall do nothing to prejudice the Plan's subrogation or recovery interest or to prejudice the Plan's ability to enforce the terms of this Plan provision. This includes, but is not limited to, refraining from making any settlement or recovery that attempts to reduce or exclude the full cost of all Benefits provided by the Plan.

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

Failure To Reimburse or Cooperate

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

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

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

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

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

Benefits paid by the Plan may also be benefits advanced.

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

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

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

name, which does not obligate the Plan in any way to pay the covered person part of any recovery the Plan might obtain.

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

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

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

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

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

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

If the covered person's estate, parent, guardian, or conservator asserts a claim against a third party based on the covered person's injury or illness, the covered person's estate, parent, guardian, or conservator and any settlement or judgment recovered by the estate, parent, guardian, or conservator shall be subject to the Plan's liens and other rights to the same extent as if the covered person had asserted the claim against the third party. The Plan may assign its rights to enforce liens and other rights.

Surrogacy Arrangements

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

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

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

If the covered person’s estate, parent, guardian, or conservator asserts a claim against a third party based on the Surrogacy Arrangement, the covered person’s estate, parent, guardian, or conservator and any settlement or judgment recovered by the estate, parent, guardian, or conservator shall be subject to our liens and other rights to the same extent as if the covered person had asserted the claim against the third party. The Plan may assign its rights to enforce its liens and other rights.

Interpretation

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

Jurisdiction

By accepting Benefits (whether the payment of such Benefits is made to the covered person or made on behalf of the covered person to any Provider) from the Plan, the covered person agrees that any court proceeding with respect to this *Chapter 11: Subrogation and Right of Recovery*, may be brought in any court of competent jurisdiction as the Plan may elect. By accepting such Benefits, the covered person hereby submits to each such jurisdiction, waiving whatever rights may correspond to them by reason of present or future domicile.

Chapter 12: Privacy

Joint Notice of Privacy Practices

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

Introduction

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

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

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

What This Notice Applies To

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

Duties and Obligations of the Plans

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

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

When the Plans May Use and Disclose Your PHI

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

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

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

- **Treatment.** The Plans may disclose your PHI to your Providers for treatment, including the provision of care or the management of that care. For example, the Plans might disclose PHI to assist in

diagnosing a medical condition or for pre-certification activities.

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

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

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

Authorizing Release of Your PHI

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

Interaction with State Privacy Laws

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

Fundraising

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

Underwriting

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

Your Rights With Respect to Your PHI

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

If You Believe Your Privacy Rights Have Been Violated

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

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

To contact the Church Pension Group Privacy Officer:

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

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

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

Effective Date

This Notice is effective as of August 29, 2018.

Changes

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

Chapter 13: Glossary

Accidental Injury

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

Ambulance Services

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

Annual Enrollment

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

Authorized Service

This term is only used for Plans administered by Anthem BCBS. In the Plan Document Handbook for Plans administered by Anthem BCBS, see *Chapter 13A* for a definition of this term.

Bed and Board

This term is only used for Plans administered by Cigna. In the Plan Document Handbook for Plans administered by Cigna, see *Chapter 13A* for a definition of this term.

Behavioral Health In-Home Programs

This term is only used for Plans administered by Anthem BCBS. In the Plan Document Handbook for Plans administered by Anthem BCBS, see *Chapter 13A* for a definition of this term.

Benefits

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

Benefit Maximum(s)

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

Billed Group

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

Biologic

This term is only used for Plans administered by Cigna. In the Plan Document Handbook for Plans administered by Cigna, see *Chapter 13A* for a definition of this term.

Blue Distinction Center for Transplants

This term is only used for Plans administered by Anthem BCBS. In the Plan Document Handbook for Plans administered by Anthem BCBS, see *Chapter 13A* for a definition of this term.

Cafeteria Plan[17]

A Cafeteria Plan, also known as a section 125 plan, is a separate written plan, maintained by an employer, that offers employees a choice between receiving their compensation in cash or as part of an employee benefit. If taken as a benefit, the employee generally receives two tax advantages: (1) employee contributions toward Cafeteria-Plan benefits are made on a pre-tax basis, and (2) employer contributions toward an employee's Cafeteria-Plan benefits are not taxed. An employee's elections under a Cafeteria Plan are generally irrevocable until the beginning of the next plan year, although a Cafeteria Plan may permit an employee to revoke an election and make a new one mid-year following the occurrence of a Significant Life Event.

Charges

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

Claims Administrator

The company that the Plan Sponsor chose to administer its health Benefits provided through this Plan. The Claims Administrator is either Anthem BCBS or Cigna, as applicable. The Claims Administrator provides administrative claims payment services only and does not assume any financial risk or obligation with respect to claims.

Coinsurance

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

Congenital Anomaly

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

Coordination of Benefits

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

[17] The Medical Trust does **not** maintain a Cafeteria Plan for the purposes of receiving employer and employee contributions; Participating Groups or employers must maintain their own, separate Cafeteria Plan in order to benefit from the tax advantages described above.

Copayment

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

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

Cosmetic Services

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

Coverage Tier

Coverage Tiers represent coverage classifications based on the number of Members covered. Contribution rates correspond to the Coverage Tier type (Single, Eligible Individual + Spouse/Domestic Partner, Eligible Individual + Child, Eligible Individual + Children, Family)

Covered Health Service(s)

Medically Necessary healthcare services and supplies that are:

- described in *Chapter 3: Coverage*
- not excluded as described in *Chapter 4: Exclusions and Limitations*, and
- provided in accordance with such Plan.

In order to be Covered Health Services, such services or supplies must be provided:

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

Covered Transplant Procedure

This term is only used for Plans administered by Anthem BCBS. In the Plan Document Handbook for Plans administered by Anthem BCBS, see *Chapter 13A* for a definition of this term.

Custodial Care Services

Anthem BCBS and Cigna define this term differently. For more information, see *Chapter 13A*, which contains the definition of the term used by the applicable Claims Administrator.

Deductible(s)

Deductibles are amounts to be paid by you or your enrolled Dependents before Benefits are payable under this Plan. Deductibles are in addition to any Coinsurance. Once the Deductible maximum in the Summary of Benefits and Coverage has been reached, you and your family need not satisfy any further Deductible for the rest of that Plan Year. You should note that (1) Network and Out-of-Network Deductibles accumulate separately, but (2) medical and pharmacy Deductibles cross-accumulate.

Dependent

A Spouse, Domestic Partner, or Child of an Eligible Individual. A "Surviving Dependent" means a Surviving Child, Surviving Domestic Partner, or Surviving Spouse, as applicable.

Child(ren)
An Eligible Individual's, Eligible Individual's Spouse's, or, if Domestic Partner benefits are provided by the Participating Group, a Domestic Partner's, biological child, stepchild, legal ward,[18] foster child,[19] or legally adopted child, or a child who has been placed for adoption with the Eligible Individual, Eligible Individual's Spouse, or, if applicable, Domestic Partner. A child will be considered to be "placed for adoption" on the date when the Eligible Individual becomes legally obligated to support that child prior to that child's adoption.

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

Spouse
An Eligible Individual'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 an Eligible Individual who meets the qualifications listed in *Chapter 2: Eligibility and Enrollment*, and is enrolled in the Plan at the time of the Eligible Individual's death. A Surviving Child shall also include a Child of an Eligible Individual born or adopted within 12 months of the Eligible Individual's death.

Surviving Domestic Partner
A Domestic Partner of an Eligible Individual who meets the qualifications listed in *Chapter 2: Eligibility and Enrollment*, and is enrolled in the Plan at the time of the Eligible Individual's death.

Surviving Spouse
A Spouse of an Eligible Individual who meets the qualifications listed in *Chapter 2: Eligibility and Enrollment*, and is enrolled in the Plan at the time of the Eligible Individual's death.

Detoxification

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

Developmental Delay

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

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

[19] A foster child is an individual who is placed with the Eligible Individual by an authorized placement agency or by judgment, decree or other order of any court of competent jurisdiction.

Disabled Child

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

Durable Medical Equipment

Anthem BCBS and Cigna define this term differently. For more information, see *Chapter 13A*, which contains the definition of the term used by the applicable Claims Administrator.

Eligible Dependent

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

Eligible Individual

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

Eligible Small Employer

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

Emergency Medical Condition

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

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

Employee

An individual employed by a Participating Group, including individuals on an approved leave of absence, short-term disability or long-term disability. In no event will an independent contractor be considered to be an Employee.

> **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 six (6) months in a year.
>
> **Temporary Employee**
> An Employee who is scheduled to be employed for a limited time or whose work is contemplated or intended for a particular project or need, usually of a short duration such as three (3) months.

Episcopal Church Clergy and Employees' Benefit Trust (ECCEBT)

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

Dependents.

Essential Health Benefits

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

Experimental/Investigative/Unproven

Anthem BCBS and Cigna define this term differently. For more information, see *Chapter 13A*, which contains the definition of the term used by the applicable Claims Administrator.

Facility

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

Former Employee

Pre-65 Former Employee
A former Employee of a Participating Group of the EHP who is less than 65 years of age and not otherwise eligible for the EHP or SEE Plan as an Employee:

(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 Employee who was normally scheduled to work and was compensated for 1,000 or more hours per year, and
(b) at the time of separation from employment with The Episcopal Church, was at least 55 years of age, or, if younger, was eligible for a disability retirement benefit under a pension plan sponsored by The Church Pension Fund or its affiliates prior to December 31, 2017, and
(c) if a Lay Employee, has a minimum of five years of service with The Episcopal Church OR, if a cleric, has earned a minimum of five years of Credited Service under The Church Pension Fund Clergy Pension Plan.

Post-65 Former Employee
Clergy:
A former Employee who:

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

Lay:
A former Employee who:

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

Member of Religious Order who:

a) is age 65 or older, and

b) either (1) meets the definition of Post-65 Former Employee Clergy above OR (2) is a former Member of a Religious Order that is a Participating Group of the EHP.

Freestanding Ambulatory Facility

The term "Freestanding Ambulatory Facility" means an institution, at which surgical procedures are performed on an Outpatient basis (no patients stay overnight), which meets all of the following requirements:

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

A Physician's office does not qualify as a Freestanding Ambulatory Facility.

Group Administrator

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

Health Insurance Portability and Accountability Act of 1996 (HIPAA)

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

HIPAA Special Enrollment Event

A certain subset of Significant Life Events, as described in *Chapter 2: Eligibility and Enrollment*, where, as a result of the event, an Eligible Individual is eligible to enroll themself and their Eligible Dependents for coverage under the Plan outside of the Annual Enrollment period, and the employer of the Eligible Individual is responsible for providing a Summary of Benefits and Coverage (SBC) for each applicable Plan within 90 days of any resulting enrollment.

Home Health Care

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

Home Health Care Agency

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

Hospice Care Program

The term “Hospice Care Program” means:

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

Hospice Care Services

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

Hospice Facility

An institution or part of it which:

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

Hospital

Anthem BCBS and Cigna define this term differently. For more information, see *Chapter 13A*, which contains the definition of the term used by the applicable Claims Administrator.

Hospital Confinement or Confined in a Hospital

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

- A registered bed patient in a Hospital upon the recommendation of a Physician
- Receiving Mental Health and Substance Use Disorder Treatment in a mental health or substance use disorder Residential Treatment Center

ID Card

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

Ineligible Provider

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

Injury

Bodily harm from an accident.

Inpatient

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

Intensive Care Unit

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

Intensive Outpatient Programs

Anthem BCBS and Cigna define this term differently. For more information, see *Chapter 13A*, which contains the definition of the term used by the applicable Claims Administrator.

Maternity Care

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

Maximum Allowed Amount / Maximum Reimbursable Charge

Anthem BCBS uses the term "Maximum Allowed Amount," and Cigna uses the term "Maximum Reimbursable Charge." These terms represent similar concepts but are defined differently. For more information, see *Chapter 13A*, which contains the definition of the term used by the applicable Claims Administrator.

Medicaid

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

Medical Board

The Medical Board of The Church Pension Fund, as may be appointed by the Chief Executive Officer and President of The Church Pension Fund or their delegate from time to time. As of January 1, 2023, the Medical Board is Aflac Incorporated (formerly known as Zurich American Life Insurance Company).

Medical Pharmaceutical

This term is only used for Plans administered by Cigna. In the Plan Document Handbook for Plans administered by Cigna, see *Chapter 13A* for a definition of this term.

Medically Necessary / Medical Necessity

Anthem BCBS and Cigna define these terms differently. For more information, see *Chapter 13A*, which contains the definition of the term used by the applicable Claims Administrator.

Medicare

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

Medicare Secondary Payer (MSP)

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

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

An exception to the MSP rules that applies to an Eligible Small Employer. For Eligible Small Employers who enroll Members in the SEE Plan, Medicare becomes the primary payer and the Medical Trust will become the secondary payer for claims by Members enrolled in the SEE Plan.

Member

An enrolled Eligible Individual or enrolled Eligible Dependent.

Member of a Religious Order

A postulant, novice or professed member of Episcopal Religious Orders, as defined in Title III, Canon 14.1[20] (a "Religious Order") and verified by the House of Bishops' Committee on Religious Communities, who has been accepted or received by the Religious Order.

Mental Health and Substance Use Disorder Treatment

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

My Admin Portal (MAP)

My Admin Portal (MAP) is CPG's online application used by benefits administrators throughout The Episcopal Church to manage employment assignments related to retirement and benefits enrollments.

MyCPG Accounts

MyCPG Accounts is a web-based tool designed to allow Members to quickly, conveniently, and safely view benefits information, update contact information, and complete Annual Enrollment.

Network Transplant Provider

This term is only used for Plans administered by Anthem BCBS. In the Plan Document Handbook for Plans administered by Anthem BCBS, see *Chapter 13A* for a definition of this term.

Network Benefits

Anthem BCBS and Cigna define this term differently. For more information, see *Chapter 13A*, which contains the definition of the term used by the applicable Claims Administrator.

Network Provider

A Physician, health professional, Hospital, pharmacy, or other individual, organization, and/or Facility that has entered into a contract, either directly or indirectly, with the Claims Administrator to provide, or arrange for the provision of, Covered Health Services to Members through negotiated reimbursement arrangements. A Network Provider for one plan may not be a Network Provider for another. The name of the Network is on your ID Card.

Non-Covered Health Services

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

Other Healthcare Facility

This term is only used for Plans administered by Cigna. In the Plan Document Handbook for Plans administered by Cigna, see *Chapter 13A* for a definition of this term.

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

Other Healthcare Professional

This term is only used for Plans administered by Cigna. In the Plan Document Handbook for Plans administered by Cigna, see *Chapter 13A* for a definition of this term.

Out-of-Network Benefits

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

Out-of-Network Facility

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

Out-of-Network Provider

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

Out-of-Pocket Limit

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

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

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

The annual individual and family Out-of-Pocket Limit amounts are shown on the Summaries of Benefits and Coverage. You should note that (1) Network and Out-of-Network costs accumulate towards separate Out-of-Pocket Limits, but (2) medical and pharmacy costs cross-accumulate towards the individual and/or family Out-of-Pocket Limit, as applicable.

Outbreak Period

The Outbreak Period is the period between March 1, 2020, and a future date that is 60 days after the announced end of the national emergency caused by COVID-19.[21]

Outpatient

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

[21] On January 30, 2023, the Biden Administration announced its intent to end the national emergency and public health emergency declarations on May 11, 2023.

Partial Hospitalization Program

This term is only used for Plans administered by Anthem BCBS. In the Plan Document Handbook for Plans administered by Anthem BCBS, see *Chapter 13A* for a definition of this term.

Participating Group

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

Pay or Play Rules

The employer shared responsibility provisions under the Affordable Care Act, which require certain employers (called "applicable large employers" or ALEs) to either offer minimum essential coverage that is "affordable" and that provides "minimum value" to their full-time employees (and their dependents), or potentially make an employer shared responsibility payment to the IRS. The employer shared responsibility provisions are sometimes referred to as "the employer mandate" or "the pay or play provisions."

Pharmacy & Therapeutics (P&T) Committee

This term is only used for Plans administered by Cigna. In the Plan Document Handbook for Plans administered by Cigna, see *Chapter 13A* for a definition of this term.

Physical Therapy

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

Physician

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

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

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 Code and is exempt from the requirements of ERISA.

Episcopal Health Plan (EHP)
A program of medical and dental plans through which Members are provided health benefits. Benefits are provided through the Medical Trust.

Medicare Secondary Payer (MSP) Small Employer Exception (SEE) Plan
A program of medical plans through which Members are provided health benefits. Benefits are provided through the Medical Trust.

This plan is applicable only to those small employers and individuals enrolled in Medicare who apply and are certified by the Centers for Medicare & Medicaid Services (CMS) as meeting the criteria to participate as a result of meeting the small employer definition and the benefits coordinating with Medicare.

Plan Administrator

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

Plan Sponsor

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

Plan Year

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

Precertification/Prior-Authorization

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

Preventive Care

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

Primary Care Physician (PCP)

Anthem BCBS and Cigna define this term differently. For more information, see *Chapter 13A*, which contains the definition of the term used by the applicable Claims Administrator.

Provider

A duly licensed professional or Facility that provides services within the scope of an applicable license, satisfies the Claims Administrator's accreditation requirements, and for Network Providers, is approved by the Claims Administrator. This includes any Provider rendering services which are required by applicable state law to be covered when rendered by such Provider. Providers that delivery Covered Health Services are described throughout this Plan Document Handbook. If you have a question about whether a Provider is covered, please call the number on the back of your ID Card.

Residential Treatment Center / Facility

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

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

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

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

- Educational care

Retail Health Clinic

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

Review Organization

This term is only used for Plans administered by Cigna. In the Plan Document Handbook for Plans administered by Cigna, see *Chapter 13A* for a definition of this term.

Seminarian

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

Semiprivate Room

A Hospital room which contains two or more beds.

Sickness

This term is only used for Plans administered by Cigna. In the Plan Document Handbook for Plans administered by Cigna, see *Chapter 13A* for a definition of this term.

Significant Life Event

An event as described in *Chapter 2: Eligibility and Enrollment*, where, as a result of the event, an Eligible Individual is eligible to make certain mid-year election changes.

Skilled Convalescent Care

Care required, while recovering from an illness or Injury, which is received in a Skilled Nursing Facility. This care requires a level of care or services less than that in a Hospital, but more than could be given at the patient’s home or in a nursing home not certified as a Skilled Nursing Facility.

Skilled Nursing Facility

Anthem BCBS and Cigna define this term differently. For more information, see *Chapter 13A*, which contains the definition of the term used by the applicable Claims Administrator.

Specialist (Specialty Care Physician / Provider or SCP)

Anthem BCBS and Cigna define this term differently. For more information, see *Chapter 13A*, which contains the definition of the term used by the applicable Claims Administrator.

Specialty Prescription Drug Products

Anthem BCBS and Cigna define this term differently. For more information, see *Chapter 13A*, which contains the definition of the term used by the applicable Claims Administrator.

Stabilize (or Stabilization)

Stabilize means, with respect to an Emergency Medical Condition: to provide such medical treatment of the condition as may be necessary to assure, within reasonable medical probability, that no material deterioration of the condition is likely to result from or occur during the transfer of the individual from a Facility via non-emergency transport, as determined by the Claims Administrator.

Surprise Billing Claim

A claim in respect of charges for Out-of-Network services described under *Surprise Billing Claims* in *Chapter 10: Other Important Plan Provisions*.

Terminal Illness

A Terminal Illness will be considered to exist if a person becomes terminally ill, as diagnosed and certified by a Physician.

Urgent Care

Medical, surgical, Hospital or related healthcare services received for a sudden, serious, or unexpected illness, Injury, or condition that requires prompt attention to avoid adverse consequences but does not pose an immediate threat to a person's life (i.e., is not an emergency), as determined by the Claims Administrator in accordance with generally accepted medical standards. Urgent Care is needed right away to relieve pain, find out what is wrong, or treat a health problem that is not life-threatening. Urgent Care is usually delivered in a walk-in setting and without an appointment. Services may be received at an Urgent Care center, a clinic, or a Physician's office. Urgent Care does not include care that could have been foreseen before leaving the immediate area where you ordinarily receive and/or were scheduled to receive services. Such care includes, but is not limited to, dialysis, scheduled medical treatments or therapy, or care received after a Physician's recommendation that the insured should not travel due to any medical condition.

Utilization Review

This term is only used for Plans administered by Anthem BCBS. In the Plan Document Handbook for Plans administered by Anthem BCBS, see *Chapter 13A* for a definition of this term.

Chapter 13A: Glossary – Additional Claims-Administrator-Specific Terms

Anthem BCBS

Authorized Service

A Covered Health Service rendered by a Provider other than a Network Provider, which has been authorized in advance (except for emergency care which may be authorized after the service is rendered) by the Claims Administrator to be paid at the Network level. The Member may be responsible for the difference between the Out-of-Network Provider's charge and the Maximum Allowed Amount / Maximum Reimbursable Charge, in addition to any applicable Network Coinsurance, Copayment, or Deductible, unless your claim is a Surprise Billing Claim. For more information, see *Chapter 7: Claims and Appeals*, as well as the information under *Surprise Billing Claims* in *Chapter 10: Other Important Plan Provisions*.

Behavioral Health In-Home Programs

A range of therapy services provided in the home to address symptoms and behaviors that, as the result of a mental disorder or substance use disorder, put the Members and others at risk of harm.

Blue Distinction Center for Transplants

A Network Transplant Provider that has been designated as a "Center of Medical Excellence" for transplants by the Claims Administrator.

Covered Transplant Procedure

Any Medically Necessary human organ and stem cell/bone marrow transplants and transfusions as determined by the Claims Administrator, including necessary acquisition procedures, collection and storage, and including Medically Necessary preparatory myeloablative therapy.

Custodial Care Services

Any type of care, including room and board, that (a) does not require the skills of professional or technical personnel; (b) is not furnished by or under the supervision of such personnel or does not otherwise meet the requirements of post-Hospital Skilled Nursing Facility care; (c) is a level such that the Member has reached the maximum level of physical or mental function and is not likely to make further significant improvement. Custodial Care includes, but is not limited to, any type of care the primary purpose of which is to attend to the Member's activities of daily living which do not entail or require the continuing attention of trained medical or paramedical personnel. Examples of Custodial Care include, but are not limited to, assistance in walking; getting in and out of bed; bathing; dressing; feeding; using the toilet; changes of dressings of non-infected, post-operative, or chronic conditions; preparation of special diets; supervision of medication that can be self-administered by the Member; general maintenance care of colostomy or ileostomy; routine services to maintain other services which, in the sole determination of the Plan, can be safely and adequately self-administered or performed by the average non-medical person without the direct supervision of trained medical and paramedical personnel, regardless of who actually provides the service; residential care and adult day care; protective and supportive care including educational services; rest care; and convalescent care.

Durable Medical Equipment

Equipment which is:

- Made to withstand prolonged use;
- Made for and mainly used in the treatment of a disease or Injury;
- Suited for use while not Confined as an Inpatient at a Hospital;
- Not normally of use to persons who do not have a disease or Injury; and
- Not for exercise or training.

Experimental/Investigative/Unproven

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

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

- Cannot be legally marketed in the United States without the final approval of the Food and Drug Administration (FDA), or other licensing or regulatory agency, and such final approval has not been granted; or
- Has been determined by the FDA to be contraindicated for the specific use; or
- Is subject to review and approval of an Institutional Review Board (IRB) or other body serving a similar function; or
- Is provided pursuant to informed consent documents that describe the drug, biologic, device, diagnostic, product, equipment, procedure, treatment, service, or supply as Experimental/Investigative/Unproven, or otherwise indicate that the safety, toxicity, or efficacy of the drug, biologic, device, diagnostic, product, equipment, procedure, treatment, service, or supply is under evaluation.

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

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

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

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

The Claims Administrator has the sole authority and discretion to identify and weigh all information and determine all questions pertaining to whether a drug, biologic, device, diagnostic, product, equipment,

procedure, treatment, service, or supply is Experimental/Investigative/Unproven.

Hospital

An institution licensed and accredited by the appropriate agency, which is primarily engaged in providing diagnostic and therapeutic facilities on an Inpatient basis for the surgical and medical diagnosis, treatment and care of injured and sick persons by or under the supervision of a staff of Physicians duly licensed to practice medicine, and which continuously provides 24-hour-a-day nursing services by registered graduate nurses physically present and on duty. "Hospital" does not mean, other than incidentally:

- An extended care Facility, nursing home, place for rest, Facility for the care of the aged;
- A custodial or domiciliary institution which has as its primary purpose the furnishing of food, shelter, training, or non-medical personal services; or
- An institution for exceptional or disabled children.

Intensive Outpatient Programs

Structured, multidisciplinary behavioral health treatment that provides a combination of individual, group, and family therapy in a program that operates no less than three (3) hours per day, three (3) days per week. Out-of-Network Facility-based Programs must occur at Facilities that are both licensed and accredited.

Maximum Allowed Amount

For Covered Health Services you receive from a Network Provider, the Maximum Allowed Amount is determined pursuant to the agreement between such Network Provider and the Claims Administrator.

For Covered Health Services you receive from an Out-of-Network Provider other than those described under *Surprise Billing Claims* in *Chapter 10: Other Important Plan Provisions*, the Plan will only pay Benefits up to the Maximum Allowed Amount. For this Plan, the Maximum Allowed Amount for such Covered Health Services will be one of the following as determined by the Claims Administrator:

- An amount determined by the Claims Administrator based on the Claims Administrator's Out-of-Network Provider fee schedule/rate, which the Claims Administrator has established through its discretion, and which the Claims Administrator reserves the right to modify after considering one or more of the following: reimbursement amounts accepted by like/similar Providers contracted with the Claims Administrator, reimbursement amounts paid by the Centers for Medicare and Medicaid Services (CMS) for the same services or supplies, and other industry cost, reimbursement and utilization data
- An amount determined by the Claims Administrator based on reimbursement or cost information from CMS
- An amount determined by the Claims Administrator based on information provided by a third-party vendor, which may reflect one or more of the following factors: (1) the complexity or severity of treatment; (2) level of skill and experience required for the treatment; or (3) comparable Providers' fees and costs to deliver care
- An amount negotiated by the Claims Administrator or a third-party vendor which has been agreed to by the Provider. This may include rates for services coordinated through case management
- An amount determined by the Claims Administrator based on or derived from the total charges billed by the Out-of-Network Provider

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

Unlike Network Providers, Out-of-Network Providers who provide Covered Health Services other than those described under *Surprise Billing Claims* in *Chapter 10: Other Important Plan Provisions*, may send you a bill and collect for the amount of the Provider's charge that exceeds the Plan's Maximum Allowed Amount. You are responsible for paying the difference between the Maximum Allowed Amount and the amount the Provider charges. This amount can be significant. Choosing a Network Provider will likely result in lower out-of-pocket

costs to you. Please call Customer Service for help in finding a Network Provider, or go to *anthem.com*.

For Covered Health Services you receive from an Out-of-Network Provider described under *Surprise Billing Claims* in *Chapter 10: Other Important Plan Provisions*, please refer to that section for more information about how the payments made to the Out-of-Network Providers are determined. If sufficient data is unavailable in the database for that geographic area to determine the Maximum Allowed Amount, then state, regional or national data may be used. If sufficient data is unavailable in the database for that geographic area to determine the Maximum Allowed Amount, then data in the database for similar services may be used. The database(s) used for these purposes will be selected by the Claims Administrator.

Medically Necessary / Medical Necessity

Procedures, supplies, equipment, or services that we conclude are:

- Appropriate for the symptoms, diagnosis, or treatment of a medical condition; and
- Given for the diagnosis or direct care and treatment of the medical condition; and
- Within the standards of good medical practice within the organized medical community; and
- Not mainly for the convenience of the Physician or another Provider, and the most appropriate procedure, supply, equipment, or service which can be safely given.

The most appropriate procedure, supply, equipment, or service must meet the following requirements:

- There must be valid scientific evidence to show that the expected health benefits from the procedure, supply, equipment, or service are clinically significant and will have a greater chance of benefit, without a disproportionately greater risk of harm or complications, than other possible treatments; and
- Generally approved forms of treatment that are less invasive have been tried and did not work or are otherwise unsuitable; and
- For Hospital stays, acute care as an Inpatient is needed due to the kind of services the patient needs or the severity of the medical condition, and that safe and adequate care cannot be given as an Outpatient or in a less intensive medical setting.

The most appropriate procedure, supply, equipment, or service must also be cost-effective compared to other alternative interventions, including no intervention or the same intervention in an alternative setting. Cost-effective does not always mean lowest cost. It does mean that as to the diagnosis or treatment of your illness, Injury, or disease, the service is: (1) not more costly than another service or group of services that is medically appropriate, or (2) the service is performed in the least costly setting that is medically appropriate. For example, we will not provide coverage for an Inpatient admission for surgery if the surgery could have been performed on an Outpatient basis or an infusion or injection of a Specialty Prescription Drug Product provided in the Outpatient department of a Hospital if the Drug could be provided in a Physician’s office or the home setting.

Network Benefits

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

Network Transplant Provider

A Provider selected to participate as a Network Transplant Provider by the Blue Cross and Blue Shield Association. Such Provider has entered into a Transplant Provider agreement to render covered transplant procedures and certain administrative functions to you for the transplant network. A Provider may be a Network Transplant Provider with respect to:

- Certain covered transplant procedures; or
- All covered transplant procedures

Partial Hospitalization Program

Structured, multidisciplinary behavioral health treatment that offers nursing care and active individual, group, and family treatment in a program that operates no less than six (6) hours per day, five (5) days per week. Out-of-Network Facility-based Programs must occur at Facilities that are both licensed and accredited.

Primary Care Physician (PCP)

A Provider who specializes in family practice, general practice, internal medicine, pediatrics, obstetrics/gynecology, geriatrics, or any other Provider as allowed by the Plan. A PCP supervises, coordinates, and provides initial care and basic medical services to a Member and is responsible for ongoing patient care.

Skilled Nursing Facility

A Facility licensed as a Skilled Nursing Facility in the state in which it is located that satisfies the Claims Administrator's accreditation requirements and, for Network Facilities, is approved by the Claims Administrator. A Skilled Nursing Facility is an institution operated alone or with a Hospital which gives care after a Member leaves the Hospital for a condition requiring more care than can be rendered at home, and is not a place mainly for care of the aged, Custodial Care, or domiciliary care, or a place for rest, educational, or similar services.

Specialist (Specialty Care Physician / Provider or SCP)

A Specialist is a Physician who focuses on a specific area of medicine or group of patients to diagnose, manage, prevent, or treat certain types of symptoms and conditions. A non-Physician Specialist is a Provider who has added training in a specific area of healthcare.

Specialty Prescription Drug Products

Typically high-cost drugs that are injected or infused in the treatment of acute or chronic diseases. Specialty Prescription Drug Products often require special handling such as temperature-controlled packaging and expedited delivery. Most Specialty Prescription Drug Products require preauthorization to be considered Medically Necessary.

Utilization Review

Evaluation of the necessity, quality, effectiveness, or efficiency of medical or behavioral health services, procedures, and/or Facilities.

Chapter 14: Contact Information

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

The Episcopal Church Medical Trust
cpg.org
800-480-9967
email: *mtcustserv@cpg.org*
Monday through Friday, 8:30 AM to 8:00 PM ET

Anthem Blue Cross and Blue Shield
anthem.com
844-812-9207
Monday through Friday, 8:30 AM to 8:00 PM ET

Anthem Behavioral Health Resource Center
844-792-5141
24 hours a day, seven days a week

Cigna Healthcare
mycigna.com
800-244-6224
Monday through Friday, 8:00 AM to 6:00 PM

Cigna Employee Assistance Program (EAP)
mycigna.com
866-395-7794
24 hours a day, seven days a week

Express Scripts
express-scripts.com
800-841-3361
24 hours a day, seven days a week

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

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

UnitedHealthcare Global Assistance
members.uhcglobal.com
+1 410-453-6330 (collect calls accepted)
24 hours a day, 7 days a week

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

Chapter 15: Your Rights and Protections Against Surprise Medical Bills

WHEN YOU GET EMERGENCY CARE OR ARE TREATED BY AN OUT-OF-NETWORK PROVIDER AT AN IN-NETWORK HOSPITAL OR AMBULATORY SURGICAL CENTER, YOU ARE PROTECTED FROM BALANCE BILLING. IN THESE CASES, YOU SHOULDN'T BE CHARGED MORE THAN YOUR PLAN'S COPAYMENTS, COINSURANCE AND/OR DEDUCTIBLE.

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

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

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

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

You're protected from balance billing for:

Emergency Services

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

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

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

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

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

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

- You're only responsible for paying your share of the cost (like the copayments, coinsurance, and deductible that you would pay if the provider or facility was in-network). Your health plan will pay any additional costs to out-of-network providers and facilities directly.
- Generally, your health plan must:
  - Cover emergency services without requiring you to get approval for services in advance (also known as "prior authorization").
  - Cover emergency services by out-of-network providers.

- Base what you owe the provider or facility (cost-sharing) on what it would pay an in-network provider or facility and show that amount in your explanation of benefits.
- Count any amount you pay for emergency services or out-of-network services toward your in-network deductible and out-of-pocket limit.

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

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

PLEASE RETURN THIS COMPLETED FORM TO:
Office of Clinical Management
The Episcopal Church Medical Trust
19 East 34th Street
New York, NY 10016
(Confidential Fax: 212-251-8891)

AUTHORIZATION

FOR USE OR DISCLOSURE OF PROTECTED HEALTH INFORMATION

1. INDIVIDUAL AUTHORIZING USE OR DISCLOSURE

_____

_____

_____

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

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

_____

_____

_____

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

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

_____

_____

_____

_____

_____

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

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

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

_____

_____

_____

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

5. PURPOSE OF AUTHORIZATION TO USE OR DISCLOSE

_____

_____

_____

_____

[List specific purposes here.]

6. DURATION OF AUTHORIZATION

_____

_____

_____

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

7. TO REVOKE THIS AUTHORIZATION, CONTACT:

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

8. AUTHORIZATION AND ACKNOWLEDGEMENT OF PRIVACY RIGHTS

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

I understand that:

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

_____ _____

Signature of Individual or Personal Representative Date

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

_____

*[Name of Personal Representative]**

_____

_____

[Authority of Personal Representative]

*Personal representative includes:

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

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

Part II – Anthem-BCBS-Specific Plan Provisions

Chapter 16: The BlueCard PPO Network

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

Providers are compensated using a variety of payment arrangements, including fee for service, per diem, discounted fees, and global reimbursement.

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

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

Network Services

When you use a Network Provider or get care as part of an Authorized Service, Covered Health Services will be covered at the Network Benefit level.[22] Regardless of Medical Necessity, Benefits will be denied for care that is not a Covered Health Service. The Plan has the final authority to decide the Medical Necessity of the service.

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

Network Providers include Primary Care Physicians/Providers (PCPs), Specialists, other professional Providers, Hospitals, and other Facilities who contract with Anthem to care for you. Referrals are never needed to visit a Network Provider, including Specialists or behavioral health Providers.

To see a Physician, call their office:

- Tell them you are an Anthem Member.
- Have your ID Card handy. The Physician's office may ask you for your group or Member ID number.
- Tell them the reason for your visit.

When you go to the office, be sure to bring your Member ID Card with you.

For services from Network Providers:

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

[22] Members may be billed for amounts in excess of the Maximum Allowed Amount if Authorized Services are provided by an Out-of-Network Provider.

- Precertification will be done by the Network Provider. (Please refer to *Chapter 17: Utilization Review (including Precertification) and Healthcare Management*, for further details.)

After Hours Care

If you need care after normal business hours, your Physician may have several options for you. You should call your Physician's office for instructions if you need care in the evenings, on weekends, or during the holidays and cannot wait until the office reopens. If you have an emergency, call 911 or go to the nearest emergency room.

Out-of-Network Services

When you do not use a Network Provider or get care as part of an Authorized Service, Covered Health Services are covered at the Out-of-Network Benefit level, unless otherwise indicated in this Plan Document Handbook.

For services from an Out-of-Network Provider:

- There is no limit to what an Out-of-Network Provider can charge, unless your claim involves a Surprise Billing Claim.
- The Out-of-Network Provider may charge you the difference between their bill and the Plan's Maximum Allowed Amount / Maximum Reimbursable Charge, plus any Deductible and/or Coinsurance/Copayments, unless your claim involves a Surprise Billing Claim.
- You may have higher cost sharing amounts (i.e., Deductibles, Coinsurance, and/or Copayments), unless your claim involves a Surprise Billing Claim.
- You will have to pay for services that are not Medically Necessary.
- You will have to pay for Non-Covered Health Services.
- You may have to file claims.
- You must make sure any necessary Precertification is done. (See *Chapter 17: Utilization Review (including Precertification) and Healthcare Management*.)

For information on how Charges from Out-of-Network Providers that involve Surprise Billing Claims are addressed, please see *Surprise Billing Claims* in *Chapter 10: Other Important Plan Provisions*.

Use the Mobile App to Connect with Anthem

As soon as you enroll in the Plan, you should download Anthem's mobile app. You can find details on how to do this at *anthem.com*. The goal is to make it easy for you to find answers to your questions. You can chat with a representative live in the app, or contact Anthem at *anthem.com*.

How to Find a Network Provider

There are four ways you can find out if a Provider or Facility is a Network Provider for this Plan. You can also find out where they are located and details about their license or training.

- See your Plan's directory of Network Providers at *anthem.com*, which lists the Physicians, Providers, and Facilities that participate as a Network Provider.
- Search for a Provider in our mobile app.
- Call Member Services to ask for a list of Physicians and Providers that participate as a Network Provider, based on specialty and geographic area.
- Check with your Physician or Provider.

If you need details about a Provider's license or training, or help choosing a Physician who is right for you, call the Member Services number on the back of your Member ID Card. TTY/TDD services are also available by dialing 711, and a special operator will get in touch with you.

The BlueCard Program

Like all Blue Cross and Blue Shield plans throughout the country, Anthem participates in a program called “BlueCard,” which provides services to you when you are outside the service area.

Coinsurance and Copayments

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

Calendar Year Deductible

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

Out-of-Pocket Limit

After the Out-of-Pocket Limit is reached, all Covered Health Services are paid in full by the health Plan for the rest of that Plan Year.

Blue Cross Blue Shield Global Core® Program

If you plan to travel outside the United States, call Member Services to find out more about your Blue Cross Blue Shield Global Core® Benefits. Benefits for services received outside of the United States may be different from services received in the United States. Remember to take an up-to-date health ID Card with you.

When you are traveling abroad and need medical care, you can call the Blue Cross Blue Shield Global Core® Service Center any time. They are available 24 hours a day, seven days a week. The toll-free number is 800-810-2583. Or you can call them collect at 804-673-1177.

If you need Inpatient Hospital care, you or someone on your behalf, should contact the Claims Administrator for Precertification. Keep in mind, if you need emergency medical care, go to the nearest Hospital. There is no need to call before you receive care.

Please refer to *Chapter 17: Utilization Review (including Precertification) and Healthcare Management*, for further information. You can learn how to get Preauthorization when you need to be admitted to the hospital for emergency or non-emergency care.

In most cases, when you arrange Inpatient Hospital care with Blue Cross Blue Shield Global Core®, claims will be filed for you. The only amounts that you may need to pay up front are any Copayment, Coinsurance, or Deductible amounts that may apply.

You will typically need to pay for the following services up front:

- Physician’s services
- Inpatient Hospital care not arranged through Blue Cross Blue Shield Global Core®
- Outpatient services

You will find the address for mailing the claim on the form.

You can get the Blue Cross Blue Shield Global Core® claim form by calling the numbers above or online at *bcbsglobalcore.com* or *cpg.org/mtdocs*.

Special Programs

24/7 NurseLine®

You may have emergencies or questions for nurses around the clock. 24/7 NurseLine® provides you with accurate health information any time of the day or night. Through one-on-one counseling with experienced nurses available 24 hours a day via a convenient toll-free number, you can make more informed decisions about the most appropriate and cost-effective use of healthcare services. A staff of experienced nurses is trained to address common healthcare concerns, such as medical triage, education, access to healthcare, diet, social/family dynamics and mental health issues. Specifically, the 24/7 NurseLine® features:

- A skilled clinical team, including licensed RNs that help you understand medical conditions, ensure you receive the right care in the right setting, and refer you to programs and tools appropriate to your condition
- Bilingual RNs, language line, and hearing-impaired services
- Access to the Audio Health Library, containing hundreds of audiotapes on a wide variety of health topics
- Proactive callbacks within 24 to 48 hours for Members referred to 911 emergency services, poison control, and pediatric Members with needs identified as either emergent or urgent
- Referrals to relevant community resources.

Anthem Health Guide

Anthem Health Guide provides you with enhanced Member Services support. You can contact a health guide with questions about Benefits, programs for your health, help scheduling Physicians' appointments, comparing costs for procedures, and more. Health guides can connect you with knowledgeable health professionals to help you manage chronic conditions, deal with an illness, or provide support for emotional concerns like anxiety or depression. Reach out to Member Services and our health guides via phone, email, app, or even chat online.

Anthem Imaging Shopper

If you need an MRI or a CT scan, it's important to know that costs can vary quite a bit depending on where you go to receive the service. Sometimes the differences are significant – anywhere from $300 to $3,000 – but a higher price doesn't guarantee higher quality. If your Plan requires you to pay a portion of this cost (like a Deductible or Coinsurance), where you go can a make a very big difference to your wallet.

How the program works:

- Your doctor lets Anthem know you will have one of these procedures.
- Anthem will check to see if the Provider who will perform the procedure offers a lower cost for the service.
- If not, Anthem may call you to give you other choices nearby.
- You choose the Provider that best meets your needs, whether it's the one your doctor suggested, or one Anthem tells you about. It's completely up to you!

Autism Spectrum Disorders (ASD) Program

The ASD Program is comprised of a specialized, dedicated team of clinicians within Anthem who have been trained on the unique challenges and needs of families with a Member who has a diagnosis of ASD. Anthem provides specialized case management services for Members with autism spectrum disorders and their families. The Program also includes Precertification and Medical Necessity reviews for Applied Behavioral Analysis, a treatment modality targeting the symptoms of autism spectrum disorders. **Note:** Coverage for the treatment of mental health and substance use disorder conditions within this program is provided in compliance with federal law.

For families touched by ASD, Anthem's ASD Program provides support for the entire family, giving

assistance wherever possible and making it easier for them to understand and utilize care, resulting in access to better outcomes and more effective use of Benefits. The ASD Program has three main components:

- Education
    - Educates and engages the family on available community resources, helping to create a system of care around the Member.
    - Increases knowledge of the disorder, resources, and appropriate usage of Benefits.
- Guidance
    - Applied Behavioral Analysis management, including clinical reviews by experienced licensed clinicians. Precertification delivers value, ensuring that the Member receives the right care, from the right Provider, at the right intensity.
    - Increased follow-up care encouraged by appointment setting, reminders, attendance confirmation, proactive discharge planning, and referrals.
    - Assure that parents and siblings have the best support to manage their own needs.
- Coordination
    - Enhanced Member experience and coordination of care.
    - Assistance in exploration of medical services that may help the Member, including referrals to medical case management.
    - Licensed behavior analysts and program managers provide support and act as a resource to the interdisciplinary team, helping them navigate and address the unique challenges facing families with an autistic Child.

Behavioral Health Resource Center

Extra support can make a big difference when facing issues such as anxiety, depression, eating disorders, or substance use. Our caring experts will work with you at no extra cost to find treatment programs and arrange confidential counseling and support services 24/7 that meet your individual and family needs. Contact the Anthem Behavioral Health Resource Center at 844-792-5141.

Inclusive Care

Part of living a healthy life is finding a doctor you trust. To make this easier for Members who are lesbian, gay, bisexual, transgender, or queer (LGBTQ+), Inclusive Care helps you find doctors who will treat you with dignity and respect and who are experienced in providing compassionate, high-quality LGBTQ+ healthcare. When using an Inclusive Care Center of Excellence, and the treatment has been pre-approved by Anthem, you may be eligible for the travel and lodging benefit. Call the Member Services number on the back of your ID Card for information.

The program is available to Members looking for:

- Access to the Plan's large Network of medical and mental health professionals, including primary and specialty care from a Provider with LGBTQ+ experience
- Expert, whole-health care, regardless of gender identity
- World Professional Association for Transgender Health (WPATH) Standards of Care for gender-affirmation services, based upon your Benefit coverage
- Counseling for mental health and emotional well-being
- Support for coming out at work
- HIV/AIDS treatment and PrEP medication
- Information on gender-affirming surgery and services, benefits, and options
- Ways to support a family member or friend who is LGBTQ+

Integrated Health Model (IHM)

Your health is invaluable. Health problems have a tremendous impact on your quality of life at work and outside of work.

Getting time with your Physician can be a challenge. Perhaps it is hard to get the support you need between visits, or you can't understand a new diagnosis or prescription. Maybe you have unmet medical needs because you don't have a personal Physician. We can help you find one. Your

Anthem nurse can help you address all of these needs and more.

The bottom line is, we know many people with health issues need support. Your Anthem nurse is here to provide that support.

- Your Anthem nurse is an experienced registered nurse.
- Your Anthem nurse can provide you with valuable support and is available to help you and your covered family members navigate certain health issues and needs.
- Your Primary Care Physician and other medical professionals are responsible for your medical care and treatment. Your Anthem nurse will not take the place of your Providers, but your Anthem nurse can help bridge the gap between your Physician and other Providers and help you receive the most from your health Benefits.

When you need support and resourceful information, you will be able to connect with your Anthem nurse – "your nurse." They will get to know you and your family and help you develop a plan to address your concerns and meet your health goals.

If your nurse is not available, others will be on hand to help.

Your nurse can help answer your questions about your health Benefits, help you access Physicians to address your healthcare needs, and let you know about other programs that may benefit you.

Be assured that we know your time is valuable and your nurse will customize their outreach efforts to your needs. For example, if you have a condition such as diabetes or high blood pressure, and you inform Anthem that you are confident in getting your prescriptions filled appropriately, seeing your Physician, having the right tests, and staying healthy, your Anthem nurse may not be making that outreach call to you. But, if you are dealing with complex medical needs, we likely will be reaching out to you and hope you will take advantage of the support and educational resources that we are here to provide.

If your Physician decides that you need to be hospitalized, we also want to reach out to you to make sure you have the support you may need before, during and after your hospitalization and recovery.

Of course, you can always reach out to us for assistance.

Your Anthem nurse can help with:

- Answering questions about a diagnosis
- Explaining your Plan Benefits
- Educating you about treatment options for specific conditions
- Providing support following an ER visit
- Counseling before a hospitalization or surgery, planning for any follow-up needs, and providing support to help with a successful recovery
- Serving as a bridge between Hospital and home after an Inpatient Hospital stay. Your Anthem nurse can help confirm medications, assist with acquisition of necessary medical equipment, and ensure follow-up services are scheduled.

Your Anthem nurse can also help with:

- Coordination of your health Benefits for services provided by Specialists, Hospitals, and pharmacies as well as any in-home care
- Understanding and accessing health and wellness information
- Providing support for behavioral health needs
- Providing specialized support for those with complex health needs
- Coaching, motivating, and empowering you to help improve your health status
- Providing education and support to help you during pregnancy

- Helping you receive the right level of care and support when you need it

Additional resources and information:

In addition to your nurse, you have an experienced multi-disciplinary team of health professionals that includes social workers, dieticians, and a pharmacist to provide support and health education to you or your covered family members.

- Your privacy is always protected in compliance with all privacy laws.

Any time you want to talk to a nurse, we encourage you to call the Member Services number on the back of your ID Card.

MyHealth Advantage

MyHealth Advantage is a free service that helps keep you and your bank account healthier. Here's how it works: The Claims Administrator will review your incoming health claims to see if the Plan can save you any money. The Claims Administrator can check to see what medications you are taking and alert your Physician if the Claims Administrator spots a potential drug interaction. The Claims Administrator also keeps track of your routine tests and checkups, reminding you to make these appointments by mailing you MyHealth Notes. MyHealth Notes summarize your recent claims. From time to time, the Claims Administrator will offer tips to save you money on prescription drugs and other healthcare supplies.

Quick Care Options

Quick Care Options helps to raise your awareness about appropriate alternatives to Hospital emergency rooms (ERs). When you need care right away, Retail Health Clinics and Urgent Care centers can offer appropriate care for less cost and leave the ER available for actual emergencies. Quick Care Options educates you on the availability of ER alternatives for non-urgent diagnoses and provides the Provider finder website to support searches for ER alternatives.

Sydney Health

Discover a powerful and more personalized health app. View all your Benefits and access wellness tools to improve your overall health with the Sydney Health app.

The Sydney Health mobile app works with you by guiding you to better overall health – and *for* you by bringing your Benefits and health information together in one convenient place. Sydney Health has everything you need to know about your Benefits, so you can make the most of them while taking care of your health.

Working with you

- Reminding you about important Preventive Care needs
- Guiding you with insights based on your history and changing health needs
- Empowering you with personalized tools to find and compare healthcare Providers and check costs
- Planning and tracking your health goals, fitness, and rewards.

Working for you

- Giving you instant access to your vision, dental, and spending account benefits
- Storing your Member ID Card so you can show, email, or fax it right from your phone
- Providing answers quickly through real-time live chat with Anthem Health Guides and nurses
- Connecting you directly to care through a symptom checker, a virtual video, or text visit

Virtual Second Opinion

Facing a medical decision? The Virtual Second Opinion program allows you access to highly specialized Physicians who can provide educational guidance for certain diagnoses, procedures, or courses of treatment. Our advanced analytics engine helps to identify you and other Members to offer support through our nurses and will refer you to an independent company that will handle your second opinion.

With the Virtual Second Opinion program, you can:

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

Telehealth

Our Members enrolled in an Anthem plan have access to LiveHealth Online 24/7. LiveHealth Online lets you talk face-to-face with a Physician through your mobile device or a computer with a webcam.

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

See *Online Visits* in *Chapter 3A* for more information.

Ask Questions About Your Healthcare Coverage

To find answers, you can:

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

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

Chapter 17: Utilization Review (including Precertification) and Healthcare Management

Your Plan includes the process of Utilization Review to decide when services are Medically Necessary or Experimental/Investigative/Unproven, as those terms are defined in this Plan Document Handbook. Utilization Review aids the delivery of cost-effective healthcare by reviewing the use of treatments and, when proper, level of care and/or the setting or place of service that they are performed. A service must be Medically Necessary to be a Covered Health Service. When level of care, setting or place of service is part of the review, services that can be safely given to you in a lower level of care or lower-cost setting/place of care will not be Medically Necessary if they are given in a higher level of care or higher cost setting/place of care.

Certain services must be reviewed to determine Medical Necessity in order for you to get Benefits. Utilization Review criteria will be based on many sources including medical policy and clinical guidelines. The Claims Administrator may decide that a treatment that was asked for is not Medically Necessary if a clinically equivalent treatment that is more cost effective is available and appropriate.

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

Reviewing Where Services are Provided

A service must be Medically Necessary to be a Covered Health Service. When level of care, setting, or place of service is reviewed, services that can be safely given to you in a lower level of care or lower cost setting/place of care will not be Medically Necessary if they are given in a higher level of care or higher cost setting/place of care. This means that a request for a service may be denied because it is not Medically Necessary for the service to be provided where it is being requested. When this happens, the service can be requested again in another place and will be reviewed again for Medical Necessity. At times, a different Provider or Facility may need to be used in order for the service to be considered Medically Necessary. Examples include, but are not limited to:

- A service may be denied on an Inpatient basis at a Hospital but may be approvable if provided on an outpatient basis at a Hospital.
- A service may be denied on an outpatient basis at a Hospital but may be approvable at a free-standing imaging center, infusion center, Ambulatory Surgery Center, or in a Physician's office.
- A service may be denied at a Skilled Nursing Facility but may be approvable in a home setting.

Utilization Review criteria will be based on many sources including medical policy and clinical guidelines. The Plan may decide that a treatment that was asked for is not Medically Necessary if a clinically equivalent treatment that is more cost-effective is available and appropriate. "Clinically equivalent" means treatments that for most Members will give you similar results for a disease or condition.

Coverage for or payment of the service or treatment reviewed is not guaranteed even if the Plan decides your services are Medically Necessary. For Benefits to be covered, on the date you get service:

- You must be eligible for Benefits
- Fees must be paid for the time period that services are given
- The service or supply must be a Covered Health Service under your Plan
- The service cannot be subject to an exclusion under your Plan
- You must not have exceeded any applicable limits under your Plan

Types of Utilization Reviews

Pre-service Review—A review of a service, treatment or admission for a Benefit coverage

determination which is done before the service or treatment begins or admission date.

Precertification—A required pre-service review for a Benefit coverage determination for a service or treatment. Certain services require Precertification in order for you to get Benefits. The benefit coverage review will include a review to decide whether the service meets the definition of Medical Necessity or is Experimental/Investigative/Unproven as those terms are defined in this Plan Document Handbook.

For admissions following emergency care, you, your Authorized Representative or Physician must tell the Claims Administrator as soon as you are Stabilized. For childbirth admissions, Precertification is not needed unless there is a problem and/or the mother and baby are not sent home at the same time. Precertification is not required for the first 48 hours for a vaginal delivery or 96 hours for a cesarean section. Admissions longer than 48/96 hours require Precertification.

Continued Stay/Concurrent Review—A Utilization Review of a service, treatment or admission for a Benefit coverage determination which must be done during an ongoing stay in a Facility or course of treatment.

Both pre-service and continued stay/concurrent reviews may be considered urgent when, in the view of the treating Provider or any Physician with knowledge of your medical condition, without such care or treatment, your life or health or your ability to regain maximum function could be seriously threatened, or you could be subjected to severe pain that cannot be adequately managed without such care or treatment. Urgent reviews are conducted under a shorter timeframe than standard reviews.

Post-Service Review—A review of a service, treatment, or admission for a Benefit coverage that is conducted after the service has been provided. Post-service reviews are performed when a service, treatment or admission did not need a Precertification, or when a needed Precertification was not obtained. Post-service reviews are done 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.

A complete list of Anthem Medical Policies and Adopted Clinical Guidelines is available by visiting *anthem.com* and using the Provider tab for accessing information. You may also call the Customer Service number on the Member ID Card to see if the specific requested code is subject to medical policy or clinical guideline criteria.

The following list of services requiring Precertification 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

- Acute Inpatient
- Acute Rehabilitation
- LTACH (Long Term Acute Care Hospital)
- Skilled Nursing Facility
- OB delivery stays beyond the Federal Mandate minimum LOS (including newborn stays beyond the mother's stay)
- Emergency Admissions (Requires Plan notification as soon as Stabilized)

Diagnostic Testing

- Cardiac Ion Channel Genetic Testing
- Chromosomal Microarray Analysis (CMA) for Developmental Delay, Autism Spectrum Disorder, Intellectual Disability (Intellectual Developmental Disorder) and Congenital Anomalies
- Gene Expression Profiling for Managing Breast Cancer Treatment

- Gene Mutation Testing for Solid Tumor Cancer Susceptibility and Management
- Genetic Testing for Breast and/or Ovarian Cancer Syndrome
- Genetic Testing for Inherited Diseases
- Genetic Testing for Lynch Syndrome, Familial Adenomatous Polyposis (FAP) Attenuated FAP and MYH-Associated Polyposis
- Preimplantation Genetic Diagnosis Testing
- RET Proto-oncogene Testing for Endocrine Gland Cancer Susceptibility
- Wireless Capsule for the Evaluation of Suspected Gastric and Intestinal Motility Disorders
- Prostate Saturation Biopsy

Durable Medical Equipment (DME)/Prosthetics

- Augmentative and Alternative Communication (AAC) Devices / Speech Generating Devices (SGD)
- Electrical Bone Growth Stimulation
- Functional Electrical Stimulation (FES); Threshold Electrical Stimulation (TES)
- Implantable Infusion Pumps
- Lower Limb Prosthesis and Microprocessor Controlled Lower Limb Prosthesis
- Oscillatory Devices for Airway Clearance including High Frequency Chest Compression and Intrapulmonary Percussive Ventilation (IPV)
- Pneumatic Compression Devices for Lymphedema
- Ultrasound Bone Growth Stimulation
- Wheeled Mobility Devices: Wheelchairs — Powered, Motorized, With or Without Power Seating Systems and Power Operated Vehicles (POVs)
- Prosthetics: Electronic or externally powered and select other prosthetics (myoelectric-UE)
- Standing Frame

Gender Affirmation / Gender-Affirming Surgery

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
- Axicabtagene ciloleucel (Yescarta™) (CAR) T-cell immunotherapy treatment
- Tisagenlecleucel (Kymriah™) (CAR) T-cell immunotherapy treatment
- Gene Therapy Treatment & Replacement
- Intrathecal treatment of Spinal Muscular Atrophy (SMA)

Outpatient and Surgical Services

- Aduhelm
- Air Ambulance (excludes 911 initiated emergency transport)
- Autologous Cellular Immunotherapy for the Treatment of Prostate Cancer
- Ablative Techniques as a Treatment for Barrett's Esophagus
- Balloon and Self-Expanding Absorptive Sinus Ostial Dilation
- Bariatric Surgery and Other Treatments for Clinically Severe Obesity
- Bone-Anchored and Bone Conduction Hearing Aids
- Bronchial Thermoplasty for Treatment of Asthma
- Cardio-Vascular, including:
    - 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
    - Endovascular Techniques (Percutaneous or Open Exposure) for Arterial

Revascularization of the Lower Extremities)
    - Implantable Ambulatory Event Monitors and Mobile Cardiac Telemetry
    - Implantable or Wearable Cardioverter-Defibrillator
    - Mechanical Circulatory Assist Devices (Ventricular Assist Devices, Percutaneous Ventricular Assist Devices and Artificial Hearts)
    - Mechanical Embolectomy for Treatment of Acute Stroke
    - Outpatient Cardiac Hemodynamic Monitoring Using a Wireless Sensor for Heart Failure Management
    - Partial Left Ventriculectomy
    - Transcatheter Ablation of Arrhythmogenic Foci in the Pulmonary Veins as a Treatment of Atrial Fibrillation (Radiofrequency and Cryoablation)
    - Transcatheter Closure of Patent Foramen Ovale and Left Atrial Appendage for Stroke Prevention
    - Transcatheter Heart Valve Procedures
    - Transmyocardial/Perventricular Device Closure of Ventricular Septal Defects
    - Treatment of Varicose Veins (Lower Extremities)
    - Venous Angioplasty with or without Stent Placement/ Venous Stenting
- Cochlear Implants and Auditory Brainstem Implants
- Corneal Collagen Cross-Linking
- Cryosurgical Ablation of Solid Tumors Outside the Liver
- Deep Brain, Cortical, and Cerebellar Stimulation
- Diaphragmatic/Phrenic Nerve Stimulation pacing systems
- Electric Tumor Treatment Field (TTF) for treatment of glioblastoma
- Functional Endoscopic Sinus Surgery
- Home Parenteral Nutrition
- Immunoprophylaxis for respiratory syncytial virus (RSV)
- Intraocular Anterior Segment Aqueous Drainage Devices (without extraocular reservoir)
- Keratoprosthesis
- Leadless Pacemaker
- Locally Ablative Techniques for Treating Primary and Metastatic Liver Malignancies
- Lower Esophageal Sphincter Augmentation Devices for the Treatment of Gastroesophageal Reflux Disease (GERD)
- Musculo-Skeletal Surgeries, including:
    - Axial Lumbar Interbody Fusion
    - Computer-Assisted Musculoskeletal Surgical Navigational Orthopedic Procedures of the Appendicular System
    - Cervical and Thoracic Discography
    - Implanted Devices for Spinal Stenosis
    - Implanted (Epidural and Subcutaneous) Spinal Cord Stimulators (SCS)
    - Lysis of Epidural Adhesions
    - Manipulation Under Anesthesia of the Spine and Joints other than the Knee
    - Meniscal Allograft Transplantation of the Knee
    - Percutaneous Vertebroplasty, Kyphoplasty and Sacroplasty
    - Sacroiliac Joint Fusion (*minimally invasive*)
    - Total Ankle Replacement
    - Treatment of Osteochondral Defects of the Knee and Ankle
- Ovarian and Internal Iliac Vein Embolization as a Treatment of Pelvic Congestion Syndrome
- Percutaneous and Endoscopic Spinal Surgery
- Percutaneous Neurolysis for Chronic Neck and Back Pain
- Percutaneous Vertebral Disc and Vertebral Endplate Procedures
- Perirectal Spacers for Use During Prostate Radiotherapy (Space Oar)
- Plastic/Reconstructive Surgeries/Treatments, including:
    - Abdominoplasty, Panniculectomy, Diastasis Recti Repair
    - Allogeneic, Xenographic, Synthetic and Composite Products for Wound Healing and Soft Tissue Grafting Hyperbaric Oxygen Therapy (Systemic/Topical)
    - Blepharoplasty
    - Brachioplasty
    - Breast Procedures; including Reconstructive Surgery, Implants and other Breast

Procedures
    - Chin Implant, Mentoplasty, Osteoplasty Mandible
    - Insertion/injection of prosthetic material collagen implants
    - Liposuction/lipectomy
    - Mandibular/Maxillary (Orthognathic) Surgery
    - Mastectomy for Gynecomastia
    - Oral, Pharyngeal, and Maxillofacial Surgical Treatment for Obstructive Sleep Apnea or Snoring
    - Penile Prosthesis Implantation
    - Procedures Performed on the Face, Jaw or Neck (including facial dermabrasion, scar revision)
    - Procedures Performed on Male or Female Genitalia
    - Procedures Performed on the Trunk and Groin
    - Reduction Mammaplasty
    - Repair of pectus excavatum/carinatum
    - Skin-Related Procedures
- Private Duty Nursing
- Presbyopia and Astigmatism-Correcting Intraocular Lenses
- Sacral Nerve Stimulation (SNS) and Percutaneous Tibial Nerve Stimulation (PTNS) for Urinary and Fecal Incontinence and Urinary Retention
- Sacral Nerve Stimulation as a Treatment of Neurogenic Bladder Secondary to Spinal Cord Injury
- Subtalar Arthroereisis
- Surgical and Ablative Treatments for Chronic Headaches
- Surgical Treatment of Obstructive Sleep Apnea and Snoring
- Transanal Hemorrhoidal Dearterialization (THD)
- Transendoscopic Therapy for Gastroesophageal Reflux Disease and Dysphagia
- Treatments for Urinary Incontinence
- Treatment of Temporomandibular Disorders
- Vagus Nerve Stimulation
- Viscocanalostomy and Canaloplasty

Radiation Therapy/Radiology Services

- Intensity Modulated Radiation Therapy (IMRT)
- MRI Guided High Intensity Focused Ultrasound Ablation for Non-Oncologic Indications
- Single Photon Emission Computed Tomography (SPECT) Scans for Noncardiovascular Indications
- Proton Beam Therapy
- Radiofrequency Ablation to Treat Tumors Outside the Liver
- Stereotactic Radiosurgery (SRS) and Stereotactic Body Radiotherapy (SBRT)
- Transcatheter Arterial Chemoembolization (TACE) and Transcatheter Arterial Embolization (TAE) for treating Primary or Metastatic Liver Tumors
- Transcatheter Arterial Chemoembolization (TACE) and Transcatheter Arterial Embolization (TAE) for Malignant Lesions Outside the Liver – except CNS and Spinal Cord
- Wireless Capsule Endoscopy for Gastrointestinal Imaging and the Patency Capsule

Miscellaneous

- Lower Esophageal Sphincter Augmentation Devices for the Treatment of Gastroesophageal Reflux Disease (GERD)
- SpaceOAR System
- Transcatheter Ablation of Arrhythmogenic Foci in the Pulmonary Veins as a Treatment of Atrial Fibrillation (Radiofrequency and Cryoablation)
- Outpatient Cardiac Hemodynamic Monitoring Using a Wireless Sensor for Heart Failure Management
- Autologous Cellular Immunotherapy for the Treatment of Prostate Cancer

Mental Health / Substance Abuse (MHSA)

- Acute Inpatient Admissions
- Transcranial Magnetic Stimulation (TMS)
- Intensive Outpatient Programs (IOP)
- Partial Hospitalization Programs (PHP)
- Residential Care
- Behavioral Health in-home Programs
- Applied Behavioral Analysis (ABA)

Out-of-Network Referrals

Out-of-Network Services for consideration of payment at Network benefit level (may be authorized, based on Network availability and/or Medical Necessity).

Services not requiring Precertification for coverage, but recommended for pre-determination of Medical Necessity due to the existence of post service claim edits and/or the potential cost of services to the member if denied by Anthem for lack of Medical Necessity:

(1) Procedures, equipment, and/or specialty infusion Drugs which have Medically Necessary criteria determined by Corporate Medical Policy or Adopted Clinical Guidelines.

Utilizing an Out-of-Network Provider may result in significant additional financial responsibility for you, because the Plan cannot prohibit Out-of-Network Providers from billing you for the difference between the Provider's Charge and the Benefit the Plan provides.

The ordering Provider, Facility or attending Physician should contact the Claims Administrator to request a Precertification or predetermination review ("requesting Provider"). The Claims Administrator will work directly with the requesting Provider for the Precertification request. However, you may designate an authorized representative to act on your behalf for a specific request. The authorized representative can be anyone who is 18 years of age or older.

Who is Responsible for Precertification?

Typically, Network Providers know which services need Precertification and will get any Precertification when needed. Your Primary Care Physician and other Network Providers have been given detailed information about these procedures and are responsible for meeting these requirements. Generally, the ordering Provider, Facility, or attending doctor ("requesting Provider") will get in touch with the Claims Administrator to ask for a Precertification. However, you may request a Precertification, or you may choose an authorized representative to act on your behalf for a specific request. The authorized representative can be anyone who is 18 years of age or older. The table below outlines who is responsible for Precertification and under what circumstances.

Provider Network Status	Responsibility to Get Precertification	Comments
Network, including BlueCard Providers in the service areas of Anthem Blue Cross and Blue Shield (CO, CT, IN, KY, ME, MO, NH, NV, NY, OH, VA, WI); Anthem Blue Cross (CA); Empire Blue Cross Blue Shield; and any future affiliated Blue Cross and/or Blue Shield plans resulting from a merger or acquisition by the Claims Administrator's parent company.	Provider	The Provider must get Precertification when required.

Provider Network Status	Responsibility to Get Precertification	Comments
BlueCard Provider outside the service areas of the states listed in the column above and BlueCard Providers in other states not listed and Out-of-Network / Non-Participating	Member	• Member must get Precertification when required or work with your Provider to assist in obtaining Precertification. Call Member Services at the number on the back of your ID Card. • Member may be financially responsible for charges/costs related to the service and/or setting in whole or in part if the service and/or setting is found to not be Medically Necessary.
NOTE: For an Emergency Care admission, Precertification is not required. However, you, your authorized representative, or doctor should tell the Claims Administrator as soon as you are Stabilized.		

The Claims Administrator will utilize its clinical coverage guidelines, such as medical policy, clinical guidelines, and other applicable policies and procedures to help make Medical Necessity decisions. This includes decisions about Prescription Drugs when by a medical Provider. Medical policies and clinical guidelines reflect the standards of practice and medical interventions identified as proper medical practice. The Claims Administrator reserves the right to review and update these clinical coverage guidelines from time to time.

You are entitled to ask for and get, free of charge, reasonable access to any records concerning your request. To ask for this information, call the Precertification phone number on the back of your ID Card.

If you are not satisfied with the Plan's decision under this section of your benefits, please refer to please refer to the appeal provisions in the *Chapter 7: Claims and Appeals* to see what rights may be available to you.

Decision and Notice Requirements

The Claims Administrator will review requests for benefits according to the time frames listed below. The time frames and requirements listed are based on federal laws. You may call the phone number on the back of your ID Card for more details.

Type of Review	Time frame Requirement for Decision and Notification
Urgent Pre-service Review	72 hours from the receipt of request
Non-Urgent Pre-service Review	15 calendar days from the receipt of the request
Urgent Continued Stay/Concurrent Review when request is received more than 24 hours before the end of the previous authorization	24 hours from the receipt of the request
Urgent Continued Stay/Concurrent Review when request is received less than 24 hours before the end of the previous authorization or no previous authorization exists	72 hours from the receipt of the request
Post-Service Review	30 calendar days from the receipt of the request

If more information is needed to make a decision, the Claims Administrator will tell the requesting Provider of the specific information needed to finish the review. If the Claims Administrator does not get the specific information needed by the required time frame, the Claims Administrator will make a decision based upon the information it has.

The Claims Administrator will notify you and your Provider of its decision as required by federal law. Notice may be given by one or more of the following methods: verbal, written, and/or electronic.

Important Information

From time to time, certain medical management processes (including utilization management, case management, and disease management) may be waived, enhanced, changed, or ended. An alternate benefit may be offered if, in the Plan's sole discretion, such change furthers the provision of cost-effective, value-based and/or quality services.

Certain qualifying Providers may be selected to take part in a program or a Provider arrangement that exempts them from certain procedural or medical management processes that would otherwise apply. Your claim may also be exempted from medical review if certain conditions apply.

Just because a process, Provider, or claim is exempted from the standards which otherwise would apply, it does not mean that this will occur in the future or will do so in the future for any other Provider, claim or Member. The Plan may stop or change any such exemption with or without advance notice.

You may find out whether a Provider is taking part in certain programs or a Provider arrangement by contacting the Member Services number on the back of your ID Card.

The Claims Administrator also may identify certain Providers to review for potential fraud, waste, abuse, or other inappropriate activity if the claims data suggests there may be inappropriate billing practices. If a Provider is selected under this program, then the Claims Administrator may use one or more clinical utilization management guidelines in the review of claims submitted by this Provider, even if those guidelines are not used for all Providers delivering services to this Plan's Members.

Health Plan Individual Case Management

The Claims Administrator's individual health plan case management programs (Case Management) helps coordinate services for Members with healthcare needs due to serious, complex, and/or chronic health conditions. The Claims Administrator's programs coordinate benefits and educate Members who agree to take part in the Case Management program to help meet their health-related needs.

The Claims Administrator's Case Management programs are confidential and voluntary and are made available at no extra cost you. These programs are provided by, or on behalf of and at the request of, your health plan Case Management staff. These Case Management programs are separate from any Covered Services you are receiving.

If you meet program criteria and agree to take part, the Claims Administrator will help you meet your identified healthcare needs. This is reached through contact teamwork with you and/or your authorized representative, treating Physician(s), and other Providers.

In addition, the Claims Administrator may assist in coordinating care with existing community-based programs and services to meet your needs. This may include giving you information about external agencies and community-based programs and services.

In certain cases of severe or chronic illness or Injury, the Plan may provide benefits for alternate care that is not listed as a Covered Service. The Plan may also extend Covered Services beyond the Benefit Maximums of this Plan. The Claims Administrator will make any recommendation of alternate or extended benefits to the Plan on a case-by-case basis, if at the Claims Administrator's discretion, the alternate or extended benefit is in the best interest of you and the Plan, and you or your authorized representative agree to the alternate or extended benefit in writing. A decision to provide extended benefits or approve alternate care in one case does not obligate the Plan to provide the same benefits again to you or to any other Member. The Plan reserves the right, at any time, to alter or stop providing extended benefits or approving alternate care. In such case, the Claims Administrator will notify you or your authorized representative in writing.

Church Pension Group Services Corporation ("CPGSC"), doing business as the Episcopal Church Medical Trust, maintains a series of health and welfare plans (the "Plans") for eligible employees (and their eligible dependents) of The Episcopal Church. The Medical Trust serves only eligible Episcopal employers. The Plans that are self-funded are funded by the Episcopal Church Clergy and Employees' Benefit Trust ("ECCEBT"), a voluntary employees' beneficiary association within the meaning of section 501(c)(9) of the Code.

The Plans are church plans within the meaning of section 3(33) of ERISA and section 414(e) of the Code. Not all Plans are available in all areas of the United States or outside the United States, and not all Plans are available on both a self-funded and fully insured basis. Additionally, the Plan may be exempt from federal and state laws that may otherwise apply to health insurance arrangements. The Plans do not cover all health care expenses, so Members should read this Plan Document Handbook carefully to determine which benefits are covered, as well as any applicable exclusions, limitations, and procedures.

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

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

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

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