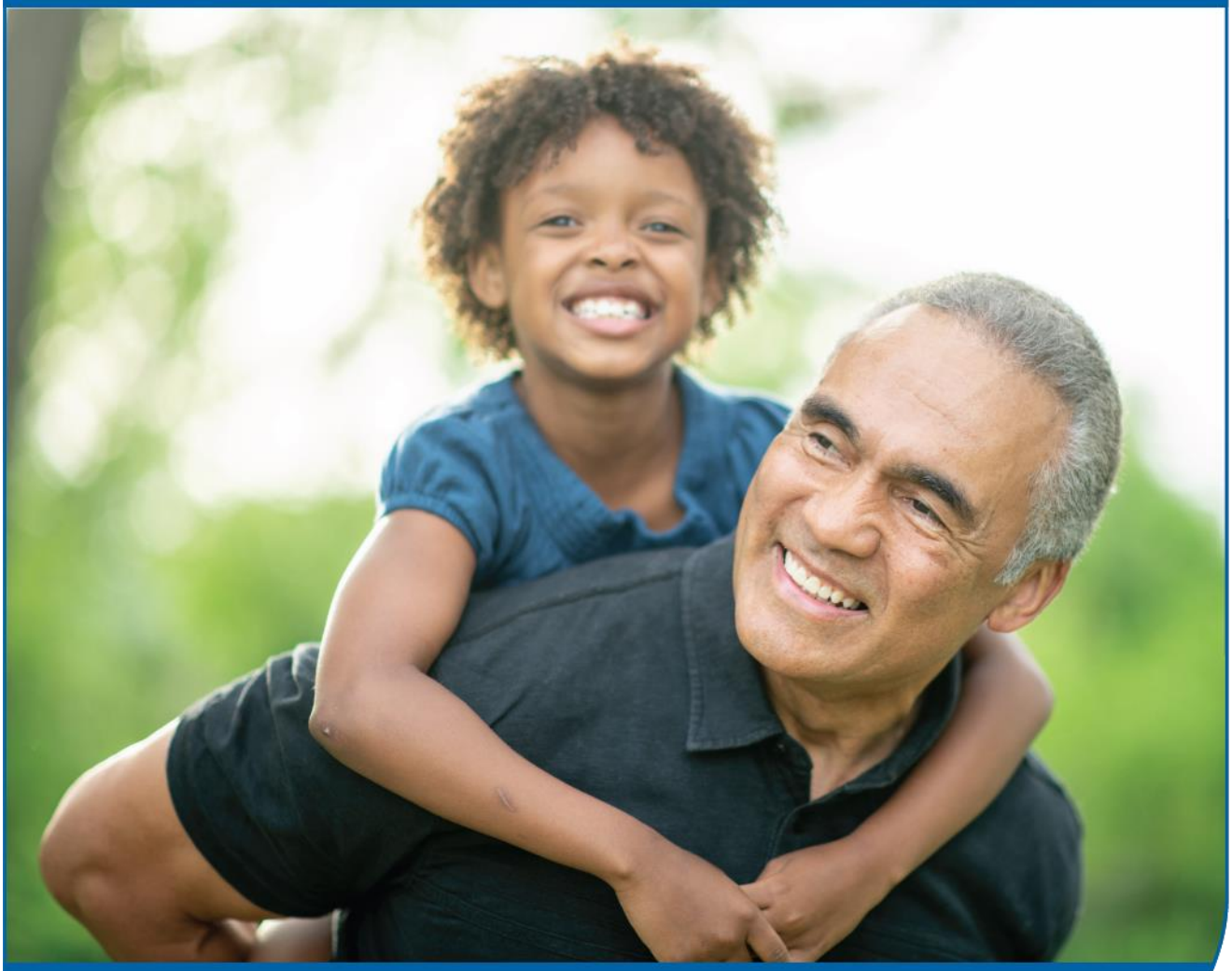
Cigna

# 2023 Plan Handbook
# Cigna Dental Plans



**DPPO Plans**
Basic Dental (DD50)
Dental & Orthodontia (DD25)
Preventive Dental (DDPV)

Benefits effective as of January 1, 2023

EPISCOPAL CHURCH MEDICAL TRUST

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# Introduction

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

# Chapter 1: Summaries of Benefits and Coverage

# *Cigna Dental Benefit Summary*
# *Episcopal Church Medical Trust*
# *01/01/2023 (DD50: Basic Dental)*

**Administered by:** Cigna Health and Life Insurance Company

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

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

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|---|---|
| ***Cross Accumulation*** | All deductibles, plan maximums, and service specific maximums cross accumulate between in and out of network. Benefit frequency limitations are based on the date of service and cross accumulate between in and out of network. |
| ***Calendar Year Benefits Maximum*** | The plan will only pay for covered charges up to the yearly Benefits Maximum, when applicable. Benefit-specific Maximums may also apply. |
| ***Calendar Year Deductible*** | This is the amount you must pay before the plan begins to pay for covered charges, when applicable. Benefit-specific deductibles may also apply. |
| ***Carryover Provision*** | Certain Dental Expenses incurred and applied toward the Individual or Family Deductible during the last 3 months of the calendar year will be applied toward the next year's Deductible. |
| ***Pretreatment Review*** | Pretreatment review is available on a voluntary basis when dental work in excess of $200 is proposed. |
| ***Alternate Benefit Provision*** | When more than one covered Dental Service could provide suitable treatment based on common dental standards, Cigna will determine the covered Dental Service on which payment will be based and the expenses that will be included as Covered Expenses. |
| ***Oral Health Integration Program (OHIP)*** | Cigna Dental Oral Health Integration Program offers enhanced dental coverage for customers with the following medical conditions: diabetes, heart disease, stroke, maternity, head and neck cancer radiation, organ transplants and chronic kidney disease. There's no additional charge for the program, and those who qualify are eligible to receive reimbursement of their coinsurance for certain related dental procedures. Eligible customers can also receive guidance on behavioral issues related to oral health. Reimbursements under this program are not subject to the annual deductible, but will be applied to and are subject to the plan annual maximum. For more information including how to enroll in this program and a complete list of program terms and eligible medical conditions, go to www.mycigna.com or call customer service 24/7 at 1.800.CIGNA24. |
| ***Timely Filing*** | Out of network claims submitted to Cigna after 365 days from date of service will be denied. |
| ***Benefit Limitations:*** *Benefit frequency limitations are based on date of service and cross accumulate between in and out of network.* | |
| Oral Evaluations/Exams | 3 per calendar year |
| X-rays (routine) | Bitewings: 2 per calendar year |
| X-rays (non-routine) | Complete series of radiographic images and panoramic radiographic images: Limited to a combined total of 1 per 36 months. |
| Diagnostic Casts | Payable only in conjunction with orthodontic workup. |
| Cleanings | 3 per calendar year, including periodontal maintenance procedures following active therapy. |
| Fluoride Application | 2 per calendar year for children under age 19. |
| Sealants (per tooth) | Limited to posterior tooth. 1 treatment per tooth every 36 months for children under age 14. |
| Space Maintainers | Limited to non-orthodontic treatment for children under age 19. |
| Inlays, Crowns, Bridges, Dentures and Partials | Replacement every 60 months if unserviceable and cannot be repaired. Benefits are based on the amount payable for non-precious metals. No porcelain or white/tooth-colored material on molar crowns or bridges. |
| Denture and Bridge Repairs | Reviewed if more than once. |
| Denture Relines, Rebases and Adjustments | Covered if more than 6 months after installation. 1 per 36 months. |
| Prosthesis Over Implant | 1 every 60 months if unserviceable and cannot be repaired. Benefits are based on the amount payable for non-precious metals. No porcelain or white/tooth colored material on molar crowns or |

***Benefit Exclusions:***
Covered Expenses will not include, and no payment will be made for the following:

- Procedures and services not included in the list of covered dental expenses;
- Diagnostic: cone beam imaging; covered only in conjunction with Class IX Implant coverage
- Preventive Services: instruction for plaque control, oral hygiene and diet;
- Restorative: ceramic, resin, or acrylic materials on crowns or bridges on or replacing the upper and or lower first, second and/or third molars;
- Periodontics: bite registrations; splinting;
- Prosthodontic: precision or semi-precision attachments;
- Orthodontics: orthodontic treatment;
- Procedures, appliances or restorations, except full dentures, whose main purpose is to change vertical dimension, diagnose or treat conditions of dysfunction of the temporomandibular joint (TMJ), stabilize periodontally involved teeth or restore occlusion;
- Athletic mouth guards;
- Services performed primarily for cosmetic reasons;
- Personalization or decoration of any dental device or dental work;
- Replacement of an appliance per benefit guidelines;
- Services that are deemed to be medical in nature;

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

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

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

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# *Cigna Dental Benefit Summary*
# *Episcopal Church Medical Trust*
# *01/01/2023 (DD25: Dental & Orthodontia)*

**Administered by:** Cigna Health and Life Insurance Company

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

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

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| ***Non-Network Reimbursement*** | For services provided by a non-network dentist, Cigna Dental will reimburse according to the Maximum Reimbursable Charge. The MRC is calculated at the 80th percentile of all provider amounts in the geographic area. The dentist may balance bill up to their usual fees. |
| ***Cross Accumulation*** | All deductibles, plan maximums, and service specific maximums cross accumulate between in and out of network. Benefit frequency limitations are based on the date of service and cross accumulate between in and out of network. |
| ***Calendar Year Benefits Maximum*** | The plan will only pay for covered charges up to the yearly Benefits Maximum, when applicable. Benefit-specific Maximums may also apply. |
| ***Calendar Year Deductible*** | This is the amount you must pay before the plan begins to pay for covered charges, when applicable. Benefit-specific deductibles may also apply. |
| ***Carryover Provision*** | Certain Dental Expenses incurred and applied toward the Individual or Family Deductible during the last 3 months of the calendar year will be applied toward the next year's Deductible. |
| ***Pretreatment Review*** | Pretreatment review is available on a voluntary basis when dental work in excess of $200 is proposed. |
| ***Alternate Benefit Provision*** | When more than one covered Dental Service could provide suitable treatment based on common dental standards, Cigna will determine the covered Dental Service on which payment will be based and the expenses that will be included as Covered Expenses. |
| ***Oral Health Integration Program (OHIP)*** | Cigna Dental Oral Health Integration Program offers enhanced dental coverage for customers with the following medical conditions: diabetes, heart disease, stroke, maternity, head and neck cancer radiation, organ transplants and chronic kidney disease. There's no additional charge for the program, and those who qualify are eligible to receive reimbursement of their coinsurance for certain related dental procedures. Eligible customers can also receive guidance on behavioral issues related to oral health. Reimbursements under this program are not subject to the annual deductible, but will be applied to and are subject to the plan annual maximum. For more information including how to enroll in this program and a complete list of program terms and eligible medical conditions, go to www.mycigna.com or call customer service 24/7 at 1.800.CIGNA24. |
| ***Timely Filing*** | Out of network claims submitted to Cigna after 365 days from date of service will be denied. |
| ***Benefit Limitations:*** *Benefit frequency limitations are based on date of service and cross accumulate between in and out of network.* | |
| Oral Evaluations/Exams | 3 per calendar year |
| X-rays (routine) | Bitewings: 2 per calendar year |
| X-rays (non-routine) | Complete series of radiographic images and panoramic radiographic images: Limited to a combined total of 1 per 36 months. |
| Diagnostic Casts | Payable only in conjunction with orthodontic workup. |
| Cleanings | 3 per calendar year, including periodontal maintenance procedures following active therapy. |
| Fluoride Application | 2 per calendar year for children under age 19. |
| Sealants (per tooth) | Limited to posterior tooth. 1 treatment per tooth every 36 months for children under age 14. |
| Space Maintainers | Limited to non-orthodontic treatment for children under age 19. |
| Inlays, Crowns, Bridges, Dentures and Partials | Replacement every 60 months if unserviceable and cannot be repaired. Benefits are based on the amount payable for non-precious metals. No porcelain or white/tooth-colored material on molar crowns or bridges. |
| Denture and Bridge Repairs | Reviewed if more than once. |
| Denture Relines, Rebases and Adjustments | Covered if more than 6 months after installation. 1 per 36 months |
| Prosthesis Over Implant | 1 every 60 months if unserviceable and cannot be repaired. Benefits are based on the amount payable for non-precious metals. No porcelain or white/tooth colored material on molar crowns or |

***Benefit Exclusions:***
Covered Expenses will not include, and no payment will be made for the following:

- Procedures and services not included in the list of covered dental expenses;
- Diagnostic: cone beam imaging; covered only in conjunction with Class IX Implant coverage
- Preventive Services: instruction for plaque control, oral hygiene and diet;
- Restorative: ceramic, resin, or acrylic materials on crowns or bridges on or replacing the upper and or lower first, second and/or third molars;
- Periodontics: bite registrations; splinting;
- Prosthodontic: precision or semi-precision attachments;
- Procedures, appliances or restorations, except full dentures, whose main purpose is to change vertical dimension, diagnose or treat conditions of dysfunction of the temporomandibular joint (TMJ), stabilize periodontally involved teeth or restore occlusion;
- Athletic mouth guards;
- Services performed primarily for cosmetic reasons;
- Personalization or decoration of any dental device or dental work;
- Replacement of an appliance per benefit guidelines;

- Services that are deemed to be medical in nature;
- Services and supplies received from a hospital;
- Drugs: prescription drugs;
- Charges in excess of the Maximum Reimbursable Charge

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# *Cigna Dental Benefit Summary*
# *Episcopal Church Medical Trust*
# *01/01/2023 (DDPV: Preventive Dental)*

**Administered by:** Cigna Health and Life Insurance Company

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

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

| | |
|---|---|
| ***In-Network Reimbursement*** | For services provided by a Cigna Dental PPO network dentist, Cigna Dental will reimburse the dentist according to a Fee Schedule or Discount Schedule. |
| ***Non-Network Reimbursement*** | For services provided by a non-network dentist, Cigna Dental will reimburse according to the Maximum Reimbursable Charge. The MRC is calculated at the 80th percentile of all provider amounts in the geographic area. The dentist may balance bill up to their usual fees. |
| ***Cross Accumulation*** | All deductibles, plan maximums, and service specific maximums cross accumulate between in and out of network. Benefit frequency limitations are based on the date of service and cross accumulate between in and out of network. |
| ***Calendar Year Benefits Maximum*** | The plan will only pay for covered charges up to the yearly Benefits Maximum, when applicable. Benefit-specific Maximums may also apply. |
| ***Calendar Year Deductible*** | This is the amount you must pay before the plan begins to pay for covered charges, when applicable. Benefit-specific deductibles may also apply. |
| ***Pretreatment Review*** | Pretreatment review is available on a voluntary basis when dental work in excess of $200 is proposed. |
| ***Alternate Benefit Provision*** | When more than one covered Dental Service could provide suitable treatment based on common dental standards, Cigna will determine the covered Dental Service on which payment will be based and the expenses that will be included as Covered Expenses. |
| ***Oral Health Integration Program (OHIP)*** | Cigna Dental Oral Health Integration Program offers enhanced dental coverage for customers with the following medical conditions: diabetes, heart disease, stroke, maternity, head and neck cancer radiation, organ transplants and chronic kidney disease. There's no additional charge for the program, and those who qualify are eligible to receive reimbursement of their coinsurance for certain related dental procedures. Eligible customers can also receive guidance on behavioral issues related to oral health. Reimbursements under this program are not subject to the annual deductible, but will be applied to and are subject to the plan annual maximum. For more information including how to enroll in this program and a complete list of program terms and eligible medical conditions, go to www.mycigna.com or call customer service 24/7 at 1.800.CIGNA24. |
| ***Timely Filing*** | Out of network claims submitted to Cigna after 365 days from date of service will be denied. |
| ***Benefit Limitations****: Benefit frequency limitations are based on date of service and cross accumulate between in and out of network.* | |
| Oral Evaluations/Exams | 3 per calendar year |
| X-rays (routine) | Bitewings: 2 per calendar year |
| X-rays (non-routine) | Complete series of radiographic images and panoramic radiographic images: Limited to a combined total of 1 per 36 months. |
| Cleanings | 3 per calendar year, including periodontal maintenance procedures following active therapy. |
| Fluoride Application | 2 per calendar year for children under age 19. |
| Sealants (per tooth) | Limited to posterior tooth. 1 treatment per tooth every 36 months for children under age 14. |
| Space Maintainers | Limited to non-orthodontic treatment for children under age 19. |
| Inlays, Crowns, Bridges, Dentures and Partials | Replacement every 60 months if unserviceable and cannot be repaired. Benefits are based on the amount payable for non-precious metals. No porcelain or white/tooth-colored material on molar crowns or bridges. |
| Denture and Bridge Repairs | Reviewed if more than once. |
| Denture Relines, Rebases and Adjustments | Covered if more than 6 months after installation. 1 per 36 months. |
| Prosthesis Over Implant | Replacement every 60 months if unserviceable and cannot be repaired. Benefits are based on the amount payable for non-precious metals. No porcelain or white/tooth-colored material on molar crowns or bridges. |

***Benefit Exclusions:***
Covered Expenses will not include, and no payment will be made for the following:

- Procedures and services not included in the list of covered dental expenses;
- Diagnostic: cone beam imaging;
- Preventive Services: instruction for plaque control, oral hygiene and diet;
- Restorative: ceramic, resin, or acrylic materials on crowns or bridges on or replacing the upper and or lower first, second and/or third molars;
- Periodontics: bite registrations; splinting;
- Prosthodontic: precision or semi-precision attachments;
- Implants: implants or implant related services;
- Orthodontics: orthodontic treatment;
- Procedures, appliances or restorations, except full dentures, whose main purpose is to change vertical dimension, diagnose or treat conditions of dysfunction of the temporomandibular joint (TMJ), stabilize periodontally involved teeth or restore occlusion;
- Athletic mouth guards;

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

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# Chapter 2: Eligibility and Enrollment

Individuals who are eligible for participation in the EHP, SEE Plan or GMAP are also eligible for dental coverage through the Medical Trust. The eligibility criteria for these Plans is set forth below.

## 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****

[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.

**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.*

### 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

## Eligibility for the Group Medicare Advantage Plan (GMAP)

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

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

### Eligible Individuals and Eligible Dependents must be enrolled in Medicare Parts A and B in order to enroll in the GMAP medical Plans, but not in the Post-65 Former Employee dental Plans.

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

- A Post-65 Former Employee who is enrolled in Medicare Parts A and B
- A Pre-65 Former Employee who is enrolled in Medicare Parts A and B
- Cleric receiving benefits under The Church Pension Fund Clergy Long-Term Disability Plan who is enrolled in Medicare Parts A and B
- An Employee under the age of 65 whose employment has terminated, who is enrolled in Medicare Parts A and B on account of their disability, and who was either (i) enrolled in the EHP or SEE Plan as of the date of their disability or (ii) eligible for enrollment in the EHP or SEE Plan as of the date of their disability and who subsequently experiences a Significant Life Event.

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

- 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
- A Disabled Child of an Eligible Individual enrolled in a Plan sponsored by the Medical Trust
- A Surviving Spouse or Surviving Domestic Partner 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 Surviving Child of a deceased Post-65 Former Employee or Pre-65 Former Employee who (i) in each case, was enrolled in a Plan sponsored by the Medical Trust at the time of their death, and (ii) is also a Disabled Child

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

#### Ineligible Individuals

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

- A parent or other relative of an Eligible Individual, including grandchildren and in-laws, not listed in the Eligible Dependents section above
- An individual 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 the Eligible Individual / Eligible Individual's Spouse / Domestic Partner
- Any individual who is not enrolled in both Medicare Part A and Part B
- Any individual who is under arrest, incarcerated, imprisoned, escaped from confinement, under supervised release, on medical furlough, required to reside in mental health facilities, required to

reside in halfway houses, required to live under home detention, or confined completely or partially in any way under a penal statute or rule.
- Any individual who does not reside in the United States.
- 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

## 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

[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.

or placement for adoption, or a decrease through death or Dependent gaining own health benefits)
- Change in Dependent status (e.g., becoming ineligible by reaching a limiting age)
- Change in employment status of 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

[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.

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 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

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

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

**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

[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.

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 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

[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.

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**

[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.

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.

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.

## 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,

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

[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.

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, Cigna, any Group Administrator or any Provider, or any personnel of any of the foregoing.
- Commit theft from the Plan Administrator, Cigna, any Group Administrator or any Provider.
- Performs an act that constitutes fraud or makes an intentional misrepresentation of material fact in procuring coverage, such as knowingly (1) misrepresenting participation status, (2) presenting an invalid prescription or physician order, or (3) misusing or letting someone else misuse an ID Card to obtain care under false pretenses. Note: Any 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 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.

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*

[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.

[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.

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 (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

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

[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.

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 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: Cigna Dental PPO Network

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

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

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

You can access the dental provider directory:

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

**Choosing a Network Provider**

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

Choice—You can choose any provider participating in the network.
Convenience—Usually, there are no claim forms to file.
Discounts—Your out-of-pocket cost may be lower due to the PPO contracted rate.

**Choosing An Out-of-Network Provider**

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

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

# Chapter 4: Coverage for the Dental Plan

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

A covered expense is that portion of a dentist's charge that is payable for a covered service delivered to a covered person, provided that:

- The service is ordered or prescribed by a Dentist or other appropriate Provider
- The service is Medically Necessary and/or Dentally Necessary
- The service is within the scope of coverage limitations
- The Deductible amount in the applicable SBC has been met
- The maximum benefit in the applicable SBC has not been exceeded
- The charge does not exceed the amount allowed under the Alternate Benefit Provision
- For Class I, II or III, the service is started and completed while coverage is in effect

## Covered Benefits

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

The SBCs list common dental procedures and are not exhaustive.

Contact Cigna if you have any questions about your benefits.

*A Note about Teledentistry*. Teledentistry (i.e., virtual or online) services are covered only when administered in conjunction with procedures and services which are covered under this Plan. Covered dental services delivered through teledentistry are covered to the same extent the Plan covers services rendered through in-person contact including the same cost-share, frequency limitations or any applicable benefit maximums or lack thereof.

## Limitations & Exclusions - All Dental Plans

*GENERAL LIMITATIONS*. The following general limitations apply to Benefits:

- Any treatment received outside of the United States is not covered.
- Replacement of a partial denture, complete denture, fixed bridge, any prosthesis over implant, or the addition of teeth to a partial denture is not covered, unless (1) the replacement is needed due to a Medically Necessary and/or Dentally Necessary extraction of an additional Functioning Natural Tooth while the person is covered under this Plan, or (2) the denture, bridge or prosthesis is unserviceable and cannot be repaired and it has been 60 or more calendar months since the denture, bridge or prosthesis was originally installed (or last replaced).
- Replacement of a crown, bridge, onlay, post/post and core, or other laboratory prepared or CAD/CAM prepared restoration, partial denture, or complete denture within 60 months of original installation (or last replacement) is not covered unless:
    - the replacement is made necessary by the placement of an original opposing complete

denture or the Medically Necessary and/or Dentally Necessary extraction of a Functioning Natural Tooth; or
    - the crown, bridge, onlay, post/post and core, other laboratory prepared or CAD/CAM prepared restoration, partial denture, or complete denture while in the mouth, has been damaged beyond repair as a result of an injury received while the Member is covered by the Plan.
- Replacement of any amalgam or resin-based composite restoration involving the same surface(s) on the same tooth by the same Dentist or a different Dentist in the same office within the frequency limitation determined by Cigna is not covered.
- A combination of radiographic images (such as ten or more periapical radiographic images; or a panoramic radiographic image with bite-wing radiographic images) completed on the same date of service will not be covered when the allowance meets or exceeds the allowance for an intraoral complete series of radiographic images. Plan reimbursement will be based on an intraoral complete series.
- Cone Beam imaging is covered only in conjunction with coverage of Class IX implants (if covered by the Plan).
- Localized delivery of antimicrobial agents via a controlled release vehicle into diseased crevicular tissue is covered only on teeth with both periodontal pocket depths of 5 mm or greater and a prior history of periodontal therapy. Not covered when more than eight (8) of these procedures are reported on the same date of service.
- Tissue preparation such as gingivectomy/gingivoplasty or crown lengthening is not covered as a separate allowance on the same date as a restoration on the same tooth.
- When covered by the Plan, any prosthesis over an implant is subject to the same exclusions, limitations, frequency limitations as standard traditional restorative, fixed and removable prosthetics.
- Otherwise covered services are not covered to the extent that billed charges exceed the rate of reimbursement as described in the applicable SBC.
- Any replacement of a crown, bridge, partial denture, or complete denture which is or can be made usable according to commonly accepted dental standards is not covered.
- Crowns, inlays, cast restorations, or other laboratory prepared or CAD/CAM prepared restorations on teeth are not covered, unless the tooth cannot be restored with an amalgam or resin-based composite restoration due to major decay or fracture.
- The benefits provided under this Plan will be reduced so that the total payment will not be more than 100% of the charge made for the dental service, if benefits are provided for that service under both this Plan and any expense plan or prepaid treatment program sponsored or made available by the Member's employer.

*EXCLUSIONS*. Covered services will not include, and no payment will be made for:

- any services not stated in the applicable SBC;
- procedures that are deemed to be medical services or are a covered expense under any medical plan which provides group hospital, surgical, or medical benefits whether or not on an insured basis;
- any charges, including ancillary charges, for services and supplies received from a hospital, outpatient facility, ambulatory surgical center or similar facility;
- services rendered by anyone other than a Dentist or other appropriate Provider (as determined by Cigna)
- charges incurred due to injuries which are intentionally self-inflicted;
- charges for or in connection with an injury or illness arising out of, or in the course of any employment for wage or profit;
- charges for or in connection with an injury or illness which is covered under any workers' compensation or similar law;
- charges made by a hospital owned or operated by or which provides care or performs services

for, the United States Government, if such charges are directly related to a military-service-connected condition;
- services or supplies received as a result of dental disease, defect or injury due to an act of war, declared or undeclared;
- consultations and/or evaluations associated with services that are not covered;
- cosmetic dentistry or cosmetic dental surgery (dentistry or dental surgery performed solely to improve appearance), which includes but is not limited to the following: bleaching (tooth whitening), in office and/or at home, enamel microabrasion, odontoplasty, facings, repairs to facings or replacement of facings on crowns or bridge units on molar teeth;
- replacement of fixed and/or removable appliances (including fixed and removable orthodontic appliances, if orthodontics is covered) that have been lost, stolen, or damaged due to patient abuse, misuse, or neglect;
- procedures, services, supplies, restorations, or appliances (except complete dentures), whose sole or primary purpose is to change or maintain vertical dimension;
- procedures, services, supplies, restorations or appliances whose main purpose is to diagnose or treat jaw joint problems, including dysfunction of the temporomandibular joint and craniomandibular disorders, or other conditions of the joints linking the jawbone and skull, including the complex muscles, nerves and other tissues related to that joint;
- the restoration of teeth which have been damaged by erosion, attrition, abfraction or abrasion;
- bite registration or bite analysis;
- precision or semi-precision attachments;
- any procedure, service, supply or appliance used primarily for the purpose of splinting;
- porcelain, ceramic, resin, or acrylic materials on crowns or pontics on, or replacing the upper or lower first, second and/or third molars;
- services to correct congenital malformations, including the replacement of congenitally missing teeth;
- procedures, restorations, appliances or services to stabilize periodontally involved teeth or to restore occlusion;
- myofunctional therapy;
- replacement of a partial denture or complete denture which can be made serviceable;
- prescription drugs;
- treatment of jaw fractures and/or orthognathic surgery;
- the treatment of cleft lip and cleft palate;
- charges for sterilization of equipment, infection control processes and procedures, disposal of medical waste or other requirements mandated or recommended by the Centers for Disease Control and Prevention (CDC), OSHA or other regulatory agencies (Cigna considers these to be incidental to and part of the charges for services provided and not separately chargeable);
- charges for travel time; transportation costs;
- personal supplies, including but not limited to toothbrushes, rotary toothbrushes, floss holders, and water irrigation devices;
- oral hygiene instructions, tobacco counseling, substance use counseling, and nutritional counseling;
- charges for broken appointments; completion of or copying of claim forms; duplication of radiographic images and/or exams required by a third party; expenses incurred in preparing or copying dental reports or itemized bills;
- charges for telephone calls or telephone consultations (other than teledentistry, which is covered to the extent described above);
- charges for treatment or surgery that does not meet plan guidelines;
- general anesthesia or intravenous sedation when used for the purposes of anxiety control or patient management, unless it meets Cigna's clinical criteria (e.g., for certain pediatric patients);
- indirect pulp capping on the same date of service as a permanent restoration (Cigna considers

this to be incidental to and part of the charges for services provided and not separately chargeable);
- endodontic treatment and/or periodontal (gum tissue and supporting bone) surgery of teeth exhibiting a poor or hopeless periodontal prognosis;
- intentional root canal treatment in the absence of injury or disease solely to facilitate a restorative procedure;
- services to the extent the Member is compensated under any group medical plan;
- house/extended care facility calls; hospital calls; office visits for observation (during regularly scheduled hours) when no other services are performed; office visits after regularly scheduled hours; and case presentations;
- procedures performed by a Dentist who is a member of the Member's family, except in the case of a dental emergency when no other Dentist is available. (For these purposes, a Member's family is limited to a Spouse, siblings, parents, children, grandparents, and the Spouse's siblings and parents.);
- dental services that do not meet commonly accepted dental standards;
- replacement of teeth beyond the normal adult dentition of thirty-two (32) teeth;
- services not included in the applicable SBC, unless Cigna agrees to accept such expense as a covered dental expense, in which case payment will be made consistent with similar services which would provide the least expensive professionally satisfactory result;
- to the extent that the Member is in any way paid or entitled to payment for those expenses by or through a public program, other than Medicaid;
- charges in excess of the Maximum Reimbursable Charge allowances;
- procedures for which a charge would not have been made if the person had no insurance or for which the person is not legally required to pay;[15]
- charges arising out of or relating to any violation of a healthcare-related state or federal law or which themselves are a violation of a healthcare-related state or federal law;
- otherwise covered dental services to the extent that payment is unlawful where the Member resides when the expenses are incurred;
- charges for or in connection with experimental procedures or treatment methods not recognized and approved by the American Dental Association or the appropriate dental specialty organization;
- charges which would not have been made in any facility, other than a hospital or a correctional institution owned or operated by the United States Government or by a state or municipal government if the person had no insurance;
- services for which benefits are not payable according to the "General Limitations" section;
- charges for care, treatment or surgery that is not Medically Necessary and/or Dentally Necessary;
- charges for services rendered prior to the date the Member is covered under the Plan or after the date coverage ends under the Plan;
- charges for personalization or decoration of any dental device or dental work;
- stress breakers; or
- athletic mouth guards.

[15] For example, if Cigna determines that a provider has waived, reduced, or forgiven any portion of its charges and/or any portion of the Copayment, Deductible, and/or Coinsurance amount(s) that the Member is required to pay for a covered service without Cigna's express consent, Cigna shall have the right to deny the payment of benefits in connection with the covered service, or reduce the Benefits in proportion to the amount of the Copayment, Deductible, and/or Coinsurance amounts waived, forgiven or reduced, regardless of whether the provider represents that the Member remains responsible for any amounts that the Plan does not cover. Cigna shall have the right to require the Member to provide proof sufficient to Cigna that the Member has made their required cost share payment(s) prior to the payment of any benefits by Cigna. This exclusion includes, but is not limited to, charges of an Out-of-Network Provider who has agreed to charge the Member or has charged the Member at a Network benefits level or some other benefits level not otherwise applicable to the services received.

## Additional Plan-Specific Exclusions

*Preventive Dental (DDPV) DPPO Plan*. Covered services will not include, and no payment will be made for:

- services associated with the diagnosis, placement, treatment, repair, removal or replacement of a dental implant, or any other services related to implants;
- orthodontic treatment;
- diagnostic casts, diagnostic models or study models; or
- harmful habits treatment.

*Basic Dental (DD50) DPPO Plan*. Covered services will not include, and no payment will be made for:

- orthodontic treatment;
- diagnostic casts, diagnostic models or study models; or
- harmful habits treatment.

*Dental & Orthodontia (DD25) DPPO Plan*. Covered services will not include, and no payment will be made for:

- additional/incremental costs associated with optional/elective orthodontic materials including but not limited to: ceramic, clear, or lingual brackets, or other cosmetic appliances including clear aligners; orthognathic surgery and associated incremental costs; appliances to guide minor tooth movement; and services which are not typically included in orthodontic treatment. These services will be identified on a case-by-case basis.

# Chapter 5: Details and Definitions

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

**Alternate Benefit Provision**

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

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

**Annual Enrollment**

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

**Benefits**

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

**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.”

**Coinsurance**

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

**Contracted Fee (Cigna Dental Preferred Provider)**

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

**Copayment**

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

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

**Coverage Tier**

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

### Deductibles

Deductibles are expenses 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 dental deductible for the rest of that Plan Year.

### Dentist

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

### Dependent

A Spouse, Domestic Partner, or Child of 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,[16] foster child,[17] 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*

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

[17] 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.

*Enrollment*, and is enrolled in the Plan at the time of the Eligible Individual's death.

**Disabled Child**

An eligible Child 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.

**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 Care to Relieve Pain**

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

**Employee**

An individual 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.

**Expense Incurred**

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

- Dentures, crowns, or bridgework—the date they are seeded or cemented

- Root canal therapy—the date the pulp chamber is opened

**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.

**Functioning Natural Tooth**

The term Functioning Natural Tooth means a natural tooth which is performing its normal role in the mastication (i.e., chewing) process in the Member's upper or lower arch and which is opposed in the Member's other arch by another natural tooth or prosthetic (i.e., artificial) replacement.

A natural tooth means any tooth or part of a tooth that is organic and formed by the natural development for the body (i.e., not manufactured). Organic portions of a tooth include the crown enamel and dentin, the root cementum and dentin, and the enclosed pulp (nerve).

**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.

**Identification Card**

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

**Maximum Reimbursable Charge**

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

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

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

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

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

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

**Medicaid**

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

**Medical Board**

The Medical Board of The Church Pension Fund, as may be appointed by the Chief Executive Officer and President of The Church Pension Fund 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).

**Medically Necessary and/or Dentally Necessary**

Services provided by a Provider are Medically Necessary and/or Dentally Necessary if they are determined by Cigna to be:

- required for the diagnosis and/or treatment of the particular dental condition or disease; and
- consistent with the symptom or diagnosis and treatment of the dental condition or disease; and
- commonly and usually noted throughout the medical/dental field as proper to treat the diagnosed dental condition or disease; and
- the most fitting level or service which can safely be given to the Member.

A diagnosis, treatment and service with respect to a dental condition or disease, is not Medically Necessary and/or Dentally Necessary if made, prescribed or delivered solely for convenience of the patient or provider.

**Medicare**

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

**Medicare Secondary Payer (MSP)**

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[18] (a "Religious Order") and verified by the House of Bishops' Committee on Religious Communities, who has been accepted or received by the Religious Order.

**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.

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

**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.[19]

**Participating Group**

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

**Participating Provider (Cigna Dental Preferred Provider)**

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

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

**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.

Group Medicare Advantage Plan (GMAP)
A program of medical and dental plans through which Members are provided health benefits on or after enrolling in Medicare Parts A and B. A Group Medicare Advantage plan provides coverage for medical expenses not covered or partially covered by Original Medicare (Part A and B). It may also provide benefits for expenses not covered by the Original Medicare Plan such as pharmacy benefits and vision care. A Group Medicare Advantage plan is another way to get Medicare Part A and Part B coverage. Medicare Advantage plans, sometimes called "Part C," are offered by Medicare-approved private companies that must follow rules set by Medicare.

**Plan Administrator**

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

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

**Plan Sponsor**

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

**Plan Year**

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

**Predetermination of Benefits**

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

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

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

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

Predetermination of Benefits is not a guarantee of a set payment. Payment is based on the services that are actually delivered and the coverage in force at the time services are completed.

**Provider**

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

**Network Provider**

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

**Out-of-Network Provider**

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

**Seminarian**

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

**Significant Life Event**

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

# Chapter 6: Coordination of Benefits

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

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

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

**Plan**

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

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

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

**Closed Panel Plan**

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

**Primary Plan**

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

**Secondary Plan**

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

**Allowable Expense**

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

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

- An expense or service or a portion of an expense or service that is not covered by any of the plans is not an allowable expense.
- If you are covered by two or more plans that provide services or supplies on the basis of reasonable and customary fees, any amount in excess of the highest reasonable and customary fee is not an

allowable expense.

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

**Claim Determination Period**

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

**Reasonable Cash Value**

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

**Order of Benefit Determination Rules**

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

1. The plan that covers you as an enrollee or an employee shall be the primary plan and the plan that covers you as a dependent shall be the secondary plan
2. If you are a dependent child whose parents are not divorced or legally separated, the primary plan shall be the plan which covers the parent whose birthday falls first in the calendar year as an enrollee or employee
3. If you are the dependent of divorced or separated parents, benefits for the dependent shall be determined in the following order:
    - first, if a court decree states that one parent is responsible for the child's healthcare expenses or health coverage and the plan for that parent has actual knowledge of the terms of the order, but only from the time of actual knowledge
    - then, the plan of the parent with custody of the child
    - then, the plan of the spouse of the parent with custody of the child
    - then, the plan of the parent not having custody of the child
    - finally, the plan of the spouse of the parent not having custody of the child
4. The plan that covers you as an active employee (or as that employee's dependent) shall be the primary plan and the plan that covers you as laid-off or retired employee (or as that employee's dependent) shall be the secondary plan. If the other plan does not have a similar provision and, as a result, the plans cannot agree on the order of benefit determination, this paragraph shall not apply.
5. The plan that covers you under a right of continuation which is provided by federal or state law shall be the secondary plan and the plan that covers you as an active employee or retiree (or as that employee's dependent) shall be the primary plan. If the other plan does not have a similar provision and, as a result, the plans cannot agree on the order of benefit determination, this paragraph shall not apply.

If none of the above rules determines the order of benefits, the plan that has covered you for the longer

period of time shall be primary.

**Effects of Benefits on this Plan**

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

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

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

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

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

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

# Chapter 7: Other Important Plan Provisions

### Assignment of Benefits

You may not assign to any party, including, but not limited to, a Provider of healthcare services or items, your right to Benefits under this Plan, nor may you assign any administrative, statutory, or legal rights or causes of action you may have, including, but not limited to, any right to make a claim for Plan Benefits, to request Plan or other documents, to file appeals of denied claims or grievances, or to 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 Cigna to pay any healthcare Benefits under this policy to a Network Provider or Out-of-Network Provider. When you authorize the payment of your healthcare Benefits to a Network Provider, you authorize the payment of the entire amount of the Benefits due on that claim. If a Provider is overpaid because of accepting duplicate payments from you and Cigna, it is the Provider's responsibility to reimburse the overpayment to you. Cigna may pay all healthcare Benefits for covered health services directly to a Network Provider without your authorization. You may not interpret or rely upon this discrete authorization or permission to pay any healthcare Benefits to a Network Provider or Out-of-Network Provider as the authority to assign any other rights under this policy to any party, including, but not limited to, a Provider of healthcare services or items. No payment by the Plan pursuant to such authorization shall be considered recognition by the Plan of a duty or obligation to pay a provider of services or supplies except to the extent the Plan actually chooses to do so.

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

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

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

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

### Alternate Payee Provision

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

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

### Unclaimed Property

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

### Reliance on Documents and Information

Information required by the Medical Trust may be provided in any form or document that the Medical Trust considers acceptable and reliable. The Medical Trust relies on the information provided by individuals when evaluating coverage and Benefits under the Plans. All such information, therefore, must be accurate, truthful, and complete. The Medical Trust is entitled to conclusively rely upon, and will be protected for any action taken in good faith in relying upon, any information 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.

### Dentist/Patient Relationship

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

Furthermore, nothing in these Plans will limit or otherwise restrict a Dentist's judgment with respect to the Dentist's ultimate responsibility for patient care in the provision of dental services to 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 Episcopal Church, the Medical Trust or the employer and any employee. All employees are subject to discharge to the same extent as if these Plans had never been adopted.

### Plan Administration

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

### Right to Amend or Terminate the Plan

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

### No Guarantee of Tax Consequences

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

### Plan Information and Rights

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

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

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

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

The Plan is a church plan within the meaning of section 3(33) of 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 Identification Card to be used by someone else or if you use the card before coverage is in effect or after coverage has ended, you will be liable for payment of any expenses incurred resulting from the unauthorized use. Fraudulent misuse could also result in termination of the coverage. Fraudulent statements on enrollment forms and/or claims for services or payment involving all media (paper or electronic) may invalidate any payment or claims for services and be grounds for voiding the Member's coverage. This includes fraudulent acts to obtain medical services and/or prescription drugs.

### Additional Information on Covered and Excluded Benefits

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

**Arbitration**

Subject to exhaustion of the procedures set forth in *Chapter 9: How to File a Claim*, 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 9: How to File a Claim*, 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 8: Subrogation and Right of Recovery

### Definitions

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

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

For purposes of this provision, a “covered person” includes anyone on whose behalf the Plan pays or provides any Benefit including, but not limited to, the representative of the Plan Member’s estate, heir, descendant, a minor Child or Dependent of any Plan Member or person entitled to receive any Benefits from the Plan. 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, Cigna or its representative including, but not limited to, completing, signing and submitting any applications or other forms or statements as the Plan, Cigna or its representative may reasonably request 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, Cigna, 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 Cigna or otherwise to comply with the terms of this Subrogation and Right of Recovery Chapter is considered a breach of contract. As such, the Plan has the right to 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, Cigna or their respective agents, or otherwise failing to abide by the terms of the Plan, including this Subrogation and Right of Recovery Chapter. If the Plan incurs attorneys' fees and costs to collect third-party settlement funds held by the covered person or the covered person's representative, the Plan has the right to recover those fees and costs from the covered person. The covered person will also be required to pay interest on any amounts the covered person holds which should have been returned to the Plan, at the prime rate from time to time published by *The Wall Street Journal*.

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

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

Benefits paid by the Plan may also be benefits advanced.

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

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

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

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

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

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

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

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

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

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

asserted the claim against the third party. The Plan may assign its rights to enforce liens and other rights.

**Interpretation**

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

**Jurisdiction**

By accepting Benefits (whether the payment of such Benefits is made to the covered person or made on behalf of the covered person to any Provider) from the Plan, the covered person agrees that any court proceeding with respect to this *Chapter 8: 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 9: How to File a Claim

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

**Claim Reminders**

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

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

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

The claims address is:

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

## How to Appeal a Denial of Benefits

**When You Have a Complaint or Appeal**

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

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

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

**Start With Member Services**

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

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

**Appeals Procedure**

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

**Level One Appeal**

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

Your written request should include:

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

Please submit this information to:

Cigna Dental Appeals
PO Box 188044
Chattanooga, TN 37422

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

**Level Two Appeal**

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

Your written request should include:

- Specific request for a voluntary review
- Enrollee's name, address, and ID number
- Service for which coverage was denied
- Any new, relevant information that was not provided during the internal appeal
- Signed, written authorization for healthcare providers to release relevant medical information to the Plan

Please submit this information to:

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

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

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

**Requirements relating to 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 7: Other Important Plan Provisions* legal action may be pursued only and exclusively by submitting the matter to arbitration.

# Chapter 10: Privacy

## Joint Notice of Privacy Practices

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

### Introduction

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

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

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

### What This Notice Applies To

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

### Duties and Obligations of the Plan

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

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

### When the Plan May Use and Disclose Your PHI

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

- Disclosures to You. The Plans will disclose your PHI to you or your personal representative within the legally specified period following a request.
- Government Audit. The Plans will make your PHI available to the U.S. Department of Health and Human Services when it requests information relating to the privacy of PHI.
- As Required by Law. The Plans will disclose your PHI when required to do so

by federal, state, or local law. For example, the Plans may disclose your PHI when required by national security laws or public health disclosure laws.

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

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

- Business Associates. The Plans may contract with other businesses for certain Plan administrative services. The Plans may release your PHI to one or more of their business associates for Plan administration if the business associate agrees in writing to protect the privacy of your information.
- Plan Sponsor. The Episcopal Church Medical Trust, as sponsor of the Plans, will have access to your PHI for Plan administration purposes. Unless you authorize the Plans otherwise in writing (or your individual identifying data is deleted from the information), your PHI will be available only to the individuals who need this information to conduct these Plan administration activities, but this release of your PHI will be limited to the minimum disclosure required, unless otherwise permitted or required by law.

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

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

**Authorizing Release of Your PHI**

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

**Interaction with State Privacy Laws**

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

**Fundraising**

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

**Underwriting**

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

**Your Rights with Respect to your PHI**

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

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

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

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

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

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

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

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

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

*If You Are a Person in the European Union, the Following Provisions Will Also Be Applicable to You*: For the purposes of the General Data Protection Regulation 2016/679 (the "GDPR"), the Data Controller is Church Pension Group Services Corporation registered in the State of Delaware in the

United States with a registered address at 19 East 34th Street, New York, NY 10016.

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

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

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

Data Retention

We only retain PHI collected for a limited time period as long as we need it to fulfill the purposes for which 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.

# For More Information

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

**The Episcopal Church Medical Trust**

***www.cpg.org***

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

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

**Cigna DENTAL**

***www.cigna.com***

(800) 244-6224

*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, Cigna and the Members shall be interpreted, construed and enforced in accordance with, the laws of the State of New York without regard to the conflict of law principles thereof.*

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

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