Administrative Policy Manual

Effective as of January 1, 2024

EPISCOPAL CHURCH MEDICAL TRUST

The Episcopal Church Medical Trust
Administrative Policy Manual
for
Group Administrators
of
Participating Groups

Effective as of January 1, 2024

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Introduction

Our Mission

The Episcopal Church Medical Trust's (the "Medical Trust" or "we / our") mission 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.

As the Group Administrator of your Participating Group's health benefits, we know that your employees, former employees, congregations, institutions, and management look to you for answers to their health benefit questions. In an effort to make your job easier, we have developed this Administrative Policy Manual to provide you with our policies and procedures.

We realize there are times you will need the expertise of our staff via telephone or email; however, we know that reference materials can also answer your questions or questions from your employees and former employees. We hope this manual will help you understand the roles, responsibilities, rules and definitions regarding our policies, procedures, and operations. Please note that our policies, procedures, and operations are subject to change at any time, and we will do our best to inform you of such changes in a timely manner.

Our Work

We maintain contractual relationships with various health plan vendors on your behalf. We are the plan sponsor of all Medical Trust health plans.

We offer you plan designs and vendor choices from our product array. You can select the Plan(s) that best meet your group's needs. We review health plan offerings with you annually, or upon request, to ensure that you get up-to-date information and confirm that all of your health plan needs are being met.

We are committed to providing high-quality plan administration services to you. This includes:

- Keeping you abreast of information or changes that may affect your employees' and former employees' health benefits
- Providing access to our Client Services Call Center for you and your Members
- Providing access to a member of our Benefits Relationship Management (BRM) team (formerly known as Integrated Benefits Account Management Services (IBAMS)) for any questions you may have and coordination you may need
- Processing your enrollment and termination requests in a timely manner
- Providing billing and reconciliation services to help you keep your account current
- Filing IRS Form 1094-B and providing Members with IRS Form 1095-B for use in filing their taxes in order to comply with the Affordable Care Act's reporting requirements

We strive to provide you with the tools you need to successfully administer your employee healthcare benefits program through the Medical Trust.

Definitions

This section defines common terms used throughout this document. Defined terms are identified throughout this document with capital letters.

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.

> **Active Annual Enrollment**
> During an Active Annual Enrollment, an enrolled Eligible Individual is required by the Plan to take specific actions to prevent any loss of coverage.
>
> An Active Annual Enrollment generally takes place for a Participating Group upon first joining the Plan, when a Plan ceases to be available for the upcoming plan year, or when there is a significant change to the existing Plans.
>
> **Passive Annual Enrollment**
> During a Passive Annual Enrollment, an Eligible Individual is not required by the Plan to take any action. Any Eligible Individual who does not take action will be deemed to have elected to continue their current plan selections for the upcoming plan year and to have consented to any applicable rate changes.[1] However, the Plan encourages Eligible Individuals to log on to the Annual Enrollment website to verify demographic information and existing coverage and to update any data that is not accurate.

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,” or, in MAP, a “Billing Account.”

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

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

[2] A Cafeteria Plan must meet certain legal requirements, so we recommend that you consult with your own legal advisor in order to ensure compliance. The Medical Trust does **not** maintain a Cafeteria Plan for the purposes of receiving employer and employee contributions; Participating Groups or employers must maintain their own, separate Cafeteria Plan in order to benefit from the tax advantages described above.

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).

Denominational Health Plan (DHP)
A Church-wide program of healthcare benefit plans authorized[3] by the General Convention and administered by The Church Pension Fund (CPF), with benefits provided through the Medical Trust. The resolutions require that all domestic dioceses, parishes, missions and other ecclesiastical organizations or bodies subject to the authority of The Episcopal Church enroll clergy and lay Employees who are scheduled to work a minimum of 1,500 hours annually.[4]

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,[5] foster child,[6] 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. See the Appendix for the affidavit. A "Domestic Partnership" refers to the partnership between two Domestic Partners.

Spouse
An Eligible Individual's lawfully married partner evidenced by a marriage certificate or in the case of a common-law spouse, evidenced by a written court order.

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[3] Pursuant to General Convention Resolutions 2009-A177, 2012-B026, 2018-C023 and Title I, Canon 8, of the Canons of The Episcopal Church.

[4] Although the DHP mandates enrollment of Employees who are scheduled to work a minimum of 1,500 hours annually, the Medical Trust sets the minimum eligibility for the Plans. An Employee normally scheduled to work 1,000 or more compensated hours per plan year is an Eligible Individual for the EHP.

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

[6] 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.

Surviving Child
A Child of an Eligible Individual who meets the qualifications listed in the Eligibility section 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 the Eligibility section 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 the Eligibility section and is *enrolled in the Plan* at the time of the Eligible Individual's death.

Disabled Child
An eligible Child who has been determined by the Medical Trust (or its delegate) to have become totally and permanently impaired physically or mentally prior to age 25, to the extent that 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
This definition can be found in the Eligibility for the Episcopal Health Plan (EHP), the Small Employer Exception (SEE) Plan, and the Eligibility for the Group Medicare Advantage Plan (GMAP) sections of this manual.

Eligible Individual
This definition can be found in the Eligibility for the Episcopal Health Plan (EHP), the Small Employer Exception (SEE) Plan, and the Eligibility for the Group Medicare Advantage Plan (GMAP) sections of this manual.

Eligible Small Employer
An employer that (1) is eligible to participate in the Medical Trust plans, (2) does not employ 20 or more employees in 20 or more calendar weeks in the current or preceding calendar year, and (3) has met the requirements established by the Centers for Medicare and Medicaid Services (CMS) to qualify as a small employer under the Medicare Secondary Payer Rules.

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

Seasonal Employee
An Employee, who normally performs work during certain seasons or periods of

the year, whose compensated employment is scheduled to last less than six (6) months in a year.

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

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

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
<u>Clergy:</u>
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.

<u>Lay</u>:
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 5 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.

Group Administrator
The individual authorized by the Participating Group to administer its employee benefits program. Important note: When using MAP, the administrator roles of "Diocese Administrator," "Group Administrator," and "Institution Administrator with Group Administrator Access" have the access rights for managing employee healthcare benefits. Any of these individuals could be a Group Administrator, as this term is used in this Administrative Policy Manual. Check with your Benefits Relationship Manager (formerly IBAMS account representative) for more information.

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, 2024, the Medical Board is American Family Life Assurance Company of New York (Aflac).

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[7] (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.

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

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. Also known in MAP as a “Benefits Group.”

Pay or Play Rules
The employer shared responsibility provisions under the Affordable Care Act, which require certain employers (called “applicable large employers” or ALEs) to either offer minimum essential coverage that is “affordable” and that provides “minimum value” to their full-time employees (and their dependents), or potentially make an employer shared responsibility payment to the IRS. The employer shared responsibility provisions are sometimes referred to as “the employer mandate” or “the pay or play provisions.”

Plan(s)
The medical and dental plans (i.e., health plans) maintained by the Medical Trust for the benefit of Members. The Plan is intended to qualify as a “church plan” as defined by Section 414(e) of the Internal Revenue Code and is exempt from the requirements of the Employee Retirement Income Security Act of 1974, as amended (ERISA).

> **Episcopal Health Plan (EHP)**
> A program of medical and dental plans through which Members are provided health benefits. Benefits are provided through the Medical Trust.
>
> **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.

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

Significant Life Event (SLE)
An event as described in the Plan Election and Enrollment Guidelines section, where as a

result of the event, the Eligible Individual is eligible to make certain mid-year election changes.

Terms and Conditions

Introduction and Purpose

The Medical Trust is the sponsor of the Plans for the benefit of Eligible Individuals and Eligible Dependents of Participating Group(s).

The Participating Group participates in the Plan(s) maintained by the Medical Trust for the benefit of its Eligible Individuals and Eligible Dependents.

This section of the Administrative Policy Manual sets forth the terms and conditions by which the Medical Trust will offer, and the Participating Group will accept, participation in the Plans. The Participating Group's acceptance shall be effective upon the earlier of the date the Participating Group Agreement is signed by the Group Administrator (or other authorized person) or the receipt of the Participating Group's contribution to the Medical Trust under the Plan.

Participating Group Obligations

The Participating Group agrees as follows:

1. Affiliate of The Episcopal Church. The Participating Group is, and at all times during which this Agreement is in effect will be, an "Affiliate" of The Episcopal Church. The Medical Trust serves only ecclesiastical societies, dioceses, missionary districts or other bodies subject to the authority of and/or associated or affiliated with the Church.

2. Plan Offering. Only Medical Trust health plans may be offered to employees of a Participating Group and entities within the Participating Group (e.g., parishes and institutions) ("Related Entities"). The Participating Group and Related Entities shall not maintain any additional health benefit programs, including fully insured or self-funded plans, if the Participating Group or Related Entities have enrolled Members in the Medical Trust's health benefits; provided, however, that the Participating Group may maintain a non-Medical Trust dental program if the Medical Trust's dental program is not selected by the Participating Group.

3. Contributions. The Participating Group shall make the contributions determined by the Medical Trust at the time and in the manner specified by the Medical Trust. Interest determined by the Medical Trust may be required on any contribution made after the due date established by the Medical Trust. In addition, a late contribution may serve as the basis for termination of the Participating Group Agreement and participation in the Plan(s).

4. Information and Cooperation. The Participating Group shall provide to the Medical Trust or its delegate all information reasonably necessary for the administration of the Plan(s) selected by the Participating Group at the time and in the form and manner specified by the Medical Trust or its delegate. The Participating Group shall cooperate with the Medical Trust as necessary to permit the Medical Trust to effectively administer the Plan(s).

5. Tax Reporting. To the extent that any benefits provided under the Plan are includable in income and/or wages of a Member, the Participating Group shall

satisfy all tax reporting obligations under Federal, state and local law. While most benefits provided under the Plan are intended to be excludable from Federal income tax, the cost of certain benefits (such as health benefits provided to family members and domestic partners who do not qualify as dependents for Federal income tax purposes) may be includible in income and/or wages of the Member. Additionally, pursuant to the Affordable Care Act, Participating Groups may be required to report the value of the coverage provided to its Employees on Form W-2 (for reporting purposes only). The Internal Revenue Service (IRS) has provided a temporary exemption from this reporting requirement for employers who participate in self-funded church plans, such as the Medical Trust's Plans. Applicable employers are also required to satisfy the requirements of the Employer Mandate reporting Forms 1094-C and 1095-C and if the employer offers an HRA, the employer may be required to file Forms 1094-B and 1095-B.

6. Health Savings Account (HSA) Contributions. To the extent that the Participating Group elects to offer a Consumer-Directed Health Plan (CDHP), the employer shall make all employer contributions to the HSA pursuant to the terms and conditions of a Cafeteria Plan. The Medical Trust sponsors and maintains a Cafeteria Plan specifically designed to help satisfy the non-discrimination rules for HSA contributions, called The Episcopal Church Medical Trust Flexible Benefits Plan for HSA Contributions. As applicable, employers are set up automatically to use this plan, without any action by the employer necessary, unless the employer elects to use its own Cafeteria Plan (in which case, the employer hereby represents and warrants that its Cafeteria Plan satisfies, and at all times during which the Participating Group Agreement is in effect will continue to satisfy, the requirements of Section 125 of the Internal Revenue Code).

7. Use and Disclosure of Data. The Participating Group hereby consents to the use or disclosure by the Medical Trust of any data or other information generated in connection with the Plan (e.g., employee census data, the Participating Group's health plan selections, etc.) for purposes of plan design or administration or for any other purpose that is consistent with the Church Pension Group's Privacy Policy available at ***cpg.org***.

8. Other Obligations. The responsibilities of the Participating Group include, but are not limited to, the following:

    - Selecting Plans to be offered to its parishes and/or participating entities. The Participating Group may choose from the various Plans available under the EHP and SEE Plan, if eligible. If a Participating Group chooses to offer both Anthem BCBS and Cigna plans to their eligible Employees, they must offer the equivalent plan from each vendor. For instance, a Participating Group may offer the Anthem BCBS PPO 90 and the Cigna OAP PPO 90, but may not only offer the Anthem BCBS PPO 90 and the Cigna OAP PPO 70. The Participating Group may change the Plan(s) it offers during the annual renewal period and may be required to change the Plans it offers if the Medical Trust eliminates Plans previously offered by the Participating Group. The Participating Group may not make mid-year changes to the Plan(s) it offers, with the exception of adding the Small Employer Exception (SEE) Plan and the Standalone EAP Plan.

- Determining whether or not to offer Domestic Partner benefits. Domestic Partner benefits will be administered by the Plan in accordance with General Convention Resolution 1997-C024.
- Providing Eligible Individuals with educational materials describing our self-funded Plans, including the Summary of Benefits and Coverage. Materials relating to our self-funded Plans can be found at ***cpg.org/mtdocs***.
- Confirming that Members meet the Plan's eligibility criteria.
- Maintaining a Cafeteria Plan to maximize the tax treatment of the contributions to The Medical Trust.
- Communicating elections and changes to the Plan in a timely manner as outlined in the Plan Election and Enrollment Guidelines chapter of this manual.
- Maintaining records of enrolled Eligible Individuals and their enrolled Eligible Dependents related to compensation and health plan enrollment and election decisions. This includes, but is not limited to, marriage certificates, birth certificates, divorce decrees, court orders, adoption decrees and Domestic Partnership Affidavits. The Plan may request a copy of required documentation at any time.
- Collecting and providing Social Security Numbers or Individual Tax Identification Numbers of enrolled Eligible Individuals and enrolled Eligible Dependents for federal reporting purposes to the Plan.
- Notifying the Plan of new Eligible Individuals to take part in Annual Enrollment.
- Providing the Plan with notice of an enrolled Eligible Individual's termination of employment, graduation from seminary or change of status, where the Participating Group is made aware of the event, within 30 days of the event.
- Notifying terminated enrolled Eligible Individuals of the date coverage ends and their responsibility for any claims incurred after the date coverage ends. This does not apply to Eligible Individuals who enroll in the Extension of Benefits program.
- Providing the Plan with statistical data and other information satisfactory in form and accuracy within a reasonable time after a request.
- Providing the Plan with such information as it may request from time to time to enable it to comply with its regulatory reporting obligations, including but not limited to information on employer/employee premium splitting pursuant to Section 204 of the Consolidated Appropriations Act, 2021, on or before the deadline set forth in such request.
- Complying with applicable federal and state laws and regulations, including HIPAA, the Affordable Care Act, the Medicare Secondary Payer rules and the rules under section 125 of the Internal Revenue Code applicable to Cafeteria Plans.
- Executing (in hard copy or electronically) any required paperwork or documentation such as the annual Plan Selections of Medical and/or Dental Renewal Exhibit(s) indicating its Plan elections and providing any other information called for by the Plan.
- Providing Employees with all required compliance notices which can be obtained from ***cpg.org/mtdocs*** (under Regulatory Notices).
- Providing Employees with copies of the Summaries of Benefits and Coverage (SBC) with enrollment materials. These can be obtained from ***cpg.org/mtdocs*** (under Regulatory Notices). Employers must provide SBCs:
    - To new Eligible Individuals (e.g., new hires) by the first day they are eligible to enroll in the Plan

- During Annual Enrollments and renewals unless the Member enrolls themselves through MyCPG Accounts, in which case the SBCs are made available to them electronically
- Within 90 days following a mid-year enrollment resulting from a Significant Life Event (e.g., marriage, new child)
- To individuals qualifying for an Extension of Benefits and annually during the applicable Annual Enrollment period for individuals continuing on an Extension of Benefits
- Upon request (no later than 7 business days following receipt of request)

In addition, the Participating Group may be deemed to satisfy its duties through actions by a parish or other entity, but the Participating Group remains responsible for the duties if they are not carried out in an appropriate manner or timely fashion.

9. Denominational Health Plan (DHP). The Participating Group understands that the Medical Trust has been authorized by the General Convention of The Episcopal Church to implement the Denominational Health Plan as set forth in General Convention Resolutions 2009-A177, 2012-B026, 2018-C023 and Title I, Canon 8, of the Canons of The Episcopal Church. Accordingly, the Participating Group agrees to cooperate with the Medical Trust with respect to all matters relating to the implementation of the DHP.

   The resolutions require that all domestic dioceses, parishes, missions and other ecclesiastical organizations or bodies subject to the authority of The Episcopal Church enroll clergy and lay Employees who are scheduled to work a minimum of 1,500 hours annually.[8] All groups who are required to participate were to provide healthcare benefits through the Medical Trust no later than January 1, 2013.

   Dioceses must have a group-wide employer cost-sharing policy for medical benefits coverage. The policy must provide that the level of cost-sharing is the same for both eligible clergy and eligible lay Employees. An eligible Employee is an Employee who works and is compensated for a minimum of 1,500 hours annually. Individual employers within the group can offer a higher level of cost-share, but it must apply equally to clergy and lay.

   In addition, the General Convention's mandate to the Medical Trust provides that, as part of its effort to contain healthcare premium costs, the Medical Trust must reduce the disparity of those costs among the dioceses.

   It is the dioceses' responsibility to communicate the policy to their participants. The Plan expects the diocese to enforce its group-wide policies along with the Plan's eligibility and enrollment rules as part of DHP requirements.

[8] Although the DHP mandates enrollment of Employees who are scheduled to work a minimum of 1,500 hours annually, the Medical Trust sets the minimum eligibility for the Plans. An Employee normally scheduled to work 1,000 or more compensated hours per plan year is an Eligible Individual for the EHP.

Plan Obligations

The Plan shall provide or make available benefits pursuant to the Administrative Policy Manual and to the terms and conditions of the Plan(s) selected by the Participating Group on the Medical and/or Dental Renewal Exhibit(s) provided as part of the annual renewal or new group quote process.

Acknowledgments

The Participating Group acknowledges the following:

1. Plan Status. The Medical Trust funds certain of its Plans through a trust, known as The Episcopal Church Clergy and Employees' Benefit Trust ("ECCEBT") that is intended to qualify as a voluntary employees' beneficiary association ("VEBA") under Section 501(c)(9) of the Internal Revenue Code. The Medical Trust is the plan sponsor of each of the health plans described in this document. The Plans are intended to qualify as "church plans" within the meaning of Section 414(e) of the Internal Revenue Code and are exempt from the requirements of the Employee Retirement Income Security Act of 1974, as amended ("ERISA"). For purposes of determining the status of a Plan under state insurance laws, each Plan is deemed to be sponsored by a single employer under the Church Plan Parity and Entanglement Prevention Act. Additionally, the Plan may be exempt from state mandated benefit laws and other state insurance laws that may otherwise apply to health insurance arrangements. 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.

2. Plan Terms and Conditions. The terms and conditions of each Plan, including but not limited to assignment of benefits, subrogation and the claims determination and appeals process, are governed by the official Plan documents. The Medical Trust has the authority to interpret the terms of the Plan documents and make Plan determinations in its sole discretion.

3. No Advice. The Medical Trust does not provide investment, tax, medical, legal or other advice.

4. New York Law. The Plan shall be construed, regulated and administered under the applicable provisions of the Code and the laws of the State of New York without giving effect to principles of conflicts of laws. Each Member, each Participating Group and each Billed Group consents to the venue and exclusive jurisdiction of the courts located in New York City in the State of New York.

5. No Healthcare Services. The Medical Trust 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 the Medical Trust. The availability of any particular provider cannot be guaranteed and provider network composition is subject to change. The Plan does not cover all health expenses.

6. Claims Data. The Medical Trust cannot make available to any Participating Group claims data that is specific to the Participating Group's Members. The Medical Trust may periodically make available claims data in an aggregate, de-identified format, depending upon the size of the Participating Group.

7. HIPAA Privacy. The Plan is treated as a "covered entity" under the Health Insurance Portability and Accountability Act of 1996 (HIPAA) and, as such, is subject to the HIPAA privacy and security requirements. The Medical Trust will use and disclose protected health information in connection with the Plan only as permitted or required under HIPAA, subject to such further restrictions, as the Medical Trust may deem necessary or appropriate.

8. Administrative Policy Manual. The Administrative Policy Manual describes the Participating Group's responsibilities with respect to the Plan. The Participating Group agrees to abide by the terms outlined in the Administrative Policy Manual. This Administrative Policy Manual may be updated by the Medical Trust from time to time, in the Medical Trust's sole discretion and with or without notice. Each Participating Group shall be bound by the terms and conditions of the Administrative Policy Manual as may be in effect from time to time. The current version of this Administrative Policy Manual is available at ***cpg.org/apm***.

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 towards coverage, confirming that Members meet the eligibility criteria described below and for maintaining documentation related to the Members' enrollment and elections. The Medical Trust may request a copy of required documentation at any time.

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

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

Eligible Individuals

- An 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[9] 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[9] 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 GMAP***
- A pre-65 Surviving Dependent, not eligible for Medicare, of a deceased Post-65

[9] 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.

Former Employee or Pre-65 Former Employee who, in each case, was enrolled in a Plan sponsored by the Medical Trust at the time of their death***
- A pre-65 Dependent, of a Pre-65 Former Employee enrolled in the GMAP****

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

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 for notifying The Medical Trust when they no longer meet the SEE criteria noted below.

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

Eligible Individuals and their Eligible Dependents described below must be part of a Participating Group that is participating in the 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 that does not employ 20 or more employees in 20 or more calendar weeks in the current or preceding calendar year, and the employer must be approved by CMS as a small employer. See the MSP SEE Eligibility Certification Form.

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 Blue Cross and Blue Shield 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[10] 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[10] 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 section, under Divorce.*
***The Dependent must be enrolled under the Eligible Individual's Plan.*

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

[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.

- 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

Standalone Employee Assistance Program (EAP) Plan

As described in the EHP section above, 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 an Eligible Individual for the SEE Plan who waives coverage as a qualified opt out is deemed to also be waiving EHP coverage.)

Please note that Eligible Individuals who enroll in Medical Trust health coverage (including the SEE Plan) 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.

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.

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

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

Eligible Individuals (must provide (i) a Social Security or Individual Taxpayer Identification Number; and (ii) proof of enrollment in Medicare Part A and Part B)

- 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 (i) a Social Security or Individual Taxpayer Identification Number; and (ii) proof of enrollment in Medicare Part A and Part B)

- 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.

- An Eligible Individual for the EHP or SEE Plan
- 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

Important Notes

Medicare Secondary Payer (MSP)

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

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

Medicare beneficiaries are free to reject employer plan coverage and retain Medicare as their primary coverage. However, when Medicare is the primary payer, employers cannot offer such Employees (or their Spouses) secondary coverage for items and services covered by Medicare. Medicare states that an employer cannot sponsor,

contribute to, or otherwise facilitate enrollment in coverage intended only to supplement Medicare's benefits (e.g., individual Medicare supplement health plans, Medicare HMOs, or Group Medicare Advantage plans) for Medicare beneficiaries who are otherwise eligible for active group medical coverage. Therefore, the Plan does not offer group Medicare supplement health plans, group Medicare HMOs or Group Medicare Advantage plans to Employees and their Spouses over age 65 who are Medicare beneficiaries, and the Employee and their eligible Spouse can no longer receive a subsidy under The Church Pension Fund Post-Retirement Medical Assistance Plan. Failure to comply with the MSP rules can result in penalties assessed against the employer. It is the employer's responsibility to comply with the MSP rules and by participating in the Plans the employer agrees to indemnify and hold the Medical Trust harmless from any claims resulting from the failure to comply with the MSP rules.

Note that the MSP rules do not apply to standalone dental coverage.

Small Employer Exception

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

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

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

Because Medicare will become the primary payer of claims covered under Medicare Part A, to participate in the SEE Plan, any members of the family who are eligible must be enrolled in Medicare Part A. Medicare Part A insurance helps cover the cost of inpatient care in hospitals, skilled nursing facilities, hospices, and home healthcare situations.

For all other coverage, such as doctor visits, outpatient procedures, and prescription drug coverage, the Medical Trust plan will remain the primary payer of benefits. However, if an Employee or Eligible Dependent elects to enroll in Medicare Part B coverage, Medicare will become the primary payer of Part B claims and the Medical Trust plan will coordinate benefit payments with Medicare and become the secondary payer.

When Medicare becomes the primary payer for claims under Medicare Part A or Part B, the cost to employers of providing medical coverage may be reduced. Employees' hospitalization costs, including out-of-pocket expenses such as deductibles and

coinsurance, will typically be lower as well. In addition to the cost savings typically realized with Medicare as the primary payer of the claims, additional savings can be realized by using network providers. The Member will usually pay less for services from network providers than from out-of-network providers.
Individuals who are enrolled in the SEE Plan will continue to have access to the additional benefits included in the Medical Trust plans, such as

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

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

Working for the Church after Retirement

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

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

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

Note that the MSP rules do not apply to standalone dental coverage.

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 the GMAP are automatically enrolled in the Cigna EAP and thus should not be enrolled in the Standalone EAP Plan.

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

Eligible Individuals who elect not to enroll in the GMAP are not considered to have waived EHP coverage as a qualified opt out, and therefore cannot be enrolled in the Standalone EAP Plan.

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[11] 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)

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

- Change in the number of Eligible Dependents (e.g., an increase through marriage, birth, adoption or placement for adoption, or a decrease through death or Dependent gaining own health benefits)
- 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 healthcare provider's discontinuation of participation in a Plan network is not a Significant Life Event and does not permit an election change.

The effective date of coverage for an election change due to a Significant Life Event is the first day of the month 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 the occurrence of the Significant Life Event and of the 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 such election changes 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 Significant Life Event and 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, below. 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 employer is responsible for providing the Member a Summary of Benefits and Coverage (SBC) for each applicable Plan and a Notice of Special Enrollment within 90 days of enrollment resulting from a HIPAA Special Enrollment Event.

Reporting Eligibility and Enrollment Changes

The Group Administrator must report all changes that affect Member benefit coverage and Plan elections to the Plan when they occur, but no later than 60 days after the occurrence. Examples of what should be reported include:

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

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

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

The following additional requirements also apply:

- Health Plan choice may be restricted if an Eligible Individual has Eligible Dependents living outside the service area of a particular Plan.
- If a local managed care plan is elected, additional enrollment forms from the local plan option may be required.
- Pre-65 Former Employees and Post-65 Former Employees who do not receive any contribution assistance from the Participating Group may submit enrollment forms directly to the Plan.
- Certain additional requirements may apply under the GMAP that should be taken into consideration in the processing of enrollment paperwork. Therefore, to ensure timely access to 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[12]
- Options to add or remove Eligible Dependents
- The deadline for submitting Plan elections

[12] Employer/Employee cost share information is not provided, as such cost sharing is determined by each individual Participating Group.

- 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 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.[13]

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.

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

IMPORTANT NOTES:

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

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

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

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

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

Enrolled Children of such a Pre-65 Former Employee may also remain enrolled in the EHP for so long as they remain an Eligible Dependent.[14]

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.

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.

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.

IMPORTANT NOTES:

- The birth of a newborn Child constitutes a Significant Life Event that allows an Eligible Individual or an Eligible Individual's Spouse/Domestic Partner who is not enrolled in the Plan to enroll as of the date of birth of the newborn Child.
- A newborn Child may not enroll in the Plan if the Eligible Individual is not enrolled in the Plan.
- The newborn child of a Dependent Child will not be covered by the Plan, even for the first 30 days, unless that child is placed for adoption by, or is a legal ward or foster child of, the Eligible Individual or Eligible Individual's Spouse/Domestic Partner.

[14] 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.

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.[15]

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.[15]

[15] 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.

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

Children of Surviving Spouses of Limited Means

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

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

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

A QMCSO is a judgment, decree or order (including approval of a settlement agreement) or administrative notice that is issued pursuant to a state domestic relations law (including a community property law) or through an administrative process, which directs that a child must be covered under a health plan. The Plan has delegated to the applicable Participating Group the responsibility to determine if a medical child support order is qualified. If the Participating Group determines that a separated or divorced Spouse or any state child support or Medicaid agency has obtained a QMCSO, and if the Participating Group offers Dependent coverage, the Plan will allow the enrolled Eligible Individual to provide coverage for any Children named in the QMCSO.
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.[16]

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.

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

Guidelines and Effective Dates of Coverage for Eligible Individuals/Dependents
Quick Reference Chart

Type of Eligible Individual / Eligible Dependent	Guidelines for Eligible Individuals / Eligible Dependents	Guidelines for employers / Participating Groups*
New Employees and Newly Eligible Employees	New Employees and newly Eligible Individuals will generally have **30 days** after the Employee's date of hire, or date they became eligible, to request enrollment in writing. The effective date of coverage is the first day of the month coincident with or following the date they become eligible.	The employer or Participating Group will have **60 days** from date of new hire or other Significant Life Event to submit the enrollment transaction through MAP.**
Religious Orders	A postulant, novice or professed Member of a Religious Order will generally have **30 days** after the date in which they are received or accepted by the Religious Order to request enrollment in writing. The effective date of coverage for a postulant, novice or professed Member of a Religious Order is the first day of the month coincident with or following the date in which they are received or accepted by the Religious Order.	The employer or Participating Group will have **60 days** from date in which the postulant, novice or professed Member of a Religious Order is received or accepted by the Religious Order to submit the enrollment transaction through MAP.**
Seminarians	The Seminarian must make any elections no later than **30 days** after the seminary's published registration deadline for that semester. 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 employer or Participating Group will have **60 days** from the seminary's published registration deadline for that semester to submit the enrollment transaction through MAP.**

New Children (Birth or Adoption)	The Eligible Individual must elect to enroll the new Child for coverage within **30 days** of the birth or adoption (or placement for adoption, if earlier) 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 or adoption (or placement for adoption), as applicable.	The employer or Participating Group will have **60 days** from the date of the Child's birth or adoption (or placement for adoption) to submit the enrollment transaction through MAP.**
Marriage or Establishment of a Domestic Partnership	Eligible Individuals will generally have **30 days** after marriage or the establishment of a Domestic Partnership (as certified by a Domestic Partnership Affidavit), as applicable, to request a new Spouse's or a new Domestic Partner's enrollment in writing. An Eligible Individual may enroll their eligible Domestic Partner for coverage only if they are part of a Participating Group that offers Domestic Partner coverage.	The employer or Participating Group will have **60 days** from date of marriage or the establishment of a Domestic Partnership, as applicable, submit the enrollment transaction through MAP.**

* In all cases, the Member must have given their employer or the Group Administrator timely notice of the event and their new election.

**In certain extenuating circumstances that prevented an administrator from entering the Member's timely election, enrollments by the employer or Participating Group through MAP may be possible beyond 60 days following the event. Any request for an extension must be approved by CPG and in no circumstances can an enrollment be processed beyond 180 days from the 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[17] (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[17] (except if the Child is a Disabled Child in accordance with the terms of the Plan)
- The date on which monthly contributions are deemed delinquent, as determined by the Plan in its sole discretion.
- The date the Plan ceases to exist

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

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

For Cause

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

- Threaten the safety of the plan administrator, a third-party administrator, any Group Administrator or any provider, or any personnel of any of the foregoing.
- Commit theft from the plan administrator, a third-party administrator, any Group Administrator or any provider.
- Performs an act that constitutes fraud or makes an intentional misrepresentation of material fact in procuring coverage, such as knowingly (1) misrepresenting participation status, (2) presenting an invalid prescription or physician order, or (3) misusing or letting someone else misuse an ID card to obtain care under false

[17] 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.

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[18] 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[18] or later if the Child is a Disabled Child in accordance with the terms of the Plan. If the Surviving Dependents leave the EHP, they may not return to the Plan, unless they are eligible to enroll in and elect to enroll in the GMAP.

Dependents

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

Divorce or Dissolution of a Domestic Partnership

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

Employees and Seminarians

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

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

The Pre-65 Spouse or Domestic Partner enrolled in the EHP who gets divorced from (or dissolves a Domestic Partnership with) a Post-65 Former Employee or Pre-65 Former Employee can stay enrolled in the EHP. However, if the Spouse or Domestic Partner leaves the EHP, then they cannot enroll again with the Plan until they become

[18] 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.

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.[19] 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[20] starting on the first day of the month following the termination event.
    - Note that, because the SEE Plan requires that the Eligible Individual be actively working for an Eligible Small Employer, Eligible Individuals enrolled in the SEE Plan who terminate employment will be offered continuation of coverage under the EHP in the Extension of Benefits program.
- Spouses and Domestic Partners whose coverage is terminated as a result of the Employee no longer meeting the Plan's eligibility requirements for the EHP or SEE Plan (e.g., as the result of a termination of employment or reduction of scheduled hours), the Employee's death, divorce, legal separation or termination of a Domestic Partnership are offered an extension of 36 months starting on the first day of the month following the termination event.
    - If the couple divorces (or dissolves their Domestic Partnership) while on an Extension of Benefits, the divorced Spouse (or former Domestic Partner) of the former Employee may choose to remain on their own extension for the remaining period of the current extension.
    - Note that, with respect to former Domestic Partners, an Extension of Benefits will only be available if the Participating Group offers coverage to Domestic Partners generally.
- Dependent Children whose coverage is terminated (including as a result of reaching age 30) are offered an extension of up to 36 months starting on the first day of the month following the termination event.
- Seminarians who cease to be a Seminarian are offered an extension of 36 months starting on the first day of the month following graduation or other separation event.
- Employees whose Medical Trust coverage terminates under the terms of The Church Pension Fund Clergy Long-Term Disability Plan are offered an extension

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

[20] 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.

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.

No Member may be enrolled as an Eligible Individual in more than one medical Plan or more than one dental Plan (or have two or more enrollments in the same medical or dental Plan) at the same time. For example, and without limiting the generality of the foregoing, an Employee who works for two Episcopal Employers and who is an Eligible Individual for the EHP by virtue of their employment with each of them cannot be enrolled in the EHP through both of their employers simultaneously.

Plan Sponsor

We maintain contractual relationships with various health plan vendors on your behalf. We are the plan sponsor of all Medical Trust health plans.

Forfeitures

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 forfeited. Forfeitures 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.

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 to another party, such as a third-party administrator, that party shall act with the same discretion and authority as the Medical Trust.

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.

Reliance on Documents and Information

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

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. 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***.

My Admin Portal (MAP)

My Admin Portal (MAP) is designed to allow Group Administrators (as defined in Definitions) to gain direct access to the Plan's enrollment database and manage Member enrollment.

MAP is a user-friendly and secure web-based portal. Group Administrators are sent an online invitation, which provides them with the ability to create an online account to access MAP through the internet at ***cpg.org/map***.

Group Administrators can complete transactions affecting the Participating Group's medical, dental, life and/or disability products offered by CPG.

The transactions available through MAP for healthcare benefits include:

- New enrollments
- Coverage changes
- Coverage terminations
- Employee demographic changes
- Employee address and phone
- Dependent changes
- Annual plan selections for existing Participating Groups

Most transactions entered into MAP are processed overnight and visible the following business day. Some transactions entered into MAP may trigger edits and be held for review. These transaction requests are normally reviewed and resolved within a reasonable period of time based on complexity. Most processed transactions are reported to health plan vendors by the Plan on a weekly basis.

A change log of MAP transactions is available in MAP.

Reports, such as enrollment reports and Annual Enrollment reports, may also be available through MAP.

Group Administrators may review and update open billing statements for all Billed Groups within their Participating Group. Changes to coverage made between billing date and the billing freeze date of the statement will be reflected on that month's bill. Once the bill freezes, any changes will be reflected in the following month's bill as a retro change (add/term). Group Administrators can also review past billing statements and payment history by Billed Group.

If the Group Administrator is unsure of how to process a change because of its unique nature, then the Group Administrator can write a message in the Special Requests or Instruction box at the bottom of the Employee's coverage screen advising the Medical Trust of the unique change requested. These changes are held for review and processed by Client Services.

The Plan actively solicits suggestions and feedback on MAP from Group Administrators for future system enhancements.

Billing

The Plan is responsible for sending billing statements, collecting remittances and crediting payments to Billed Group accounts. The Plan is able to send billing statements to:

- The Participating Group
- One of its Billed Groups (e.g., a parish) which is paying the monthly contributions directly to the Plan
- An enrolled Eligible Individual who is paying the monthly contributions directly to the Plan

Process

The Plan sends billing statements for the next month's coverage on or around the 12th business day of each month. A copy of the Medical Trust's billing schedule is available in MAP.

All billing statements contain:

- Name(s) of enrolled Eligible Individual(s)
- Client Number(s)
- Account number (same as Billed Group number)
- Plan name(s)
- Coverage Tier(s)
- Account balance information
- Payment due date
- Retroactive adjustments
- Payments received

The Administrators of Billed Groups and directly billed enrolled Eligible Individuals are responsible for making payments in a timely manner and ensuring that enrollment changes reach the Plan as soon as possible.

If a former employer subsidizes any portion of the monthly contribution for a Pre-65 Former Employee or Post-65 Former Employee, the related monthly contributions will be billed to the former employer. If the related monthly contribution is billed to the Pre-65 Former Employee or Post-65 Former Employee, no information will be provided to the former employer regarding the Pre-65 Former Employee's or Post-65 Former Employee's plan election or billing status, in accordance with applicable privacy regulations.

The Plan agrees to:

- Send monthly billing statements that has a payment remittance stub (including a return envelope, if the bill is sent via physical mail) in a timely manner
- Perform a quality assurance check on a sample of billing statements each month
- Post payments (including automated payments) to the Billed Group account Resolve all disputed billing or collection amounts in a timely fashion
- Notify Billed Groups of changes to the processes and procedures relating to billing and collection

- Notify Billed Groups and Members of account status if an account becomes overdue

All Billed Groups should:

- Review the bill for completeness and accuracy. For example, checking for the following:
    - Are all covered Members included and correctly listed?
    - Are Coverage Tiers, periods and monthly contributions accurate for each Member?
    - Were terminated coverages removed?
    - Were changes processed as requested?
    - Were new coverages added?
    - Have prior payments been posted to the account?
        - If a check has been mailed, was the correct payment remittance stub included? Not including the correct payment remittance stub and/or no payment remittance stub may cause payment allocation delays and result in such payment not being timely reflected on the Billed Group account
    - If a payment is made by wire / ACH, was the Billed Group's account number included?
- Reconcile the billing statement based on current enrollment records
- Contact Client Services or use MAP to determine if requested changes have been processed after the billing date
- Contact Client Services to note corrections or disputed amounts
- Make any necessary changes to health Plans in MAP
- Remit payments in a timely manner in accordance with the instructions on the billing statement
    - Make checks payable to ECCEBT (Episcopal Church Clergy and Employees' Benefit Trust)
    - Note the Billed Group's account number, which is located under the barcode of the remittance stub on the check memo
    - Include the correct billing statement payment remittance stub along with the check
    - Mail payments to the lockbox:

ECCEBT
75 Remittance Drive
Suite 6109
Chicago, IL 60675-6109

IMPORTANT NOTE: Do not send forms, correspondence, enrollment items and/or plan elections with payments to the lockbox. Correspondence sent to the lockbox will not be forwarded to the Plan. Correspondence should be sent to the Episcopal Church Medical Trust, 19 East 34th Street, New York, NY, 10016, by fax to (877) 432-9274, or by email to ***mtcustserv@cpg.org***.

Delinquent Notice

It is important to keep the Billed Group account current and make payments on a timely basis. The Plan makes every effort to work with Billed Groups that fall behind in

their payments to bring their accounts current. If, however, payment is not received within three months after the due date, the Plan will institute the following process:

- Billed Groups that are two months past due will receive a letter reminding them of the overdue payment ("first notice")
- Billed Groups that are three months past due will be contacted in writing about the delinquency ("second notice"). The Plan must receive payment within 14 calendar days of the notice date in order to remove the delinquent status of the account. The notice will include a sample termination letter that will be sent to each enrolled Eligible Individual in the event that health coverage must be terminated due to non-payment.
- All amounts must be paid within 14 calendar days; provided, however, that amounts subject to a bona fide dispute (as reasonably determined by the Medical Trust) will be set aside for reconciliation and resolution and must be paid within 14 calendar days of resolution.
- If the Billed Group is a congregation or other institution of a Participating Group, the Participating Group will also be notified of the delinquency.
- If the account remains delinquent 14 calendar days after the notice date as specified in the second notice, a third notice will be sent to the Billed Group, and the Participating Group (if applicable).
- A termination letter will also be sent separately to each enrolled Eligible Individual of a Billed Group announcing the coverage termination effective date that will take effect if payment of the past due amount is not made.

Cancellation Notice

If the account remains delinquent 14 calendar days after the date of the third notice, a fourth and final Notice of Cancellation of Group Coverage with a cancellation effective date will be sent to the Billed Group. A copy of the Notice of Cancellation will also be sent to the Participating Group, if applicable. Extension of Benefits offers will be sent to each formerly enrolled Eligible Individual whose coverage has been terminated as a result of such non-payment. The Plan will continue to bill the past due balance. The Plan reserves the right to terminate coverage retroactive to the last day of the last month for which the Billed Group paid for coverage, and, in the event of such a retroactive termination, to retract from the provider any paid claims incurred following the termination date and to instruct the provider to bill the Member directly.

Delinquent Pre-65 Former Employee Payments

Members enrolled in the EHP whose contributions are two months overdue will be contacted in writing about the delinquency. A second notice will be sent when contributions are three months overdue, notifying the Member of the coverage termination effective date if the past-due amounts are not paid. Coverage will be terminated after contributions are more than three months overdue. The Plan will continue to bill the past due balance. The Plan reserves the right to terminate coverage retroactive to the last day of the last month for which the Member paid for coverage, and, in the event of such a retroactive termination, to retract from the provider any paid claims incurred following the termination date and to instruct the provider to bill the Member directly.

Delinquent Post-65 Former Employee Payments (including Group Medicare Advantage Plan Members)

Members enrolled in the GMAP whose contributions are two months overdue will be contacted in writing about the delinquency. A second notice will be sent when contributions are three months overdue, notifying the Member of the coverage termination effective date if the past-due amounts are not paid. Coverage will be terminated after contributions are more than three months overdue. The Plan will continue to bill the past due balance.

Cancellation for Delinquent Extension of Benefits Payment

The coverage of Members enrolled in the Plan's Extension of Benefits program whose contributions are overdue will be terminated after their contributions are three months past due. The Plan will continue to bill the past due balances. The Plan reserves the right to terminate coverage retroactive to the last day of the last month for which the Member paid for coverage, and, in the event of such a retroactive termination, to retract from the provider any paid claims incurred following the termination date and to instruct the provider to bill the Member directly.

Overpayments and Underpayments

Payments are reflected in the "Payments received" section of the billing statement. If the amount paid does not equal the "Total amount due last statement," an underpayment or overpayment will result. This will appear as a "Balance forward" on the billing statement.

In MAP under the "Amount Due" column, the amount will display in red when the account is not paid and will display in green when the account is overpaid. When the bill is current it will appear in black.

Group Administrators should verify the billing statement against the current monthly enrollment record. This prevents overpaying for terminated coverage, ensures that new coverage has been added and verifies changes made since the last billing date. A retroactive section will appear on the bill when dated changes are made.

Group Administrators should contact Client Services immediately to address billing questions or discrepancies.

The Plan will set aside disputed items until an investigation is completed. Coverage will not be terminated as long as payment on undisputed balances is made.

Retroactive Terminations

A request to terminate coverage for an enrolled Eligible Individual should be made within 30 days of the applicable Significant Life Event. Retroactive termination requests must be received within 60 days of the termination event. If a request is received after that date, the requested date may not be granted and may be adjusted forward. The Plan will review each retroactive termination request and will make the final determination on whether the date will be approved. This would be reflected in the retroactive adjustment section of the billing statement.

If a former Member used health services after the termination date and claims were paid by the Plan, if permitted under applicable law, the Plan reserves the right to retract the paid claims from the provider and instruct the provider to bill the Member directly.

The Plan does not pro-rate contribution requirements for any health Plan regardless of the termination date or the effective date. Any monthly contribution 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 billed.

Disclaimers

The Plan(s) described in this Administrative Policy Manual are sponsored by the Church Pension Group Services Corporation ("CPGSC"), also known as The Episcopal Church Medical Trust (the "Medical Trust"). The Plans that are self-funded are funded by The Episcopal Church Clergy and Employees' Benefit Trust ("ECCEBT"), a voluntary employees' beneficiary association within the meaning of section 501(c)(9) of the Internal Revenue Code.

This Administrative Policy Manual should not be viewed as an offer of coverage, or investment, tax, medical or other advice. By participating in the Plan, each Participating Group agrees to the terms of set forth in this Administrative Policy Manual. In the event of a conflict between this Administrative Policy Manual and the official Plan documents (Plan Document Handbook and summaries of benefits and coverages), the official Plan documents will govern. This Administrative Policy Manual may be updated by the Medical Trust from time to time, in the Medical Trust's sole discretion and with or without notice. Each Participating Group shall be bound by the terms and conditions of the Administrative Policy Manual as may be in effect from time to time. The current version of this Administrative Policy Manual is available at ***cpg.org/APM***.

The Plan, and this Administrative Policy Manual, are governed by, and the rights and obligations of the Medical Trust, ECCEBT, each Participating Group, the Members and any person who is, or claims to be, eligible for participation in the Plan, 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 and the ECCEBT (collectively, "CPG"), retain the right to amend, terminate or modify the terms of the Plans, as well as any post-retirement health subsidy, at any time, for any reason and unless required by law, without notice.

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

For purposes of determining the status of a Plan under state insurance laws, each Plan is deemed to be sponsored by a single employer under the Church Plan Parity and Entanglement Prevention Act. Additionally, the Plan may be exempt from state-mandated benefit laws and other state insurance laws that may otherwise apply to health insurance arrangements.

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.

Privacy Statement to Members

Joint Notice of Privacy Practices

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

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

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

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

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

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

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

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

Disclosures to You. The Plans will disclose your PHI to you or your personal representative within the legally specified period following a request.

Government Audit. The Plans will make your PHI available to the U.S. Department of Health and Human Services when it requests information relating to the privacy of PHI.

As Required By Law. The Plans will disclose your PHI when required to do so by federal, state or local law. For example, the Plans may disclose your PHI when required by national security laws or public health disclosure laws.

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

- **Treatment.** The Plans may disclose your PHI to your providers for treatment, including the provision of care or the management of that care. For example, the Plans might disclose PHI to assist in diagnosing a medical condition or for pre-certification activities.
- **Payment.** The Plans may use and disclose your PHI to pay benefits. For example, the Plans might use or disclose PHI when processing payments, sending explanations of benefits (EOBs) to you, reviewing the medical necessity of services rendered, conducting claims appeals and coordinating the payment of benefits between multiple medical plans.
- **Healthcare 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.** ECMT, as sponsor of the Plans, will have access to your PHI for plan administration purposes. Unless you authorize the Plans otherwise in writing (or your individual identifying data is deleted from the information), your PHI will be available only to the individuals who need this information to conduct these plan administration activities, but this release of your PHI will be limited to the minimum disclosure required, unless otherwise permitted or required by law.

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

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

Any other use or disclosure of your PHI not identified in this section will be made only with your written authorization.

Authorizing Release of Your PHI
To authorize release of your PHI, you must complete a medical information authorization form. An authorization form is available at ***cpg.org*** or by calling (800) 480-9967. You have the right to limit the type of information that you authorize the Plans to disclose and the persons to whom it should be disclosed.

You may revoke your written authorization at any time. The revocation will be followed to the extent action on the authorization has not yet been taken.

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

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

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

Your Rights With Respect to Your PHI
You have the following rights regarding PHI the Plans maintain about you:

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

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

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

Right to Amend. You have the right to request that the Plans amend your PHI or record if you believe the information is incorrect or incomplete. To request an amendment, you must submit a written request to the Medical Trust Plan Administration at ***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 accurate and complete.

Right to an Accounting of Disclosures. You have the right to receive information about when your PHI has been disclosed to others. Certain exceptions apply to this rule. For example, a Plan does not need to account for disclosures made to you or with your written authorization, or for disclosures that occurred more than six years before your request. To request an accounting of disclosures, you must submit your request in writing to the Medical Trust-Plan Administration at ***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 Medical Trust Plan Administrator will then notify you of any additional information required for the accounting request. A Plan will provide you with the date on which a disclosure was made, the name of the person or entity to whom PHI was disclosed, a description of the PHI that was disclosed, the reason for the disclosure and certain other information. If you request this accounting more than once in a 12-month period, you may be charged a reasonable, cost-based fee for responding to these additional requests. You may contact Medical Trust Plan Administration at ***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.

EPISCOPAL CHURCH MEDICAL TRUST

Domestic Partnership Affidavit

I. DECLARATION

We,_____, and,_____,
(Print Eligible Individual's Full Name) (Print Domestic Partner's Full Name)

represent and affirm, jointly and individually, that we are engaged in a domestic partner relationship in accordance with the following criteria and are eligible for healthcare benefits as Domestic Partners under the health Plan offered by my Participating Group through The Episcopal Church Medical Trust (the "Medical Trust").

II. STATUS

1. We are at least eighteen (18) years of age and mentally competent to enter into a legal contract.
2. We have maintained a legal residence together for the past 12 months and intend to remain so indefinitely.
3. Neither of us is married to or legally separated from anyone else.
4. We are each other's sole Domestic Partner, are two adults who have chosen to share one another's lives in a mutually exclusive partnership that resembles marriage and intend to remain so indefinitely.
5. We are not in this relationship solely for the purpose of obtaining benefits coverage.
6. We are not related by blood to a degree of closeness that would prohibit legal marriage in the state or jurisdiction in which we legally reside.

Date criteria of Domestic Partnership were first satisfied:
_____/_____/_____
(Month) (Day) (Year)

III. CHANGE IN DOMESTIC PARTNERSHIP

1. We agree to notify the Medical Trust if there is any change in our status as Domestic Partners as attested to in this Affidavit, which would affect our eligibility for healthcare benefits (for example, if we cease to reside together or if we are no longer each other's Domestic Partner). We agree to notify the Medical Trust within thirty (30) days of such change by filing a Statement of Dissolution of Domestic Partnership, affirming that the Domestic Partnership status has ended as of its date of execution.

2. After such dissolution, I,_____(Eligible Individual), understand that a subsequent Domestic Partnership Affidavit may not be filed until any subsequent Domestic Partner relationship meets the criteria specified in Section II of this Affidavit. (The 12-month relationship period specified under Section II may be waived if the subsequent Affidavit is filed for the same Domestic Partner who is signatory to this Affidavit.)

IV. ACKNOWLEDGMENTS

1. We understand that failure to notify the Medical Trust when a Domestic Partnership has been dissolved or the use of false or misleading documents to obtain coverage may have serious legal consequences. If health claims have been paid by the Medical Trust or one of its healthcare vendors as a result of false representations, we understand that the Medical Trust and/or its healthcare vendor will seek reimbursement of those expenses and reserves the right to pursue the matter through civil legal action.

2. We have provided the information in this Affidavit for use by the Medical Trust for the sole purpose of determining our eligibility for Domestic Partnership benefits.

3. We understand that the value of Domestic Partnership benefits coverage may be taxable as income.

4. We understand that some courts have recognized non-marriage relationships as the equivalent of marriage for the purpose of establishing and dividing community property and that the filing of this affidavit may have other legal consequences.

5. We understand that even though we may be eligible for healthcare benefits as determined by the Medical Trust's criteria for Domestic Partnerships, healthcare benefits may not be available in every medical market or from every Participating Group.

We submit the following copies of two items as proof evidencing our cohabitation and mutual support:

_____ Joint bank account statements
_____ Joint credit card statements
_____ Loan agreement indicating joint obligation
_____ Property Deed
_____ Residential tenants lease
_____ Common public utility or telephone bills

6. We understand that if we are eligible for healthcare benefits as Domestic Partners and subject to any other exception to coverage, coverage will commence as of the first of the month following our eligibility determination.

V. STATEMENT

We affirm, under penalty of perjury, that the assertions in this Affidavit are true and correct.

Eligible Individual Signature	Domestic Partner Signature
Phone Number	Phone Number
Email Address	Email Address
Street Address	Date
City, State, Zip	

Witnessed by:

Name and Title of Group Administrator	
Signature of Group Administrator	Date

EPISCOPAL CHURCH MEDICAL TRUST

Statement of Dissolution of Domestic Partnership

This Statement of Dissolution of Domestic Partnership ("Statement of Dissolution") serves as notification to The Episcopal Church Medical Trust (the "Medical Trust") of the termination of the domestic partnership between the persons named below.

Eligible Individual's Name _____ Date of Birth _____

Phone Number _____ Email Address _____

Street Address, City, State, Zip _____

Domestic Partner's Name _____ Date of Birth _____

Phone Number _____ Email Address _____

Street Address, City, State, Zip _____

CERTIFICATION

I hereby certify that, as of the date written below, my domestic partnership, as defined by the Medical Trust, with the above-named person has terminated or no longer meets the criteria for coverage under the health plans offered through the Medical Trust (the "Plans"). I understand that:

- As of the date that this domestic partnership terminates, my former Domestic Partner ceases to be eligible for the benefits that are available to Domestic Partners under the Plans,
- A subsequent Affidavit of Domestic Partnership may not be filed until all the requirements as outlined in such affidavit are met, and
- It is my responsibility to provide a copy of this form to my former Domestic Partner.

I have read and understand this Statement of Dissolution, including the information on the back of this form. I affirm, under penalty of perjury, that the assertions in this Statement of Dissolution are true and correct.

Eligible Individual or Domestic Partner Signature _____ Date _____

General Information

Filing a Statement of Dissolution of Domestic Partnership

- Either partner can file a Statement of Dissolution of Domestic Partnership
- Provide all of the requested information on the Statement of Dissolution
- Submit your signed Statement of Dissolution to your Group Administrator along with your enrollment form terminating your Domestic Partner from coverage, keeping a copy for your records.

Important Notes

- A Statement of Dissolution of Domestic Partnership filed with the Medical Trust does not invalidate a written beneficiary designation on file with The Church Pension Fund and its affiliates.
- A Domestic Partner may be eligible for an Extension of Benefits after this domestic partnership terminates, if the Medical Trust is notified in a timely manner. The Domestic Partner will be responsible for the full amount of the monthly contributions and will be billed directly.
- Failure to timely notify the Medical Trust of the termination of this domestic partnership, may result in medical expenses being erroneously paid on the Domestic Partner's behalf. The Eligible Individual is responsible for repaying any overpaid health benefits claims.

For Office Use Only:

Statement of Dissolution Effective Date:

_____

Reviewed By: _____

EPISCOPAL CHURCH MEDICAL TRUST

Child Affidavit

This form must be used if you want to enroll your Child for coverage outside of the initial or Annual Enrollment period, for example, as a result of a Significant Life Event. In order to determine whether your Child meets the eligibility requirements for coverage under your Participating Group's health Plan, this form must be completed, signed and returned to the Group Administrator of your Participating Group.

ELIGIBLE INDIVIDUAL INFORMATION

Name:_____ SSN:_____

Address: _____

CHILD ELIGIBILITY

In order to be eligible for coverage under your benefits, a Child must meet both of the following requirements:

1. The Child is the Eligible Individual's: *(CHECK ONE)*

- ❑ Biological Child
- ❑ Foster Child (an individual who is placed with the Eligible Individual by an authorized placement agency or by judgment, decree or other order or any court of competent jurisdiction)
- ❑ Legally Adopted Child
- ❑ Legal Ward (A legal ward is a person under the age of 18 placed under the care of a guardian by an authority of law.)
- ❑ Child placed with Eligible Individual for Adoption
- ❑ Spouse's Child (and not legally a Child of the Eligible Individual)
- ❑ Domestic Partner's Child (and not legally a Child of the Eligible Individual) (only applicable where Domestic Partnership benefits are offered by the Participating Group)

2. The Child is: *(CHECK ONE)*

- ❑ 30 years of age or younger
- ❑ a Disabled Child*

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

Name:________________________________D.O.B.:___________Sex: ________
[Last, First, Middle] [mm/dd/yyyy] [M/F]

Name:________________________________D.O.B.:___________Sex: ________
[Last, First, Middle] [mm/dd/yyyy] [M/F]

Name:________________________________D.O.B.:___________Sex: ________
[Last, First, Middle] [mm/dd/yyyy] [M/F]

Name:________________________________D.O.B.:___________Sex: ________
[Last, First, Middle] [mm/dd/yyyy] [M/F]

Name:________________________________D.O.B.:___________Sex: ________
[Last, First, Middle] [mm/dd/yyyy] [M/F]

Name:________________________________D.O.B.:___________Sex: ________
[Last, First, Middle] [mm/dd/yyyy] [M/F]

DESCRIPTION OF SIGNIFICANT LIFE EVENT

____
____
____
____
____

CERTIFICATION

I certify under the penalty of perjury that the information provided above is correct to the best of my knowledge and that the Children listed on this form fully meet the listed definition of eligibility. I agree to provide proof of my relationship to the Child(ren) listed above upon request by my Participating Group or Plan and agree to notify my Participating Group immediately if there is a change in the status of any Child listed above. I have reviewed the benefit enrollment materials and agree to the terms and conditions listed there.

____ ____________________
Eligible Individual's Signature Date Signed

01/24

EPISCOPAL CHURCH MEDICAL TRUST

Coverage and Eligibility Exception Request Form

The Episcopal Church Medical Trust (the "Medical Trust") provides healthcare coverage for Eligible Individuals of The Episcopal Church and its institutions. Exceptions for healthcare coverage outside of the Medical Trust's eligibility rules may be made for an individual employed or formerly employed by an institution that is part of a Participating Group. Exceptions must be requested by the individual with requisite authority to make benefits decisions on behalf of the Participating Group and must be approved by the Medical Trust on an annual basis (initially upon enrollment and then during each Annual Enrollment period).

Completion of this request form does not guarantee that the individual shall be approved for coverage under the Medical Trust. If the individual is approved for coverage, documentation of the individual's plan election must be provided to the Medical Trust no later than 30 days after the approval has been granted, and coverage will commence on the first of the month following the receipt of the enrollment submission.

Name of individual for whom the request is made:

_____
(First, Middle, Last Name)

_____
(Address, City, State & Zip)

_____
(Phone Number & Email Address)

Date of Birth:_____/_____/_____ Gender: _____
Month Day Year

Describe the service the individual performs and explain why the individual should be covered by the Medical Trust. Include duties, the number of hours per week the individual works and the period of time the individual performs the duties.

_____
_____
_____
_____

If the individual is currently covered or eligible for coverage by another health plan, why does the individual need coverage from the Medical Trust? For example, has there been or will there be a Significant Life Event that necessitates a change?

_____
_____
_____
_____

Please provide any other information or comments that may be helpful to the determination.

_____

_____

_____

STATEMENT

I,_____, _____,
(First, Middle, Last Name) (Title)

hereby certify that the above named individual is employed by an institution that is part of a Participating Group. I certify that I am the individual with requisite authority to make benefits decisions on behalf of the Participating Group. I further certify under penalty or perjury that the information I have provided is accurate. I understand that if any of the above information is untrue, the Participating Group with which the individual is associated will be responsible for reimbursing the Medical Trust for any amount it was induced to pay in reliance on the information provided. I understand that I have the responsibility of informing and agree to inform the Medical Trust of any changes in the above information.

Signature: _____ Date: ____ / _____ / _____
Month Day Year

Name of Participating Group: _____

Name of person to contact for further information:

_____
(Full Name, Title, Phone Number, and Email Address)

RETURN THIS COMPLETED FORM TO:

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

Fax: (877) 432-9274
Email: ***mtcustserv@cpg.org***

TO BE COMPLETED BY THE MEDICAL TRUST:

Date received: _____ Decision: _____

Officer's Signature: _____Date: _____/ _____/ _____
Month Day Year

Date approval for coverage expires: _____/ _____/ _____
Month Day Year

01/24

EPISCOPAL CHURCH MEDICAL TRUST

Group Administrators Contacts Guide

Client Services

Administrators' Line: (855) 215-5990
Fax: (877) 432-9274
Email: ***admin-assist@cpg.org***

MAP

For training or other MAP issues:
Contact your Benefits Relationship Manager (formerly IBAMS account representative).

Billing

Send payments payable to ECCEBT to:

ECCEBT
75 Remittance Drive
Suite 6109
Chicago, IL 60675-6109

General Correspondence for Members

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

Fax: (877) 432-9274
Email: ***mtcustserv@cpg.org***

Web Page and Directions

To access MAP and other CPG web applications, go to ***signin.cpg.org***
To access all forms and publications, go to ***cpg.org/mtdocs***
To access the Administrators Resource Center, go to ***cpg.org/arc***
To access the most recent version of the Administrative Policy Manual, go to ***cpg.org/apm***

EPISCOPAL CHURCH MEDICAL TRUST

Vendor Contact Information

Anthem Blue Cross and Blue Shield
anthem.com
(844) 812-9207

Cigna Medical
mycigna.com
(800) 244-6224

Cigna EAP
mycigna.com
(866) 395-7794

Delta Dental
deltadentalins.com

Kaiser Permanente
kp.org

Colorado	(877) 883-6698
Georgia:	(866) 800-1486
Mid-Atlantic States:	(877) 740-4117
Northwest:	(866) 800-3402
Northern California:	(800) 663-1771
Southern California:	(800) 533-1833

EyeMed Vision Care
eyemedvisioncare.com/ecmt
(866) 723-0513

Express Scripts (Pharmacy Benefit)
express-scripts.com
(800) 841-3361

Health Advocate
healthadvocate.com
(866) 695-8622

UnitedHealthcare Global Assistance
members.uhcglobal.com
(800) 527-0218 (from US, Canada, Puerto Rico, Virgin Islands, Bermuda)

UnitedHealthcare Group Medicare Advantage
uhcretiree.com/ecmt
(866) 519-5401

Medical Trust Client Services Team at the Church Pension Group
cpg.org
(800) 480-9967

Medical Trust Acronyms Guide

BCBS	Blue Cross and Blue Shield
BRM	Benefits Relationship Management
CDHP	Consumer-Directed Health Plan
CMS	Center for Medicare and Medicaid Services (see “Medicare”)
CPF	Church Pension Fund
CPG	Church Pension Group
CS	Client Services
DHP	Denominational Health Plan
EAP	Employee Assistance Program
EBAC	Episcopal Business Administrators Conference
ECCEBT	Episcopal Church Clergy and Employee’s Benefit Trust
EHP	Episcopal Health Plan
EOB	Explanation of Benefits (sometimes also used for Extension of Benefits)
EPO	Exclusive Provider Organization
ERISA	Employee Retirement Income Security Act of 1974
GMAP	Group Medicare Advantage Plan
HIPAA	Health Insurance Portability and Accountability Act
HSA	Health Savings Account
MAP	My Admin Portal
MHPA	The Mental Health Parity Act
MHPAEA	Mental Health Parity & Addict Equity Act of 2008
MH/SA	Mental Health/Substance Abuse
MSP	Medicare Secondary Payer
MT	Medical Trust

NOCC	Notice of Creditable Coverage
OAP	The Cigna Open Access Plus network
OON	Out of Network
OOP	Out-of-Pocket
PC	Partnership Conference
PCP	Primary Care Physician
PDP	Prescription Drug Plan (often used by Medicare)
POS	Point-of-Service
PPO	Preferred Provider Organization
R&C	Reasonable and Customary
SBC	Summary of Benefits and Coverage
SEE	Small Employer Exception
SLE	Significant Life Event
SNF	Skilled Nursing Facility
UHC	UnitedHealthcare
U&C	Usual and Customary
VEBA	Voluntary Employees' Beneficiary Association