Anthem BlueCross BlueShield | QuantumHealth

2026 Plan Document Handbook

PPO Plans

BlueCard PPO 100
BlueCard PPO 90
BlueCard PPO 80
BlueCard PPO 70

CDHPs

Consumer-Directed Health Plan 15 (CDHP-15)
Consumer-Directed Health Plan 20 (CDHP-20)
Consumer-Directed Health Plan 40 (CDHP-40)

Benefits effective as of January 1, 2026

EPISCOPAL CHURCH MEDICAL TRUST

Introduction

The Episcopal Church Medical Trust (the "Medical Trust") maintains a series of benefit Plans (each a "Plan" and collectively, the "Plans") for the Eligible Individuals of The Episcopal Church and their Eligible Dependents. Since 1978, the Plans sponsored by the Medical Trust have served the dioceses, parishes, schools, missionary districts, seminaries, and other institutions subject to the authority of The Episcopal Church. The Medical Trust serves thousands of active Employees, retirees, and their Eligible Dependents. The Plans are intended to qualify as "church plans" within the meaning of Section 414(e) of the Internal Revenue Code (the "Code") and are exempt from the requirements of the Employee Retirement Income Security Act of 1974, as amended ("ERISA").

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

The mission of the Medical Trust is to administer a comprehensive benefit plan while balancing compassion with financial stewardship. This is a unique mission in the world of healthcare benefits, and we believe that our experience serving The Episcopal Church offers a level of expertise that is unparalleled.

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

Benefits described in this Plan Document Handbook are effective as of January 1, 2026. Please note that capitalized terms used in this section but not defined here have the meanings ascribed to them in the body of the Plan Document Handbook below.

A Note About How This Plan Document Handbook Is Organized

In order to provide a more seamless experience to Members choosing between Plans using the networks of Anthem BCBS and Cigna, this Plan Document Handbook is divided into two parts:

- **Part I** addresses topics that are consistent between the Plans using the Anthem BCBS and Cigna networks – for example, eligibility and basic coverage terms.
    - Chapters ending in "A" contain supplements specific to Anthem BCBS or Cigna to topics addressed in the corresponding chapter – for example, *Chapter 3* addresses basic coverage terms, and *Chapter 3A* contains Anthem-BCBS-specific or Cigna-specific modifications to those terms.
- **Part II** addresses topics handled differently by Anthem BCBS and Cigna – for example, how the applicable network is maintained.

Table of Contents

PART I—EPISCOPAL CHURCH MEDICAL TRUST PLAN PROVISIONS 4

Chapter 1: Important Notices 4

Chapter 2: Eligibility and Enrollment 5

Chapter 3: Coverage 25

Chapter 3A: Coverage – Network-Specific Modifications 38

Chapter 4: Exclusions and Limitations 41

Chapter 4A: Exclusions and Limitations – Network-Specific Modifications 48

Chapter 5: Quantum Health – Care Coordination, Prior Authorization & Care Management 49

Chapter 6: Pharmacy Benefits (Administered by Express Scripts) 54

Chapter 7: Other Programs and Services 59

Chapter 8: Claims and Appeals 62

Chapter 9: Coordination of Benefits 72

Chapter 10: Medicare Secondary Payer (MSP) ─ Small Employer Exception (SEE) 74

Chapter 11: Other Important Plan Provisions 76

Chapter 12: Subrogation and Right of Recovery 82

Chapter 13: Privacy 86

Chapter 14: Glossary 91

Chapter 14A: Glossary – Additional Network-Specific Terms 104

Chapter 15: Contact Information 108

Chapter 16: Your Rights and Protections Against Surprise Medical Bills 109

PART II—ANTHEM-BCBS-SPECIFIC PLAN PROVISIONS 112

Chapter 17: The BlueCard PPO Network 112

Part I—Episcopal Church Medical Trust Plan Provisions

Chapter 1: Important Notices

Newborns' and Mothers' Health Protection Act of 1996

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

Women's Health and Cancer Rights Act of 1998

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

For more information, contact the Plan Sponsor.

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

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

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

Chapter 2: Eligibility and Enrollment

Eligibility for the Episcopal Health Plan (EHP)

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

To be eligible, 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
- An Employee who is on a paid leave of absence or on a legally mandated unpaid leave (provided they met the eligibility criteria described in the first bullet and were a Member immediately preceding such leave)
- A Seminarian
- 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 under The Church Pension Fund Clergy Long-Term Disability Plan who was either (1) enrolled in the EHP or MSP-SEE Plan as of the date of their disability or (2) eligible for enrollment in the EHP or MSP-SEE Plan as of the date of their disability and who subsequently experiences a Significant Life Event that entitles them to subsidized medical coverage under The Church Pension Fund Clergy Long-Term Disability Plan

Eligible Dependents

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

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

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

- 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 who is not enrolled at a seminary that is or is part of a Participating Group
- 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 the local jurisdiction's employment requirements (e.g., age or work visa requirements)
- A person who would otherwise be an Eligible Individual or Eligible Dependent who refuses to provide a Social Security Number
- A person who would otherwise be an Eligible Individual or Eligible Dependent who does not have their primary residence in the United States
- A Dependent's dependent who is not a legal ward of, a foster child of, legally adopted by, or 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 in which an individual who does not meet the eligibility requirements listed above may choose to request a special eligibility determination from the Plan. Under these circumstances, 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. The Plan will review the case presented and provide an individual eligibility determination within approximately 30 days after receipt of the form. If eligibility is granted, the effective date of coverage will be the first of the month following the receipt of the enrollment form. The Coverage and Eligibility Exception Request Form is provided in the Appendix section of the *Administrative Policy Manual*.

Standalone Employee Assistance Program (EAP) Plan

The Plan offers the Employee Assistance Program (EAP) with Cigna as a standalone Plan that Participating Groups may offer to Employees who are Eligible Individuals for EHP coverage but are not enrolled in such coverage.

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 are Eligible Individuals for EHP coverage and decline to enroll in the coverage. All Employees of a Billed Group that offers the Standalone EAP Plan who declined EHP coverage 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 when determining eligibility for participation in the EHP. For participation in the MSP-SEE Plan, eligibility for Medicare will be taken into account when determining eligibility.

Eligibility for the Medicare Secondary Payer Small Employer Exception (MSP-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 certain 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 that 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 MSP-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 MSP-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 MSP-SEE Plan

The Medical Trust determines the minimum eligibility for the Plans. The employer or Participating Group is responsible for determining whether the Employee is eligible for any employer contributions toward coverage, confirming that Members meet the eligibility criteria described below, and 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 if either the Eligible Individual or their employer no longer meets the SEE criteria set forth below.

To be eligible, Eligible Individuals and their Eligible Dependents (described below) must be part of a Participating Group that is participating in the MSP-SEE Plan.

In addition to the eligibility criteria set forth below, the following requirements must be met in order for participation in the MSP-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 the Centers for Medicare & Medicaid Services (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 using the Anthem BCBS or Cigna network.

Note: When the above criteria have been met, the Eligible Individual's Dependents who are younger than 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, but only for the applicable stability period
- An Employee who is on a paid leave of absence or on a legally mandated unpaid leave (provided they met the eligibility criteria described in the first bullet and were a Member immediately preceding such leave)
- 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 MSP-SEE Plan as of the date of their disability

Eligible Dependents

- A Spouse of an enrolled Eligible Individual*
- A Domestic Partner of an enrolled Eligible Individual, if Domestic Partner benefits are elected by the Participating Group
- A Child of an enrolled Eligible Individual, who is 30[2] years of age or younger on December 31 of the Plan Year
- A Disabled Child of an enrolled Eligible Individual, who is older than 30[2] years of age on December 31 of the Plan Year, provided their 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 MSP-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 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
- 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 the local jurisdiction's employment requirements (e.g., age or work visa requirements)
- A person who would otherwise be an Eligible Individual or Eligible Dependent who refuses to provide a Social Security Number
- A person who would otherwise be an Eligible Individual or Eligible Dependent who does not have their primary residence in the United States
- A Dependent's dependent who is not a legal ward of, a foster child of, legally adopted by, or 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 are Eligible Individuals for EHP coverage but are not enrolled in such coverage. (Please note that an Eligible Individual for the MSP-SEE Plan who declines coverage is deemed to also be declining EHP coverage.)

Please note that Eligible Individuals who enroll in Medical Trust health coverage (including the MSP-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.

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

Eligibility for the Standalone EAP Plan is limited to Employees who are Eligible Individuals for EHP coverage and decline to enroll in the coverage. All Employees of a Billed Group that offers the Standalone EAP Plan who declined EHP coverage 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

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, 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-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 MSP-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 such Employees and their eligible Spouses 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; 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.

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 to the Medical Trust for each participant who may be eligible. (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 becomes the primary payer of claims under Medicare Part A and, if applicable, Medicare Part B, for approved participants. The MSP-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 MSP-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 MSP-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)
- Healthcare navigation services
- Travel assistance

Participation in the MSP-SEE Plan is not mandatory. Although the employer and the individual Employee may be approved to participate in the MSP-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 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 MSP-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.

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 coverage and benefits under the Plan. Eligible Individuals must provide all required information (including their and their enrolled Eligible Dependent's Social Security Number) through a MyCPG Accounts submission or by submitting 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 they experience a Significant Life Event.

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

Significant Life Events

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

- Change in marital status (e.g., marriage, divorce, legal separation, or annulment of marriage)
- Establishment or termination of a Domestic Partnership (in Participating Groups offering Domestic Partner coverage)
- Change in the number of Eligible Dependents (e.g., an increase through marriage, birth, adoption, or placement for adoption, or a decrease through death or Dependent gaining own health benefits)
- 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 employer contributions or eligibility for such contributions, 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 subsequently moved to 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
- Change in the eligibility of a post-65 actively working Eligible Individual or Eligible Individual's Spouse to participate in the MSP-SEE Plan or GMAP
- Enrollment in a "qualified health plan" through a health insurance exchange in the individual market
- Any other Significant Life Events provided under the applicable regulations and provided for under the employer's Cafeteria Plan

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

The effective date of coverage for an election change due to a Significant Life Event is the first day of the month coincident with or following the Significant Life Event (except in the case of birth, adoption, or placement for adoption of a Child, in which case coverage will be effective retroactive to the date of the event). The Eligible Individual must notify the Group Administrator of the occurrence of the Significant Life Event and of the election changes no later than 30 days after the Significant Life Event (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 (see below under *HIPAA Special Enrollment Events*)). 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 consider the request only 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

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

information regarding the late request. The Medical Trust will determine, in its sole discretion, whether the late request will be accepted. In addition, the request must be approved by the applicable third-party administrator.

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's submission of the required information to the Medical Trust. The Medical Trust cannot consider extenuating circumstances that led to the Eligible Individual failing to provide timely notice of the Significant Life Event and of their new election. In no event will the Medical Trust consider a request for an enrollment change or new enrollment submitted to the Medical Trust more than 180 days after the occurrence of the Significant Life Event.

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

The employer is responsible for providing the Member with 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 with 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. Eligible Individuals may also report certain changes through MyCPG Accounts; Group Administrators are responsible for ensuring that changes are reported. 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 an enrolled Eligible Individual or an enrolled Eligible Dependent)
- Employee retirement
- 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 (or report the event through MyCPG Accounts). For Significant Life Events reported through MyCPG Accounts, the Group Administrator is responsible for reviewing the event and any requested coverage change and approving or denying the coverage change within seven (7) days of the report. The Group Administrator should request supporting documentation regarding Dependent eligibility or loss of eligibility.

For Significant Life Events not reported through MyCPG Accounts, the Group Administrator must then notify the Medical Trust through MAP 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 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 (e.g., of address or phone number) can and should be reported to the Plan when they occur through MAP or MyCPG Accounts.

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, MSP-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 in the fall, and changes become 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[4]
- Options to add or remove Eligible Dependents
- The deadline for submitting Plan elections
- Links to Summaries of Benefits and Coverage (SBCs)
- Reference material and other helpful resources

Seminarian Annual Enrollment

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

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

Clergy on Long-Term Disability

Please note that clergy who are Eligible Individuals because they are receiving benefits under The Church Pension Fund Clergy Long-Term Disability Plan are not eligible to participate in Annual Enrollment – their existing Plan elections will remain in place for so long as they remain an Eligible Individual on that basis, unless they experience a Significant Life Event and change their elections.

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 enrolled in the Plan in a timely manner. **Completed MAP submissions must be received by the Plan within 60 days of the event**. See the guidelines for coverage effective date in the *Significant Life Events* and *HIPAA Special Enrollment Events* sections above.

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, 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 the 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.

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

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 and 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/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, they must wait for an applicable Significant Life Event to occur or wait to enroll at the beginning of any subsequent semester, in which case coverage will start on the first day of the month in which 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 can make an enrollment change in connection with an applicable Significant Life Event or during 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 their employment, 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, they must wait for an applicable Significant Life Event to occur or wait for 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 GMAP. If the enrolled Spouse/Domestic Partner is not Medicare-eligible, the enrolled Spouse/Domestic Partner may remain in the EHP until becoming Medicare-eligible, at which time they too will no longer be 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.[5]

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

Important Notes:

- An Employee who terminates their employment with a Participating Group and 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).

[5] *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.*

- 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 (1) have subsequently experienced a Significant Life Event or (2) 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.[6]

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.

Please be advised that an Eligible Individual reporting an Eligible Dependent via MyCPG Accounts does **not** automatically enroll them in the Plan, unless the Eligible Individual specifically selects a medical and/or dental plan option in which to enroll such Eligible Dependent, the Eligible Individual submits the enrollment request, and the request is timely approved by their Group Administrator. If you are an Eligible Individual and you have gained a new Eligible Dependent whom you intend to enroll in the Plan, please ensure that enrollment is completed and verified within the 30 days following the Significant Life Event.

Newborn 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

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

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 on Newborn Children:

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

Adopted Children

Upon timely notification, coverage for the Child will be effective on the date of adoption or, if earlier, placement for adoption, in each case, by an Eligible Individual or an Eligible Individual's Spouse/Domestic Partner. If the Eligible Individual does not elect to enroll the Child within 30 days of that date, 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, 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, if they are a 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, the eligible Domestic Partner may not enroll until the next Annual Enrollment period or until a Significant Life Event occurs.

Medicare-Ineligible 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 ineligible for Medicare and 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.[7]

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, MSP-SEE Plan, or GMAP, and the Child continues to meet the Plan's eligibility requirements in all aspects other than age.[7]

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.

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

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 of determining whether 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 must also meet the requirements above.

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

Children of 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.[8]

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, 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.

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

Termination of Individual Coverage

The Group Administrator must submit a request to terminate coverage for an enrolled Eligible Individual through MAP no later than 30 days after the termination event. If the Plan receives a termination request thereafter, 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 on 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, an Employee's scheduled hours are reduced below the eligibility threshold, or a Seminarian graduates from seminary)[9]
  - The Dependent no longer meets the eligibility requirements for any reasons other than death or turning age 30[10] (e.g., a Spouse is no longer eligible due to divorce from an enrolled Eligible Individual, or an enrolled Eligible Individual ceases to be a Dependent's legal guardian)
  - The Participating Group's participation with the Plan terminates
- The last day of the year in which an enrolled Dependent Child reaches age 30[10] (except if the Child is a Disabled Child in accordance with the terms of the Plan)
- The date on which monthly contributions are deemed delinquent, as determined by the Plan in its sole discretion
- The date the Plan ceases to exist

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

Coverage termination dates resulting from a Significant Life Event in connection with which 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 Sponsor, Quantum Health, the Claims Administrator, Express Scripts, any other plan vendor, any Group Administrator, any Provider, or any personnel of any of the foregoing.
- Commit theft from the Plan Sponsor, Quantum Health, the Claims Administrator, Express Scripts, any other plan vendor, any Group Administrator, or any Provider.
- Performs an act that constitutes fraud or makes an intentional misrepresentation of material fact in procuring coverage, such as knowingly (1) misrepresenting participation status, (2) presenting an invalid prescription or physician order, or (3) misusing or letting someone else misuse an ID Card to obtain care under false pretenses. Note: Any Eligible Individual or Dependent's fraud will be reported to the authorities for prosecution, and appropriate civil remedies will be pursued.

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

Persons Barred from Enrolling

A person who would otherwise be an Eligible Individual or Eligible Dependent cannot enroll if such individual has had their eligibility terminated for cause due to their actions.

Death and Surviving Dependents

Except as otherwise stated below, Surviving Dependents are not eligible to remain covered by the EHP, MSP-SEE Plan, or GMAP. Coverage will be terminated following the Eligible Individual's death, and Surviving Dependents who were covered under the EHP or MSP-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

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[9] *For the full eligibility requirements, see Eligibility for the Episcopal Health Plan (EHP), Eligibility for the Medicare Secondary Payer Small Employer Exception (MSP-SEE) Plan, or Eligibility for the Group Medicare Advantage Plan (GMAP), as applicable.*

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

Individual'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 MSP-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 MSP-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 MSP-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 MSP-SEE Plan at that time can remain covered in the EHP until becoming Medicare-eligible, at which time the individual will no longer be eligible for the EHP and must actively enroll in the GMAP, if eligible. Enrolled Children may remain in the EHP until the last day of the year in which they turn 30[11] or later if the Child is a Disabled Child in accordance with the terms of the Plan. If the Surviving Dependents leave the EHP, they may not return to the Plan, unless they are eligible to enroll in and elect to enroll in the GMAP.

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

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

A Surviving Spouse or Surviving Domestic Partner of a Pre-65 Former Employee, Post-65 Former Employee, or a Cleric receiving benefits under The Church Pension Fund Clergy Long-Term Disability Plan who was not enrolled in the EHP or GMAP at the time of the Eligible Individual's death, but who was eligible for enrollment in the EHP or GMAP on such date by virtue of their status as the Spouse or Domestic Partner of such Eligible Individual, may enroll in the GMAP once they become Medicare eligible after a Significant Life Event occurs or during future Annual Enrollment Periods.

Children enrolled in the EHP may remain in the EHP until the last day of the year in which they turn 30[11] or later if the Child is a Disabled Child in accordance with the terms of the Plan. If the Surviving Dependents leave the EHP, they may not return to the Plan, unless they are eligible to enroll in and elect to enroll in the GMAP.

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.

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

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 the dissolution of the Domestic Partnership).

Employees and Seminarians

The Spouse/Domestic Partner enrolled in the EHP or the MSP-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 remain enrolled in the EHP. However, if the Spouse or Domestic Partner leaves the EHP, they cannot enroll again with the Plan until they become eligible for the GMAP. The Spouse or Domestic Partner can leave the GMAP and join again during 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 remain enrolled in the GMAP. The Spouse or Domestic Partner can leave the GMAP and join again during 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.[12] 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 MSP-SEE Plan (e.g., as the result of a termination of employment, a reduction of scheduled hours, or due to the closure of their employer) are offered an extension of 36 months[13] starting on the first day of the month following the termination event.
  - Note that, because the MSP-SEE Plan requires that the Eligible Individual be actively working for an Eligible Small Employer, Eligible Individuals enrolled in the MSP-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 MSP-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 be available only 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.

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

[13] *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.*

- Employees whose Medical Trust coverage terminates under the terms of The Church Pension Fund Clergy Long-Term Disability Plan are offered an extension of 36 months starting on the first day of the month following the termination under The Church Pension Fund Clergy Long-Term Disability Plan.

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

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

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

The Plan notifies individuals regarding their eligibility for an Extension of Benefits within five business days of receiving a termination notice from the Group Administrator. Such notification from the Plan may be by physical mail or by electronic means. The notification includes an enrollment form and an invoice for contributions that are due and an explanation of the monthly contributions and duration of the extension. If the current Plan is no longer available, an alternate option may be offered.

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

Coverage in effect at the time of the applicable event continues until the last day of the month in which the event occurs. Coverage under the Extension of Benefits program is effective the first of the month following the applicable event so that there is no coverage gap between the termination date and enrollment in the Extension of Benefits.

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

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

Coverage under the Extension of Benefits program will cease on the earliest of the following:
- The date that required monthly contributions to the Plan are deemed delinquent, as determined by the Plan in its sole discretion
- The date the Member becomes a Post-65 Former Employee, is enrolled in Medicare Parts A and B and is not an Eligible Individual for the EHP or MSP-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 MSP-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 Notes:**
    - 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.
    - An official closing of a Participating Group (as determined by the Medical Trust in its sole discretion) will not result in the cessation of coverage under the Extension of Benefits program, and the pricing of such coverage will be determined by the Medical Trust in its sole discretion.
- The last day of the month in which the death of the Member occurred (surviving Dependents who were enrolled through the Member's Extension of Benefits 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 on 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 an Eligible Dependent in the same Plan (EHP, MSP-SEE Plan, or GMAP). Therefore, an Eligible Individual who participates in the Plan based on their own eligibility may not be an Eligible 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, MSP-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 different Participating Groups, one that offers dental benefits and one that does not, either 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 Members' behalf. We are the Plan Sponsor of all Medical Trust health plans.

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

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.

Chapter 3: Coverage

Payment terms apply to all Covered Health Services. Please refer to the Summary of Benefits and Coverage for details, including applicable Deductible, Copayment, and Coinsurance information. All Covered Health Services must be Medically Necessary and not Experimental/Investigative/Unproven, whether provided through Network Providers or Out-of-Network Providers. Regardless of Medical Necessity, Benefits will be denied for care that is not a Covered Health Service. The Plan has the final authority to decide the Medical Necessity of the service.

Acupuncture

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

Allergy Services

Allergy testing and treatment.

Ambulance Service

Medically Necessary Ambulance Services are a Covered Health Service when:

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

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

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

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

Non-emergency Ambulance Services are subject to Medical Necessity reviews by Quantum Health. When using an air ambulance for non-emergency transportation, Quantum Health (or the Claims Administrator) reserves the right to select the air ambulance Provider.

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

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

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

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

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

Important Notes on Air Ambulance Benefits

- Benefits are available for air ambulance only when it is not appropriate to use a ground or water ambulance. For example, if using a ground ambulance would endanger your health and your medical condition requires a more rapid

transport to a Facility than the ground ambulance can provide, the Plan will cover the air ambulance. Air ambulance will also be covered if you are in an area that a ground or water ambulance cannot reach.

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

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

Applied Behavioral Analysis (ABA)

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

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

Assistant Surgery

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

Bariatric Surgery (for Clinically Severe Obesity)

Surgical treatment of obesity is only covered for patients meeting Medical Necessity criteria.

Breast Cancer Care

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

Breast Reconstructive Surgery

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

Cellular Therapy

Plans using the Anthem BCBS and Cigna networks both cover Cellular Therapy but manage these Benefits differently. Cigna refers to this benefit as "Advanced Cellular Therapy." For more information, see *Chapter 3A*, which describes how these Benefits are provided for Plans using the applicable network.

Chiropractic Care

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

Clinical Trials

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

Benefits are limited to the following trials:

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

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

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

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

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

All other requests for clinical trials services, including requests that are not part of approved clinical trials, will be reviewed according to clinical coverage guidelines and related policies and procedures.

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

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

Consultation Services

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

Dental Services

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

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

Other Dental Services

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

Diabetes

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

Dialysis Outpatient Treatment

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

Durable Medical Equipment, Medical Devices and Supplies

The Plan covers the purchase or rental of Durable Medical Equipment that is ordered or prescribed by a Physician and that is Medically Necessary. Refer to the Glossary of Terms for the definition of Durable Medical Equipment.

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

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

Coverage for Durable Medical Equipment is limited to the lowest-cost alternative as determined by Quantum Health.

For more information about covered medical services and supplies, contact Quantum Health.

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

Emergency Services

Life-Threatening Medical Emergency or Serious Accidental Injury

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

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

Medically Necessary services will be covered whether you get care from a Network Provider or Out-of-Network Provider. Emergency health services you get from an Out-of-Network Provider will be covered as a Network service and will not require Prior Authorization. The Out-of-Network Provider can only charge you any applicable Deductible, Coinsurance, and/or Copayment and cannot bill you for the difference between the Maximum Allowed Amount / Maximum Reimbursable Charge and their billed charges until your condition has Stabilized and the Out-of-Network Provider has complied with the notice and consent process as described under *Surprise Billing Claims in Chapter 11: Other Important Plan Provisions*. Your cost shares will be based on the Maximum Allowed Amount / Maximum Reimbursable Charge and will be applied to your Network Deductible and Network Out-of-Pocket Limit.

Treatment you receive after your condition has Stabilized are not emergency health services. If you receive such services from an Out-of-Network Provider, refer to the information under *Out-of-Network Services* in *Chapter 17* of this Plan Document Handbook for more details on how this will impact your benefits.

For the definitions of Emergency Medical Condition and Stabilize, please refer to *Chapter 14: Glossary*.

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

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

The following emergency services are covered:
- Treatment in a Hospital emergency room or other emergency care Facility for a condition that can be classified as an Emergency Medical Condition or for Injuries received in an accident
- Outpatient professional services, X-ray and/or lab services performed at the emergency room and billed by the Facility as part of the emergency room visit
- Advanced radiological imaging (MRIs, MRAs, CAT Scans, PET Scans, etc.) billed by the Facility as part of the emergency room visit
- Ambulance Services

If time permits, speak to your Physician to direct you to the best place for treatment. Be sure to show your ID Card at the emergency room, and if you are admitted, notify Quantum Health as soon as possible (for clarity, notification will in no event be deemed "possible" prior to the time you are Stabilized).

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

Erectile Dysfunction

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

Foot Care

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

Gender Affirmation Surgery and Services

This Plan provides Benefits for many of the Charges for gender-affirming surgery and services for Members diagnosed with gender identity disorder, also known as gender dysphoria. Gender-affirming surgery and services must be approved by Quantum Health for the type of procedure requested and requires Prior Authorization. Charges for services that are not authorized for the gender-affirming surgery and services requested will not be considered Covered Health Services. Some conditions apply, and all services must be authorized by Quantum Health as outlined in *Chapter 5*.

General Anesthesia Services

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

Such anesthesia service includes the following procedures when given to cause muscle relaxation, loss of feeling, or loss of consciousness:
- Spinal or regional anesthesia
- Injection or inhalation of a drug or other agent (local infiltration is excluded)

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

Gene Therapy Services

Gene Therapy Services are covered when Medically Necessary and not Experimental/Investigative/Unproven. These services require Prior Authorization and must be provided by an approved Provider at an approved facility. Charges for services that are not authorized or that are provided by Providers or at facilities not approved by Quantum Health will not be considered Covered Health Services.

Genetic Testing

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

Habilitative Services

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

Hearing Aids

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

Home Health Care Services

Home Health Care provides a program for the Member's care and treatment in the home. The program consists of required intermittent skilled care, which may include observation, evaluation, teaching, and nursing services consistent with the diagnosis, established and approved in writing by the Member's attending Physician. Services may be performed by either Network Providers or Out-of-Network Providers. Limited to 210 visits per Plan Year (for Members enrolled in a Plan using the Anthem BCBS network) or 210 days per Plan Year (for Members enrolled in a Plan using the Cigna network). Visit maximum is combined for Network and Out-of-Network services. This limit does not apply to visits related to Mental Health and Substance Use Disorder Treatment or home infusion services. The Physician's statement and recommended program may require Prior Authorization. Please refer to *Chapter 5* for details.

Covered Health Services:

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

Covered Health Services for Home Health Care do not include:

- Food, housing, homemaker services, sitters, or home-delivered meals
- Home Health Care services that are not Medically Necessary or of a non-skilled level of care
- Services and/or supplies that are not included in the Home Health Care plan
- Services of a person who ordinarily resides in the Member's home or is a member of the family of either the Member or Member's Spouse
- Any services for any period during which the Member is not under the continuing care of a Physician
- Convalescent or Custodial Care when the Member has spent a period of time for recovery of an illness or surgery and when skilled care is not required or the services being rendered are only for aid in daily living, i.e., for the convenience of the Member
- Maintenance therapy

- Acupuncture Services
- Chiropractic Services

Home Infusion Services

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

Hospice Care Services

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

The services and supplies listed below are Covered Health Services when given by a Hospice for the palliative care of pain and other symptoms that are part of a terminal disease. Palliative care means care that controls pain and relieves symptoms, but is not meant to cure a Terminal Illness. Covered Health Services include:
- Care from an interdisciplinary team with the development and maintenance of an appropriate plan of care
- Short-term Inpatient Hospital care when needed in periods of crisis or as respite care
- Skilled nursing services, home health aide services, and homemaker services given by or under the supervision of a registered nurse
- Social services and counseling services from a licensed social worker
- Nutritional support such as intravenous feeding and feeding tubes
- Physical Therapy, occupational therapy, speech therapy, and respiratory therapy given by a licensed therapist
- Pharmaceuticals, medical equipment, and supplies needed for the palliative care of a condition, including oxygen and related respiratory therapy supplies
- Bereavement (grief) services, including a review of the needs of the bereaved family and the development of a care plan to meet those needs, both before and after the Member's death. Bereavement services are available to surviving Members of the immediate family for one year after the Member's death. The surviving member of the immediate family must be enrolled in the Plan to be eligible for bereavement services.

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

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

Hospital Services

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

Inpatient Services

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

Service and Supplies

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

Remember to call Quantum Health at least two weeks prior to any planned surgery or Hospital admission. For an emergency admission, call Quantum Health as soon as possible (for clarity, notification will in no event be deemed "possible" prior to the time you are Stabilized). Otherwise, your Benefits may be denied for each Hospital admission or surgery that is not granted Prior Authorization.

The Medical Necessity and length of any Hospital stay are subject to review by Quantum Health. If Quantum Health determines that the admission or surgery is not Medically Necessary, no Benefits will be paid. See *Chapter 5* of this Plan Document Handbook for additional information.

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

If you follow the notification and Prior Authorization requirements outlined above, your Benefits will be unaffected, and you and the Plan avoid expenses related to unnecessary healthcare. However, if you do not follow the procedures required by this Plan, the Plan may deny all related covered Hospital expenses. In addition, if you fail to follow the Prior Authorization requirements and subsequently Quantum Health retrospectively reviews the treatment and/or services you received and determines they were not Medically Necessary, Benefits may be denied, and you may be responsible for all non-covered expenses.

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

Human Organ and Tissue Transplant Services

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

Hypnosis

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

Maternity Care

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

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

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

In addition, Quantum Health offers a Personal Care Guide program to assist expectant mothers. This program offers educational materials and extra assistance with locating Providers. Contact Quantum Health for more information.

Mental Health and Substance Use Disorder Treatment

Plans using the Anthem BCBS and Cigna networks both cover Mental Health and Substance Use Disorder Treatment but manage these Benefits differently. For more information, see *Chapter 3A*, which describes how these Benefits are provided for Plans using the applicable network.

Nutritional Counseling

Nutritional counseling is covered but is limited to six (6) visits per Plan Year (limit applies to office/Outpatient setting only). Visit maximum is combined for Network Providers and Out-of-Network Providers.

This Benefit is unlimited if related to a diagnosis of diabetes. The foregoing limits also do not apply to care received in connection with a primary diagnosis of a mental health or substance use disorder condition; instead, limits and cost-sharing terms applicable to Mental Health and Substance Use Disorder Treatment will apply.

Online Visits

The Plan provides access to telehealth services through Teladoc, accessed via Quantum Health. Teladoc offers primary, behavioral health, acute care, mental health, dermatology, and Nutritional counseling services.

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

Oral Surgery

Covered Health Services include the following:

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

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

Orthognathic Surgery

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

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

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

Other Covered Health Services

The Plan provides the following services when Medically Necessary:

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

Out-of-Network Freestanding Ambulatory Facility

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

Outpatient Laboratory Services, CT Scans, and MRIs

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

Outpatient Hospital Services

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

Outpatient Short-Term Rehabilitation

- Physical Therapy, Speech and Hearing Therapy, Cognitive Therapy and Occupational Therapy are covered at 60 visits per Plan Year per type of therapy, and not combined with any other therapy. The foregoing limits do not apply to care received in connection with a primary diagnosis of a mental health or substance use disorder condition, Autism Spectrum Disorders or Developmental Delays.
- Pulmonary rehabilitation/respiratory therapy limited to 18 visits per Plan Year not combined with any other therapy.
- Cardiac rehabilitation limited to 36 visits per Plan Year not combined with any other therapy.
- Vision therapy, limited to 16 visits per Plan Year, not combined with any other therapy.

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

Physician Services

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

Prescription Drugs

For coverage information, see *Chapter 6: Pharmacy Benefits*.

Preventive Services

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

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

Covered Health Services fall under the following broad groups:

- Services with an “A” or “B” rating from the United States Preventive Services Task Force. Examples of these services are screenings for:
  - Breast cancer
  - Cervical cancer
  - Colorectal cancer
  - High blood pressure
  - Type 2 Diabetes Mellitus
  - Cholesterol
  - Child and adult obesity
- Immunizations for Children, adolescents, and adults recommended by the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention

- Preventive Care and screenings for infants, Children, and adolescents as provided for in the comprehensive guidelines supported by the Health Resources and Services Administration
- Preventive Care and screening for women as listed in the guidelines supported by the Health Resources and Services Administration, including the following:
  - Women's contraceptives (including contraceptive devices such as diaphragms, intrauterine devices (IUDs), and implants), sterilization procedures, and counseling
  - Breastfeeding support, supplies (benefits for breast pumps limited to one pump per pregnancy), and counseling
  - Gestational diabetes screening
- Preventive Care services for smoking cessation and tobacco cessation for Members age 18 and older as recommended by the United States Preventive Services Task Force, including counseling
- Preventive hearing exams

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

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

Prosthetic Appliances

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

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

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

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

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

Reconstructive Surgery

Plans using the Anthem BCBS and Cigna networks both cover Reconstructive Surgery but manage these Benefits differently. For more information, see *Chapter 3A*, which describes how these Benefits are provided for Plans using the applicable network.

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

Reproductive Health Services

Contraceptive Benefits

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

Sterilization Services

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

Termination of Pregnancy

The Plan includes Benefits for a therapeutic termination of pregnancy, which is a termination recommended by a Provider that is performed to save the life or health of the mother or the termination of a pregnancy that is a result of

incest or rape. The Plan also provides Benefits for an elective (voluntary) termination of pregnancy, which is performed for reasons other than those described above.

Infertility Coverage

The Plan also includes Benefits for the diagnosis and treatment of infertility. Covered Health Services include diagnostic and exploratory procedures to determine whether a Member suffers from infertility. This includes surgical procedures to correct a diagnosed disease or condition affecting the reproductive organs. This includes, but is not limited to, endometriosis (tissue lining the uterus moves to other parts of the body), collapsed/clogged fallopian tubes, or testicular failure. Covered fertilization services include artificial insemination, in-vitro fertilization, GIFT (gamete intra-fallopian transfer), or ZIFT (zygote intra-fallopian transfer) procedures, including related collection of semen and/or eggs from a Member. (Collection from an individual who is not a Member is never covered.)

When planned cancer or other medical treatment is likely to produce infertility/sterility, the Plan covers the collection of sperm, cryopreservation of sperm, ovulation induction and retrieval of oocyte (egg), oocyte cryopreservation, ovarian tissue cryopreservation, in vitro fertilization, and embryo cryopreservation. Long-term storage costs (anything longer than 12 months) is not covered.

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

Infertility Prescription Drugs

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

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

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

Retail Health Clinic

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

Skilled Nursing Facility Care/Rehabilitation Hospital

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

Skilled Convalescent Care during a period of recovery is characterized by:
- A favorable prognosis
- A reasonably predictable recovery time
- Services and/or Facilities less intense than those of the acute general Hospital but greater than those normally available at the Member’s residence

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

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

Benefits will not be provided when:
- A Member reaches the maximum level of recovery possible and no longer requires other than routine care.
- Care is primarily Custodial Care, not requiring definitive medical or 24-hour-a-day nursing service.

- No specific medical conditions exist that require care in a Skilled Nursing Facility.
- The care rendered is for other than Skilled Convalescent Care.

Smoking Cessation

Smoking cessation services are covered, including counseling.

Surgical Care

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

Urgent Care

Urgent Care services are covered.

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

Chapter 3A: Coverage – Network-Specific Modifications

Anthem BCBS

Payment terms apply to all Covered Health Services. Please refer to the Summary of Benefits and Coverage for details, including applicable Deductible, Copayment and Coinsurance information. All Covered Health Services must be Medically Necessary and not Experimental/Investigative/Unproven, whether provided through Network Providers or Out-of-Network Providers. Regardless of Medical Necessity, Benefits will be denied for care that is not a Covered Health Service. The Plan has the final authority to decide the Medical Necessity of the service.

Cellular Therapy

The Plan includes benefits for cellular therapy services when Quantum Health approves the benefits in advance through Prior Authorization. Please see *Chapter 5: Quantum Health – Care Coordination, Prior Authorization & Care Management* for details on the Prior Authorization process. To be eligible for coverage, services must be Medically Necessary and performed by an approved Provider at an approved treatment center. Even if a Provider is a Network Provider for other services, it may not be an approved Provider for certain cellular therapy services. Please call Quantum Health to find out which Providers are approved Providers.

Emergency Services

Blue Cross Blue Shield Global Core

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

Human Organ and Tissue Transplant Services

The Plan includes coverage for Medically Necessary human organ and tissue transplants.

Covered Procedures

Covered procedures, when approved by Quantum Health, include:
- Any Medically Necessary human solid organ, tissue, and stem cell/bone marrow transplants and infusions; and
- Any Medically Necessary acquisition procedures, mobilization, collection, and storage. It also includes Medically Necessary myeloablative or reduced intensity preparative chemotherapy, radiation therapy, or a combination of these therapies.

Notification

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

Centers of Medical Excellence (CME) Transplant Providers

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

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

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

duties for the transplant network. A Provider may be a Network Transplant Provider for certain Covered Transplant Procedures or all Covered Transplant Procedures.
Out-of-Network (PAR) Transplant Provider: Providers participating in the Plan's networks but not designated as a Centers of Medical Excellence for Transplant or Blue Distinction Center + or Blue Distinction Center for Transplant.

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

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

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

Covered Transplant Benefit Period

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

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

Prior Approval and Precertification

You must contact Quantum Health to discuss benefit coverage when it is determined a transplant may be needed. You must do this before you have an evaluation and/or work-up for a transplant. Quantum Health will assist you in maximizing your benefits by providing coverage information, including details regarding what is covered and whether any clinical coverage guidelines, medical policies, Network Transplant Provider requirements, or exclusions are applicable. Contact Quantum Health at the telephone number on the back of your ID Card and ask for the transplant coordinator. Even if Quantum Health issues a prior approval for the Covered Transplant Procedure, you or your Provider must call Quantum Health for Prior Authorization prior to the transplant whether this is performed in an Inpatient or outpatient setting. Your Provider must certify, and Quantum Health must agree, that the covered procedure is Medically Necessary. Not getting Prior Authorization will result in a denial of benefits.

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

Transportation and Lodging

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

Contact Quantum Health for detailed information. Quantum Health will follow Internal Revenue Service (IRS) guidelines in determining what expenses can be paid.

Travel and lodging expenses are limited to $10,000 per lifetime. Certain expenses are not covered, such as gratuities, valet parking, furnishings, and entertainment. Additionally, coverage for travel and lodging expenses is subject to applicable IRS limits. Contact Quantum Health for further information on eligible travel and lodging expenses.

When the required procedures are followed and you use one of the designated transplant facilities, your Benefits will be unaffected, and you and the Plan avoid unnecessary expenses. However, if a transplant procedure is not performed at a Network Transplant Provider Facility, the Plan will not cover travel and lodging expenses.

If you choose not to have a transplant performed at a Network Transplant Provider Facility, you must still follow the notification and Prior Authorization requirements outlined in the previous section. If you do not follow the procedures required by this Plan, the Benefits will be denied.

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

Mental Health and Substance Use Disorder Treatment

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

Covered Health Services include the following:

- Applied Behavioral Analysis (ABA) treatment when Medically Necessary
- Inpatient services, including psychotherapy, psychological testing, electroconvulsive therapy, and Detoxification
- Residential treatment in a licensed Residential Treatment Center that offers individualized and intensive treatment
- Outpatient services including:
  - Office visits
  - Therapy and treatment
  - Partial Hospitalization/Day Treatment Programs
  - Intensive Outpatient Programs
- Home Health Care Services for a mental disorder or substance use disorder, when it is Medically Necessary for such care to be provided at home (See the *Home Health Care Services* section above for further information.)
- Online visits through LiveHealth Online when available in your area (See the *Online Visits* section below for further information.)

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

- Psychiatrist
- Psychologist
- Licensed Clinical Social Worker (LCSW)
- Mental Health Clinical Nurse Specialist
- Licensed Marriage and Family Therapist (LMFT)
- Licensed Professional Counselor (LPC)
- Any agency licensed by the state to give these services, when they have to be covered by law

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

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

Reconstructive Surgery

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

Chapter 4: Exclusions and Limitations

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

Admissions for Non-Inpatient Services

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

Administrative Charges

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

Before Coverage Begins/After Coverage Ends

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

Blood

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

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

Certain Providers

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

Comfort and Convenience Items

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

Cosmetic Services

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

Court-Ordered Services

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

Crime and Incarceration

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

Custodial Care Services and Rest Care

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

Daily Room Charges

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

Dental Care

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

Educational Services

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

Excessive Expenses

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

Experimental/Investigative/Unproven Services

Treatments, procedures, equipment, drugs, devices, or supplies (hereafter called "services") that are, in Quantum Health's judgment, Experimental/Investigative/Unproven (as such term is defined in *Chapter 14: Glossary*) for the diagnosis for which the Member is being treated. An Experimental/Investigative/Unproven service is not made eligible for coverage by the fact that other treatment is considered by a Member's Physician to be ineffective or not as effective as the service or that the service is prescribed as the most likely to prolong life.

Family Members

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

Foot Care

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

Free Services

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

Genetic Screening

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

Government Programs

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

Hair

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

Health Spa

Expenses incurred at a health spa or similar Facility.

Hearing Aid Replacements, Batteries, and Repairs

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

Illegal Services

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

Inpatient Rehabilitation Programs

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

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

Maintenance Care

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

Maternity Care

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

Never Events

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

Not Generally Accepted Services

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

Not Medically Necessary Services

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

Nutrition and Weight-Loss Treatment and Services

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

OIG Excluded Drugs

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

Prescription Drugs

Refer to *Chapter 6: Pharmacy Benefits* for exclusions under the pharmacy Benefit.

Private Duty Nursing

Except when provided through the Home Health Care benefit.

Private Rooms

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

Reproductive Services

Fees or direct payment to a donor for sperm or ovum donations, monthly fees for maintenance and/or storage of frozen semen, eggs, or embryos (except as described under “*Infertility Coverage*” when planned cancer or other medical treatment is likely to produce infertility/sterility), oral contraceptives (these may be covered under your pharmacy Benefit), reversal of voluntary sterilization, and surrogate parenting.

Research Screenings

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

Residential Accommodations

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

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

Safe Surroundings

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

Shoes and Orthotics

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

Spider Veins

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

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

Supplies or equipment not Medically Necessary for the treatment of an Injury or illness. Items that are considered not Medically Necessary include, but are not limited to, any of the following situations:
1. The item is intended to be used for athletic, exercise, or recreational activities, as opposed to assisting the individual in the activities of daily living; or
2. The item is intended for environmental control or a home modification (for example, electronic door openers, air cleaners, ramps, elevators, stair glides, wheelchair attachments, accessories for stair-climbing); or
3. The item includes an additional feature or accessory, or is a non-standard or deluxe item, that is primarily for the comfort and convenience of the individual (for example, customized options on wheelchairs, hand controls to drive, electric vehicle lifts for wheelchairs); or
4. The item is specifically designed for outdoor use (for example, specially designed manual wheelchairs for beach access, specially designed power mobility devices for rough terrain, manual wheelchairs for sports); or
5. The item represents a duplicative piece of equipment that is intended to be used as a backup device, for multiple residences, or for traveling, etc. (for example, back-up manual wheelchair when a power wheelchair is the individual's primary means of mobility, a second wheeled mobility device specifically for work or school use, car seats); or
6. The item represents a product upgrade to a current piece of equipment that is either fully functional or replacement of a device when the item can be cost-effectively repaired.

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

Durable Medical Equipment items that are not covered include but are not limited to those that are listed below:
- Bed-related items: bed trays, over-the-bed tables, bed wedges, pillows, custom bedroom equipment, and mattresses, including nonpower mattresses, custom mattresses, and posturepedic mattresses
- Bath-related items: bath lifts, nonportable whirlpools, bathtub rails, toilet rails, raised toilet seats, bath benches, bath stools, handheld showers, paraffin baths, bath mats, and spas
- Fixtures to real property: ceiling lifts and wheelchair ramps
- Car/van Modifications
- Air quality Items: room humidifiers, vaporizers, and air purifiers
- Other equipment: centrifuges, needleless injectors, heat lamps, heating pads, cryo units, cryotherapy machines, ultraviolet cabinets that emit Ultraviolet A (UVA) rays, sheepskin pads and boots, postural drainage board, AC/DC

adaptors, scales (baby and adult), stair gliders, elevators, saunas, cervical and lumbar traction devices, exercise equipment, and diathermy machines

Therapy Services

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

Thermograms and Thermography

Thermograms and thermography services.

Transportation

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

Vision Care

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

Vision Surgeries

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

Waived Cost Share Out-of-Network

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

Waived Fees

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

War / Military Duty

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

Workers’ Compensation

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

applies whether or not you claim the Benefits or compensation. It also applies whether or not you recover from any third party.

Chapter 4A: Exclusions and Limitations –
Network-Specific Modifications

Anthem BCBS

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

No Additional Exclusions

Chapter 5: Quantum Health – Care Coordination, Prior Authorization & Care Management

To best assist covered individuals with navigation of the healthcare system, the Plan includes a "Care Coordination Program" provided by Quantum Health. The Care Coordination Program is intended to help Members better understand their available health and welfare benefits, obtain quality healthcare and services in the most appropriate setting, reduce unnecessary medical costs, and allow early identification of complex medical conditions using "Care Coordinators," "Medical Management Standards" and "Care Management." The Care Coordinators are available to Members and their Providers for information, help, and guidance, and can be reached toll-free by calling **1-866-871-0629.**

The Care Coordinators

Quantum Health provides a single point of contact through "Care Coordinators" or "Patient Service Representatives" for Members and Providers to help with Member navigation through their individual healthcare journey, including, but not limited to:

- Answering questions about eligibility, Plan Benefits and coverage levels,
- Locating Providers based on network status and individual Member needs,
- Outreaching to Members and educating them about the benefits of using Network Providers and other resources available under the Plan,
- Identifying and educating Members about availability of community resources,
- Initiating and coordinating referrals,
- Identifying Members who may benefit from Care Management,
- Facilitating Prior Authorization determinations as "pre-service" and "concurrent" claims in accordance with the Plan's Claims and Appeals procedures*;
- Advising on claim and appeal status, how to understand an Explanation of Benefits ("EOBs") and health care bills, and
- Other general customer service functions on behalf of the Plan.

*As an added courtesy, if a Member or Provider inquires about coverage for a service that would generally be subject to a medical judgment review in a "post-service" claim as defined under the Plan, the Care Coordinators will offer an opportunity for a "pre-determination." Pre-determinations are not considered "claims" under the Plan's Claims and Appeals procedures and are generally suggested for services being rendered in an office or in outpatient setting where medical judgment may be involved and there is no Prior Authorization requirement under the Plan. This allows the Member and Provider to better estimate coverage levels for services under the Plan prior to incurring the expense and to provide the Member with an opportunity to seek and receive care from a Network Provider and maximize Benefits under the Plan. To find out if a potential service requires Prior Authorization or is eligible for a pre-determination, you should reach out to **the Care Coordinators at 1-866-871-0629.**

**If you have any questions about your Benefits under the Plan,
you should reach out to the Care Coordinators at 1-866-871-0629.**

The Member's Role in Care Coordination

Members play a vital role in the Care Coordination process. To maximize Benefits available under the Plan, you should familiarize yourself with and follow the Care Coordination processes outlined below and any other applicable Plan provisions. **Please note that failure to comply with requirements under the Plan can result in significant Benefit reductions, which may include balance billing or denials of coverage for certain services. When in doubt, contact the Care Coordinators at 1-866-871-0629.**

1. Use In-Network Providers where Possible to Reduce Your Out-of-Pocket Costs.

   The Plan offers a broad network of Providers and the Benefits under the Plan are more generous when a Member receives services from a Network Provider (aka, "in-network"). **To find Network Providers, please visit MyQuantumCare.org, call the Care Coordinators at 1-866-871-0629, or use the Provider directory located at https://www.anthem.com/find-care/ (type your Member ID number in the box under "Use Member ID for Basic Search" and then click "Continue") for Members enrolled in Plans using the Anthem BCBS network and *https://hcpdirectory.cigna.com/web/public/bsOAPProviders* (after clicking "search," click the "Continue as guest" option) for Members enrolled in Plans using the Cigna network**. Please note that the Provider directory provided through Anthem BCBS or Cigna, as applicable, is the definitive listing of Network

Providers – if you find a Provider through Quantum Health, **always verify their network status using the Provider directory**, and then re-confirm their network status with the Provider before receiving services. The Summary of Benefits and Coverage ("SBC") provided by the Plan identifies the coverage differences between services provided in-network and out-of-network. Generally, receiving services from Out-of-Network Providers will result in increased Member financial responsibility and could result in balance billing by the Provider for many non-emergency services as explained in *Chapter 16*.

2. Designate a Network Primary Care Physician.

   While not required, to maximize Benefits under the Plan and streamline the coordination of care, all Members are strongly encouraged to designate a network Primary Care Physician (PCP). A successful healthcare journey generally begins with a PCP who maintains a relationship with the Member, coordinates with the Plan and other Providers and supplies ongoing general healthcare evaluation, guidance, and care management.

   Members are encouraged to begin all healthcare events or inquiries with a call or visit to their designated PCP. Because the PCP takes part in Care Coordination, they will help with submission of Prior Authorization requests and may receive updates from the Plan to enable the PCP to supply ongoing healthcare guidance.

   If you have trouble finding a PCP, the Care Coordinators can supply a list of network PCPs based on your individual needs. **Care Coordinators: 1-866-871-0629.** Once you have selected a PCP, please be sure to **verify their network status using the Provider directory**.

3. Understand what Services require Prior Authorization.

   To provide Care Coordination and to maximize Benefits payable under the Plan, the following care, services, and procedures must be authorized before they are provided ("Prior Authorization" or "Pre-certification") under the Plan's Medical Management Standards (also commonly referred to as utilization review).

Services Requiring Prior Authorization (In-Network and Out-of-Network)	
Medical/Surgical Services	**Mental Health / Substance Use Disorder Services**
• Inpatient Hospital Admissions (Inpatient) • Skilled Nursing Facility Admissions (Inpatient) • Hospice Care (Inpatient and Outpatient) • Organ, Tissue and Bone Marrow Transplants (Inpatient) • Outpatient Surgeries provided in a Hospital Setting (Outpatient) • Home Health (Outpatient) • Diagnostics MRI/MRA/PET (Outpatient) • Genetic Testing (Outpatient) • Oncology Services – Chemotherapy, Radiation and Clinical Trials (Outpatient) • Dialysis (Outpatient) • Durable Medical Equipment over $1,500 and all Rentals	• Inpatient Hospital Admissions (Inpatient) • Residential Treatment Center Admissions (Inpatient) • Partial Hospitalization (Outpatient) • Intensive Outpatient Services (Outpatient)

4. Understand the Prior Authorization Process.

   A. Timing of Request.

   Prior Authorization requests should be made to the Care Coordinators at least **three business days** before a scheduled service, treatment, procedure, inpatient admission or any other service requiring Prior Authorization except in the following circumstances:

   - For an "emergency" hospital admission or outpatient procedure, notification to the Care Coordinators should be made on or before the next business day after the admission or procedure. For the purposes of this subsection only, "emergency" is defined as a procedure that has not been previously scheduled and cannot be delayed without harming the Member's health. Notwithstanding the foregoing, with

respect to an Emergency Medical Condition, notification will not be required prior to the time the Member is Stabilized.

- Notification should be made upon Member identification as a potential organ or tissue transplant recipient.
- Maternity admission notifications should be submitted thirty (30) days before the expected delivery date, whenever possible.

B. Submission of a Request.

Members are ultimately responsible for ensuring that all Prior Authorizations are approved and on file prior to the provision of service to maximize Benefits under the Plan. Most Prior Authorization requests are submitted to the Care Coordinators by a designated PCP, other PCP, or other healthcare Provider via the Plan's provider portal, by facsimile or by calling the Care Coordinators at **1-866-871-0629** as listed on the back of the Member identification card.

C. Evaluation of the Request.

Submitted Prior Authorization requests considered pre-service claims and are reviewed to determine if the requested service is: (a) specifically covered or excluded under the terms of the Plan or (b) considered Experimental/Investigative/Unproven **and** (c) medically necessary under the Plan's Medical Management Standards discussed below. Depending on the request, the Care Coordinators may contact the requesting Provider and/or treating Provider to obtain additional clinical information to support the request and will suspend the claim for 45 days to allow the Provider to send the information. At the end of the 45-day period, the claim will be denied as an administrative denial if the information is not provided.

D. Ongoing Courses of Treatment.

Quantum Health will regularly monitor inpatient hospital stays, other institutional admissions, or ongoing courses of treatment for a Member receiving ongoing care and will examine the use of alternative levels of care or facilities, if necessary, under the Medical Management Standards discussed below. Quantum Health will communicate regularly with attending Providers, discharge planners of Facilities, the Member and/or Member's family to monitor the Member's progress and expect and initiate planning for discharge needs.

If Quantum Health reduces or terminates an already approved course of treatment or is reviewing an ongoing course of treatment in a claim involving urgent care, the claim shall be treated as a concurrent care claim under the Plan's Claims and Appeals procedures. Otherwise, it shall be treated as a pre-service or post-service claim as applicable.

5. Understand the Impact of Failure to Request Prior Authorization.

Failure to timely submit a Prior Authorization request may result in a reduction of Benefits or a denial of coverage as reflected in this Plan Document Handbook and/or the SBC.

However, a Member will not be penalized for failure to obtain Prior Authorization if a prudent layperson, who has an average knowledge of health and medicine, could reasonably expect that the absence of immediate medical attention would jeopardize the life or long-term health of the individual. Members who receive care on this basis should contact the Care Coordinators no later than two (2) business days after receiving care or a hospital admittance. Notwithstanding the foregoing, with respect to an Emergency Medical Condition, notification will not be required prior to the time the Member is Stabilized.

6. Understand that Participation in the Care Coordination Program is not a Guarantee of Benefits.

Quantum Health strives to supply accurate and up-to-date information about Provider network status, benefit estimates and Plan coverage through the Care Coordination Program. However, engagement with the Care Coordinators for any reason, including pre-determinations, is not a guarantee of Benefits. Members are still responsible for educating themselves on the Benefits available to them (under the Plan and as otherwise provided by the Plan Sponsor, their employer or community resources).

Further, Prior Authorization approvals issued by Quantum Health mean that the medical condition, services, and care settings meet the Medical Management Standards adopted by the Plan. The approvals do not guarantee that the service will be a Covered Health Service at the time the claim is submitted for processing as a post-service claim, that the Member is eligible for such Benefits, that other benefit conditions such as Copayments, Deductibles, Coinsurance, or Out-of-Pocket Limits have been satisfied or that the Member will not be subject to

balance billing where services are provided by an Out-of-Network Provider. Final determinations of coverage and eligibility for Benefits are made by the Plan when the claim is submitted for payment.

The Plan's Medical Management Standards

Determinations involving medical judgment (i.e., Experimental/Investigative/Unproven and Medical Necessity) that require interpretation of clinical information are reviewed by a clinician under the terms of the Plan and the clinical review criteria approved by the Plan Sponsor. If the clinician is not able to justify coverage based on the established criteria or no applicable criteria is available, it is referred to a medical director for review using the general clinical review criteria, medical director criteria or is referred to a "Peer Reviewer." A Peer Reviewer is a staff medical director or an independent reviewer but will be a Doctor of Medicine or a Doctor of Osteopathic Medicine or in the same licensure category as the ordering Provider.

If an initial adverse determination is pending or issued by Quantum Health based on medical judgment, the ordering Provider may request a peer-to-peer conversation with the Peer Reviewer to discuss the determination and supply more information that may support coverage. The peer-to-peer must be requested by the ordering Provider prior to the Member (or Authorized Representative) filing an appeal under the Plan's Claims and Appeals procedures.

If a drug, device, medical treatment or other procedure is reviewed and recommended under the Quantum Health Oncology Management programs, Quantum Health will be guided by the written medical guidelines and criteria used as part of Quantum Health's Oncology Management programs in determining whether a drug, device, medical treatment or other procedure will be deemed to be Experimental/Investigative/Unproven.

Compliance with the Mental Health Parity and Addiction Equity Act

The Mental Health Parity and Addiction Equity Act and regulations issued thereunder ("MHPAEA") generally require that the Plan may not impose a financial requirement or treatment limitation on any mental health / substance use disorder Benefits offered under the Plan unless the requirement or treatment limitation meets certain requirements, as documented by a comparative analysis.

Certain components of the Care Coordination Program, including the Prior Authorization and concurrent review requirements and the use of other "Medical Management Standards" (medical judgment determinations of Medical Necessity, medical appropriateness and designation as Experimental/Investigative/Unproven treatment to make Benefit determinations) are generally considered nonquantitative treatment limitations (NQTLs) under MHPAEA.

The Care Coordination Program is intended to be compliant with the MHPAEA in its design and application because:

- The Plan's Prior Authorization and concurrent review and Medical Management Standards are reasonably designed to detect or prevent fraud, waste and abuse.
- The processes, strategies, evidentiary standards and other factors used to design the Prior Authorization, concurrent review and Medical Management Standards requirements for mental health or substance use disorder Benefits in each classification are comparable to and no more restrictive than those processes, strategies, evidentiary standards, or other factors used to design the Prior Authorization, concurrent review and Medical Management Standards to substantially all of the medical and surgical Benefits in the same classification as reflected above.
- The clinical criteria applied by the Plan under the Medical Management Standards as written and in operation for medical/surgical and mental health / substance use disorder Benefits are generally recognized independent professional medical or clinical standards (generally, InterQual, the Claims Administrator's or network's medical criteria and Quantum Health medical director criteria consistent with generally accepted standards of care).
- The Plan's Prior Authorization, concurrent review and Medical Management Standards, as written and in operation, are not applied to mental health or substance use disorder Benefits in any classification more restrictively or more stringently than and are impartially applied comparably to the Prior Authorization, concurrent review and Medical Management Standards applied to substantially all medical/surgical Benefits in the same classification.

Care Management

Quantum Health's Approach to Care Management

Quantum Health uses a primary nurse model for chronic condition as well as acute condition management. This enhanced approach supplies one nurse to address clinical needs for all chronic and acute issues.

Our primary nurse model has three foundational drivers for change:

- Humanistic: Help Members with acute and chronic needs by assigning a single nurse (a “Personal Care Guide” or “PCG”) to the Member and their family and a heightened attention to psychosocial issues that can negatively affect health, quality of life and financial outcomes.

- Clinical: Identify and prioritize Members in need of clinical outreach. Improve adherence to quality measures for preventive health and management of chronic conditions.

- Financial: Identify and outreach to Members at risk for future high costs while encouraging preventive care and chronic condition management to improve health and reduce costs.

Initial Outreach and Intake

During outreach, the PCG will discuss the Member's treatment, perform a physical assessment, perform a medication reconciliation to ensure there are no duplications or interactions, perform a depression screening with subsequent referrals to EAP or Network Providers, as well as focus on the physical and emotional needs of the Member.

The PCG will look at the Member’s barriers to care and individual needs. In addition to the depression screening, they will evaluate the Member’s financial issues, knowledge deficits, and any cultural barriers.

The PCG nurse will consult with the Member, their family (if requested), the attending Physician, and other members of the Member’s treatment team to aid in facilitating/implementing proactive plans of care which supply the most appropriate health care and services in a prompt, efficient and cost-effective manner. They help with benefits, incidental health care issues, becoming healthier, finding resources or navigating an unexpected healthcare journey.

Ongoing Support

Conversations with the Member would occur at least monthly, if not more often, and continue until the Member’s health goals and needs are met.

The primary PCG nurse will align with the Member and be the single point of contact for them, their family and caregivers, and Providers. Each Member journey is different, and the types of services provided by the PCG will differ based on the condition managed and the needs of the individual Member, but generally the PCG nurse will:

- Provide comprehensive benefit education/utilization support
- Drive PCP designation and steerage to Network Providers
- Encourage Provider involvement
- Deliver Prior Authorization help
- Perform pre-admission, pre-discharge, and post-discharge engagement
- Coordinate for utilization review and discharge planning
- Identify gaps in care and alleviate clinical, financial, and humanistic barriers
- Coordinate second opinions, drive utilization to other third-party vendor tools, and introduce community resources
- Perform behavioral health screening

Chapter 6: Pharmacy Benefits (Administered by Express Scripts)

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

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

Drug Formulary

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

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

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

It is also important to note that drugs included on the formulary list are routinely updated. To find the most up-to-date list of covered drugs, call Quantum Health. It should be noted that all drugs listed on the formulary may not be covered due to Plan exclusions and limitations.

Generic Medications

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

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

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

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

What’s Covered

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

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

- Needles and syringes
- Over-the-counter and legend prenatal vitamins

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

Coverage Management Programs

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

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

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

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

If you have any questions regarding coverage of a specific drug, please check the Express Scripts website at *express-scripts.com* or call Quantum Health.

What's Not Covered

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

- Compounded medications (unless the National Drug Code of the compounded medication is identical to a covered medication)
- Medication for which the cost is recoverable under any workers' compensation or occupational disease law or from any state or governmental agency
- Medication for which there is no legal obligation to pay, or medication furnished by a drug or medical service for which no charge is made to the individual
- Medication that is to be taken by or administered to an individual, in whole or in part, while they are a patient in a licensed Hospital, rest home, sanitarium, extended care Facility, Skilled Nursing Facility, convalescent Hospital, nursing home, or similar institution that operates on its premises, or allows to be operated on its premises, a Facility for dispensing pharmaceuticals
- Non-federal legend drugs
- Any prescription refilled in excess of the number of refills specified by the Physician or practitioner, or any refill dispensed after one year from the Physician's or practitioner's original order
- Drugs whose sole purpose is to promote or stimulate hair growth (e.g., Rogaine or Propecia) or for cosmetic purposes only (e.g., Renova or Vaniqa)

- Drugs labeled “Caution: Limited by federal law to investigational use” or other experimental or investigational drugs (as determined by Express Scripts), even though a charge is made to the individual
- Certain immunization agents
- Blood products
- Immune globulins
- Topical dental fluorides
- Therapeutic devices or appliances
- Mifeprex
- Contraceptive devices
- Drugs to treat impotency for females only
- Yohimbine
- Lamisil
- Seasonale at a retail pharmacy
- Drugs or other items that are illegal under applicable law

This is not an exhaustive list of exclusions. If you have any questions regarding coverage of a specific drug, please check the Express Scripts website at *express-scripts.com* or call Quantum Health.

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

Using a Retail Pharmacy

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

For maintenance medications, the retail pharmacy program allows for a total of three fills at a retail pharmacy (one original fill and two refills). Maintenance medications are prescriptions commonly used to treat conditions that are considered chronic or long-term. These conditions usually require regular, daily use of medicines. Examples of maintenance medications are those used to treat high blood pressure, heart disease, asthma, and diabetes. Each fill can be for no more than a 30-day supply. Note that you are allowed a total of three fills, even if each is for less than 30 days. The full cost of any additional fills at a retail pharmacy will be the Member’s responsibility (and will not count towards your Out-of-Pocket Limit); additionally, a penalty may be charged in connection with such additional fills, which will not be covered by the Plan.

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

At a nonparticipating pharmacy, you must pay in full for your prescription and submit a claim for reimbursement. If the pharmacy charges you more than the allowed amount (based on pricing at a participating pharmacy), you will be reimbursed based on the allowed amount minus the Copayment or Coinsurance. You should mail your claims for reimbursement to the address on the form. You can obtain a copy of the claim form from the Express Scripts website at *express-scripts.com* or by calling Quantum Health.

Any reimbursement will be sent directly to you and made according to the Plan’s prescription drug Benefit, as outlined on the Summary of Benefits and Coverage. If any request for reimbursement is denied or reduced other than for Copayments or Coinsurance, please refer to the appeal provisions in *Chapter 8: Claims and Appeals*.

Using Home Delivery

Home delivery should be used for maintenance medications. You can receive up to a 90-day supply of medication for one Copayment or Coinsurance payment. Prescriptions must be filled as prescribed by your Physician—refills cannot be combined to equal a 90-day supply. Please refer to the Summary of Benefits and Coverage for details about home delivery Copayments and Coinsurance.

The prescription drug program will maintain a retail refill limit policy. The retail refill limit requires that you use home delivery if you are prescribed a maintenance medication, rather than refilling multiple prescriptions for the same drug at a retail pharmacy. If you or a covered Dependent receives a prescription for a maintenance medication, and you do not use home delivery, you may be responsible for the full cost of your prescriptions (and such amounts will not count towards your Out-of-Pocket Limit), and you may incur a penalty, which will not be covered by the Plan. See “*Using a Retail Pharmacy*,” above, for more information.

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

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

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

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

Once you have initiated your prescription delivery through mail-order, you can request refills online at *express-scripts.com* or by calling Express Scripts' member services department at 800-841-3361. Refill requests received by Express Scripts by 12:00 PM are filled and shipped the same day.

Specialty Drugs – Medical Channel Management (Accredo)

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

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

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

To confirm whether a medication you take is part of the specialty program, you may call the number on your ID Card.

Express Scripts Special Care Pharmacy (Accredo)

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

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

Drug Utilization Review

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

SaveOnSP Copay Assistance Program

The Episcopal Church Medical Trust has collaborated with SaveOnSP to help our Members save money on certain specialty medications by maximizing copay assistance from manufacturers.

SaveOnSP works in conjunction with The Medical Trust's current pharmacy program through Express Scripts. Participants in the SaveOnSP program will continue to receive their specialty medications through Accredo, Express Scripts' specialty home delivery provider, but will receive these specialty pharmacy medications free of charge ($0). SaveOnSP leverages the Affordable Care Act state benchmark requirements to reclassify certain specialty medications under the category of non-Essential Health Benefits in order to provide savings both to the Member and the Medical Trust. The list of specialty pharmacy medications included in the program can be found at *SaveonSP.com/cpg*.

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

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

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

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

If you have any questions or concerns, call Quantum Health.

Emergency Pharmacist Consultation

Access to pharmacists is available 24 hours a day, 7 days a week, for emergency consultation, by calling Express Scripts' member services department at 800-841-3361.

Pharmacy Locator

A voice-activated system for locating participating retail pharmacies within specific zip codes is available by calling Quantum Health. This information is also available at *express-scripts.com*.

Printed Materials for the Visually Impaired

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

Filing a Claim

See *Chapter 8* for information on claims and appeals.

Chapter 7: Other Programs and Services

Cigna Employee Assistance Program (EAP)

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

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

To access the Cigna EAP services, register on the EAP website at *mycigna.com* and use the employer ID "Episcopal" or call 866-395-7794. If you previously registered a myCigna account while you participated in another Cigna plan, policy, or product (medical or dental, for instance, including Plans sponsored by the Medical Trust), you may need to reregister to access online EAP resources.

If you are unsure whether the Cigna EAP is the right resource for a particular need or if you would like to discuss available benefits and resources, please call Quantum Health.

Pastoral Support Network (PSN)

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

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

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

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

Healthy Rewards

Through the Cigna EAP, get discounts* on the health products and programs you use every day:
- Nutritional Meal Delivery Service
- Fitness Memberships and Devices**
- Vision Care, Lasik Surgery, Hearing Aids
- Alternative medicine
- Yoga Products and Virtual Workouts**

Log in to *myCigna.com* and navigate to Healthy Rewards Discount Programs under the Wellness Tab.

Healthy Rewards is a discount program. Some Healthy Rewards programs are not available in all states, and programs may be discontinued at any time. If the Plan includes coverage for any of these services, this program is in addition to, not instead of, your Plan benefits. Healthy Rewards programs are separate from your Plan benefits.* ***A discount program is NOT insurance, and you must pay the entire discounted charge.* *All goods, services, and discounts offered through Healthy Rewards are provided by third parties who are solely responsible for their products, services, and discounts.*

***Fitness Membership and Devices along with Yoga Products and Virtual Workouts can be accessed only by logging in to myCigna.com and navigating to the Healthy Rewards Discount Program.*

EyeMed Vision Care

If you enroll in the Plan, you will receive vision Benefits through EyeMed Vision Care's Insight Network®.

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

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

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

To contact EyeMed's Member Services team, call 866-723-0513, or call Quantum Health.

UHC Global Travel Medical Assistance

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

The program includes these features:

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

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

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

For more information about UnitedHealthcare Global Assistance services, please call Quantum Health.

Hinge Health

Hinge Health is available at no cost to Members enrolled in a Plan using the Anthem BCBS or Cigna network.

Through the Hinge Health Digital Musculoskeletal (MSK) Clinic, participants have access to personalized musculoskeletal care programs depending on their specific musculoskeletal needs. Participants will register online through the Hinge Health website or app, complete a clinically validated screener to determine which program best fits their musculoskeletal needs. The programs include:

- Prevention – Program designed to increase education with regard to key strengthening and stretching activities around healthy habits. The Prevention program is software-based and offered through the Hinge Health app.
- Chronic – Program designed to address long-term back and joint pain. It includes personalized app-guided exercise therapy sessions, one-on-one access to a personalized health coach, personalized education content, and behavioral health support. The Chronic Program consists of (i) the Hinge Health proprietary exercise band systems and technologies; (ii) coaching and alert features; and (iii) Cloud-based data capture and reporting capabilities; and (iv) personalized analytics capabilities. Participants in the chronic program may also be offered access to virtual sessions with a licensed physical therapist and/or the non-invasive ENSO High Frequency Impulse Therapy™ pain management device and service, as appropriate, for symptomatic relief and management of pain.
- Acute – Program designed to address recent injuries. It includes live virtual sessions with a dedicated licensed physical therapist along with software-guided rehabilitation and education.
- Surgery – Program designed to address pre/post-surgery rehab for the most common musculoskeletal Surgeries. It includes personalized app-guided exercise therapy sessions, 1:1 access to a personalized health coach and physical therapist, personalized education content, and behavioral health support. It is designed as a continuation of the Chronic Program.
- Expert Medical Opinion – Service offering second opinions for elective musculoskeletal procedures.

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

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

To be eligible for these Hinge Health programs, in addition to being a Member enrolled in a Plan using the Anthem BCBS or Cigna network, you must (i) be age 18 or older, (ii) be located in the United States, and (iii) be approved through the clinical suitability evaluation performed by Hinge Health prior to enrollment.

To get started with Hinge Health, visit *hingehealth.com/ecmt* to enroll. If you have any questions regarding Hinge Health, call Quantum Health.

Chapter 8: Claims and Appeals

This chapter describes the claims and appeals procedures for services received through the Plan.

Filing a Claim

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

You may get the required claim forms from the website listed on your ID Card or by contacting Quantum Health.

Timely Filing of Out-of-Network Claims

The Claims Administrator will consider claims for coverage under the Plans when proof of loss (a claim) is submitted within 180 days (for Members enrolled in Plans using the Anthem BCBS network) or 365 days (for Members enrolled in Plans using the Cigna network), as applicable, for Out-of-Network Benefits after services are rendered. If services are rendered on consecutive days, such as for a Hospital Confinement, the limit will be counted from the last date of service. If claims are not submitted within the timeframe described above for Out-of-Network Benefits, the claim will not be considered valid and will be denied.

Claim Reminders

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

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

You should submit claims for each individual Member. Please do not attach or staple claims together. If additional information is needed to process your claim, you or your Provider(s) will be notified.

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

Send complete information to the appropriate Plan vendor.

Send claims for medical or behavioral health services received through a Plan using the **Anthem BCBS** network to:

Anthem Blue Cross and Blue Shield
P.O. Box 60007
Los Angeles, CA 90060

Send claims for medical or behavioral health services received through a Plan using the **Cigna** network to:

Cigna Healthcare
P.O. Box 188061
Chattanooga, TN 37422-8061
Payer ID: 62308

Send claims for pharmacy services to:

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

If you have any questions regarding your claim, please call Quantum Health at 1-866-871-0629.

All claims must be received within 180 days (for Members enrolled in Plans using the Anthem BCBS network) or 365 days (for Members enrolled in Plans using the Cigna network), as applicable, following the date services were received, or they will be denied, and any amount you pay will not count towards your Out-Of-Pocket Limit.

Authorized Representative

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

How to Appeal a Denial of Benefits

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

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

An appeal relating to a "claim for Benefits" as described above, for which the Adverse Benefit Determination (as defined below) is based upon an adverse eligibility determination (for example, a determination that a Member was not eligible to be enrolled in the Plan) is referred to as an "Eligibility-Based Claims Appeal"; provided, that an urgent pre-service or concurrent appeal shall not be considered to be an Eligibility-Based Claims Appeal. The procedures governing Eligibility-Based Claims Appeals are similar to, but differ somewhat from, the procedures governing other appeals of Adverse Benefit Determinations, as described further below.

A "claim for Benefits" does *not* include an eligibility inquiry or request, or an attempt to enroll or disenroll a person in or from the Plan, in the absence of a claim as described above. An appeal of a decision with respect to such an eligibility inquiry or request, or enrollment or disenrollment attempt, is referred to as a "Non-Claims Appeal." Different procedures govern Non-Claims Appeals; see "*Non-Claims Appeals*," below, for more information on Non-Claims Appeals.

If your claim for Benefits is denied:

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

Notice of Adverse Benefit Determination

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

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

The denial of an eligibility inquiry or request, or of an attempt to enroll or disenroll a person in or from the Plan, in the absence of a claim for Benefits, is not an Adverse Benefit Determination.

Appeals of Adverse Benefit Determinations

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

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

For purposes of these appeal provisions, the "Appeals Reviewer" means, as applicable to a given appeal: (i) Quantum Health, for appeals of Adverse Benefit Determinations that relate to medical or behavioral health services that are not Eligibility-Based Claims Appeals, (ii) Express Scripts for appeals of Adverse Benefit Determinations that relate to prescription drug services that are not Eligibility-Based Claims Appeals, or (iii) the Medical Trust, for Eligibility-Based Claims Appeals.

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

For urgent pre-service and concurrent services, you may obtain an expedited appeal. You or your Authorized Representative may request it verbally or in writing. All necessary information, including the Appeals Reviewer's decision, can be sent between the Appeals Reviewer and you by telephone, facsimile (fax), or other similar method. To file an appeal for a claim for Benefits involving urgent pre-service or concurrent care, you or your Authorized Representative must provide at least the following information:

- The identity of the claimant and the identification number from their ID Card
- Phone number
- The date(s) of the medical service
- The specific medical condition or symptom

- The Provider's name
- The service or supply for which approval of Benefits was sought
- A description of why the claimant disagrees with the initial Adverse Benefit Determination
- Any reasons why the appeal should be processed on a more expedited basis
- Any documentation or other information to support the appeal request

The Appeals Reviewer will respond within 72 hours from the request of the appeal. If your medical or behavioral health appeal is denied, you may request a second-level appeal. An appropriate reviewer who did not make the determination on the initial appeal will conduct the second-level appeal. Again, Quantum Health will respond within 72 hours of the receipt of the second-level appeal. If your second-level appeal is denied, you may request an expedited external review. For prescription drug appeals, there is only one level of urgent pre-service appeal prior to external review. Please also note that concurrent appeals are not applicable to prescription drug services.

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

For medical and behavioral health services:

Quantum Health - Appeals Department
Phone: (866) 952-0340
Fax: (877) 498-3681

For clinical[14] appeals involving prescription drug services:

Express Scripts
Phone: 1-800-753-2851
Fax: 1-877-852-4070

For administrative[15] appeals involving prescription drug services:

Express Scripts
Phone: 1 800-946-3979
Fax: 1-877-328-9660

Please note that urgent claims and appeals submitted by mail will not be considered for urgent processing unless a subsequent phone call or fax identifies the appeal as urgent.

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

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

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

For appeals relating to medical and behavioral health services that are not Eligibility-Based Claims Appeals:

Quantum Health - Appeals Department
5240 Blazer Parkway
Dublin, OH 43017
Fax: 1-877-498-3681

[14] A clinical appeal is an appeal that is based on clinical conditions of coverage that are set by the Plan. For example, an appeal of a prior authorization denial.

[15] An administrative appeal is an appeal that is based on the Plan's benefit design.

For clinical[14] appeals involving prescription drug services that are not Eligibility-Based Claims Appeals:

Express Scripts
Attn: Clinical Appeals Department
P.O. Box 66588
St. Louis, MO 63166-6588
Fax: 1-877-852-4070

For administrative[15] appeals involving prescription drug services that are not Eligibility-Based Claims Appeals:

Express Scripts
Attn: Administrative Appeals Department
P.O. Box 66587
St. Louis, MO 63166-6587
Fax: 1-877-328-9660

For Eligibility-Based Claims Appeals:

The Episcopal Church Medical Trust
Attn: Benefits Policy – Medical Appeals
19 E 34th St
New York, NY 10016

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

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

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

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

Notification of the Outcome of the Non-Urgent Appeal

If you appeal a nonurgent pre-service claim for Benefits, Quantum Health or Express Scripts (if and as applicable) will notify you of the outcome of the appeal within 15 days after receipt of your request for appeal. For non-urgent pre-service Eligibility-Based Claims Appeals, the Medical Trust will notify you of the outcome of the appeal within 30 days of your request for appeal.

If you appeal a post-service claim for Benefits, Quantum Health or Express Scripts (if and as applicable) will notify you of the outcome of the appeal within 30 days after receipt of your request for appeal. For post-service Eligibility-Based Claims Appeals, the Medical Trust will notify you of the outcome of the appeal within 60 days of your request for appeal.

Appeal Denial

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

Voluntary Second-Level Appeals (Post-Service and Non-Urgent Pre-Service, excluding Eligibility-Based Claims Appeals)

If you are dissatisfied with Quantum Health's or Express Scripts' (as applicable) first-level appeal decision, a voluntary second-level appeal is available. Your appeal must be received within 60 days of receiving the Adverse Benefit

Determination of the first appeal. If you would like to initiate a second-level appeal, you or your Authorized Representative must submit the following information:

- Your name and the identification number from your ID Card
- Phone number
- The date(s) of medical service(s)
- The Provider's name
- The service or supply for which approval of Benefits was sought
- A description of why the claimant disagrees with the initial Adverse Benefit Determination
- Any other documentation or other information to support the appeal request

Send your second-level appeal to the appropriate address listed under "First-Level Appeals (Post-Service and Non-Urgent Pre-Service)," above.

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

No voluntary second-level appeals are available following the determination of an Eligibility-Based Claims Appeal or a Non-Claims Appeal.

External Review Program

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

The Episcopal Church Medical Trust has contracted with Quantum Health to facilitate the external review program for medical and behavioral health appeals, and with MCMC Services LLC ("MCMC"), a subcontractor of Express Scripts, for pharmacy benefit appeals. Quantum Health or MCMC, as applicable, will rotate between several EROs to conduct the review of your appeal.

If you would like, you have the right to appoint an Authorized Representative to act on your behalf in filing and pursuing your external review request. The Authorized Representative should provide notice to you of the commencement of the external review, and Quantum Health or MCMC, as applicable, may verify the Authorized Representative's appointment with you prior to recognizing their status. In any event, a Provider with knowledge of your medical condition acting in connection with an urgent care claim will be recognized by this Plan as your Authorized Representative.

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

The notice of Adverse Benefit Determination that you receive from the Plan or its designee will describe the process to follow if you wish to pursue an external review. You must submit your external review request in writing within four (4) months of the date you received the Adverse Benefit Determination notice. If the last filing date would fall on a Saturday, Sunday, or federal holiday, the last filing date is extended to the next day that is not a Saturday, Sunday, or federal holiday. You also must include a copy of the notice of Adverse Benefit Determination and all other pertinent information that supports your request.

External Review Program – Medical and Behavioral Health Appeals

Only Adverse Benefit Determinations involving medical judgment, such as a denial based on Medical Necessity, determinations involving a rescission of coverage, and determinations involving Surprise Billing Claims will be eligible for external review. For example, external review will not be available for a denial based on your ineligibility to participate in the Plan or other Eligibility-Based Claims Appeals (except to the extent that it involves a rescission of coverage). External review is never available for Non-Claims Appeals.

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

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

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

Quantum Health – Appeals Department
5240 Blazer Parkway
Dublin, OH 43017
Fax: 1-877-498-3681

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

Request for External Review – Medical and Behavioral Health Appeals

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

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

Preliminary Review – Medical and Behavioral Health Appeals

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

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

Within one (1) business day after completion of the preliminary review, the Plan or its designee must issue to you a notification in writing. If the request is complete but not eligible for external review, such notification will include the reasons for its ineligibility. If the request is not complete, such notification will describe the information or materials needed to make the request complete, and the Plan or its designee must allow you to perfect the request for external review within the four (4) month filing period or within the 48-hour period following the receipt of the notification, whichever is later.

Referral to ERO – Medical and Behavioral Health Appeals

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

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

extent the information or documents are available and the ERO considers them appropriate, will consider the following in reaching a decision:

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

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

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

Expedited External Review – Medical and Behavioral Health Appeals

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

(a) an Adverse Benefit Determination, if the Adverse Benefit Determination involves a medical condition for which the time frame for completion of an expedited internal appeal would seriously jeopardize your life or health or would jeopardize your ability to regain maximum function and you have filed a request for an expedited internal appeal; or
(b) an Adverse Benefit Determination that concerns an admission, availability of care, continued stay, or healthcare item or service regarding an issue for which you received emergency services, but have not been discharged from a Facility.

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

Referral of Expedited Review to ERO – Medical and Behavioral Health Appeals

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

External Review Program – Pharmacy Benefit Appeals

The right to request an independent external review may be available for an Adverse Benefit Determination involving medical judgment, rescission, or a decision based on medical information, including determinations involving treatment that is considered experimental or investigational.

The external review will be conducted by an independent review organization with medical experts that were not involved in the prior determination of the claim.

To submit an external review, the request must be mailed or faxed to:

MCMC Services, LLC – Express Scripts Appeal Program
1451 Rockville Pike, Suite 440
Rockville, MD 20852
Fax: 1-800-882-4715

The request must be received within 4 months of the date of the final internal Adverse Benefit Determination. If the last filing date would fall on a Saturday, Sunday, or federal holiday, the last filing date is extended to the next day that is not a Saturday, Sunday, or federal holiday.

Standard External Review: MCMC will review the external review request within 5 business days to determine if it is eligible to be forwarded to an ERO and the Member will be notified within 1 business day of the decision.

If the request is eligible to be forwarded to an ERO, the request will randomly be assigned to an ERO and the appeal information will be compiled and sent to the ERO within 5 business days of assigning the ERO. The ERO will notify the claimant in writing that it has received the request for an external review and if the ERO has determined that the claim involves medical judgment or rescission, the letter will describe the claimant's right to submit additional information within 10 business days for consideration to the ERO. Any additional information the claimant submits to the ERO will also be sent back to Express Scripts for reconsideration. The ERO will review the claim within 45 calendar days from receipt of the request and will send the claimant, the Plan, and Express Scripts written notice of its decision. If the ERO has determined that the claim does not involve medical judgment or rescission, the ERO will notify the claimant in writing that the claim is ineligible for a full external review.

Urgent External Review: Once an urgent external review request is submitted, the claim will immediately be reviewed to determine if it is eligible for an urgent external review. An urgent situation is one where in the opinion of the attending provider, the application of the time periods for making non-urgent care determinations could seriously jeopardize the life or health or the ability for the Member to regain maximum function or would subject the Member to severe pain that cannot be adequately managed without the care or treatment that is the subject of the claim.

If the claim is eligible for urgent processing, the claim will immediately be reviewed to determine if the request is eligible to be forwarded to an ERO, and the claimant will be notified of the decision. If the request is eligible to be forwarded to an ERO, the request will randomly be assigned to an ERO and the appeal information will be compiled and sent to the ERO. The ERO will review the claim within 72 hours from receipt of the request and will send the claimant written notice of its decision.

Non-Claims Appeals

You have the right to submit a Non-Claims Appeal to the Plan to appeal the denial of an eligibility inquiry or request, or of an attempt to enroll or disenroll a person in or from the Plan. You must file the Non-Claims Appeal within 180 days of the denial that you are appealing. You will have the opportunity to submit written comments, documents, records, and other information supporting your Non-Claims Appeal. The Medical Trust's review of your Non-Claims Appeal will take into account all information you submit, regardless of whether it was submitted or considered in the initial determination.

The Plan provides for one mandatory level of appeal. You or your Authorized Representative must submit a request for review to the following address:

The Episcopal Church Medical Trust
Attn: Benefits Policy – Medical Appeals
19 E 34th St
New York, NY 10016

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

The Medical Trust will generally notify you of the outcome of the appeal within 90 days of your request for appeal. If the Medical Trust needs additional time (up to 90 days) to review the appeal, you will be notified of the reason(s) for the delay and the anticipated response date, which may not exceed a total of 180 days from the date the Medical Trust receives the appeal. If the appeal is denied, CPF's written response will give the specific reason(s) for the denial and the applicable plan's provision(s) on which the final denial decision is based.

Requirements Relating to Commencing Legal Action

No legal action of any kind related to a Benefit decision (or any other Plan-related decision) may be commenced by you, unless it is commenced within one (1) year of the Plan's final decision with respect to such matter. If the Plan decides an appeal is untimely, the Plan's latest decision on the merits of the underlying claim or Benefit request (or other determination) is the final decision date. You must exhaust the Plan's mandatory internal appeals procedure, not including any voluntary level of appeal, before taking legal action of any kind against the Plan. As described in more detail in *Chapter 11: Other Important Plan Provisions*, legal action may be pursued only and exclusively by submitting the matter to arbitration.

Chapter 9: Coordination of Benefits

When a Member is covered under more than one group health Plan that provides coverage for the same expense as the Plan, the Plan will coordinate the Benefits it pays with the payments from the other Plan(s). This coordination is to prevent duplicative payments for any service or supply. One Plan will be considered “primary” and responsible for paying expenses first, and the other Plan will be considered “secondary” and responsible for paying expenses second.

When the Plan is primary, it will pay Benefits according to Plan rules. When the Plan is secondary, the Plan will adjust its payments so that the total combined amount paid by both Plans does not exceed the amount this Plan would have paid if it were primary.

The term “group health plan,” as it relates to Coordination of Benefits, includes employer or group plans and most government or tax-supported plans, including Medicare and TRICARE. It also includes group insurance and subscriber contracts, such as union welfare plans and benefits provided under any group or individual automobile no-fault or fault-type policy or contract. Benefits are not coordinated with personal, individual insurance policies, unless otherwise described in this Plan Document Handbook. Members must inform the Plan any time the Member has other group health plan coverage.

The Plan follows specific rules to establish which plan is primary and which is secondary in determining the order in which Benefits will be paid. Rules may vary as a result of specific situations, based on the Coordination of Benefits provisions of each plan and due to generally accepted industry criteria. For persons eligible for Medicare, for example, Medical Trust Benefits will generally be primary only as required by federal Medicare rules and regulations and will not be primary for any Employee whose employment status has been terminated (such Employees must enroll in Medicare Parts A and B as soon as they qualify; otherwise, Benefits may be reduced). Further, in determining the Benefits payable under the Plan, the Plan will not take into account the fact that you or any Eligible Dependent(s) are eligible for or receive benefits under a Medicaid plan.

Typically, the following rules apply to coordinate Benefits, in the order stated below, until it is clear which plan is primary.

General Rules

Any group health plan that does not contain a Coordination of Benefits provision will be the primary Plan.

When all plans covering a Member contain a Coordination of Benefits provision, Benefits will be coordinated based on the following rules:

The plan covering a person other than as a Dependent (e.g., an active Employee or retiree) is primary, and the plan covering a person as a Dependent is secondary.

If a person is covered by two group health plans and Medicare, and under federal law, Medicare is secondary to the plan covering the person as a Dependent and primary to the plan covering the person as other than a Dependent (e.g., a retiree), then the order of payment is reversed so that the plan covering the individual as a Dependent is primary, and the other plan is secondary.

The plan covering a person as an active Employee is primary and the plan covering the person as a retiree is secondary.

Child Covered Under More Than One Plan

The order of benefits when a Dependent Child is covered by more than one plan is as follows:

The primary plan is the plan of the parent whose birthday (month and day) is earlier in the calendar year if:
- The parents are married;
- The parents are not separated (regardless of whether they ever have been married); or
- A court decree awards joint custody without specifying that one parent has the responsibility to provide healthcare coverage.

If both parents have the same birthday (month and day), the plan that has covered either of the parents longer is primary.

If the specific terms of a court decree state that one of the parents is responsible for the Child’s healthcare coverage or expenses, and the plan of that parent has knowledge of the decree, that plan is primary. If the parent designated by the

decree has no coverage for the Child but that parent's Spouse does, the Spouse's plan is primary.
If the parents are not married, are separated (regardless of whether they were ever married), or are divorced and there is no court decree allocating responsibility for the Child's healthcare coverage or expenses, the order of benefit determination among the plans is as follows:

- The plan of the custodial parent; then
- The plan of the Spouse of the custodial parent; then
- The plan of the noncustodial parent; then
- The plan of the Spouse of the noncustodial parent.

Active or Inactive Employee

The plan that covers a person as an active Employee (or the person's Dependents) who is not laid off, terminated, or retired is primary. The plan that covers a person (or the person's Dependents) as a laid-off, terminated, or retired Employee is secondary. If both the person and the person's Dependents are covered as retirees, the Dependent's retiree coverage is primary for the Dependent's claims. If the other plan does not have this rule and if, as a result, the plans do not agree on the order of benefits, this rule is ignored.

Continuation Coverage

If a person whose coverage is provided under a right of continuation required by federal or state law or by the Medical Trust's continuation of coverage provisions is also covered under another plan, the plan covering the person as an employee, member, or retiree (or as that individual's Dependent) is primary, and the continuation coverage is secondary. If the other plan does not have this rule and if, as a result, the plans do not agree on the order of benefits, this rule is ignored.

Longer or Shorter Length of Coverage

The plan that has covered the person for the longer period of time is primary.

If none of the above rules determine which plan is the primary plan, the allowable expenses will be shared equally between the plans. This Plan will never pay more than it would have paid had it been primary.

This Plan provides Benefits relating to medical expenses incurred as a result of an automobile accident on a secondary basis. Benefits payable under this Plan will be coordinated with, and secondary to, benefits provided or required by any no-fault automobile insurance statute, whether or not a no-fault policy is in effect, and/or any other automobile insurance. Any Benefits provided by this Plan will be subject to the Plan's reimbursement and/or subrogation provisions.

Whenever payments that should have been made by this Plan have been made by any other plan(s), this Plan has the right to pay the other plan(s) any amount necessary to satisfy the terms of the Plan's Coordination of Benefits provision. Amounts paid will be considered Benefits paid under this Plan, and, to the extent of such payments, the Plan will be fully released from any liability regarding the person for whom the payment was made.

Chapter 10: Medicare Secondary Payer (MSP) ─ Small Employer Exception (SEE)

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

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

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

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

What Your Employer Needs to Do

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

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

What You Need to Do

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

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

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

How It Works

If you have an Inpatient hospitalization while enrolled in the MSP-SEE Plan, the Hospital or Facility will send its billed charges to Medicare. Medicare will then pay the allowed amount minus the Part A Deductible.

The portion of the allowed amount that is not paid by Medicare will then be sent to the Claims Administrator who will process the portion not paid by Medicare, minus the Plan’s Deductible and your cost share.

In administering the Plan’s role as the secondary payer of claims, the Claims Administrator does not look at the Provider status to determine the Benefits. All claims are processed at the Network Benefit level, regardless of whether the Facility is in the applicable network. The Provider must, however, participate with Medicare or accept Medicare assignment in order for Medicare to consider the claim for primary payment.

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

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

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

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

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

Chapter 11: Other Important Plan Provisions

Assignment of Benefits

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

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

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

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

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

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

Surprise Billing Claims

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

Unless an Out-of-Network Provider gives a Member proper notice of its charges (as described in more detail below) and the Member gives written consent to such charges (such consent following such proper notice is referred to as the Member's "Out-of-Network Consent"), charges for services furnished by an Out-of-Network Provider in a Network Facility while the Member is receiving network services at that Network Facility: (1) are payable at the Network Benefit cost-sharing level; and (2) the allowed amount used to determine the Plan's Benefit payment is the "recognized amount" determined in accordance with applicable state or federal law, or, if less, the amount actually billed by the Out-of-Network Provider.

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

Surprise Billing Claims – Out-of-Network Emergency Services Charges & Air Ambulance Charges

1. Emergency Services and air ambulance charges are covered at the Network Benefit cost-sharing level if services are received from an Out-of-Network Provider.

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

The Member is responsible for applicable Network Benefit cost-sharing amounts (any Deductible, Copay, or Coinsurance) for such Emergency Services or air ambulance services. Any such Deductible will accumulate toward the Member's Network Deductible, and any such Deductible, Copay, or Coinsurance will accumulate toward the Member's Network Out-of-Pocket Limit. The Member is not responsible for any charges that may be made in excess of the allowed amount for such Emergency Services or air ambulance services. If the Out-of-Network Provider bills you for an amount higher than the amount you owe as indicated on the Explanation of Benefits (EOB) for such Emergency Services or air ambulance services, contact Quantum Health at the phone number on your ID Card.

Surprise Billing Claims – Out-of-Network Consent

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

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

If an Out-of-Network Provider obtains a Member's Out-of-Network Consent, the cost-sharing principles described under *Out-of-Network Services,* in *Chapter 17*, will apply.

Continuity of Care

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

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

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

Special Election for Employees and Spouses Age 65 and over

If an Eligible Individual remains actively employed after reaching age 65 and is eligible to participate in the Plan, the Eligible Individual and/or eligible Spouse may choose to remain covered under the Plan without reduction for Medicare

Benefits. An Eligible Individual and/or Spouse may also choose to end coverage under the Plan and enroll only in Medicare; however, neither the Eligible Individual nor the Spouse may be enrolled in a Group Medicare Advantage plan or Medicare Supplement plan sponsored by the Medical Trust. If coverage remains under the Plan, the Plan will be the primary payer of Benefits, and Medicare will be the secondary payer (unless the Eligible Individual and/or Spouse qualifies for a MSP-SEE Plan).

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

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

Alternative Payee Provision

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

Any payment made by the Plan in accordance with this provision will fully release the Plan and the Claims Administrator of their liability to the Member.

Unclaimed Property

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

Reliance on Documents and Information

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

No Waiver

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

Jurisdiction and Venue

By participating in the Plan or by seeking or receiving any benefit under the Plan, each Member consents, subject to the Member's agreement to arbitrate set forth in the "Arbitration" section below, to the venue and exclusive jurisdiction of the courts located in New York City in the State of New York.

No Guarantee of Tax Consequences

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

Physician/Patient Relationship

This Plan is not intended to disturb the Physician/patient relationship. Physicians and other Providers are not agents or delegates of the employer, the Medical Trust, the ECCEBT, Quantum Health, the Claims Administrator or Express Scripts. Any Provider, including any employee or other individual associated with such Provider, who provides medical

services to a Member does so as an independent contractor and shall be solely responsible for any medical advice and medical services provided or not provided to the Member. Nothing contained in the Plan will require a Member to commence or continue medical treatment by a particular Provider. Furthermore, nothing in the Plan will limit or otherwise restrict a Physician's judgment with respect to the Physician's ultimate responsibility for patient care in the provision of medical services to the Member.

The Plan Is Not a Contract of Employment

Nothing contained in the Plan will be construed as a contract or condition of employment between the employer and any employee. All employees are subject to discharge to the same extent as if the Plan had never been adopted.

Plan Administration

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's determinations are final and binding. To the extent that the Medical Trust delegates administrative authority under the Plan(s) to another party, such as a Claims Administrator or Quantum Health, that party shall act with the same discretion and authority as the Medical Trust.

Recovery of Overpayments

If any Benefit payment is made erroneously, in duplication, or in excess of the amount appropriately payable under the Plan, the Member or the third-party recipient of payment with respect to such Member (for example, a Provider), as applicable, shall be deemed to be a constructive trustee of such excess amount and shall be responsible for repaying such amount in such manner as prescribed by the Plan (or by the Claims Administrator or another service provider on behalf of the Plan). Failure to hold such funds in trust and to repay them will be deemed a breach of such person's fiduciary duty to the Plan.

Use of Rebates

From time to time, the Plan may receive rebates in connection with payment for Covered Health Services. The Plan uses such rebates to defray Plan expenses, including payment for Covered Health Services and fees payable to Plan vendors.

Plan Information and Rights

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

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

This Plan Document Handbook, together with portions of the Summaries of Benefits and Coverage expressly referenced herein, constitutes the entire Plan document and supersedes any and all prior agreements or understandings, whether written, oral, electronic or in any other medium, with respect to the terms of the Plan.

The Plan and this Plan Document Handbook are governed by, and the rights and obligations of the Medical Trust, the ECCEBT, Quantum Health, the Claims Administrator, Express Scripts, 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, CPGSC, and the ECCEBT (collectively, "CPG"), retain the right to amend, terminate, or modify the terms of the Plan, as well as any post-retirement health subsidy, at any time, for any reason, and unless required by applicable law, without notice.

The Plan is a church plan within the meaning of Section 3(33) of ERISA and Section 414(e) of the Code and is exempt from ERISA. Not all Plans are available in all areas of the United States, and not all Plans are available on both a self-funded and fully insured basis. Additionally, the Plan may be exempt from federal and state laws that may otherwise apply to health insurance arrangements. The Plan does not cover all healthcare expenses, and Members should read

this document carefully to determine which Benefits are covered, as well as any applicable exclusions, limitations, and procedures.

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. 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.

Unauthorized Use of Identification Card

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

Arbitration

Subject to exhaustion of the procedures set forth in *Chapter 8: Claims and Appeals*, a Member who believes that they are entitled to Benefits under the Plan may pursue such claim only and exclusively by submitting the matter to arbitration. Any such arbitration must be commenced no later than one (1) year after the date the procedures set forth in *Chapter 8: Claims and Appeals* are exhausted.

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

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

Waiver of Class, Collective, and Representative Actions

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

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

In any arbitration, the Member may not seek or receive any remedy that has the purpose or effect of providing additional benefits or monetary relief to any other Member or beneficiary. Notwithstanding anything to the contrary in this Plan, if,

for any reason, a court of competent jurisdiction were to find this restriction on the scope of remedies unenforceable or invalid as to a particular controversy, claim, or dispute, then the requirement to arbitrate shall no longer apply to such controversy, claim, or dispute, and that controversy, claim, or dispute shall be filed, litigated, and adjudicated in a court of competent jurisdiction and not in arbitration.

Chapter 12: Subrogation and Right of Recovery

Definitions

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

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

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

Subrogation

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

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

Reimbursement

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

Constructive Trust

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

Lien Rights

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

First-Priority Claim

By accepting Benefits from the Plan (whether the payment of such Benefits is made to the covered person or made on behalf of the covered person to any Provider), the covered person acknowledges that this Plan's recovery rights are a first-priority claim against all responsible parties and are to be paid to the Plan before any other claim for the covered person's damages. Further, this first-priority right to payment is superior to any and all claims, debts, or liens asserted by any medical providers, including, but not limited to, hospitals or emergency treatment facilities, that assert a right to payment from funds payable from or recovered from an allegedly responsible third party and/or insurance carrier. Such

superiority shall be notwithstanding anything to the contrary in any agreement between the covered person and such medical provider, whenever such agreement may be entered into, unless the Plan has provided an express written waiver of this provision.

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

Applicability to All Settlements and Judgments

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

Cooperation

The covered person shall fully cooperate with the Plan's efforts to recover its Benefits paid. It is the duty of the covered person to notify the Plan within 30 days of the date when any notice is given to any party, including an insurance company or attorney, of the covered person's intention to pursue or investigate a claim to recover damages or obtain compensation due to Injury, illness, or condition sustained by the covered person and as soon as reasonably practicable, but in any event within five (5) days, after learning of any settlement offer, judgment award, or decision regarding such compensation. The covered person and their agents shall provide all information requested by the Plan, the Claims Administrator, or their respective representatives, including, but not limited to, completing, signing, and submitting any applications or other forms or statements as the Plan, the Claims Administrator, or their respective representatives may reasonably request and providing all documents related to or filed in personal injury litigation. Failure to provide this information may result in the institution of court proceedings against the covered person. The covered person shall make any court appearances reasonably requested by the Plan.

The covered person will provide the Plan, the Claims Administrator, or their respective representatives notice of any recovery the covered person or their agent obtains prior to their receipt of such recovery or, if the covered person or their agent did not learn of the recovery prior to such receipt, within five (5) days after the recovery. The covered person will refrain from any disbursement of settlement proceeds or any other recovery prior to fully satisfying the Plan's subrogation and reimbursement interest.

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

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

Failure to Reimburse or Cooperate

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

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

The covered person's failure to cooperate with the Plan or the Claims Administrator or otherwise to comply with the terms of this Subrogation and Right of Recovery chapter is considered a breach of contract. As such, the Plan has the right to suspend or terminate benefits to the covered person, the covered person's dependents, the enrolled Eligible Individual, or dependents of the enrolled Eligible Individual; deny future benefits; take legal action against the covered person; and/or set off from any future benefits the value of benefits the Plan has paid relating to any sickness, injury, or other medical condition caused or alleged to have been caused by any third party to the extent not recovered by the Plan due to the covered person or the covered person's representative not cooperating with the Plan, the Claims

Administrator, or their respective agents, or otherwise failing to abide by the terms of the Plan, including this Subrogation and Right of Recovery chapter. If the Plan incurs attorneys' fees and costs to collect third-party settlement funds held by the covered person or the covered person's representative, the Plan has the right to recover those fees and costs from the covered person. The covered person will also be required to pay interest on any amounts the covered person holds which should have been returned to the Plan, at the prime rate from time to time published by *The Wall Street Journal*.

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

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

Benefits paid by the Plan may also be benefits advanced.

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

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

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

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

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

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

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

The provisions of this Subrogation and Right of Recovery chapter apply to the parent(s), guardian(s), or other representative(s) of a dependent child who incurs a sickness, injury, or other medical condition caused by any third

party. If a parent or guardian may bring a claim for damages arising out of a minor's sickness, injury, or other medical condition, the terms of this Subrogation and Right of Recovery chapter shall apply to that claim.

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

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

Surrogacy Arrangements

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

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

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

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

Interpretation

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

Jurisdiction

By accepting Benefits from the Plan (whether the payment of such Benefits is made to the covered person or to any Provider on behalf of the covered person), the covered person agrees that any court proceeding with respect to this *Chapter 12: Subrogation and Right of Recovery* may be brought in any court of competent jurisdiction as the Plan may elect. By accepting such Benefits, the covered person hereby submits to each such jurisdiction, waiving whatever rights may correspond to them by reason of present or future domicile.

Chapter 13: Privacy

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”).

This Joint Notice of Privacy Practices (the ‘’Notice’’) is required by HIPAA to inform you of your rights regarding the use and disclosure of your PHI. In particular, this Notice describes how the Plans, and employees of the Medical Trust that are responsible for internal administration of the Plans, may use and disclose your Protected Health Information (“PHI”). It further describes how you can access and control this information.

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. PHI does not include employment records held by your employer in its role as an employer.

What This Notice Applies To

This Notice applies only to health benefits offered under the Plans. The health benefits offered under the Plans include, but may not be limited to, medical benefits, prescription drug benefits, dental benefits, the health care flexible spending account, and any health care or medical services offered under the Employee Assistance Program benefit. This Notice does not apply to benefits offered under the Plans that are not health benefits.

Some of the Plans provide benefits through the purchase of insurance. If you are enrolled in an insured Plan, you will also receive a separate notice from that Plan, which applies to your rights under that Plan.

Duties and Obligations of the Plans

The privacy of your PHI is protected by HIPAA. The Plans are required by law to:
- Maintain the privacy of your PHI
- Provide you with a notice of the Plans’ legal duties and privacy practices with respect to your PHI
- Abide by the terms of the Notice currently in effect

When the Plans May Use and Disclose Your PHI

The following categories describe the ways the Plans are required to use and disclose your PHI without obtaining your written authorization:
- **Disclosures to You.** The Plans will disclose your PHI to you or your personal representative within the legally specified period following a request.
- **Government Audit.** The Plans will make your PHI available to the U.S. Department of Health and Human Services when it requests information relating to the privacy of PHI.
- **As Required By Law.** The Plans will disclose your PHI when required to do so by federal, state, or local law. For example, the Plans may disclose your PHI when required by national security laws or public health disclosure laws.

The following categories describe the ways that the Plans may use and disclose your PHI without obtaining your written authorization:
- **Treatment.** The Plans may disclose your PHI to your providers for treatment, including the provision of care or the management of that care. For example, the Plans might disclose PHI to assist in diagnosing a medical condition, for pre-certification activities, or to a specialist involved in your treatment.
- **Payment.** The Plans may use and disclose your PHI to pay benefits. For example, the Plans might use or disclose PHI when processing payments, sending explanations of benefits (“EOBs”) to you, reviewing the medical necessity of services rendered, conducting claims appeals and coordinating the payment of benefits between multiple medical plans.
- **Health Care Operations.** The Plans may use and disclose your PHI for Plan operational purposes. For example, the Plans may use or disclose PHI for quality assessment and claim audits.

- **Public Health Risks.** The Plans may disclose your PHI for certain required public health activities (such as reporting disease outbreaks) or to prevent serious harm to you or other potential victims where abuse, neglect or domestic violence is involved.
- **National Security and Intelligence Activities.** The Plans may disclose your PHI for specialized government functions (such as national security and intelligence activities).
- **Health Oversight Activities.** The Plans may disclose your PHI to health oversight agencies for activities authorized by law (such as audits, inspections, investigations and licensure).
- **Lawsuits and Disputes.** The Plans may disclose your PHI in the course of any judicial or administrative proceeding in response to a court's or administrative tribunal's order, subpoena, discovery request or other lawful process.
- **Law Enforcement.** The Plans may disclose your PHI for a law enforcement purpose to a law enforcement official, if certain legal conditions are met (such as providing limited information to locate a missing person).
- **Research.** The Plans may disclose your PHI for research studies that meet all privacy law requirements (such as research related to the prevention of disease or disability).
- **To Avert a Serious Threat to Health or Safety.** The Plans may disclose your PHI to avert a serious threat to the health or safety of you or any other person.
- **Workers' Compensation.** The Plans may disclose your PHI to the extent necessary to comply with laws and regulations related to workers' compensation or similar programs.
- **Coroners, Medical Examiners and Funeral Directors.** The Plans may disclose your PHI to coroners, medical examiners or funeral directors for purposes of identifying a decedent, determining a cause of death or carrying out their respective duties with respect to a decedent.
- **Organ and Tissue Donation.** If you are an organ donor, the Plans may release your PHI to organizations that handle organ procurement or organ, eye or tissue transplantation or to an organ donation bank, as necessary to facilitate organ or tissue donation and transplantation.
- **Military and Veterans.** If you are a member of the armed forces, the Plans may release your PHI as required by military command authorities.
- **Inmates.** If you are an inmate of a correctional institution or under the custody of a law enforcement official, the Plans may release your PHI to the correctional institution or law enforcement official. This release would be necessary (1) for the institution to provide you with health care; (2) to protect your health and safety or the health and safety of others; or (3) for the safety and security of the correctional institution.
- **Business Associates.** The Plans may contract with other businesses for certain plan administrative services. The Plans may release your PHI to one or more of their business associates for plan administration if the business associate agrees in writing to protect the privacy of your information.
- **Plan Sponsor.** 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.

These uses and disclosures may be effectuated in an electronic format.

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

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

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

Authorizing Release of Your PHI

To authorize release of your PHI, you must complete a medical information authorization form. An authorization form is available at *www.cpg.org* or by calling (800) 480-9967. You have the right to limit the type of information that you authorize the Plans to disclose and the persons to whom it should be disclosed. You may revoke your written authorization at any time, provided that no action has already been taken based on the authorization.

Interaction with State Privacy Laws

If the state in which you reside provides more stringent privacy protections than HIPAA, and if such state laws apply to your participation in the Plans, 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 at the contact information provided at the end of this Notice.

Fundraising

The Plans may contact you to support their fundraising activities. We will not disclose your PHI to third parties (other than business associates) for fundraising activities without your explicit written authorization. You have the right to opt out of receiving such communications. If you wish to opt out of fundraising communications, you may contact the Church Pension Group Privacy Officer or follow the instructions provided in the communication.

Underwriting

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

Reproductive Health Care Privacy

The Plans will not, unless compelled by law, use or disclose your PHI when it is sought to:

- Conduct a criminal, civil, or administrative investigation into or impose criminal, civil, or administrative liability on any person for the mere act of seeking, obtaining, providing, or facilitating reproductive health care, where such health care is lawful under the circumstances in which it is provided; or
- Identify any person for the purpose of conducting such investigation or imposing such liability.

In the event that the Plans receive a request for information potentially related to reproductive health care, it is the Plans' policy to seek a signed attestation form from the requester that the use or disclosure is not for any prohibited purpose specified above.

For the purposes of this Notice, reproductive health care means health care that affects your health in all matters relating to the reproductive systems and to its functions and processes. This includes, but is not limited to, health care related to: contraception, including emergency contraception, preconception screening and counselling, management of a pregnancy and pregnancy related conditions, including pregnancy screening, prenatal care, miscarriage management of preeclampsia, hypertension during pregnancy, gestational diabetes, mola pregnancy, ectopic pregnancy, and/or pregnancy termination, fertility and infertility diagnoses and treatment, including assisted reproductive technology like IVF, conditions that affect the reproductive system such as perimenopause, menopause, endometriosis, adenomyosis and other types of care, services and supplies used for the diagnosis and treatment of conditions related to your reproductive health system such as mammography.

Your Rights With Respect to Your PHI

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

1. **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. You may also have the right to request that Providers and other Covered Entities restrict disclosure of your PHI to the Plans if you have paid in full for the services from which such PHI was derived.

2. **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.

3. **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 legal proceedings or for use in such 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. You have the right to receive a copy of your PHI in an electronic format if it is maintained electronically. Additionally, if you request, we can transmit this electronic copy directly to another person or entity you designate.

4. **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.

5. **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. 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 Administration 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.

6. **Breach Notification.** You have the right to receive a notification from the Plans if there is a breach of your unsecured PHI. In the event of a breach of your unsecured PHI, we will notify you without unreasonable delay, but no later than 60 calendar days after discovering the breach. The notification will include a description of the breach, the types of information involved, steps you can take to protect yourself, and what we are doing to address the breach.

7. **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*.

Under the GDPR, you may have additional or overlapping rights. These include the right to:

- Access and export your PHI;
- Request deletion or updates to PHI;
- Object to or restrict PHI usage;
- Be informed about any automated decision-making of PHI, including the significance and consequences of such processing for you;
- Object at any time to the Plans' use of PHI for direct marketing purposes
  File a complaint to an EU Data Protection Authority if you believe the Plans have not complied with applicable laws; and
- Withdraw your consent at any time, if the Plans obtained your consent to use your PHI.

Data Retention
We only retain PHI collected for a limited time period as long as we need it to fulfill the purposes for which it was initially collected, 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. To file a complaint with us, contact the Privacy Officer using the contact information provided below. To file a complaint with HHS, visit their website at www.hhs.gov/hipaa/filing-a-complaint or call 800-368-1019. 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 for Civil Rights
200 Independence Avenue, SW
Washington, DC 20201
(202) 619-0257 | (877) 696-6775 (toll-free)
www.hhs.gov/about/contact-us/index.html

Effective Date

This Notice is effective as of May 29, 2025.

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 previously acquired PHI that it currently maintains as well as PHI it receives or maintains in the future, as permitted by applicable law. Any material amendment to the terms of this Notice and these information practices will be communicated to you via postal mail or otherwise electronically with your prior written consent.

Chapter 14: Glossary

Accidental Injury

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

Ambulance Services

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

Annual Enrollment

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

Appeals Reviewer

See *Chapter 8* for the definition of this term.

Benefits

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

Benefit Maximum(s)

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

Billed Group

A Participating Group or one of its congregations, schools, or other bodies that is billed by the Plan and responsible for paying monthly contributions. Also sometimes called a "List Bill," "Account Number," or, in My Admin Portal (MAP), a "Billing Account."

Biologic

This term is used only for Plans using the Cigna network. In the Plan Document Handbook for Plans using the Cigna network, see *Chapter 14A* for the definition of this term.

Blue Distinction Center for Transplants

This term is used only for Plans using the Anthem BCBS network. In the Plan Document Handbook for Plans using the Anthem BCBS network, see *Chapter 14A* for the definition of this term.

Cafeteria Plan[17]

A Cafeteria Plan, also known as a Section 125 plan, is a separate written plan, maintained by an employer, that offers employees a choice between receiving their compensation in cash or as part of an employee benefit. If taken as a benefit, the employee generally receives two tax advantages: (1) employee contributions toward Cafeteria-Plan benefits are made on a pre-tax basis, and (2) employer contributions toward an employee's Cafeteria-Plan benefits are not taxed. An employee's elections under a Cafeteria Plan are generally irrevocable until the beginning of the next plan

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

year, although a Cafeteria Plan may permit an employee to revoke an election and make a new one mid-year after a Significant Life Event occurs.

Charges

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

Claims Administrator

The company that the Plan Sponsor chose to administer the health Benefits provided through this Plan. The Claims Administrator is either (1) IEC Group, Inc. *d/b/a* AmeriBen for Plans using the Anthem BCBS network or (2) Allegiance Benefit Plan Management, Inc., for Plans using the Cigna network, as applicable. The Claims Administrator provides administrative services only and does not assume any financial risk or obligation with respect to claims.

Coinsurance

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

Congenital Anomaly

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

Coordination of Benefits

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

Copayment

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

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

Cosmetic Services

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

Coverage Tier

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

Covered Health Service(s)

Medically Necessary healthcare services and supplies that are:
- described as covered in *Chapter 3: Coverage* (or in *Chapter 6: Pharmacy Benefits (Administered by Express Scripts)*)
- not excluded as described in *Chapter 4: Exclusions and Limitations* (or in *Chapter 6: Pharmacy Benefits (Administered by Express Scripts)*, and
- provided in accordance with the Plan.

In order to be Covered Health Services, such services or supplies must be provided:
- when the Plan is in effect,
- prior to the effective date of any of the individual termination conditions set forth in this Plan Document Handbook; and
- only when the person who receives services is a covered person and meets all eligibility requirements specified in the Plan.

Covered Transplant Procedure

This term is used only for Plans using the Anthem BCBS network. In the Plan Document Handbook for Plans using the Anthem BCBS network, see *Chapter 14A* for the definition of this term.

Custodial Care Services

Anthem BCBS and Cigna define this term differently. For more information, see *Chapter 14A*, which contains the definition of the term used for purposes of the applicable network.

Deductible(s)

Deductibles are amounts to be paid by you or your enrolled Dependents before Benefits are payable under this Plan (except for most Preventive Care and most services requiring a Copayment). Deductibles are in addition to any Coinsurance. Once the Deductible maximum in the Summary of Benefits and Coverage has been reached, you and your family need not satisfy any further Deductible for the rest of that Plan Year. Amounts paid under copayment assistance programs, manufacturer drug coupon programs, or other similar programs do not count towards any Deductibles. You should note that (1) Network and Out-of-Network Deductibles accumulate separately, but (2) medical and pharmacy Deductibles cross-accumulate.

Dependent

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

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

Domestic Partners
Two adults who have chosen to share one another's lives in a mutually exclusive partnership that resembles marriage. The Plan requires completion of the Domestic Partnership Affidavit to confirm that the requirements of the Plan are met. See the Appendix of the *Administrative Policy Manual* 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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[18] A legal ward is a minor placed under the care of a guardian by an authority of law.
[19] A foster child is an individual who is placed with the Eligible Individual by an authorized placement agency or by judgment, decree, or other order of any court of competent jurisdiction.

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

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

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

Detoxification

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

Developmental Delay

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

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 Child's death. The Medical Trust (or its delegate) may, in its sole discretion, require periodic certification of an individual's continuing disability.

Durable Medical Equipment

Anthem BCBS and Cigna define this term differently. For more information, see *Chapter 14A*, which contains the definition of the term used for purposes of the applicable network.

Eligibility-Based Claims Appeal

See *Chapter 8* for the definition of this term.

Eligible Dependent

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

Eligible Individual

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

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 & Medicaid Services (CMS) to qualify as a small employer under the Medicare Secondary Payer Rules.

Emergency Medical Condition

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

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

Employee

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

Seasonal Employee
An Employee who normally performs work during certain seasons or periods of the year and 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.

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

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

Essential Health Benefits

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

Experimental/Investigative/Unproven

Anthem BCBS and Cigna define this term differently. For more information, see *Chapter 14A*, which contains the definition of the term used for purposes of the applicable network.

Facility

A Facility, including but not limited to, a Hospital, Freestanding Ambulatory Facility, chemical dependency treatment Facility, Skilled Nursing Facility, Home Health Care Agency, or mental health Facility, as defined in this Plan Document Handbook.

The Facility must be licensed, accredited, registered, or approved by The Joint Commission or the Commission on Accreditation of Rehabilitation Facilities (CARF), as applicable, or meet specific rules set by Anthem or Cigna, as applicable.

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 MSP-SEE Plan as an Employee:

(a) who at the time of separation from active employment was either participating in the EHP or eligible to participate in the EHP as an Employee who was normally scheduled to work and was compensated for 1,000 or more hours per year, and

(b) at the time of separation from employment with The Episcopal Church, was at least 55 years of age, or, if younger, was eligible for a disability retirement benefit under a pension plan sponsored by The Church Pension Fund or its affiliates prior to December 31, 2017, and

(c) if a Lay Employee, has a minimum of five years of service with The Episcopal Church OR, if a cleric, has earned a minimum of five years of Credited Service under The Church Pension Fund Clergy Pension Plan.

Post-65 Former Employee

Clergy:

A former Employee who:

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

Lay:

A former Employee who:

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

Member of Religious Order who:

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

Freestanding Ambulatory Facility

An institution at which surgical procedures are performed on an Outpatient basis (no patients stay overnight) that meets all of the following requirements:

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

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

Group Administrator

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

Health Insurance Portability and Accountability Act of 1996 (HIPAA)

The Health Insurance Portability and Accountability Act of 1996, as amended, and the regulations issued thereunder. HIPAA is a federal law that, among other things, provides rights and protections for participants and beneficiaries in group health plans by regulating the portability and continuity of group health coverage. HIPAA limits exclusions based on preexisting conditions, prohibits discrimination based on health status factors, and gives individuals a special opportunity to enroll in a group health plan in certain circumstances. The Administrative Simplification Provisions of HIPAA address the privacy and security of certain health information.

HIPAA Special Enrollment Event

A certain subset of Significant Life Events, as described in *Chapter 2: Eligibility and Enrollment*, as a result of which, an Eligible Individual is eligible to enroll themselves and their Eligible Dependents for coverage under the Plan outside of the Annual Enrollment period. The employer of the Eligible Individual is responsible for providing a Summary of Benefits and Coverage (SBC) for each applicable Plan within 90 days of any resulting enrollment.

Home Health Care

Care, by a licensed program or Provider, for the treatment of a patient in the patient's home, consisting of required intermittent skilled care, which may include observation, evaluation, teaching, and nursing services consistent with the diagnosis, established and approved in writing by the patient's attending Physician.

Home Health Care Agency

A Provider that renders care through a program for the treatment of a patient in the patient's home, consisting of required intermittent skilled care, which may include observation, evaluation, teaching, and nursing services consistent with the diagnosis, established and approved in writing by the patient's attending Physician. It must be licensed and accredited by the appropriate agency.

Hospice Care Program

The term "Hospice Care Program" means:
- A coordinated, interdisciplinary program designed to meet the special physical, psychological, spiritual, and social needs of the Terminally Ill Member and their families
- A program that provides palliative and supportive medical, nursing, and other health services through home or Inpatient care during the illness
- A program for persons who have a Terminal Illness and for the families of those persons

Hospice Care Services

Any services provided by a Hospital, a Skilled Nursing Facility or a similar institution, a Home Health Care Agency, a Hospice Facility, or any other licensed Facility or agency under a Hospice Care Program.

Hospice Facility

An institution or part of it which:
- Primarily provides care for Terminally Ill patients
- Is accredited by the National Hospice Organization
- Fulfills any licensing requirements of the state or locality in which it operates
- Meets such additional requirements as may be imposed by the Claims Administrator and Anthem or Cigna, as applicable

Hospital

Anthem BCBS and Cigna define this term differently. For more information, see *Chapter 14A*, which contains the definition of the term used for purposes of the applicable network.

Hospital Confinement or Confined in a Hospital

A person will be considered Confined in a Hospital if they are:
- A registered bed patient in a Hospital upon the recommendation of a Physician
- Receiving Mental Health and Substance Use Disorder Treatment in a mental health or substance use disorder Residential Treatment Center

ID Card

The latest card given to you showing your identification and group numbers, the type of coverage you have, and the date coverage became effective. Also known as an "Identification Card."

Ineligible Provider

A Provider that does not meet the minimum requirements to become a contracted Provider with the applicable network. Services rendered to a Member by such a Provider are not eligible for payment.

Injury

Bodily harm from an accident.

Inpatient

A Member who is treated as a registered bed patient in a Hospital and for whom a room and board charge is made.

Intensive Care Unit

A special unit of a Hospital that (1) treats patients with serious illnesses or Injuries, (2) can provide special life-saving methods and equipment, (3) admits patients without regard to prognosis, and (4) provides constant observation of patients by a specially trained nursing staff.

Intensive Outpatient Programs

Anthem BCBS and Cigna define this term differently. For more information, see *Chapter 14A*, which contains the definition of the term used for purposes of the applicable network.

Maternity Care

Obstetrical care received both before and after the delivery of a Child or Children. It also includes care for miscarriage or abortion. It includes regular nursery care for a newborn infant as long as the mother's Hospital stay is a covered benefit and the newborn infant is an eligible Member under the Plan.

Maximum Allowed Amount / Maximum Reimbursable Charge

Anthem BCBS uses the term "Maximum Allowed Amount," and Cigna uses the term "Maximum Reimbursable Charge." These terms represent similar concepts but are defined differently. For more information, see *Chapter 14A*, which contains the definition of the term used for purposes of the applicable network.

Medicaid

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

Medical Board

The Medical Board of The Church Pension Fund, as may be appointed by the Chief Executive Officer and President of The Church Pension Fund or their delegate from time to time. Currently, the Medical Board is American Family Life Assurance Company of New York (Aflac).

Medical Pharmaceutical

This term is used only for Plans using the Cigna network. In the Plan Document Handbook for Plans using the Cigna network, see *Chapter 14A* for the definition of this term.

Medically Necessary / Medical Necessity

Anthem BCBS and Cigna define these terms differently. For more information, see *Chapter 14A*, which contains the definition of the term used for purposes of the applicable network.

Medicare

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

Medicare Secondary Payer (MSP)

The term used when Medicare pays secondary to an active plan covering a Medicare beneficiary.

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

An exception to the MSP rules that applies to an Eligible Small Employer. For Eligible Small Employers who enroll Members in the MSP-SEE Plan, Medicare becomes the primary payer and the Medical Trust will become the secondary payer for claims by Members enrolled in the MSP-SEE Plan.

Member

An enrolled Eligible Individual or enrolled Eligible Dependent. As used throughout this Plan Document Handbook, "you" and "your" refer to a Member, unless otherwise clearly required by context (for example, if context indicates that "you" are not enrolled in the Plan).

Member of a Religious Order

A postulant, novice, or professed member of Episcopal Religious Orders, as defined in Title III, Canon 14.1[20] (a "Religious Order") and included on the official list of recognized Religious Orders maintained by the House of Bishops' Standing Committee on Religious Communities, who has been accepted or received by the Religious Order.

Mental Health and Substance Use Disorder Treatment

Covered Health Services for the diagnosis and treatment of mental illnesses or substance use disorders. The fact that a condition is listed in the current Diagnostic and Statistical Manual of the American Psychiatric Association does not mean that treatment for the condition is a Covered Health Service.

My Admin Portal (MAP)

My Admin Portal (MAP) is CPG's online application used by benefits administrators throughout The Episcopal Church to manage the reporting of employment relationships and enrollment in retirement plans and other benefits.

MyCPG Accounts

MyCPG Accounts is a web-based tool designed to allow Members to quickly, conveniently, and safely view benefits information, update contact information, report Significant Life Events, and complete benefits enrollment.

Network Benefits

Anthem BCBS and Cigna define this term differently. For more information, see *Chapter 14A*, which contains the definition of the term used for purposes of the applicable network.

Network Provider

A Physician, health professional, Hospital, pharmacy, or other individual, organization, and/or Facility that has entered into a contract, either directly or indirectly, with the applicable network to provide, or arrange for the provision of, Covered Health Services to Members through negotiated reimbursement arrangements. A Network Provider for one plan may not be a Network Provider for another. The name of the network is on your ID Card. A Hospital that is a Network Provider may also be referred to as a "Network Hospital," a Facility that is a Network Provider may also be referred to as a "Network Facility," and a Physician that is a Network Provider may also be referred to as a "Network Physician."

Network Transplant Provider

This term is used only for Plans using the Anthem BCBS network. In the Plan Document Handbook for Plans using the Anthem BCBS network, see *Chapter 14A* for the definition of this term.

Non-Claims Appeal

See *Chapter 8* for the definition of this term.

Non-Covered Health Services

Services that are not Benefits specifically provided under the Plan, are excluded by the Plan, are provided by an Ineligible Provider, or are otherwise not eligible to be Covered Health Services, whether or not they are Medically Necessary.

Other Healthcare Facility

This term is used only for Plans using the Cigna network. In the Plan Document Handbook for Plans using the Cigna network, see *Chapter 14A* for the definition of this term.

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

Other Healthcare Professional

This term is used only for Plans using the Cigna network. In the Plan Document Handbook for Plans using the Cigna network, see *Chapter 14A* for the definition of this term.

Out-of-Network Benefits

Benefits for Covered Health Services that are provided by or directed by an Out-of-Network Physician either at a Network Facility or at an Out-of-Network Facility.

Out-of-Network Provider

A Provider, including but not limited to, a Hospital, Freestanding Ambulatory Facility, Physician, Skilled Nursing Facility, Hospice Facility, Home Health Care Agency, other medical practitioner or Provider of medical services or supplies, that does not have an agreement or contract with the applicable network to provide services to its Members at the time services are rendered. A Hospital that is an Out-of-Network Provider may also be referred to as an "Out-of-Network Hospital," a Facility that is an Out-of-Network Provider may also be referred to as an "Out-of-Network Facility," and a Physician that is an Out-of-Network Provider may also be referred to as an "Out-of-Network Physician."

Out-of-Pocket Limit

The maximum amount of a Member's cost-share payments during a Plan Year. When the Out-of-Pocket Limit is reached, the level of Benefits is increased to 100% of the Maximum Allowed Amount / Maximum Reimbursable Charge for Covered Health Services.

The following costs will never apply to the Out-of-Pocket Limit:
- Any charges for services or supplies that are not Covered Health Services
- The amount of any reduced Benefits if you don't obtain Prior Authorization for services when required
- Charges that exceed the Maximum Allowed Amount / Maximum Reimbursable Charge
- Penalties
- Copayments for certain specialty pharmaceutical drugs listed at *express-scripts.com*
- Amounts paid under copayment assistance programs, manufacturer drug coupon programs, or other similar programs

The annual individual and family Out-of-Pocket Limit amounts are shown on the Summaries of Benefits and Coverage. You should note that (1) network and out-of-network costs accumulate towards separate Out-of-Pocket Limits, but (2) medical and pharmacy costs cross-accumulate towards the individual and/or family Out-of-Pocket Limit, as applicable.

Outpatient

Outpatient care, sometimes called ambulatory care, is defined as medical care or treatment that does not require an overnight stay in a hospital or medical facility. Outpatient care may be administered in a medical office or a hospital, but, most commonly, it is provided in a medical office or Outpatient surgery center.

Partial Hospitalization Program

This term is used only for Plans using the Anthem BCBS network. In the Plan Document Handbook for Plans using the Anthem BCBS network, see *Chapter 14A* for the definition of this term.

Participating Group

A diocese, congregation, agency, school, organization, or other body subject to the authority of and/or affiliated with The Episcopal Church, which has elected to participate in the Plan. Also known as a "Benefits Group" in My Admin Portal (MAP).

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."

Physical Therapy

The care of disease or Injury by such methods as massage, hydrotherapy, heat, or similar care.

Physician

A licensed medical practitioner who is practicing within the scope of their license and who is licensed to prescribe and administer drugs or to perform surgery. This term also includes any other licensed medical practitioner whose services are required to be covered by law in the locality where the policy is issued if they are:
- Operating within the scope of their license, and
- Performing a service for which Benefits are provided under this Plan when performed by a Physician.

Plan(s)

The medical and dental plans (i.e., health plans) maintained by the Medical Trust for the benefit of Members. The Plan is intended to qualify as a "church plan" as defined by Section 414(e) of the Code and is exempt from the requirements of ERISA.

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

Medicare Secondary Payer Small Employer Exception (MSP-SEE) Plan
A program of medical plans through which Members are provided health benefits. Benefits are provided through the Medical Trust.

This plan is applicable only to those small employers and individuals enrolled in Medicare who apply and are certified by the Centers for Medicare & Medicaid Services (CMS) as meeting the criteria to participate as a result of meeting the small employer definition and the benefits coordinating with Medicare.

Plan Sponsor

The legal entity that has adopted the Plan and has authority regarding its operation, amendment, and termination. ***The Plan Sponsor is not Quantum Health or the Claims Administrator. The Plan Sponsor is the Medical Trust.***

Plan Year

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

Prior Authorization

The approval that a Provider must receive from Quantum Health, prior to services being rendered, in order for certain services and Benefits to be covered under the Plan.

Preventive Care

Routine healthcare, including screenings, check-ups, and patient counseling, to prevent or discover illness, disease, or other health problems.

Primary Care Physician (PCP)

Anthem BCBS and Cigna define this term differently. For more information, see *Chapter 14A*, which contains the definition of the term used for purposes of the applicable network.

Provider

A duly licensed professional or Facility that provides services within the scope of an applicable license, is approved by the applicable network (for Network Providers), and meets such additional requirements as may be imposed by the Claims Administrator and Anthem or Cigna, as applicable. This includes any Provider rendering services that are required by applicable state law to be covered when rendered by such Provider. Providers that delivery Covered Health Services are described throughout this Plan Document Handbook. If you have a question about whether a Provider is covered, please call the number on the back of your ID Card.

Quantum Health

Quantum Health, Inc., which the Plan Sponsor has contracted with to perform care coordination, Prior Authorization and care management services for the Plans, as described in more detail in *Chapter 5*.

Residential Treatment Center

A Provider licensed and operated as required by law, which includes:
- Room, board, and skilled nursing care (either an RN or LVN/LPN) available on site at least eight hours daily with 24 hours availability
- A staff with one or more Physicians available at all times
- Residential treatment that takes place in a structured Facility-based setting
- The resources and programming to adequately diagnose, care, and treat a psychiatric and/or substance use disorder
- Facilities are designated residential, subacute, or intermediate care, and may occur in care systems that provide multiple levels of care
- Is fully accredited by The Joint Commission (TJC), the Commission on Accreditation of Rehabilitation Facilities (CARF), the National Integrated Accreditation for Healthcare Organizations (NIAHO), or the Council on Accreditation (COA)

The term Residential Treatment Center does not include a Provider, or that part of a Provider, used mainly for:
- Nursing care
- Rest care
- Convalescent care
- Care of the aged
- Custodial Care
- Educational care

Retail Health Clinic

A Facility that provides limited basic medical care services to Members on a “walk-in” basis. These clinics normally operate in major pharmacies or retail stores. Medical services are typically provided by Physicians Assistants and Nurse Practitioners. Services are limited to routine care and treatment of common illnesses for adults and Children.

Seminarian

A full-time student, as defined by the seminary, enrolled at a seminary that is or is part of a Participating Group.

Semiprivate Room

A Hospital room that contains two or more beds.

Significant Life Event

An event as described in *Chapter 2: Eligibility and Enrollment*, as a result of which, an Eligible Individual is eligible to make certain mid-year election changes.

Skilled Convalescent Care

Care required, while recovering from an illness or Injury, which is received in a Skilled Nursing Facility. This care requires a level of care or services less than that provided in a Hospital but more than could be given at the patient’s home or in a nursing home not certified as a Skilled Nursing Facility.

Skilled Nursing Facility

Anthem BCBS and Cigna define this term differently. For more information, see *Chapter 14A*, which contains the definition of the term used for purposes of the applicable network.

Specialist (Specialty Care Physician / Provider or SCP)

Anthem BCBS and Cigna define this term differently. For more information, see *Chapter 14A*, which contains the definition of the term used for purposes of the applicable network.

Specialty Prescription Drug Products

Anthem BCBS and Cigna define this term differently. For more information, see *Chapter 14A*, which contains the definition of the term used for purposes of the applicable network.

Stabilize (or Stabilization)

Stabilize means, with respect to an Emergency Medical Condition: to provide such medical treatment of the condition as may be necessary to assure, within reasonable medical probability, that no material deterioration of the condition is likely to result from or occur during the transfer of the individual from a Facility via non-emergency transport, as determined by Quantum Health.

Surprise Billing Claim

A claim in respect of charges for Out-of-Network services described under *Surprise Billing Claims* in *Chapter 11: Other Important Plan Provisions*.

Terminal Illness

A Terminal Illness will be considered to exist if a person becomes terminally ill, as diagnosed and certified by a Physician.

Urgent Care

Medical, surgical, Hospital, or related healthcare services received for a sudden, serious, or unexpected illness, Injury, or condition that requires prompt attention to avoid adverse consequences but does not pose an immediate threat to a person's life (i.e., is not an emergency), as determined by Quantum Health in accordance with generally accepted medical standards. Urgent Care is needed right away to relieve pain, find out what is wrong, or treat a health problem that is not life-threatening. Urgent Care is usually delivered in a walk-in setting and without an appointment. Services may be received at an Urgent Care center, a clinic, or a Physician's office. Urgent Care does not include care that could have been foreseen before leaving the immediate area where you ordinarily receive and/or were scheduled to receive services. Such care includes, but is not limited to, dialysis, scheduled medical treatments or therapy, or care received after a Physician's recommendation that the insured should not travel due to any medical condition.

Chapter 14A: Glossary – Additional Network-Specific Terms

Anthem BCBS

Blue Distinction Center for Transplants

A Network Transplant Provider that has been designated as a “Center of Medical Excellence” for transplants by Anthem BCBS.

Covered Transplant Procedure

Any Medically Necessary human organ and stem cell/bone marrow transplants and transfusions as determined by Quantum Health, including necessary acquisition procedures, collection and storage, and including Medically Necessary preparatory myeloablative therapy.

Custodial Care Services

Any type of care, including room and board, that (a) does not require the skills of professional or technical personnel; (b) is not furnished by or under the supervision of such personnel or does not otherwise meet the requirements of post-Hospital Skilled Nursing Facility care; (c) is a level such that the Member has reached the maximum level of physical or mental function and is not likely to make further significant improvement. Custodial Care includes, but is not limited to, any type of care the primary purpose of which is to attend to the Member’s activities of daily living which do not entail or require the continuing attention of trained medical or paramedical personnel. Examples of Custodial Care include, but are not limited to, assistance in walking; getting in and out of bed; bathing; dressing; feeding; using the toilet; changes of dressings of non-infected, post-operative, or chronic conditions; preparation of special diets; supervision of medication that can be self-administered by the Member; general maintenance care of colostomy or ileostomy; routine services to maintain other services which, in the sole determination of the Plan, can be safely and adequately self-administered or performed by the average non-medical person without the direct supervision of trained medical and paramedical personnel, regardless of who actually provides the service; residential care and adult day care; protective and supportive care including educational services; rest care; and convalescent care.

Durable Medical Equipment

Equipment which is:

- Made to withstand prolonged use;
- Made for and mainly used in the treatment of a disease or Injury;
- Suited for use while not Confined as an Inpatient at a Hospital;
- Not normally of use to persons who do not have a disease or Injury; and
- Not for exercise or training.

Experimental/Investigative/Unproven

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

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

- Cannot be legally marketed in the United States without the final approval of the Food and Drug Administration (FDA), or other licensing or regulatory agency, and such final approval has not been granted; or
- Has been determined by the FDA to be contraindicated for the specific use; or
- Is subject to review and approval of an Institutional Review Board (IRB) or other body serving a similar function; or
- Is provided pursuant to informed consent documents that describe the drug, biologic, device, diagnostic, product, equipment, procedure, treatment, service, or supply as Experimental/Investigative/Unproven, or otherwise indicate that the safety, toxicity, or efficacy of the drug, biologic, device, diagnostic, product, equipment, procedure, treatment, service, or supply is under evaluation.

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

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

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

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

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

If a drug, device, medical treatment or other procedure is reviewed and recommended under the Quantum Health Oncology Management programs, Quantum Health will be guided by the written medical guidelines and criteria used as part of Quantum Health's Oncology Management programs in determining whether a drug, device, medical treatment or other procedure will be deemed to be Experimental/Investigative/Unproven.

Hospital

An institution licensed and accredited by the appropriate agency, which is primarily engaged in providing diagnostic and therapeutic facilities on an Inpatient basis for the surgical and medical diagnosis, treatment and care of injured and sick persons by or under the supervision of a staff of Physicians duly licensed to practice medicine, and which continuously provides 24-hour-a-day nursing services by registered graduate nurses physically present and on duty. "Hospital" does not mean, other than incidentally:

- An extended care Facility, nursing home, place for rest, Facility for the care of the aged;
- A custodial or domiciliary institution which has as its primary purpose the furnishing of food, shelter, training, or non-medical personal services; or
- An institution for exceptional or disabled children.

Intensive Outpatient Programs

Structured, multidisciplinary behavioral health treatment that provides a combination of individual, group, and family therapy in a program that operates no less than three (3) hours per day, three (3) days per week. Out-of-Network Facility-based Programs must occur at Facilities that are both licensed and accredited.

Maximum Allowed Amount

For Covered Health Services you receive from a Network Provider, the Maximum Allowed Amount is determined pursuant to the agreement between such Network Provider and Anthem BCBS.

For Covered Health Services you receive from an Out-of-Network Provider other than those described under *Surprise Billing Claims* in *Chapter 10: Other Important Plan Provisions*, the Plan will only pay Benefits up to the Maximum

Allowed Amount. For this Plan, the Maximum Allowed Amount for such Covered Health Services will be one of the following as determined by the Claims Administrator (or Anthem BCBS on its behalf):

- An amount determined by the Claims Administrator (or Anthem BCBS on its behalf) based on the Out-of-Network Provider fee schedule/rate, which the Claims Administrator (or Anthem BCBS on its behalf) has established through its discretion, and which the Claims Administrator (or Anthem BCBS on its behalf) reserves the right to modify after considering one or more of the following: reimbursement amounts accepted by like/similar Providers contracted with the Claims Administrator (or Anthem BCBS), reimbursement amounts paid by the Centers for Medicare & Medicaid Services (CMS) for the same services or supplies, and other industry cost, reimbursement and utilization data
- An amount determined by the Claims Administrator (or Anthem BCBS on its behalf) based on reimbursement or cost information from CMS
- An amount determined by the Claims Administrator (or Anthem BCBS on its behalf) based on information provided by a third-party vendor, which may reflect one or more of the following factors: (1) the complexity or severity of treatment; (2) level of skill and experience required for the treatment; or (3) comparable Providers' fees and costs to deliver care
- An amount negotiated by the Claims Administrator (or Anthem BCBS on its behalf) or a third-party vendor which has been agreed to by the Provider. This may include rates for services coordinated through case management
- An amount determined by the Claims Administrator (or Anthem BCBS on its behalf) based on or derived from the total charges billed by the Out-of-Network Provider

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

Unlike Network Providers, Out-of-Network Providers who provide Covered Health Services other than those described under *Surprise Billing Claims* in *Chapter 10: Other Important Plan Provisions*, may send you a bill and collect for the amount of the Provider's charge that exceeds the Plan's Maximum Allowed Amount. You are responsible for paying the difference between the Maximum Allowed Amount and the amount the Provider charges. This amount can be significant. Choosing a Network Provider will likely result in lower out-of-pocket costs to you. Please call Quantum Health for help in finding a Network Provider, or use the information in *Chapter 17*.

For Covered Health Services you receive from an Out-of-Network Provider described under *Surprise Billing Claims* in *Chapter 10: Other Important Plan Provisions*, please refer to that section for more information about how the payments made to the Out-of-Network Providers are determined. If sufficient data is unavailable in the database for that geographic area to determine the Maximum Allowed Amount, then state, regional or national data may be used. If sufficient data is unavailable in the database for that geographic area to determine the Maximum Allowed Amount, then data in the database for similar services may be used. The database(s) used for these purposes will be selected by the Claims Administrator (or Anthem BCBS on its behalf).

Medically Necessary / Medical Necessity

Procedures, supplies, equipment, or services that Quantum Health determines are:

- Appropriate for the symptoms, diagnosis, or treatment of a medical condition; and
- Given for the diagnosis or direct care and treatment of the medical condition; and
- Within the standards of good medical practice within the organized medical community; and
- Not mainly for the convenience of the Physician or another Provider, and the most appropriate procedure, supply, equipment, or service which can be safely given.

The most appropriate procedure, supply, equipment, or service must meet the following requirements:

- There must be valid scientific evidence to show that the expected health benefits from the procedure, supply, equipment, or service are clinically significant and will have a greater chance of benefit, without a disproportionately greater risk of harm or complications, than other possible treatments; and
- Generally approved forms of treatment that are less invasive have been tried and did not work or are otherwise unsuitable; and
- For Hospital stays, acute care as an Inpatient is needed due to the kind of services the patient needs or the severity of the medical condition, and that safe and adequate care cannot be given as an Outpatient or in a less intensive medical setting.

The most appropriate procedure, supply, equipment, or service must also be cost-effective compared to other alternative interventions, including no intervention or the same intervention in an alternative setting. Cost-effective does not always mean lowest cost. It does mean that as to the diagnosis or treatment of your illness, Injury, or disease, the service is: (1) not more costly than another service or group of services that is medically appropriate, or (2) the service is performed in the least costly setting that is medically appropriate. For example, the Plan will not provide coverage for

an Inpatient admission for surgery if the surgery could have been performed on an Outpatient basis or an infusion or injection of a Specialty Prescription Drug Product provided in the Outpatient department of a Hospital if the Drug could be provided in a Physician's office or the home setting.

Network Benefits

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

Network Transplant Provider

A Provider selected to participate as a Network Transplant Provider by the Blue Cross and Blue Shield Association. Such Provider has entered into a Transplant Provider agreement to render Covered Transplant Procedures and certain administrative functions to you for the transplant network. A Provider may be a Network Transplant Provider with respect to:

- Certain Covered Transplant Procedures; or
- All Covered Transplant Procedures

Partial Hospitalization Program

Structured, multidisciplinary behavioral health treatment that offers nursing care and active individual, group, and family treatment in a program that operates no less than six (6) hours per day, five (5) days per week. Out-of-Network Facility-based Programs must occur at Facilities that are both licensed and accredited.

Primary Care Physician (PCP)

A Provider who specializes in family practice, general practice, internal medicine, pediatrics, obstetrics/gynecology, geriatrics, or any other Provider as allowed by the Plan. A PCP supervises, coordinates, and provides initial care and basic medical services to a Member and is responsible for ongoing patient care.

Skilled Nursing Facility

A Facility licensed as a Skilled Nursing Facility in the state in which it is located that satisfies Anthem BCBS's accreditation requirements and, for Network Facilities, is approved by Anthem BCBS. A Skilled Nursing Facility is an institution operated alone or with a Hospital which gives care after a Member leaves the Hospital for a condition requiring more care than can be rendered at home, and is not a place mainly for care of the aged, Custodial Care, or domiciliary care, or a place for rest, educational, or similar services.

Specialist (Specialty Care Physician / Provider or SCP)

A Specialist is a Physician who focuses on a specific area of medicine or group of patients to diagnose, manage, prevent, or treat certain types of symptoms and conditions. A non-Physician Specialist is a Provider who has added training in a specific area of healthcare.

Specialty Prescription Drug Products

Typically high-cost drugs that are generally used in the treatment of acute or chronic diseases. Specialty Prescription Drug Products often require special handling such as temperature-controlled packaging and expedited delivery. Most Specialty Prescription Drug Products require Prior Authorization to be considered Medically Necessary. You may determine whether a medication is a Specialty Prescription Drug Product by calling Quantum Health at the telephone number on your ID Card.

Chapter 15: Contact Information

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

The Episcopal Church Medical Trust
cpg.org
800-480-9967
email: *mtcustserv@cpg.org*
Monday through Friday, 8:30 AM to 8:00 PM ET

Cigna Employee Assistance Program (EAP)
mycigna.com
866-395-7794
24 hours a day, seven days a week

Express Scripts
express-scripts.com
800-841-3361
24 hours a day, seven days a week

EyeMed Vision Care
eyemedvisioncare.com/ecmt
866-723-0513
Monday through Saturday, 8:00 AM to 11:00 PM ET, and Sunday, 11:00 AM to 8:00 PM ET

Quantum Health
MyQuantumCare.org
866-871-0629
Monday to Friday, 8:30 AM to 10 PM ET

UnitedHealthcare Global Assistance
uhcglobal.com
+1 410-453-6330 (collect calls accepted)
24 hours a day, 7 days a week

For more information about **EyeMed Vision Care** and **UnitedHealthcare Global Assistance**, *visit cpg.org/active-lay-employees/insurance/health-and-wellness/additional-benefits/.*

For Members enrolled in a Plan using the Anthem BCBS network who are travelling outside the United States:

Blue Cross Blue Shield Global Core® Service Center
bcbsglobalcore.com
+1 800-810-2583
+1 804-673-1177 (for collect calls)
24 hours a day, 7 days a week

Chapter 16: Your Rights and Protections Against Surprise Medical Bills

WHEN YOU GET EMERGENCY CARE OR ARE TREATED BY AN OUT-OF-NETWORK PROVIDER AT AN IN-NETWORK HOSPITAL OR AMBULATORY SURGICAL CENTER, YOU ARE PROTECTED FROM BALANCE BILLING. IN THESE CASES, YOU SHOULDN'T BE CHARGED MORE THAN YOUR PLAN'S COPAYMENTS, COINSURANCE AND/OR DEDUCTIBLE.

What is "balance billing" (sometimes called "surprise billing")?

When you see a doctor or other health care provider, you may owe certain out-of-pocket costs, like a copayment, coinsurance, or deductible. You may have additional costs or have to pay the entire bill if you see a provider or visit a health care facility that isn't in your health plan's network.

"Out-of-network" means providers and facilities that haven't signed a contract with your health plan to provide services. Out-of-network providers may be allowed to bill you for the difference between what your plan pays and the full amount charged for a service. This is called "**balance billing**." This amount is likely more than in-network costs for the same service and might not count toward your plan's deductible or annual out-of-pocket limit.

"Surprise billing" is an unexpected balance bill. This can happen when you can't control who is involved in your care—like when you have an emergency or when you schedule a visit at an in-network facility but are unexpectedly treated by an out-of-network provider. Surprise medical bills could cost thousands of dollars depending on the procedure or service.

You're protected from balance billing for:

Emergency Services

If you have an emergency medical condition and get emergency services from an out-of-network provider or facility, the most they can bill you is your plan's in-network cost-sharing amount (such as copayments, coinsurance, and deductibles). You **can't** be balance billed for these emergency services. This includes services you may get after you're in stable condition, unless you give written consent and give up your protections not to be balanced billed for these post-stabilization services.

Certain services at an in-network hospital or ambulatory surgical center

When you get services from an in-network hospital or ambulatory surgical center, certain providers there may be out-of-network. In these cases, the most those providers can bill you is your plan's in-network cost-sharing amount. This applies to emergency medicine, anesthesia, pathology, radiology, laboratory, neonatology, assistant surgeon, hospitalist, or intensivist services. These providers **can't** balance bill you and may **not** ask you to give up your protections not to be balance billed.

If you get other types of services at these in-network facilities, out-of-network providers **can't** balance bill you, unless you give written consent and give up your protections.

You're never required to give up your protections from balance billing. You also aren't required to get out-of-network care. You can choose a provider or facility in your plan's network.

When balance billing isn't allowed, you also have these protections:

- You're only responsible for paying your share of the cost (like the copayments, coinsurance, and deductible that you would pay if the provider or facility was in-network). Your health plan will pay any additional costs to out-of-network providers and facilities directly.
- Generally, your health plan must:
  - Cover emergency services without requiring you to get approval for services in advance (also known as "prior authorization").
  - Cover emergency services by out-of-network providers.
  - Base what you owe the provider or facility (cost-sharing) on what it would pay an in-network provider or facility and show that amount in your explanation of benefits.
  - Count any amount you pay for emergency services or out-of-network services toward your in-network deductible and out-of-pocket limit.

If you think you've been wrongly billed, contact the federal No Surprises Help Desk at 1-800-985-3059.

Visit *cms.gov/nosurprises/consumers* for more information about your rights under federal law.

PLEASE RETURN THIS COMPLETED FORM TO:
Office of Clinical Management
The Episcopal Church Medical Trust
19 East 34th Street
New York, NY 10016
(Confidential Fax: 212-251-8891)

AUTHORIZATION
FOR USE OR DISCLOSURE OF PROTECTED HEALTH INFORMATION

1. INDIVIDUAL AUTHORIZING USE OR DISCLOSURE

____
____
____

[Print name and address of individual who is the subject of the information.]

2. HEALTH PLAN(S) SPONSORED BY CHURCH PENSION GROUP SERVICES CORPORATION MAINTAINING THE RECORDS THAT ARE TO BE USED OR DISCLOSED (each Health Plan)

____
____
____

[Print name and address of each health plan or other specific description.]

3. DESCRIPTION OF PROTECTED HEALTH INFORMATION TO BE USED OR DISCLOSED*

____
____
____
____
____

[Specifically describe the information to be used or disclosed. Include meaningful details such as date of service, type of service provided, level of detail to be released, origin of information, etc. Attach additional sheets, if necessary.]

****IMPORTANT NOTE: Unless the authorization is expressly limited, this authorization grants the Health Plan(s) the right to use or disclose ALL of the protected health information identified, including information about any diagnosis or treatment for any medical health, substance abuse, infectious disease (such as HIV/AIDS), cancer, mental health and/or genetic condition, for the purposes described.***

4. PERSON(S) TO WHOM INFORMATION MAY BE DISCLOSED

____
____
____

[Print name of individuals or organizations to receive information, if any.]

5. PURPOSE OF AUTHORIZATION TO USE OR DISCLOSE

____
____
____
____

[List specific purposes here.]

6. DURATION OF AUTHORIZATION

____

____

____

[Specify when authorization will expire by listing (1) a date or (2) an event that relates to the patient or the purpose of the use or disclosure.]

7. TO REVOKE THIS AUTHORIZATION, CONTACT:

Office of Clinical Management
The Episcopal Church Medical Trust
19 East 34th Street
New York, NY 10016
(Confidential Fax: 212.251.8891)

8. AUTHORIZATION AND ACKNOWLEDGEMENT OF PRIVACY RIGHTS

I authorize the Health Plan or Plans identified in item 2 to use and/or disclose the protected health information, as defined under the privacy regulations promulgated pursuant to the Health Insurance Portability and Accountability Act of 1996, described in item 3 to the persons listed in item 4 for the purposes described in item 5. This authorization shall remain in force and effect until the date or event specified in item 6 unless I furnish written notice of revocation to the person specified in item 7.

I understand that:

- *a revocation is not effective to the extent that the parties named in this authorization have relied on the use or disclosure of the protected health information prior to the receipt of the revocation;*
- *information used or disclosed pursuant to this authorization may be subject to redisclosure by the recipient and may no longer be protected by federal or state law; and*
- *my health care provider(s) and health plan(s) may not condition my treatment, payment, enrollment in a health plan or eligibility for benefits (if applicable) on whether I provide authorization for the requested use or disclosure, except in certain circumstances. For example, if the purpose of a test or exam is to produce a record for my employment, I may be required to complete this authorization form before the test or exam is performed.*

____ ____________________

Signature of Individual or Personal Representative *Date*

If a personal representative is signing the form on behalf of the individual whose protected health information is to be used or disclosed, please print the name of the personal representative and describe their authority to act on behalf of the individual.

____

*[Name of Personal Representative]**

____

____

[Authority of Personal Representative]

**Personal representative includes:*

- *Person who (1) has health care power of attorney, or (2) is the parent or legal guardian of a minor.*
- *If you are not (1) or (2) above, identify your relationship to the individual and your involvement in the individual's health care. The Plan Sponsor will determine whether disclosure to you is in the best interest of the individual.*

Note to Individual: The decision of whether to accept this authorization is made solely by the person or entity whom you are authorizing to disclose information.

Part II—Anthem-BCBS-Specific Plan Provisions

Chapter 17: The BlueCard PPO Network

Your health Plan is a Preferred Provider Organization (PPO), which is a comprehensive Plan. The Plan is divided into two sets of Benefits, Network Benefits and Out-of-Network Benefits. If you choose a Network Provider, you will receive Network Benefits. Utilizing this method means you will not have to pay as much money. Your out-of-pocket expenses will be higher when you use Out-of-Network Providers. To find a Network Provider for this Plan, please see *How to Find a Network Provider* later in this section.

Providers are compensated using a variety of payment arrangements, including fee for service, per diem, discounted fees, and global reimbursement.

All Covered Health Services must be Medically Necessary and not Experimental/Investigative/Unproven. Coverage or certification of services that are not Medically Necessary or that are Experimental/Investigative/ Unproven may be denied.

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

The Medical Trust has prepared this Plan Document Handbook to help you understand your Benefits and this Plan. Please read it carefully. Your Benefits are affected by certain limitations and conditions that require you to be a wise consumer of health services and to use only those services you need. Also, Benefits are not provided for certain kinds of treatments or services, even if your Provider recommends them.

Network and Out-of-Network Services

Network Providers

The Plan has entered into an agreement with a medical network that maintains contractual agreements with certain Hospitals, Physicians, and other Providers which are called Network Providers. Because these Network Providers have agreed to charge reduced fees to Members covered under the Plan, the Plan can afford to reimburse a higher percentage of their fees.

Therefore, when a Member uses a Network Provider, that Member will receive better Benefits from the Plan than when an Out-of-Network Provider is used. It is the Member's choice as to which Provider to use.

If you receive Covered Health Services from an Out-of-Network Provider after Anthem BCBS failed to provide you with accurate information in their Provider directory at https://www.anthem.com/find-care/ (type your Member ID number in the box under "Use Member ID for Basic Search" and then click "Continue"), or after Quantum Health failed to respond to your telephone or web-based inquiry within the time required by federal law, your cost share for Covered Health Services will be based on the Network level.

To see a Physician, call their office:
- Tell them you are an Anthem BCBS Member.
- Have your ID Card handy. The Physician's office may ask you for your group or Member ID number.
- Tell them the reason for your visit.

When you go to the office, be sure to bring your Member ID Card with you.

For services from Network Providers:
- You will not need to file claims. Network Providers will file claims for Covered Health Services for you. (You will still need to pay any Coinsurance, Copayments, and Deductibles that apply.) You may be billed by your Network Provider(s) for any Non-Covered Health Services you get or when you have not followed the terms of the Plan.
- Prior Authorization will be requested by the Network Provider. (Please refer to *Chapter 5: Quantum Health – Care Coordination, Prior Authorization & Care Management* for further details.)

How to Find a Network Provider

There are three ways you can find out if a Provider or Facility is a Network Provider. You can also find out where they are located and details about their license or training.

- See your Plan's directory of Network Providers https://www.anthem.com/find-care/ (type your Member ID number in the box under "Use Member ID for Basic Search" and then click "Continue"), which lists the Physicians, Providers, and Facilities that participate as a Network Provider.
- Call the Care Coordinators at 1-866-871-0629 to ask for a list of Physicians and Providers that participate as a Network Provider, based on specialty and geographic area. You can also visit MyQuantumCare.org.
    - Please note that the Provider directory provided through Anthem BCBS is the definitive listing of Network Providers – if you find a Provider through Quantum Health, **always verify their network status using the Provider directory**, and then re-confirm their network status with the Provider before receiving services.
- Check with your Physician or Provider.

If you need details about a Provider's license or training, or help choosing a Physician who is right for you, call the Care Coordinators at Quantum Health.

Out-of-Network Services

Out-of-Network Providers have no agreements with the Plan or the Plan's medical network and are generally free to set their own charges for the services or supplies they provide. The Plan will reimburse for the allowable charges for any Medically Necessary Covered Health Services, subject to the Plan's Deductibles, Coinsurance, Copayments, limitations, and exclusions. Members must submit proof of claim before any such reimbursement will be made.

When you do not use a Network Provider, Covered Health Services are covered at the Out-of-Network Benefit level, unless otherwise indicated in this Plan Document Handbook. Before you obtain services or supplies from an Out-of-Network Provider, you can find out whether the Plan will provide Network Benefits or Out-of-Network Benefits for those Covered Health Services by contacting the Care Coordinators at Quantum Health.

For services from an Out-of-Network Provider:

- There is no limit to what an Out-of-Network Provider can charge, unless your claim involves a Surprise Billing Claim.
- The Out-of-Network Provider may charge you the difference between their bill and the Plan's Maximum Allowed Amount, plus any Deductible and/or Coinsurance/Copayments, unless your claim involves a Surprise Billing Claim.
- You may have higher cost sharing amounts (i.e., Deductibles, Coinsurance, and/or Copayments), unless your claim involves a Surprise Billing Claim.
- As with a Network Provider, you will have to pay for services that are not Medically Necessary.
- As with a Network Provider, you will have to pay for Non-Covered Health Services.
- You may have to file claims.
- You must make sure any necessary Prior Authorization is done. (See *Chapter 5: Quantum Health – Care Coordination, Prior Authorization & Care Management.)*

For information on how Charges from Out-of-Network Providers that involve Surprise Billing Claims are addressed, please see *Surprise Billing Claims* in *Chapter 10: Other Important Plan Provisions*.

If Out-of-Network Primary Care Physicians or specialists are used because the necessary service or specialty is not in the network or is not reasonably accessible to the Member due to geographic constraints (i.e., over fifty (50) miles from home or work), such Out-of-Network Covered Health Services will be covered at Network Benefit levels. Charges that meet this definition will be paid only up to the Maximum Allowed Amount (and Member cost-sharing will be determined with reference to such amount). The Member will be responsible for notifying the Care Coordinators for a review of any claim that meets this definition.

Members can contact the Care Coordinators to request, at no cost, additional information about this option for Providers outside of the network area, or about Charges involving Surprise Billing Claims, or for a list of network providers. This list will include providers who specialize in obstetrics or gynecology.

Provider Non-Discrimination

To the extent that an item or service is a Covered Health Service under the Plan, the terms of the Plan shall be applied in a manner that does not discriminate against a Provider who is acting within the scope of the Provider's license or other required credentials under applicable state law. This provision does not preclude the Plan from setting limits on

Benefits, including cost sharing provisions, frequency limits, or restrictions on the methods or settings in which treatments are provided, and does not require the Plan to accept all types of Providers as a Network Provider.

Choosing a Physician – Patient Protection Notice

The Plan does not require you to select a primary care physician (PCP) to coordinate your care, and you do not have to obtain a referral to see a specialist.

You do not need Prior Authorization, or or approval from any other person (including your PCP), in order to obtain access to obstetrical or gynecological care from a Network Provider who specializes in obstetrics or gynecology. The Provider, however, may be required to comply with certain procedures, including obtaining Prior Authorization for certain services, following a pre-approved treatment plan, or procedures for making referrals.

The BlueCard Program

Like all Blue Cross and Blue Shield plans throughout the country, Anthem BCBS participates in a program called "BlueCard," which provides services to you when you are outside the service area.

Blue Cross Blue Shield Global Core® Program

If you plan to travel outside the United States, call the Care Coordinators at Quantum Health to find out more about your Blue Cross Blue Shield Global Core® Benefits. Benefits for services received outside of the United States may be different from services received in the United States. Remember to take an up-to-date health ID Card with you.

When you are traveling abroad and need medical care, you can call the Blue Cross Blue Shield Global Core® Service Center any time. They are available 24 hours a day, seven days a week. The toll-free number is 800-810-2583. Or you can call them collect at 804-673-1177.

If you need Inpatient Hospital care, you, or someone on your behalf, should contact Quantum Health for Prior Authorization. Keep in mind, if you need emergency medical care, go to the nearest Hospital. There is no need to call before you receive care.

Please refer to *Chapter 5: Quantum Health – Care Coordination, Prior Authorization & Care Management*, for further information. You can learn how to get Prior Authorization when you need to be admitted to the Hospital for emergency or non-emergency care.

How Claims are Paid with Blue Cross Blue Shield Global Core

In most cases, when you arrange Inpatient Hospital care with Blue Cross Blue Shield Global Core®, claims will be filed for you. The only amounts that you may need to pay up front are any Copayment, Coinsurance, or Deductible amounts that may apply.

You will typically need to pay for the following services up front:
- Physician's services
- Inpatient Hospital care not arranged through Blue Cross Blue Shield Global Core®
- Outpatient services

You will need to file a claim form for any payments made up front.

You can get the Blue Cross Blue Shield Global Core® claim form by calling the numbers above or online at *bcbsglobalcore.com* or *cpg.org/mtdocs*. You will find the address for mailing the claim on the form.

Church Pension Group Services Corporation ("CPGSC"), doing business as The Episcopal Church Medical Trust, maintains a series of health and welfare plans (the "Plans") for eligible employees of The Episcopal Church and their eligible dependents. The Medical Trust serves only eligible Episcopal employers. The Plans that are self-funded are funded by The Episcopal Church Clergy and Employees' Benefit Trust (the "ECCEBT"), a voluntary employees' beneficiary association within the meaning of Section 501(c)(9) of the Code.

The Plans are "church plans" within the meaning of Section 3(33) of ERISA and Section 414(e) of the Code. Not all Plans are available in all areas of the United States or outside the United States, and not all Plans are available on both a self-funded and fully insured basis. Additionally, the Plan may be exempt from federal and state laws that may otherwise apply to health insurance arrangements. The Plans do not cover all health care expenses, so Members should read this Plan Document Handbook carefully to determine which benefits are covered, as well as any applicable exclusions, limitations, and procedures.

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

This Plan Document Handbook, together with portions of the Summaries of Benefits and Coverage expressly referenced herein, constitutes the entire Plan document and supersedes any and all prior agreements or understandings, whether written, oral, electronic or in any other medium, with respect to the terms of the Plan.

The Plan and this Plan Document Handbook are governed by, and the rights and obligations of the Medical Trust, the ECCEBT, Quantum Health, the Claims Administrator, Express Scripts, 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 CPGSC 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 applicable law, without notice.

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

Neither The Church Pension Fund nor any of its affiliates (collectively, "CPG") is responsible for the content, performance, or security of any website referenced herein that is outside the www.cpg.org domain or that is not otherwise associated with a CPG entity.