Administrative Policy Manual

Effective as of January 1, 2022

EPISCOPAL CHURCH MEDICAL TRUST

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

Effective as of January 1, 2022
Version 2

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Introduction

Our Mission

The Episcopal Church Medical Trust's (the "Medical Trust" or "we/our") mission is to balance compassion and benefits with financial stewardship. This is a unique mission in the world of healthcare benefits, and we believe that our experience and mission to serve The Episcopal Church offers a level of expertise that is unparalleled.

As the Group Administrator of your Participating Group's health benefits, we know that your Employees, Pre-65 Former Employees, Post-65 Former Employees, congregations, institutions and management look to you for answers to their health benefit questions. In an effort to make your job easier, we have developed this Administrative Policy Manual to provide you with our policies and procedures.

We realize there are times you will need the expertise of our staff via telephone or email; however, we know that reference materials can also answer your questions or questions from your Employees, Pre-65 Former Employees and Post-65 Former Employees. We hope this manual will help you understand the roles, responsibilities, rules and definitions regarding our policies, procedures and operations. Please note that our policies, procedures and operations are subject to change at any time, and we will do our best to inform you of such changes in a timely manner.

Our Work

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

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

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

- Keeping you abreast of information or changes that may affect your Employees, Pre-65 Former Employees and Post-65 Former Employees
- Providing access to our Client Services Call Center for you and your Members
- Providing access to a member of our Integrated Benefits Account Management Services (IBAMS) team for any questions you may have and coordination you may need
- Processing your enrollment and termination requests in a timely manner
- Providing billing and reconciliation services to help you keep your account current
- Providing the IRS with Form 1094-B and Members with IRS Form 1095-B for use in filing their taxes as related to the Individual Mandate

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

Definitions

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

Annual Enrollment

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

Active Annual Enrollment

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

Passive Annual Enrollment

During a Passive Annual Enrollment, a Subscriber or Eligible Individual is not required by the Plan to take any action.[1] However, the Plan encourages Subscribers and Eligible Individuals to log on to the Annual Enrollment website to verify demographic information and existing coverage and to update any data that is not accurate.

Billed Group

A Participating Group or one of its congregations, schools or other bodies, including Employees and Pre-65 Former Employees or Post-65 Former Employees, that is billed by the Plan and responsible for paying monthly contributions. Also sometimes called a "List Bill."

Coverage Tier

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

Denominational Health Plan (DHP)

A Church-wide program of healthcare benefit plans authorized by General Convention and administered by The Church Pension Fund (CPF), with benefits provided through the Medical Trust.

Dependent

A Spouse, Domestic Partner or Child of a Subscriber who meets the qualifications listed in the eligibility section.

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

Child(ren)
A Subscriber's or Spouse's biological child, stepchild, legal ward,[2] foster child,[3] legally adopted child or child who has been placed with the Subscriber/Subscriber's Spouse for adoption, and if Domestic Partner benefits are permitted by the Participating Group, a Domestic Partner's Child.

Domestic Partner
Two adults who have chosen to share one another's lives in a mutually exclusive partnership that resembles marriage. The Plan requires completion of the Domestic Partnership Affidavit to confirm that the requirements of the Plan are met. See the Appendix for the affidavit.

Spouse
A Subscriber's lawfully married husband or wife evidenced by a marriage certificate or in the case of a common-law spouse, evidenced by a written court order.

Surviving Child
A Child of a Subscriber who meets the qualifications listed in the eligibility section and is *enrolled in the Plan* at the time of the Subscriber's death. A Surviving Child shall also include a Child of a Subscriber born or adopted within 12 months of the Subscriber's death.

Surviving Domestic Partner
A Domestic Partner of a Subscriber who meets the qualifications listed in the eligibility section and is *enrolled in the Plan* at the time of the Subscriber's death.

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

Surviving Dependents
Surviving Child, Surviving Domestic Partner and/or Surviving Spouse.

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 Participant's death and continues without interruption thereafter up to the time of such individual's death. The Medical Trust (or its delegate) may, in its sole discretion, require periodic certification of an individual's continuing disability.

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

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

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

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

Eligible Small Employer
An employer that is eligible to participate in the Medical Trust plans and that employs fewer than 20 Employees for each of the 20 or more calendar weeks in the current and preceding year and has been approved by CMS as a small employer under the Medicare Secondary Payer Rules.

Employee
An individual who is normally scheduled to work and is compensated for 1,000 or more hours per year whose income must be reported on a Form W-2 or an international equivalent by a Participating Group, including individuals on an approved leave of absence, short-term disability or long-term disability.

Pre-65 Former Employee
A former Employee of a Participating Group of the EHP:

(a) who at the time of separation from active employment was either participating in the EHP or eligible to participate in the EHP as an 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 five (5) or more years of continuous service with The Episcopal Church OR if a cleric, has a vested benefit under The Church Pension Fund Clergy Pension Plan

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

Member of Religious Order who:

a) Is age 65 or older and

(b) either (1) 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.

Seasonal Employee

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

Temporary Employee

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

Episcopal Church Clergy and Employee's Benefit Trust (ECCEBT)

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

Group Administrator

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

Medical Life Participant System (MLPS)

The Medical Life Participant System (MLPS) is a web-based tool designed to make the administration of benefits easy and efficient. MLPS processes health and group life benefits enrollments in real time, and allows Group Administrators to view bills, payment history, create reports and generate mailing lists.

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. If eligible for the SEE, Medicare becomes the primary payer and the Medical Trust will pay secondary.

Member
A Subscriber or enrolled Dependent.

Member of a Religious Order
A postulant, novice or professed member of Episcopal Religious Orders, as defined in Title III, Canon 14.1[4] who has been accepted or received by the Religious Order.

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

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

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

Episcopal Health Plan (EHP)
A program of medical and dental Plans through which Eligible Individuals and Eligible Dependents of The Episcopal Church are provided health benefits. Benefits are provided through the Medical Trust.

Episcopal Health Plan (EHP) for qualified Small Employer Exception (SEE) Members
A program of medical Plans through which Eligible Individuals and Eligible Dependents of The Episcopal Church are provided health benefits. Benefits are provided through the Medical Trust.

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

This plan is applicable only to those small employers and individuals enrolled in Medicare who apply and are certified by the Centers for Medicare & Medicaid Services (CMS) as meeting the criteria to participate as a result of meeting the small employer definition and the benefits coordinating with Medicare.

Group Medicare Advantage Plan (GMAP)

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

Seminarian

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

Significant Life Event (SLE)

An event as described in the Plan Election and Enrollment Guidelines section, where as a result of the event, the Subscriber is eligible to make certain mid-year election changes.

Subscriber

The primary Individual enrolled in the Plan who meets the qualifications listed in the eligibility section.

Terms and Conditions

Introduction and Purpose

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

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

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

Participating Group Obligations

The Participating Group agrees as follows:

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

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

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

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

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

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

7. Use and Disclosure of Data. The Participating Group hereby consents to the use or disclosure by the Medical Trust of any data or other information generated in connection with the Plan for purposes of plan design or administration or for any other purpose that is consistent with the Church Pension Group's Privacy Policy available at cpg.org. The Participating Group agrees to provide evidence of such consent upon request by the Medical Trust.

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

    - Selecting Plans to be offered to its parishes and/or participating entities. The Participating Group may choose from the various Plans available under the EHP, and EHP for SEE, if eligible. If a Participating Group chooses to offer both Anthem BCBS and Cigna plans to their eligible Employees, they must offer the equivalent plan from each vendor. For instance, a Participating Group may offer the Anthem BCBS PPO 90 and the Cigna OAP PPO 90, but may not only offer the Anthem BCBS PPO 90 and the Cigna OAP PPO 70. The Participating Group may change the Plan(s) it offers annually and may be required to change the Plans it offers if the Medical Trust eliminates Plans previously offered by the Participating Group.

- Determining whether or not to offer Domestic Partner benefits. Domestic Partner benefits will be administered by the Plan in accordance with General Convention Resolution 1997-C024.
- Providing Eligible Individuals with educational materials describing the Plans, including the Summary of Benefits and Coverage. All materials can be found at *cpg.org/mtdocs*.
- Confirming that Members meet the Plan's eligibility criteria.
- Maintaining an IRC Section 125 Cafeteria Plan to maximize the tax treatment of the contributions to The Medical Trust.
- Communicating elections and changes to the Plan in a timely manner as outlined in the Plan Election and Enrollment Guidelines chapter of this manual.
- Maintaining records of Subscriber's and their enrolled Dependents related to compensation and health plan enrollment and election decisions. This includes, but is not limited to, marriage certificates, birth certificates, divorce decrees, court orders, adoption decrees and Domestic Partnership Affidavits. The Plan may request a copy of required documentation at any time.
- Collecting and providing Social Security Numbers or Individual Tax Identification Numbers of Subscribers and enrolled Dependents for federal reporting purposes to the Plan.
- Notifying the Plan of new Eligible Individuals to take part in Annual Enrollment.
- Providing the Plan with notice of a Subscriber's termination of employment, graduation from seminary or change of status, where the Participating Group is made aware of the event, within 30 days of the event.
- Notifying terminated Subscribers of the date coverage ends and their responsibility for any claims incurred after the date coverage ends. This does not apply to Subscribers who enroll in the Extension of Benefits program.
- Providing the Plan with statistical data and other information satisfactory in form and accuracy within a reasonable time after a request.
- Complying with applicable federal and state laws and regulations, including HIPAA, the Affordable Care Act, and the Medicare Secondary Payer rules.
- Executing (in hard copy or electronically) any required paperwork or documentation such as the annual Plan Selections of Medical and / or Dental Renewal Exhibit(s) indicating its Plan elections and providing any other information called for by the Plan.
- Providing Employees with all required compliance notices which can be obtained from *cpg.org/mtdocs* (under Regulatory Notices).
- Providing Employees with copies of the Summaries of Benefits and Coverage (SBC) with enrollment materials. These can be obtained from *cpg.org/mtdocs* (under Regulatory Notices). Employers must provide SBCs:
    - To newly eligible individuals (e.g. new hires) by the first day they are eligible to enroll in the Plan
    - During Annual Enrollments and renewals unless the Member enrolls through MLPS, in which case the SBCs are available electronically
    - Within 90 days from a special enrollment (e.g. marriage, new child) resulting from a Significant Life Event or HIPAA Special Enrollment Event
    - To individuals qualifying for an Extension of Benefits and annually during the applicable Annual Enrollment period
    - Upon request (no later than 7 business days following receipt of request)

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

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

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

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

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

Plan Obligations

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

Acknowledgments

The Participating Group acknowledges the following:

Plan Status. The Medical Trust funds certain of its Plans through a trust, known as The Episcopal Church Clergy and Employees' Benefit Trust ("ECCEBT") that is intended to qualify as a voluntary employees' beneficiary association ("VEBA") under Section 501(c)(9) of the Internal Revenue Code. The Medical Trust is the plan sponsor and plan administrator of each of the health plans described in this document except for a.) the HSAs maintained under the CDHP/HSA arrangements, which are maintained by individual Members, and b.) any fully-funded healthcare plan options offered by us other than the UnitedHealthcare Group Medicare Advantage (PPO) Plan. For the UnitedHealthcare Group Medicare Advantage (PPO) Plan, The Medical Trust is the plan sponsor. The Plans are intended to qualify as "church plans" within the meaning of Section 414(e) of the Internal Revenue Code, and are exempt from the requirements of the Employee Retirement Income Security Act of

1974, as amended ("ERISA"). For purposes of determining the status of a Plan under state insurance laws, each Plan is deemed to be sponsored by a single employer under the Church Plan Parity and Entanglement Prevention Act. Additionally, the Plan may be exempt from state mandated benefit laws and other state insurance laws that may otherwise apply to health insurance arrangements. Not all Plans are available in all areas of the United States, and not all Plans are available on both a self-funded and fully-funded basis.

1. Right to Amend and Terminate the Plan. The Church Pension Fund and its affiliates retain the right to amend, terminate or modify the terms of the Plan, as well as any post-retirement health subsidy[5], at any time, for any reason and unless required by law, without notice.

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

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

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

5. No Healthcare Services. The Medical Trust does not provide any healthcare services and therefore cannot guarantee any results or outcomes. Healthcare providers and vendors are independent contractors in private practice and are neither Employees nor agents of the Medical Trust. The availability of any particular provider cannot be guaranteed and provider network composition is subject to change. The Plan does not cover all health expenses.

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

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

[5] CPF currently offers a post-retirement health subsidy to eligible clergy and spouses. However, CPF is required to maintain sufficient liquidity and assets to pay its pension and other benefit plan obligations. Given uncertain financial markets and their impact on assets, CPF has reserved the right, in its discretion, to modify or discontinue the postretirement health subsidy at any time

8. Administrative Policy Manual. The Administrative Policy Manual describes the Participating Group's responsibilities with respect to the Plan. The Participating Group agrees to abide by the terms outlined in the Administrative Policy Manual. If the Medical Trust issues an updated version to the Administrative Policy Manual, the later version will take precedence over the earlier version.

Eligibility for the Episcopal Health Plan (EHP)

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

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

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

Eligible Individuals

- An Employee normally scheduled to work 1,000 or more compensated hours per plan year or who is treated as a full-time Employee under the Employer Shared Responsibility Provisions under the Affordable Care Act (Pay or Play Rules), but only for the applicable stability period
- A Seminarian who is a full-time student enrolled at a participating seminary of the Association of Episcopal Seminaries
- A Member of a Religious Order
- A Pre-65 Former Employee, not eligible for Medicare, as long as their former employer is participating in the EHP
- A cleric eligible for benefits under The Church Pension Fund Clergy Short-Term Disability Plan, or The Church Pension Fund Clergy Long-Term Disability Plan who was eligible to participate in the EHP prior to their disability

Eligible Dependents

- A Spouse*
- A Domestic Partner, if Domestic Partner benefits are elected by the Participating Group
- A Child who is 30[6] years of age or younger on December 31 of the current year**
- A Disabled Child, 30[6] years of age or older on December 31 of the current year, provided the disability began before the age of 25**
- A Pre-65 Dependent, not eligible for Medicare, of a Post-65 Former Employee enrolled in the GMAP***
- A Pre-65 Surviving Dependent of a deceased Post-65 Former Employee or Pre-65 Former Employee***
- A Pre-65 Dependent, of a Pre-65 Former Employee enrolled in the GMAP****

**For information on the eligibility of a former spouse refer to the Termination of Individual Coverage, under Divorce*
***The Dependent must be enrolled under the Subscriber's Plan.*
****The Dependent will be enrolled as a Subscriber; however, eligibility is based on the Post-65 Former Employee's status.*
*****The Dependent will be enrolled as a Subscriber; however, eligibility is based on the Pre-65 Former Employee's status.*

[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 prior to enrollment.

Ineligible Individuals

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

- A part-time Employee who is scheduled to work and be compensated for less than 1,000 hours per plan year unless such employee is required to be treated as a Full-Time employee under the Pay or Play Rules
- A Temporary Employee unless such employee is required to be treated as a Full-Time employee under the Pay or Play Rules
- A Seasonal Employee unless such employee is required to be treated as a Full-Time employee under the Pay or Play Rules
- A Seminarian who is not a full-time student or not enrolled at a participating seminary of the Association of Episcopal Seminaries
- A parent or other relative of a Subscriber, 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 to enroll in Medicare as determined by the Centers for Medicare and Medicaid (CMS), regardless of whether they are actually enrolled in Medicare
- A volunteer
- An Employee whose working papers have expired and can no longer legally work
- An individual who refuses to provide a Social Security or Individual Taxpayer Identification Number
- A Dependent's dependent who is not a legal ward, foster child, legally adopted or who has not been placed with the Subscriber/Spouse/Domestic Partner for adoption
- Any individual who is on long-term disability and eligible to enroll in Medicare Part A and Part B

Coverage and Eligibility Exceptions

There may be certain circumstances where an individual who does not meet the eligibility requirements listed above may choose to request a special eligibility determination from the Plan. The Bishop or Ecclesiastical Authority with authority over the Participating Group must submit the Coverage and Eligibility Exception Request Form to the Plan in these circumstances. The Plan will review the case presented and provide an individual eligibility determination within 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.

Important Notes

Waiting Periods

The Plan may allow Participating Groups to require that an Eligible Individual be employed 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 under Ineligible Individuals above, eligibility for Medicare/Medicaid or the receipt of Medicare/Medicaid benefits will not be taken into account in determining eligibility for participation in the EHP. For participation in the EHP for Qualified Small Employer Exception, eligibility for Medicare will be taken into account in determining eligibility.

Eligibility for the Episcopal Health Plan (EHP) for Qualified Small Employer Exception (SEE)

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

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

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

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

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

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

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

The following criteria must be met first for eligibility to be allowed in the EHP SEE:

1. The Eligible Individual must work for an employer with fewer than 20 Employees for each of the 20 or more calendar weeks in the current and preceding year and must be approved by CMS as a small employer.

2. The Eligible Individual or Eligible Dependent or both must be age 65 or over and enrolled in Medicare Part A on the basis of age only.

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

Eligible Individuals

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

Eligible Dependents

- A Spouse*
- A Domestic Partner, if Domestic Partner benefits are elected by the Participating Group
- A Child who is 30[7] years of age or younger on December 31 of the current year
- A Disabled Child, 30[7] years of age or older on December 31 of the current year, provided the disability began before the age of 25**

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

Ineligible Individuals

Individuals described below are <u>not</u> eligible to enroll in the EHP for SEE.

- Any Employee working for a Participating Group that does not meet criteria for SEE
- A part-time Employee who is scheduled to work and be compensated for less than 1,000 hours per year unless such employee is required to be treated as a Full-Time employee under the Pay or Play Rules
- A Temporary Employee unless such employee is required to be treated as a Full-Time employee under the Pay or Play Rules
- A Seasonal Employee unless such employee is required to be treated as a Full-Time employee under the Pay or Play Rules
- A Seminarian
- A parent or other relative of a Subscriber, including grandchildren and in-laws, not listed in the Eligible Dependents section above
- A volunteer
- An Employee whose working papers have expired and can no longer legally work
- An Eligible Individual or Eligible Dependent who refuses to provide a Social Security or Individual Taxpayer Identification Number
- A dependent's dependent who is not a legal ward, foster child, legally adopted or who has not been placed with the Subscriber/Subscriber's Spouse/Domestic Partner for adoption

[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 prior to enrollment.

Eligibility for the Group Medicare Advantage Plan (GMAP)

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

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

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

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

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

- A Post-65 Former Employee
- A Retired Member of a Religious Order
- A Pre-65 Former Employee who is enrolled in Medicare Parts A and B
- Cleric receiving benefits under The Church Pension Fund Clergy Long-Term Disability Plan who is enrolled in Medicare Parts A and B
- A pre-65 employee on long-term disability who is enrolled in Medicare Parts A and B

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

- A Spouse or Surviving Spouse*
- A Domestic Partner or Surviving Domestic Partner
- A Dependent Disabled Child or Surviving Dependent Disabled Child, provided the disability began before the age of 25

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

Important Notes

Medicare Secondary Payer (MSP)

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

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

Medicare beneficiaries are free to reject employer plan coverage and retain Medicare as their primary coverage. However, when Medicare is the primary payer, employers cannot offer such Employees (or their Spouses) secondary coverage for items and services covered by Medicare. Medicare states that an employer cannot sponsor or contribute to individual Medicare supplement health plans, Medicare HMOs, or Medicare Group Advantage plans for Medicare beneficiaries who are otherwise eligible for active group health coverage. Therefore, the Plan does not offer group Medicare supplement health plans, group Medicare HMOs or Medicare Group Advantage plans to Employees and their Spouses over age 65, and the Employee and their eligible Spouse can no longer receive a subsidy under The Church Pension Fund Post-Retirement Medical Assistance Plan. Failure to comply with the MSP rules can result in penalties assessed against the employer. It is the employer's responsibility to comply with the MSP rules and by participating in the Plans the employer agrees to indemnify and hold the Medical Trust harmless from any claims resulting from the failure to comply with the MSP rules.

Small Employer Exception

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

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

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

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

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

When Medicare becomes the primary payer for claims under Medicare Part A or Part B, the cost to employers of providing medical coverage may be reduced. Employees' hospitalization costs, including out-of-pocket expenses such as deductibles and coinsurance, will typically be lower as well. In addition to the cost savings typically realized with Medicare as the primary payer of the claims, additional savings can be realized by using 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 EHP SEE will continue to have access to the value-added benefits included in the Medical Trust plans, such as

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

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

Working for the Church after Retirement

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

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

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

Plan Election and Enrollment Guidelines

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

Subscriber Responsibilities

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

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

Plan Elections and Changes

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

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

Important Note: the Plan does not allow a member to enroll in or terminate dental coverage mid-year without a Significant Life Event or HIPAA Special Enrollment Event.

Significant Life Events

A Significant Life Event gives a Subscriber the opportunity to make a change to enrollment. The enrollment change must be made within 30 days of the event and must be consistent with the event. Significant Life Events include:

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

- Change in employment status of a Subscriber or Dependent, that affects Plan eligibility (e.g. termination or commencement of employment, changing from full-time to part-time employment, significant change in the employer contribution or eligibility for contribution, commencement of or return from an unpaid leave of absence, changing from Employee to Pre-65 Former Employee or Post-65 Former Employee)
- Judgment, decree or order (e.g., Qualified Medical Child Support Order (QMCSO))
- Change in residence or work site for a Subscriber or Dependent that affects network access to the current Plan

  For example, if a Subscriber previously resided in an area in which only the PPO was available and then moved into an area where the HMO and PPO are available, the Subscriber may elect a new Plan. Conversely, if a Subscriber moved out of the HMO service area, and was therefore no longer eligible for the HMO, the Subscriber may elect a new Plan.
- Significant change in the cost of the plan or a significant curtailment of medical coverage during a plan year for a Subscriber or Dependent
- Medicare or Medicaid entitlement (or loss of such entitlement)
- HIPAA Special Enrollment Event (see below)
- Enrollment in or termination of a Medicare Part D Plan
- Change in employment or insurance status of Spouse
- Qualification change of a post-65 actively working subscriber or subscriber's Spouse to participate in the EHP SEE or GMAP
- Any other Significant Life Events provided under the applicable regulations and provided for under the employer's Section 125 Plan

IMPORTANT NOTE: A healthcare provider's discontinuation of participation in a plan network is not a Significant Life Event and does not permit an election change.

The effective date of coverage for an election change due to a Significant Life Event is the first day of the month following the Significant Life Event (except in the case of birth, adoption or placement for adoption of a child). Election changes must be received by the Plan no later than 30 days after the Significant Life Event (60 days if the change relates to loss or eligibility for Medicaid Plan or State child healthcare plan) and are valid for the remainder of the current plan year.

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

HIPAA Special Enrollment Events

Certain Significant Life Events are considered to be Special Enrollment Events that would allow an Eligible Individual who is not covered by the Plan to enroll themselves and their Eligible Dependents for coverage under the Plan outside of the Annual Enrollment period. Special Enrollment Events include:

- Marriage
- Birth of a Child
- Adoption or placement for adoption of a Child

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

Eligible Individuals will generally have 30 days to enroll in the Plan after a Special Enrollment Event, but will have 60 days to enroll in the Plan as a result of a Special Enrollment Event that is a loss of eligibility for coverage under a Medicaid Plan or a state child healthcare plan or eligibility for assistance with coverage under the Plan through a Medicaid Plan or state child healthcare plan. In the case of birth, adoption or placement for adoption of a Child, coverage will be effective retroactive to the date of the event. For all other Special Enrollment Events, coverage will be effective as of the first day of the month following the month in which the request for coverage is processed.

The employer is responsible for providing the Member an SBC for each applicable plan and a Notice of Special Enrollment within 90 days of enrollment resulting from a HIPAA Special Enrollment Event.

The deadline to enroll in a group health plan sponsored by The Episcopal Church Medical Trust (a "Medical Trust Plan") under the special enrollment provisions of the Health Insurance Portability and Accountability Act (HIPAA) has been temporarily extended as a result of the COVID-19 pandemic. Guidance was issued on April 28, 2020, directing plan sponsors to disregard the "outbreak period" when calculating these deadlines. The Outbreak Period is the period from March 1, 2020 until sixty (60) days after the announced end of the COVID-19 National Emergency (or other date announced through future guidance). If there are different Outbreak Periods in different parts of the country, additional guidance will be issued. Please see the example below and for complete details please review the HIPAA Special Enrollment Rights Notice.

> *Example: For purposes of this example, assume the National Emergency ends on April 30, 2022, and accordingly the Outbreak Period ends on June 29, 2022 (i.e., the 60th day after the end of National Emergency). The Outbreak Period must be disregarded for purposes of determining the special enrollment period.*
>
> *If a plan member gives birth on March 31, 2022, the member has until July 29, 2022 (30 days after June 29, 2022, the end of the Outbreak Period), to enroll herself and her newborn in the group health plan.*

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

Reporting Eligibility and Enrollment Changes

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

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

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

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

The following additional requirements also apply:

- Health Plan choice may be restricted if a Subscriber or an Eligible Individual has Eligible Dependents living outside the service area of a particular Plan.
- If a local managed care plan is elected, additional paper enrollment forms from the local plan option must be submitted to the Plan.
- 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.
- It should be noted that certain additional requirements may apply under the GMAP that should be taken into consideration in the processing of enrollment paperwork. Therefore, to ensure timely access to prescription drug coverage, the enrollment form and all required materials must be received at least 3 months prior to your desired coverage effective date.

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

Required Information and Documentation

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

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

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

Annual Enrollment

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

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

The Annual Enrollment website contains:

- Current demographic and coverage information
- Available medical and/or dental Plans
- Full contribution rates for each Plan and Coverage Tier[8]
- 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 active 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

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

the semester in which the Seminarian is enrolling commences. The Seminary Group Administrator must provide the SBCs for all available plans to the Seminarian no later than the first day the Seminarian is eligible to enroll in coverage.

Specific Guidelines and Effective Dates of Coverage

Coverage is effective on the first day of the month following the date Eligible Individuals first become eligible to participate in the Plan or following the Significant Life Event, unless otherwise specified. Completed enrollment forms or MLPS submissions must be received by the Plan within 30 days of the event, (or 60 days if the change relates to loss or eligibility for Medicaid Plan or State child healthcare plan).

New Eligible Individual

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

However, if an Employee's date of hire is the first working day of the month and the first calendar day of the month (e.g., Sunday, June 1), coverage for the Employee will commence on the first day of that month (i.e., Sunday, June 1), provided that the Plan receives an enrollment form or MLPS submission within 30 days of that date.

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

If the Employee does not 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 or HIPAA Special Enrollment Event to occur, or wait until the next Annual Enrollment period.

Religious Orders

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

However, if a postulant, novice or member is received or accepted by the Order on the first working day of the month and the first calendar day of the month (e.g., Monday, June 1), coverage for the postulant, novice or member will commence on the first day of that month (i.e. Monday, June 1), provided that the Plan receives an enrollment form or MLPS submission within 30 days of that date.

Elections must be received by the Plan no later than 30 days after that date. If the postulant, novice or member does not enroll when initially eligible, then they must wait for an applicable Significant Life Event or HIPAA Special Enrollment Event to occur or until the next Annual Enrollment period.

Seminarians

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

Elections must be received by the Plan within 30 days of the seminary's published registration deadline for that semester.

If the Seminarian does not enroll within 30 days from the date they become eligible, then they must wait for an applicable Significant Life Event or HIPAA Special Enrollment Event to occur, or wait to enroll at the beginning of any subsequent semester and be covered starting with the first day of the month that semester begins. Enrollment will continue year-round for the duration of the time in seminary, until the seminarian is no longer eligible (for example, because of graduation).

Pre-65 Former Employees

A Pre-65 Former Employee from a Participating Group who retires but is not Medicare-eligible, may continue coverage through the Episcopal Health Plan (EHP) with no change to the coverage effective date, provided an enrollment form or MLPS submission confirming continuation of coverage and change to Pre-65 Former Employee status is received by the Plan within 30 days of the retirement date.

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

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

Once the Pre-65 Former Employee becomes Medicare-eligible, they must actively switch enrollment to the Group Medicare Advantage Plan (GMAP). If the enrolled Spouse/Domestic Partner is not Medicare-eligible at that time, then the enrolled Spouse/Domestic Partner may remain in the EHP until becoming Medicare-eligible, at which time they too 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.[9]

If the Pre-65 Former Employee has a spouse who becomes age 65 and is not actively working, 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 Subscriber is a Pre-65 Former Employee.

IMPORTANT NOTE: An Employee who terminates their employment with a Participating Group prior to meeting the eligibility requirements for a Pre-65 Former Employee will be offered an Extension of Benefits.

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

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 have subsequently experienced a HIPAA Special Enrollment Event, 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 HIPAA Special Enrollment 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.

The enrolled Children who are not a Disabled Child may also remain in the EHP until the end of the year in which they reach age 30.[10]

Health plan elections must be received by the Plan no later than 30 days after a HIPAA Special Enrollment Event or Annual Enrollment.

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 meets the 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 or HIPAA Special Enrollment 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 Subscriber's effective date. If the Subscriber does not enroll all Eligible Dependents within 30 days of a Significant Life Event or HIPAA Special Enrollment Event, then the Eligible Dependents may not enroll until the next Annual Enrollment period or until another Significant Life Event or HIPAA Special Enrollment Event occurs.

New Children

A Subscriber'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 Subscriber must enroll the new Child for coverage within 30 days of the birth to ensure claims incurred during the first 30 days are covered and for coverage to continue beyond the 30-day period. The

[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 prior to enrollment.

coverage effective date will be the date of birth. If applicable, monthly contribution rates will change to reflect the new Coverage Tier on the first day of the month following the date of birth. If a properly completed enrollment form or MLPS submission is not received by the Plan within the 30-day period, the Child may not be enrolled in the Plan until the next Annual Enrollment period or the occurrence of a subsequent Significant Life Event or HIPAA Special Enrollment Event. Please see page 26 for special enrollment provisions in effect as a result of the COVID-19 pandemic.

Note: The newborn child of a Dependent Child will not be covered by the plan, even for the first 30 days, unless that child is placed for adoption, is a legal ward or foster child of the Subscriber or Subscriber's Spouse/Domestic Partner.

Adopted Children

Upon timely notification, coverage for the Child will be effective on the date of adoption, or, if earlier, placement for adoption. The Plan will consider a Child placed for adoption as eligible for enrollment on the date when the Subscriber becomes legally obligated to support that Child prior to that Child's adoption. If the Subscriber does not enroll the Child within 30 days of that date, then the Child may not enroll until the next Annual Enrollment period or until a subsequent Significant Life Event or HIPAA Special Enrollment Event occurs. If a Child placed for adoption is not adopted, all health coverage ceases when the placement ends and will not be continued. The Plan will only cover expenses incurred by the birth mother, including the birth itself, if the birth mother is an enrolled Member on the date of birth.

Domestic Partners

A Subscriber may enroll their eligible Domestic Partner for coverage under the Plan if the Subscriber meets the Plan's eligibility requirements and is part of a Participating Group that offers Domestic Partner coverage. The Plan requires a signed affidavit attesting to the Domestic Partnership. If the Subscriber does not enroll their eligible Domestic Partner within 30 days after submission of a valid Domestic Partner Affidavit, then the eligible Domestic Partner may not enroll until the next Annual Enrollment period or until a Significant Life Event or HIPAA Special Enrollment Event occurs.

Non-Medicare-eligible Dependents

A Post-65 Former Employee and the Employee's Eligible Dependents may split enrollment between the EHP and the GMAP in cases where the Post-65 Former Employee is eligible for Medicare and the Dependents are not eligible for Medicare and are under age 65. Eligibility in the EHP will end once the Spouse/Domestic Partner becomes Medicare eligible and/or reaches age 65, at which time, the Spouse/Domestic Partner must actively switch enrollment to the GMAP. The Subscriber'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.

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 a Subscriber, the disability continues and the Child continues to meet the Plan's eligibility requirements in all aspects other than age.

In order for the Plan to confirm the status of a Disabled Child, the Subscriber must contact Client Services who will initiate the confirmation process with the Medical Board. The third-party administrator designated by the Medical Trust is the Medical Board that will review satisfactory proof of disability and determine the status of the Disabled Child. The designated third-party administrator will contact the Subscriber with the request for documentation. The Plan may require, at any time, a physician's statement certifying the ongoing physical or mental disability.

Children of Surviving Spouses of Limited Means

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

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

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

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

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

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

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

Children of a Subscriber who must be covered under the Plan in accordance with a QMCSO will be covered beginning on the date the order is approved and continuing until the date or age stipulated. However, Children may not be covered beyond the eligibility age permitted under the Plan.

If a QMCSO requires that the Subscriber provide health coverage for the Subscriber's Children and the Subscriber does not enroll the Children the Participating Group will enroll the Children upon application from the Subscriber's separated or divorced Spouse, the state child support agency or Medicaid agency, provided it is required to do so by law. The Participating Group will withhold from the Subscriber's pay their share of the cost of such coverage.

If a QMCSO requires a separated or divorced ex-Spouse of a Subscriber to cover a Child, the Subscriber may change elections and drop coverage for the Child. However, the Subscriber may not drop coverage for the Child until the other plan's coverage begins. Subscribers may not otherwise drop coverage for a Child covered pursuant to a QMCSO unless they submit written evidence to the Participating Group that the QMCSO is no longer in effect.

Leaves of Absence

Leaves of absence encompass all approved leaves with or without pay, including leaves due to Workers' Compensation, Family and Medical Leave Act, and the sentence of suspension or restriction on Ministry of a priest in accordance with Title IV, Canon 19, Section 7.[11]

If otherwise permitted by the Subscriber's employer, a Subscriber on a leave of absence may choose to decrease the Coverage Tier for the duration of the leave or Extension of Benefit and increase it again upon return from leave.

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

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

If the leave of absence is paid leave, or a legally mandated unpaid leave, the Member can retain their active coverage. If the leave of absence is unpaid, and otherwise not legally mandated, then the Member will be terminated and a letter will be sent offering an Extension of Benefits. Upon the Member's return, the employer can reinstate the Member.

Termination of Individual Coverage

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

Coverage ends the earliest of:

- The last day of the month in which:
    - The Subscriber no longer meets the eligibility requirements (e.g. Employee resigns or Seminarian graduates from seminary)
    - The Dependent no longer meets the eligibility requirements for any reasons other than death or turning age 30[12] (e.g., Spouse is no longer eligible due to divorce or Subscriber ceases to be a Dependent's legal guardian)
    - Monthly contributions cease
    - The Participating Group's participation with the Plan terminates
- The last day of the year in which an enrolled Dependent Child reaches age 30[11] except if the Child is a Disabled Child in accordance with the terms of the Plan
- The date the Plan ceases to exist

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

Death and Surviving Dependents

The coverage termination date will be the last day of the month in which the Subscriber's death occurred. The new coverage effective date for the Surviving Dependents who enroll in the Extension of Benefits program will be the first day of the month following the Subscriber's death date.

If a Surviving Spouse remarries, any new Dependents acquired after the primary Subscriber's death are ineligible for coverage under the Plan, unless the Dependent is a Child of the Subscriber born or adopted up to 12 months after the Subscriber's death. The same rules apply to Surviving Domestic Partners who engage in a new Domestic Partner relationship.

Employee/Seminarian

When an Employee or Seminarian enrolled in the EHP dies, their Surviving Dependents who are also enrolled in the EHP at that time are offered an Extension of Benefits. The coverage termination date will be the last day of the month in which the Subscriber's death occurred. The new coverage effective date for the Surviving Dependents who choose to

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

enroll in the Extension of Benefits Program will be the first day of the month following the Subscriber's date of death.

Post-65 Former Employee or Pre-65 Former Employee enrolled in Medicare

When a Post-65 Former Employee or a Pre-65 Former Employee enrolled in Medicare and enrolled in the GMAP dies, Surviving Spouses and Surviving Domestic Partners enrolled in the GMAP at the time of the Member's death can remain covered in the GMAP. Children enrolled in the EHP may remain in the EHP until the last day of the year in which they turn 30[13] 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 the GMAP.

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

When a Pre-65 Former Employee enrolled in the EHP or a cleric enrolled in the EHP and receiving benefits under The Church Pension Fund Clergy Long-Term Disability Plan who is enrolled in Medicare dies, the Surviving Spouse/Surviving Domestic Partner who is also enrolled in the EHP can remain covered until becoming Medicare-eligible, at which time the individual 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[13] 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 the GMAP.

Dependents

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

Divorce

The divorced Spouse and/or Subscriber must notify the Participating Group and the Plan of events that may cause a loss of coverage. The coverage termination date is the first of the month following the effective date of the divorce.

Employees and Seminarians
The Spouse enrolled in the EHP or the EHP SEE 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.

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

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

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

Extension of Benefits Program for the EHP

The Plan's Extension of Benefits program is similar, but not identical, to the healthcare continuation coverage provided under Federal law (known as "COBRA") for non-church plans. Because the Plan is a church plan as described under Section 3(33) of ERISA, the Plan is exempt from COBRA requirements.[14] Nonetheless, Subscribers and/or their enrolled Dependents will have the opportunity to continue benefits for a limited time in certain instances when coverage through the EHP would otherwise cease. Individuals who elect to continue coverage must pay for the coverage.

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

- Employees who are terminated are offered an extension of 36 months starting on the first day of the month following the termination event.
- Spouses and Domestic Partners whose coverage is terminated as a result of the Employee's termination, the Employee's death, divorce, or legal separation or termination of a Domestic Partnership are offered an extension of 36 months starting on the first day of the month following the termination event.
    - If the couple divorces while on an Extension of Benefits, the divorced spouse of the former Employee may choose to remain on their own extension for the remaining period of the current extension.
- Dependent Children whose coverage is terminated are offered an extension of up to 36 months starting on the first day of the month following the termination event. Seminarians who cease to be a Seminarian are offered an extension of 36 months starting on the first day of the month following graduation or other separation event.
- Employees whose Medical Trust coverage terminates under the terms of The Church Pension Fund Clergy Long-Term Disability Plan are offered an extension of 36 months starting on the first day of the month following the termination under The Church Pension Fund Long-Term Disability Plan.

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

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 5 business days of receiving a termination notice from the Group Administrator. The notification includes an enrollment form and an invoice for contributions that are due and an explanation of the monthly contributions and duration of the extension. If the current Plan is no longer available, an alternate option may be offered. The termination date is the last day of the month in which the separation event occurred.

Recipients of an Extension of Benefits offer have 21 calendar days to respond from the day the offer is mailed by the Plan (45 calendar days when a result of the death of the Subscriber). Responses must include a payment to cover the contributions that are due. Otherwise,

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

enrollment in the extension is considered declined.

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

The Plan will maintain the coverage and invoice the 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 60 days overdue
- The date the Member becomes a Post-65 Former Employee
- The first of the month following the date the Member is hired by another Participating Group and is an Eligible Individual.
- The last day of the month of the Extension of Benefit period
- The last day of the month after the individual submits a written notice to terminate coverage for medical, dental or both (30 days-notice required)
- The date a Participating Group's participation in the Plan is terminated (whether by the Participating Group or the Medical Trust) and the Participating Group enrolls in another group health plan. (The Group Administrator will be notified by the Plan of all individuals participating in the Extension of Benefits program)
- Upon death of the Member (surviving dependents may continue coverage under the remaining period of the Extension of Benefits)
- The date the Plan ceases to exist

Important Notes

Required Monthly Contributions

The Plan does not pro-rate contribution requirements for any health Plan regardless of the termination date or the effective date. Any monthly contribution rate change will be effective the first day of the month following the change. Contributions for coverage with a retroactive effective date must be paid upon enrollment.

One Type of Coverage

The Plan prohibits two Members who are each enrolled from covering each other in the same Plan (EHP, EHP SEE or GMAP). Therefore, an individual may not participate in the Plan as a Subscriber and as a Dependent in the same Plan. If two Members both work for The Episcopal Church in Participating Groups who offer different Plans, an individual may enroll as the Subscriber in one and as a Dependent in the other (e.g., Subscriber in medical Plan, Dependent in dental Plan).

Plan Sponsor

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

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

Medical Life Participant System (MLPS)

The Medical Life Participant System (MLPS) is designed to allow Group Administrators to gain direct access to the Plan's enrollment database and manage their enrollment.

MLPS is a user-friendly and secure web-based system. Group Administrators are sent an online invitation, which provides them with the ability to assign their own unique username and password to access MLPS through the Internet at mlps.cpg.org.

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

The transactions available through MLPS include:

- New enrollments
- Coverage changes
- Terminations
- Employee demographic changes
- Employee address and phone
- Dependent changes

All MLPS transactions are maintained in MLPS for historical records.

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

Enrollment reports are also available through MLPS and can be selected based on the Group Administrator's needs.

Most transactions entered into MLPS are processed overnight and loaded into the Plan's enrollment database the following business day. Some transactions entered into MLPS may trigger edits and be held for Client review. These transaction requests are normally reviewed and resolved within five business days, but may take longer based on complexity. Most processed transactions are reported to health plan vendors by the Plan on a weekly basis.

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

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

Billing

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

- The Participating Group
- One of its Billed Groups (e.g. a parish) which is paying the monthly contributions directly to the Plan
- A Subscriber who is paying the monthly contributions directly to the Plan

Process

The Plan mails billing statements for the next month's coverage around the 10th day of each month. All billing statements contain:

- Name of Subscriber(s)
- Coverage Tier(s) and contribution rate(s)
- Account balance information
- Payment due date
- Retroactive adjustments

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

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

The Plan agrees to:

- Mail monthly billing statements (including a return envelope) in a timely manner
- Perform a quality assurance check on a sample of billing statements each month
- Post payments to the Billed Group account within two working days of receipt, regardless of the amount
- Resolve all disputed billing or collection amounts in a timely fashion
- Notify Billed Groups of changes to the processes and procedures relating to billing and collection
- Notify Billed Groups and Members of account status if an account becomes overdue

All Billed Groups should:

- Review the bill for completeness and accuracy
    - Are all covered Members included and correctly listed?
    - Are Coverage Tiers, periods and monthly contributions accurate for each Member?
    - Were terminated coverages removed?
    - Were changes processed as requested?
    - Were new coverages added?

    - Have prior payments been posted to the account?
- Reconcile the billing statement based on current enrollment records
- Contact Client Services or use MLPS to determine if requested changes have been processed after the billing date
- Submit the Electronic Reconciliation Form, if necessary, to note corrections or disputed amounts. The form and instructions may be found at cpg.org. The completed form can be sent to the Plan by email to billingrecon@cpg.org or by fax to (877) 432-9274.
- Make any necessary changes to health Plans in MLPS, or send an enrollment form to the Medical Trust, 19 East 34th Street, New York, NY, 10016, or by fax to (877) 432-9274.
- Remit payments in a timely manner in accordance with the instructions on the billing statement
    - Make checks payable to ECCEBT
    - Note the Billed Group's List Bill ID on the check
    - Include the billing statement payment stub
    - Mail payments to the lockbox:

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

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

Delinquent Notice

It is important to keep the Billed Group account current and make payments on a timely basis. The Plan makes every effort to work with Billed Groups that fall behind in their payments to bring their accounts current. If, however, payment is not received within three months after the due date, the Plan will institute the following process:

- The Billed Group will be contacted in writing about the delinquency. The Plan must receive payment within 14 calendar days of the notice date in order to remove the delinquent status of the account. The notice will include a sample termination letter that will be sent to each Subscriber in the event that health coverage must be terminated.
- All undisputed amounts must be paid within 14 calendar days. Disputed amounts will be set aside for reconciliation and resolution and must be paid within 14 calendar days of resolution.
- If the Billed Group is a congregation or other institution of a Participating Group, the Participating Group will also be notified of the delinquency.
- If the account remains delinquent 14 calendar days after the notice date, a second notice will be sent to the Billed Group, the Participating Group (if applicable), and to each Subscriber announcing the cancellation date.

Cancellation Notice

If the account remains delinquent, a Notice of Cancellation of Group Coverage with a cancellation due date will be sent to the Billed Group.

- Failure to comply with the Notice of Cancellation of Group Coverage will result in termination of the Billed Group's coverage. The Notice of Cancellation will include the cancellation effective date.
- A copy of the Notice of Cancellation will also be sent to the Participating Group, if applicable.
- A termination letter will be sent separately to each Subscriber of a Billed Group notifying them of their termination effective date.

Overpayments and Underpayments

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

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

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

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

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

Retroactive Terminations

A request to terminate coverage for a Subscriber should be made within 30 days of the applicable Significant Life Event or HIPAA Special Enrollment Event. Retroactive termination requests must be received within 59 days of the termination event. If a request is received after that date, the requested date may not be granted and may be adjusted forward. The Plan will review each retroactive termination request and will make the final determination on whether the date will be approved. This would be reflected in the retroactive adjustment section of the billing statement.

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

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

first day of the month following the change. Contributions for coverage with a retroactive effective date must be paid upon billed.

Disclaimers

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

This Administrative Policy Manual contains only a partial description of the Plans and is intended for informational purposes only. It should not be viewed as a contract, an offer of coverage, or investment, tax, medical or other advice. In the event of a conflict between this Administrative Policy Manual and the official Plan documents (Plan Document Handbook and summaries of benefits and coverages), the official Plan documents will govern.

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

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

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

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

The Plan does not allow or take responsibility for any Participating Group-imposed waiting periods, probationary periods or any other additional limitations made at the Participating Group's sole discretion.

Privacy Statement to Members

Joint Notice of Privacy Practices

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

Introduction

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

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

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

What This Notice Applies To

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

Duties and Obligations of the Plans

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

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

When the Plans May Use and Disclose Your PHI

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

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

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

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

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

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

enforcement official. This release would be necessary (1) for the institution to provide you with healthcare; (2) to protect your health and safety or the health and safety of others; or (3) for the safety and security of the correctional institution.

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

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

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

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

Authorizing Release of Your PHI

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

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

Interaction with State Privacy Laws

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

Fundraising

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

Underwriting

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

Your Rights With Respect to Your PHI

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

Right to Request Restrictions. You have the right to request that the Plans restrict their uses and disclosures of your PHI. You will be required to provide specific information as to the

disclosures that you wish to restrict and the reasons for your request. The Plans are not required to agree to a requested restriction, but may in certain circumstances. To request a restriction, please write to the Church Pension Group Privacy Officer and provide specific information as to the disclosures that you wish to restrict and the reasons for your request.

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

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

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

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

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

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

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

If You Are a Person in the European Union, the Following Provisions Will Also Be Applicable to You:

For the purposes of the General Data Protection Regulation 2016/679 (the "GDPR"), the Data Controller is Church Pension Group Services Corporation registered in the State of Delaware in the United States with a registered address at 19 East 34th Street, New York, NY 10016.

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

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

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

Data Retention

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

Data Transfers

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

If You Believe Your Privacy Rights Have Been Violated

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

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

To contact the Church Pension Group Privacy Officer:

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

privacy@cpg.org

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

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

Effective Date
This Notice is effective as of August 29, 2018.

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

EPISCOPAL CHURCH MEDICAL TRUST

Domestic Partnership Affidavit

I. DECLARATION

We,_____, and,_____,
(Print Subscriber's Full Name) (Print Partner's Full Name)

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

II. STATUS

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

III. CHANGE IN DOMESTIC PARTNERSHIP

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

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

IV. ACKNOWLEDGMENTS

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

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

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

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

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

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

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

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

V. STATEMENT

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

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

Witnessed by:

Name and Title of Group Administrator	
Signature of Group Administrator	Date

EPISCOPAL CHURCH MEDICAL TRUST

Child Affidavit

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

SUBSCRIBER INFORMATION

Name:_____SSN_____

Address: _____

CHILD ELIGIBILITY

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

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

   - ☐ Biological Child
   - ☐ Foster Child (an individual who is placed with the Subscriber by an authorized placement agency or by judgment, decree or other order or any court of competent jurisdiction)
   - ☐ Legally Adopted Child
   - ☐ Legal Ward (A legal ward is a child placed under the care of a guardian by an authority of law.)
   - ☐ Child placed with Subscriber for Adoption
   - ☐ Disabled Child*
   - ☐ Spouse's Child
   - ☐ Domestic Partner's Child (only applicable where Domestic Partnership benefits are offered by the Participating Group)

2. The Child is 30 years of age or younger or is a Disabled Child.

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

Name:_____ D.O.B.:_____ Sex: _____
[Last, First, Middle] [mm/dd/yyyy] [M/F]

Name:_____ D.O.BF.:_____ Sex: _____

[Last, First, Middle] [mm/dd/yyyy] [M/F]

Name:_____ D.O.B.:_____ Sex: _____
[Last, First, Middle] [mm/dd/yyyy] [M/F]

Name:_____ D.O.B.:_____ Sex: _____
[Last, First, Middle] [mm/dd/yyyy] [M/F]

Name:_____ D.O.B.:_____ Sex: _____
[Last, First, Middle] [mm/dd/yyyy] [M/F]

Name:_____ D.O.B.:_____ Sex: _____
[Last, First, Middle] [mm/dd/yyyy] [M/F]

CERTIFICATION

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

_____ _____
Subscriber's Signature Date Signed

RETURN THIS COMPLETED FORM TO:

The Episcopal Church Medical Trust
19 East 34th Street
New York, NY 10016
Fax: (877) 432-9274
Email: mtcustserv@cpg.org

08/21

EPISCOPAL CHURCH MEDICAL TRUST

Coverage and Eligibility Exception Request Form

The Episcopal Church Medical Trust (the "Medical Trust") provides healthcare coverage for Eligible Individuals of The Episcopal Church and its institutions. Exceptions for healthcare coverage outside of the Medical Trust's eligibility rules may be made for an individual in official ministry of The Episcopal Church who is under the authority of a Bishop. Exceptions must be requested by the individual's Bishop and must be approved by the Medical Trust on an annual basis (initially upon enrollment and then during each Annual Enrollment period).

Completion of this request form does not guarantee that the individual shall be approved for coverage under the Medical Trust. If the individual is approved for coverage, an enrollment form or MLPS online submission must be provided to the Medical Trust. The enrollment form or MLPS submission must be received no later than 30 days after the approval has been granted and coverage will commence on the 1st of the month following the receipt of the enrollment form.

Name of individual for whom the request is made:

_____
(First, Middle, Last Name)

_____
(Address, City, State & Zip)

_____
(Phone Number & Email Address)

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

Date coverage is requested to begin: _____

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

_____
_____
_____
_____

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

_____
_____
_____
_____

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

_____
_____
_____
_____

STATEMENT

I,_____the Bishop of the Diocese of_____,
(First, Middle, Last Name)

hereby certify that the above named individual is in official ministry of The Episcopal Church under my authority. I further certify under penalty or perjury that the information I have provided is accurate. I understand that if any of the above information is untrue, the Participating Group with which the individual is associated will be responsible for reimbursing the Medical Trust for any amount it was induced to pay in reliance on the information provided. I understand that I have the responsibility of informing and agree to inform the Medical Trust of any changes in the above information.

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

Name of person to contact for further information:

_____
(Phone Number & Email Address)

RETURN THIS COMPLETED FORM TO:

The Episcopal Church Medical Trust
19 East 34th Street
New York, NY 10016
Fax: (877) 432-9274
Email: mtcustserv@cpg.org

TO BE COMPLETED BY THE MEDICAL TRUST:

Date received:_____ Decision: _____

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

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

08/21

EPISCOPAL CHURCH MEDICAL TRUST

Statement of Dissolution of Domestic Partnership

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

Subscriber Name _____ Date of Birth _____

Phone Number _____ Email Address _____

Street Address, City, State, Zip _____

Domestic Partner Name _____ Date of Birth _____

Phone Number _____ Email Address _____

Street Address, City, State, Zip _____

CERTIFICATION

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

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

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

Subscriber or Domestic Partner Signature _____ Date _____

General Information

Filing a Statement of Dissolution of Domestic Partnership

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

Important Notes

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

For Office Use Only:

Statement of Dissolution Effective Date:

_____

Reviewed By: _____

Group Administrators Contacts Guide

Client Services

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

MLPS

For training or other MLPS issues:

Contact your IBAMS representative.

Billing

Send Electronic Reconciliation Forms to:

Email: billingrecon@cpg.org
Fax: (212) 592-9408

Send payments payable to ECCEBT to:

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

Enrollment Forms and General Correspondence

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

Fax: (877) 432-9274

Web Page and Directions

To access all forms and publications, go to *cpg.org/mtdocs*

To access the Administrators Resource Center, go to *cpg.org/arc*

Vendor Contact Information

Cigna Medical & Dental
mycigna.com
(800) 244-6224

Cigna Behavioral Health
(Cigna EAP)
mycigna.com
(866) 395-7794

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

Kaiser Permanente
kp.org

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

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

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

Health Advocate
healthadvocate.com
(866) 695-8622

Amplifon Hearing Health Care
amplifonusa.com
(866) 349-9055

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

UnitedHealthcare Group Medicare Advantage
www.UHCRetiree.com/ECMT
(866) 519-5401

Medical Trust Client Services Call Center
(800) 480-9967

THE EPISCOPAL CHURCH MEDICAL TRUST

Medical Trust Acronyms Guide

ABH	Anthem Behavioral Health
BCBS	Blue Cross and Blue Shield
BPC	Benefits Partnership Conference
CBH	Cigna Behavioral Health
CDHP	Consumer-Directed Health Plan
CMS	Center for Medicare and Medicaid Services (see “Medicare”)
CPF	Church Pension Fund
CPG	Church Pension Group
CR	Client Relations
CS	Client Services
DHP	Denominational Health Plan
EAP	Employee Assistance Program
EBAC	Episcopal Business Administrators Conference
ECCEBT	Episcopal Church Clergy and Employee’s Benefit Trust
EHP	Episcopal Health Plan
EOB	Explanation of Benefits (sometimes also used for Extension of Benefits)
EPO	Exclusive Provider Organization
ERISA	Employee Retirement Income Security Act of 1974
GMAP	Group Medicare Advantage Plan
HIPAA	Health Insurance Portability and Accountability Act
HSA	Health Savings Account
IBAMS	Integrated Benefits Account Management Services
MHPA	The Mental Health Parity Act

MHPAEA	Mental Health Parity & Addict Equity Act of 2008
MH/SA	Mental Health/Substance Abuse
MLPS	Medical Life Participant System
MSP	Medicare Secondary Payer
MT	Medical Trust
NOCC	Notice of Creditable Coverage
OAP	The Cigna Open Access Plus Plan, a PPO model with network and out-of-network benefits
OON	Out of Network
OOP	Out-of-Pocket
PCP	Primary Care Physician
PDP	Prescription Drug Plan (often used by Medicare)
POS	Point-of-Service
PPO	Preferred Provider Organization
RRS	Regional Relationship Specialist
R&C	Reasonable and Customary
SBC	Summary of Benefits and Coverage
SEE	Small Employer Exception
SLE	Significant Life Event
SNF	Skilled Nursing Facility
UHC	UnitedHealthcare
U&C	Usual and Customary
VEBA	Voluntary Employees' Beneficiary Association