

Plan Document Handbook

Cigna Dental Plans

Benefits effective as of January 2019

The Episcopal Church Medical Trust
Our Health, Our Members, Our Church



INTRODUCTION

ABOUT US

The Episcopal Church Medical Trust (the “Medical Trust”**) maintains a series of benefit plans for the employees (and their dependents) of the Protestant Episcopal Church in the United States of America (hereinafter referred to as “the Church”). We serve only ecclesiastical societies, dioceses, missionary districts, or other bodies subject to the authority of the church. The benefit plans maintained by the Medical Trust 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”).

The Medical Trust funds certain of its benefit plans through a trust fund, 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 purpose of the ECCEBT is to provide benefits to eligible employees, former employees, and/or their dependents in the event of illness or expenses for various types of medical care and treatment.

SERVING THE CHURCH

The mission of the Medical Trust is to “balance compassionate Christian care with financial stewardship.” This is a unique mission in the world of health care benefits, and we believe that our experience and mission to serve the church offer a level of expertise that is unparalleled. If you have questions about any of our plans, please don’t hesitate to contact us. We look forward to serving you.

For more information, please visit our website at www.cpg.org. Or you may call Customer Engagement at (800) 480-9967.

** Church Pension Group Services Corporation is the sponsor of this program and is doing business under the name “The Episcopal Church Medical Trust.”*

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Cigna Dental Benefit Summary

Episcopal Church Medical Trust

01/01/2019 (DD50: Basic Dental)



Administered by: Cigna Health and Life Insurance Company

This material is for informational purposes only and is designed to highlight some of the benefits available under this plan. Consult the plan documents to determine specific terms of coverage relating to your plan. Terms include covered procedures, applicable waiting periods, exclusions and limitations.

Benefit Plan Features	Total Cigna DPPO Network		Non-Network
Network Options	Cigna DPPO Advantage	Cigna DPPO	See Non-Network Reimbursement
Reimbursement Levels	Fee Schedule	Discount on Fees	Maximum Reimbursable Charge
Calendar Year Benefits Maximum Applies to: II, III and IX expenses	\$2,000	\$2,000	\$2,000
Calendar Year Deductible			
Individual	\$0	\$50	\$50
Family	\$0	\$150	\$150
Benefit Highlights	Plan Pays	Plan Pays	Plan Pays
Class I: Diagnostic & Preventive Oral Evaluations Prophylaxis: routine cleanings X-rays: routine X-rays: non-routine Fluoride Application Sealants: per tooth Space Maintainers: non-orthodontic Emergency Care to Relieve Pain	100% No Deductible	100% No Deductible	100% No Deductible
Class II: Basic Restorative Restorative: fillings Endodontics: minor and major Periodontics: minor and major Oral Surgery: minor Repairs: Bridges, Crowns and Inlays Repairs: Dentures Denture Relines, Rebases and Adjustments	85% No Deductible	85% After Deductible	85% After Deductible
Class III: Major Restorative Inlays and Onlays Prosthesis Over Implant Crowns: prefabricated stainless steel / resin Crowns: permanent cast and porcelain Bridges and Dentures Anesthesia: general and IV sedation Oral Surgery: major Osseous Surgery	50% No Deductible	50% After Deductible	50% After Deductible
Class IX: Implants	50% No Deductible	50% After Deductible	50% After Deductible
Benefit Plan Provisions:			
In-Network Reimbursement	For services provided by a Cigna Dental PPO network dentist, Cigna Dental will reimburse the dentist according to a Fee Schedule or Discount Schedule.		
Non-Network Reimbursement	For services provided by a non-network dentist, Cigna Dental will reimburse according to the Maximum Reimbursable Charge. The MRC is calculated at the 80th percentile of all provider charges in the geographic area. The dentist may balance bill up to their usual fees.		
Cross Accumulation	All deductibles, plan maximums, and service specific maximums cross accumulate between in and out of network. Benefit frequency limitations are based on the date of service and cross accumulate between in and out of network.		
Calendar Year Benefits Maximum	The plan will only pay for covered charges up to the yearly Benefits Maximum, when applicable. Benefit-specific Maximums may also apply.		
Calendar Year Deductible	This is the amount you must pay before the plan begins to pay for covered charges, when applicable. Benefit-specific deductibles may also apply.		
Carryover Provision	Dental Expenses incurred and applied toward the Individual or Family Deductible during the last 3 months of the calendar year will be applied toward the next year's Deductible.		
Pretreatment Review	Pretreatment review is available on a voluntary basis when extensive dental work in excess of \$200 is proposed.		

Alternate Benefit Provision	When more than one covered Dental Service could provide suitable treatment based on common dental standards, Cigna HealthCare will determine the covered Dental Service on which payment will be based and the expenses that will be included as Covered Expenses.
Oral Health Integration Program (OHIP)	Cigna Dental Oral Health Integration Program offers enhanced dental coverage for customers with the following medical conditions: diabetes, heart disease, stroke, maternity, head and neck cancer radiation, organ transplants and chronic kidney disease. There's no additional charge for the program. Those who qualify get reimbursed 100% of coinsurance for certain related dental procedures. Eligible customers can also receive guidance on behavioral issues related to oral health and discounts on prescription and non-prescription dental products. Reimbursements under this program are not subject to the annual deductible, but will be applied to and are subject to the plan annual maximum. Discounts on certain prescription and non-prescription dental products are available through Cigna Home Delivery Pharmacy only, and you are required to pay the entire discounted charge. For more information including how to enroll in this program and a complete list of program terms and eligible medical conditions, go to www.mycigna.com or call customer service 24/7 at 1.800.CIGNA24.
Timely Filing	Out of network claims submitted to Cigna after 365 days from date of service will be denied.
Benefit Limitations: Benefit frequency limitations are based on date of service.	
Oral Evaluations	3 per calendar year
X-rays (routine)	Bitewings: 2 per calendar year
X-rays (non-routine)	Complete series of radiographic images and panoramic radiographic images: Limited to a combined total of 1 per 36 months
Cleanings	3 per calendar year, including periodontal maintenance procedures following active therapy
Fluoride Application	2 per calendar year for children under age 19
Sealants (per tooth)	Limited to posterior tooth. 1 treatment per tooth every 36 months for children under age 14
Space Maintainers	Limited to non-orthodontic treatment for children under age 19
Inlays, Crowns, Bridges, Dentures and Partial	Replacement every 60 months if unserviceable and cannot be repaired. Benefits are based on the amount payable for non-precious metals. No porcelain or white/tooth-colored material on molar crowns or bridges.
Denture and Bridge Repairs	Reviewed if more than once
Denture Relines, Rebases and Adjustments	Covered if more than 6 months after installation
Prosthesis Over Implant	1 every 60 months if unserviceable and cannot be repaired. Benefits are based on the amount payable for non-precious metals. No porcelain or white/tooth colored material on molar crowns or bridges.
Benefit Exclusions:	
Covered Expenses will not include, and no payment will be made for the following:	
Procedures and services not included in the list of covered dental expenses;	
Diagnostic: cone beam imaging; Preventive Services: instruction for plaque control, oral hygiene and diet;	
Restorative: veneers of porcelain, ceramic, resin, or acrylic materials on crowns or pontics on or replacing the upper and or lower first, second and/or third molars; Periodontics: bite registrations; splinting;	
Prosthodontics: precision or semi-precision attachments; initial placement of a complete or partial denture per plan guidelines;	
Orthodontics: orthodontic treatment;	
Procedures, appliances or restorations, except full dentures, whose main purpose is to: change vertical dimension; diagnose or treat conditions or dysfunction of the temporomandibular joint (TMJ); stabilize periodontally involved teeth; or restore occlusion;	
Athletic mouth guards; services performed primarily for cosmetic reasons; personalization; replacement of an appliance per benefit guidelines;	
Services that are deemed to be medical in nature; services and supplies received from a hospital; Drugs: prescription drugs	
Charges in excess of the Maximum Reimbursable Charge.	

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

Cigna Dental PPO plans are insured and/or administered by Cigna Health and Life Insurance Company (CHLIC) or Connecticut General Life Insurance Company (CGLIC), with network management services provided by Cigna Dental Health, Inc. and certain of its subsidiaries. In Texas, the insured dental plan is known as Cigna Dental Choice, and this plan uses the national Cigna DPPO network.

All Cigna products and services are provided exclusively by or through operating subsidiaries of Cigna Corporation "Cigna Home Delivery Pharmacy" refers to Tel-Drug, Inc. and Tel-Drug of Pennsylvania, L.L.C. Policy forms (for insured dental plans) in OK: HP-POL99 (CHLIC), GM6000 ELI288 et al (CGLIC); OR: HP-POL68; TN: HP-POL69/HC-CER2V1 et al (CHLIC). The Cigna name, logo, and other Cigna marks are owned by Cigna Intellectual Property, Inc.

Cigna Dental Benefit Summary

Episcopal Church Medical Trust

01/01/2019 (DD25: Dental & Orthodontia)



Administered by: Cigna Health and Life Insurance Company

This material is for informational purposes only and is designed to highlight some of the benefits available under this plan. Consult the plan documents to determine specific terms of coverage relating to your plan. Terms include covered procedures, applicable waiting periods, exclusions and limitations.

Benefit Plan Features	Total Cigna DPPO Network		Non-Network
Network Options	Cigna DPPO Advantage	Cigna DPPO	See Non-Network Reimbursement
Reimbursement Levels	Fee Schedule	Discount on Fees	Maximum Reimbursable Charge
Calendar Year Benefits Maximum Applies to: II, III and IX expenses	\$2,000	\$2,000	\$2,000
Calendar Year Deductible			
Individual	\$0	\$25	\$25
Family	\$0	\$75	\$75
Benefit Highlights	Plan Pays	Plan Pays	Plan Pays
Class I: Diagnostic & Preventive Oral Evaluations Prophylaxis: routine cleanings X-rays: routine X-rays: non-routine Fluoride Application Sealants: per tooth Space Maintainers: non-orthodontic Emergency Care to Relieve Pain	100% No Deductible	100% No Deductible	100% No Deductible
Class II: Basic Restorative Restorative: fillings Endodontics: minor and major Periodontics: minor and major Oral Surgery: minor Repairs: Bridges, Crowns and Inlays Repairs: Dentures Denture Relines, Rebases and Adjustments	85% No Deductible	85% After Deductible	85% After Deductible
Class III: Major Restorative Inlays and Onlays Prosthesis Over Implant Crowns: prefabricated stainless steel / resin Crowns: permanent cast and porcelain Bridges and Dentures Anesthesia: general and IV sedation Oral Surgery: major Osseous Surgery	85% No Deductible	85% After Deductible	85% After Deductible
Class IV: Orthodontia Coverage for Employee and All Dependents Lifetime Benefits Maximum: \$1,500	50% No Deductible	50% After Deductible	50% After Deductible
Class IX: Implants	85% No Deductible	85% After Deductible	85% After Deductible
Benefit Plan Provisions:			
In-Network Reimbursement	For services provided by a Cigna Dental PPO network dentist, Cigna Dental will reimburse the dentist according to a Fee Schedule or Discount Schedule.		
Non-Network Reimbursement	For services provided by a non-network dentist, Cigna Dental will reimburse according to the Maximum Reimbursable Charge. The MRC is calculated at the 80th percentile of all provider charges in the geographic area. The dentist may balance bill up to their usual fees.		
Cross Accumulation	All deductibles, plan maximums, and service specific maximums cross accumulate between in and out of network. Benefit frequency limitations are based on the date of service and cross accumulate between in and out of network.		
Calendar Year Benefits Maximum	The plan will only pay for covered charges up to the yearly Benefits Maximum, when applicable. Benefit-specific Maximums may also apply.		

Calendar Year Deductible	This is the amount you must pay before the plan begins to pay for covered charges, when applicable. Benefit-specific deductibles may also apply.
Carryover Provision	Dental Expenses incurred and applied toward the Individual or Family Deductible during the last 3 months of the calendar year will be applied toward the next year's Deductible.
Pretreatment Review	Pretreatment review is available on a voluntary basis when extensive dental work in excess of \$200 is proposed.
Alternate Benefit Provision	When more than one covered Dental Service could provide suitable treatment based on common dental standards, Cigna HealthCare will determine the covered Dental Service on which payment will be based and the expenses that will be included as Covered Expenses.
Oral Health Integration Program (OHIP)	Cigna Dental Oral Health Integration Program offers enhanced dental coverage for customers with the following medical conditions: diabetes, heart disease, stroke, maternity, head and neck cancer radiation, organ transplants and chronic kidney disease. There's no additional charge for the program. Those who qualify get reimbursed 100% of coinsurance for certain related dental procedures. Eligible customers can also receive guidance on behavioral issues related to oral health and discounts on prescription and non-prescription dental products. Reimbursements under this program are not subject to the annual deductible, but will be applied to and are subject to the plan annual maximum. Discounts on certain prescription and non-prescription dental products are available through Cigna Home Delivery Pharmacy only, and you are required to pay the entire discounted charge. For more information including how to enroll in this program and a complete list of program terms and eligible medical conditions, go to www.mycigna.com or call customer service 24/7 at 1.800.CIGNA24.
Timely Filing	Out of network claims submitted to Cigna after 365 days from date of service will be denied.
Benefit Limitations: Benefit frequency limitations are based on date of service.	
Oral Evaluations	3 per calendar year
X-rays (routine)	Bitewings: 2 per calendar year
X-rays (non-routine)	Complete series of radiographic images and panoramic radiographic images: Limited to a combined total of 1 per 36 months
Diagnostic Casts	Payable only in conjunction with orthodontic workup
Cleanings	3 per calendar year, including periodontal maintenance procedures following active therapy
Fluoride Application	2 per calendar year for children under age 19
Sealants (per tooth)	Limited to posterior tooth. 1 treatment per tooth every 36 months for children under age 14
Space Maintainers	Limited to non-orthodontic treatment for children under age 19
Inlays, Crowns, Bridges, Dentures and Partials	Replacement every 60 months if unserviceable and cannot be repaired. Benefits are based on the amount payable for non-precious metals. No porcelain or white/tooth-colored material on molar crowns or bridges.
Denture and Bridge Repairs	Reviewed if more than once
Denture Relines, Rebases and Adjustments	Covered if more than 6 months after installation
Prosthesis Over Implant	1 every 60 months if unserviceable and cannot be repaired. Benefits are based on the amount payable for non-precious metals. No porcelain or white/tooth colored material on molar crowns or bridges.
Benefit Exclusions:	
Covered Expenses will not include, and no payment will be made for the following:	
Procedures and services not included in the list of covered dental expenses;	
Diagnostic: cone beam imaging; Preventive Services: instruction for plaque control, oral hygiene and diet;	
Restorative: veneers of porcelain, ceramic, resin, or acrylic materials on crowns or pontics on or replacing the upper and or lower first, second and/or third molars; Periodontics: bite registrations; splinting;	
Prosthodontics: precision or semi-precision attachments; initial placement of a complete or partial denture per plan guidelines;	
Procedures, appliances or restorations, except full dentures, whose main purpose is to: change vertical dimension; diagnose or treat conditions or dysfunction of the temporomandibular joint (TMJ); stabilize periodontally involved teeth; or restore occlusion;	
Athletic mouth guards; services performed primarily for cosmetic reasons; personalization; replacement of an appliance per benefit guidelines;	
Services that are deemed to be medical in nature; services and supplies received from a hospital; Drugs: prescription drugs	
Charges in excess of the Maximum Reimbursable Charge.	

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Cigna Dental Benefit Summary
Episcopal Church Medical Trust
01/01/2019 (DDPV: Preventive Dental)



Administered by: Cigna Health and Life Insurance Company

This material is for informational purposes only and is designed to highlight some of the benefits available under this plan. Consult the plan documents to determine specific terms of coverage relating to your plan. Terms include covered procedures, applicable waiting periods, exclusions and limitations.

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

Class IV: Orthodontia Coverage for Employee and All Dependents	1% No Deductible	99% No Deductible	1% No Deductible	99% No Deductible
Benefit Plan Provisions:				
In-Network Reimbursement	For services provided by a Cigna Dental PPO network dentist, Cigna Dental will reimburse the dentist according to a Fee Schedule or Discount Schedule.			
Non-Network Reimbursement	For services provided by a non-network dentist, Cigna Dental will reimburse according to the Maximum Reimbursable Charge. The MRC is calculated at the 80th percentile of all provider charges in the geographic area. The dentist may balance bill up to their usual fees.			
Cross Accumulation	All deductibles, plan maximums, and service specific maximums cross accumulate between in and out of network. Benefit frequency limitations are based on the date of service and cross accumulate between in and out of network.			
Calendar Year Benefits Maximum	The plan will only pay for covered charges up to the yearly Benefits Maximum, when applicable. Benefit-specific Maximums may also apply.			
Calendar Year Deductible	This is the amount you must pay before the plan begins to pay for covered charges, when applicable. Benefit-specific deductibles may also apply.			
Pretreatment Review	Pretreatment review is available on a voluntary basis when dental work in excess of \$200 is proposed.			
Alternate Benefit Provision	When more than one covered Dental Service could provide suitable treatment based on common dental standards, Cigna HealthCare will determine the covered Dental Service on which payment will be based and the expenses that will be included as Covered Expenses.			
Oral Health Integration Program (OHIP)	Cigna Dental Oral Health Integration Program offers enhanced dental coverage for customers with the following medical conditions: diabetes, heart disease, stroke, maternity, head and neck cancer radiation, organ transplants and chronic kidney disease. There's no additional charge for the program, those who qualify get reimbursed 100% of coinsurance for certain related dental procedures. Eligible customers can also receive guidance on behavioral issues related to oral health and discounts on prescription and non-prescription dental products. Reimbursements under this program are not subject to the annual deductible, but will be applied to and are subject to the plan annual maximum. Discounts on certain prescription and non-prescription dental products are available through Cigna Home Delivery Pharmacy only, and you are required to pay the entire discounted charge. For more information including how to enroll in this program and a complete list of program terms and eligible medical conditions, go to www.mycigna.com or call customer service 24/7 at 1.800.CIGNA24.			
Timely Filing	Out of network claims submitted to Cigna after 365 days from date of service will be denied.			
Benefit Limitations:				
Oral Evaluations	3 per calendar year			
X-rays (routine)	Bitewings: 2 per calendar year			
X-rays (non-routine)	Complete series of radiographic images and panoramic radiographic images: Limited to a combined total of 1 per 36 months			
Diagnostic Casts	Payable only in conjunction with orthodontic workup			
Cleanings	3 per calendar year, including periodontal maintenance procedures following active therapy			
Fluoride Application	2 per calendar year for children under age 19			
Sealants (per tooth)	Limited to posterior tooth. 1 treatment per tooth every 36 months for children under age 14			
Space Maintainers	Limited to non-orthodontic treatment for children under age 19			
Inlays, Crowns, Bridges, Dentures and Partial	Replacement every 60 months if unserviceable and cannot be repaired. Benefits are based on the amount payable for non-precious metals. No porcelain or white/tooth-colored material on molar crowns or bridges.			
Denture and Bridge Repairs	Reviewed if more than once			
Denture Relines, Rebases and Adjustments	Covered if more than 6 months after installation			
Prosthesis Over Implant	Replacement every 60 months if unserviceable and cannot be repaired. Benefits are based on the amount payable for non-precious metals. No porcelain or white/tooth-colored material on molar crowns or bridges.			
Benefit Exclusions:				
Covered Expenses will not include, and no payment will be made for the following:				
Procedures and services not included in the list of covered dental expenses;				

Diagnostic: cone beam imaging; Preventive Services: instruction for plaque control, oral hygiene and diet;
Restorative: veneers of porcelain, ceramic, resin, or acrylic materials on crowns or pontics on or replacing the upper and or lower first, second and/or third molars; Periodontics: bite registrations; splinting;
Prosthetic: precision or semi-precision attachments; initial placement of a complete or partial denture per plan guidelines;
Implants: implants or implant related services
Procedures, appliances or restorations, except full dentures, whose main purpose is to: change vertical dimension; diagnose or treat conditions or dysfunction of the temporomandibular joint (TMJ); stabilize periodontally involved teeth; or restore occlusion;
Athletic mouth guards; services performed primarily for cosmetic reasons; personalization; replacement of an appliance per benefit guidelines;
Services that are deemed to be medical in nature; services and supplies received from a hospital; Drugs: prescription drugs
Charges in excess of the Maximum Reimbursable Charge

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BSD

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ELIGIBILITY AND ENROLLMENT

DEFINITIONS

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

Billed Group

A Participating Group or one of its congregations, schools or other bodies, including Employees and Pre-65 Retired Employees or Post-65 Retired 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.

Child(ren)

A Subscriber’s or Subscriber’s Spouse’s natural child, stepchild, legal ward, foster child¹, 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.

¹ 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.

Spouse

A lawful husband or wife defined by the laws of the jurisdiction where the marriage occurred.

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 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.

Disabled

A medically determinable physical or mental condition, which prevents an individual from engaging in substantial gainful activity and which can be of long-continued or indefinite duration.

Eligible Dependent

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

Eligible Individual

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

Employee

An individual 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.

Exempt Employee

An Employee who is not subject to the overtime provisions of the Fair Labor Standards Act² or other applicable state law due to the nature of the work, education requirements

² http://www.dol.gov/whd/overtime_pay.htm. For purposes of these definitions, it is assumed that the Fair Labor Standards Act applies to the employer.

of the position and salary range. Priests performing traditional duties as described by the Constitutions and Canons of the Episcopal Church are generally considered Exempt Employees by the Plan.

Non-Exempt Employee

An individual who is entitled to overtime compensation under the Fair Labor Standards Act or other applicable state law.

Pre-65 Retired 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 Exempt Employee or a Non-Exempt 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, **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

Priest

An individual ordained to the priesthood in the Episcopal Church pursuant to the Constitution and Canons or a person who has been received as a Priest into the Episcopal Church from another Christian denomination in accordance with the Constitution and Canons.

Post-65 Retired Employee

Clergy:

A former Employee who:

- (a) Is age 65 or older **and**
- (b) Has a vested benefit 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 either an Exempt Employee or a Non-Exempt Employee who 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.

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 fund 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 medical 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.

Open 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 Open Enrollment

During an Active Open Enrollment, a Subscriber or Eligible Individual is required by the

Plan to take specific actions to prevent any loss of coverage. An Active Open 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 Open Enrollment

During a Passive Open Enrollment, a Subscriber or Eligible Individual is not required by the Plan to take any action³. However, the Plan encourages Subscribers and Eligible Individuals to log on to the Open Enrollment website to verify demographic information and existing coverage and to update any data that are not accurate.

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.

Plan(s)

The medical and dental plans (i.e. health plans) maintained by the Episcopal Church Medical Trust (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. This plan is applicable only to those employers and individuals who apply and are certified by Centers for Medicare & Medicaid Services (CMS) as meeting the criteria to participate.

Medicare Supplement Health Plan (MSHP)

A program of supplemental medical and dental Plans through which Eligible Individuals and Eligible Dependents of the Episcopal Church are provided health benefits. Benefits

³ Note, however, that some states may require a new signed authorization from the employee when the amount of the payroll deduction increases

are provided through the Medical Trust. A Medicare supplement 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 Medicare supplement plan only works with the Original Medicare Plan, where Medicare pays first (primary) for a medical claim, and the Medicare supplement plan pays for the medical claim after (secondary) the Original Medicare Plan. The Original Medicare Plan and the MSHP only pay claims for services that are provided in the United States.

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 a mid-year election change.

Subscriber

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

ELIGIBILITY AND ENROLLMENT

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 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 Exempt Employee
- A Non-Exempt Employee normally scheduled to work 1,000 or more compensated hours per plan year
- A Seminarian who is a full-time student enrolled at a participating seminary of the Association of Episcopal Seminaries
- A postulant, novice or professed member of Episcopal Religious Orders⁴ who has been accepted or received by the Religious Order
- A Pre-65 Retired Employee, not eligible for Medicare, as long as his/her former employer is participating in the EHP

Eligible Dependents

- A Spouse*
- A Domestic Partner, if Domestic Partner benefits are elected by the Participating Group*
- A Child who is 30⁵ years of age or younger on December 31st of the current year*
- A Disabled Child, 30 years of age or older on December 31st of the current year, provided the disability began before the age of 25**
- A Pre-65 Dependent, of a Post-65 Retired Employee enrolled in the MSHP***
- A Pre-65 Surviving Dependent of a deceased Post-65 Retired Employee or Pre-65 Retired Employee**

**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.*

⁴ As defined in Title III, Canon 14.1, Constitution and Canons of The Episcopal Church, 2012

⁵ Local managed care plans cover children up to age 26; the eligibility rules of the regional or local plans vary and will apply.

****The Dependent will be enrolled as a Subscriber; however, eligibility is based on the Post-65 Retired Employee's status.*

Ineligible Individuals

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

- A part-time Non-Exempt Employee who is scheduled to work and be compensated for less than 1,000 hours per plan year
- A Temporary Employee
- A Seasonal Employee
- 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 Retired Employee or Pre-65 Retired Employee (or Spouse/Domestic Partner) eligible for Medicare, regardless of whether he or she is actually enrolled in Medicare
- 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
- An Employee receiving a disability retirement benefit where the disability retirement occurred prior to age 55 and who is not Medicare eligible

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 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 30 days after receipt of the form. If eligibility is granted, the effective date of coverage will be the 1st 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 does not require, or allow Participating Groups to require, that an Eligible Individual must be employed or be part of the Participating Group for any length of time before being allowed to participate in the Plan. Additional information on new hires can be found in the Plan Election and Enrollment Guidelines section.

Pre-Existing Medical Conditions

Eligibility will not be denied due to an individual's health status.

Medicare/Medicaid

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 SEE qualified members, eligibility for Medicare will be taken into account in determining eligibility.

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

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

Some Employees and/or Spouses 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 participates in this program.

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 health care 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.

For all benefits covered by Medicare Part B, such as doctor visits, outpatient procedures, and some prescription drugs, the Empire BlueCross BlueShield Plan 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 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.

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.

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 Exempt Employee
- A Non-Exempt Employee normally scheduled to work 1,000 or more compensated hours per plan year
- A Seminarian who is a full-time student enrolled at a participating seminary of the Association of Episcopal Seminaries
- A postulant, novice, or professed member of Episcopal Religious Orders⁶ who has been accepted or received by the Religious Order

Eligible Dependents

- A Spouse*
- A Domestic Partner, if Domestic Partner benefits are elected by the Participating Group
- A Child who is 30 years of age or younger on December 31st of the current year
- A Disabled Child, 30 years of age or older on December 31st 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 not eligible to enroll in the EHP for SEE.

- Any Employee working for a Participating Group that does not meet the criteria for the SEE
- A part-time Non-Exempt Employee who is scheduled to work and be compensated for less than 1,000 hours per year
- A Temporary Employee
- A Seasonal Employee
- 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 volunteer
- An Employee whose working papers have expired and can no longer legally work

⁶ As defined in Title III, Canon 14.1, Constitution and Canons of The Episcopal Church, 2012

An Eligible Individual or Eligible Dependent who refuses to provide a Social Security or Individual Taxpayer Identification number

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, Open 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 his/her elected Plan or Coverage Tier except during Open Enrollment, unless there is a Significant Life Event or a HIPAA Special Enrollment Event.

Important Note: the Plan does not allow a member to terminate dental coverage mid-year.

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, commencement of or return from an unpaid leave of absence, changing from Employee to Pre-65 Retired Employee or Post-65 Retired 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 cost or a significant curtailment of medical coverage during a plan year for a Subscriber or Dependent
- Medicare entitlement (or loss of such entitlement)
- 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 of a post 65 actively working subscriber or subscriber's Spouse to participate in the EHP SEE

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 or adoption). Election changes must be received by the Plan no later than 30 days after the Significant Life Event and are valid for the remainder of the current plan year.

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 him/herself and his or her Eligible Dependents for coverage under the Plan outside of the Open 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

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
- Retirement of an Employee
- Billing information change

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.
- Seminary Group Administrators must submit paper Enrollment Forms to the Plan instead of using the MLPS website. Forms should be mailed or faxed to Client Engagement.

- Pre-65 Retired Employees and Post-65 Retired 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 with Express Scripts Medicare — the Part D prescription drug coverage under the MSHP—that CMS has certain requirements, such as a 21 day opt out period, that need to 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

Open Enrollment

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

At the beginning of Open Enrollment, Subscribers receive a personalized letter outlining the steps required to make plan election(s) or other changes for the upcoming plan year. The letter contains information about the Open Enrollment website, instructions, a personal login and password, and the dates the Open Enrollment website will be available.

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

The Open Enrollment website contains:

- Current demographic and coverage information
- Available medical and/or dental Plans
- Full contribution rates for each Plan and Coverage Tier⁷
- Options to add or remove Eligible Dependents
- The deadline for submitting plan elections
- Reference material and other helpful resources

Newly Eligible Individuals Enrollment

Newly Eligible Individuals have a period of 30 days immediately following the hire date or date the individual became part of the Participating Group to elect a health Plan for the remainder of the current plan year. Plan elections, once made, cannot be changed for the remainder of the current plan year, unless the Member experiences a Significant Life Event or HIPAA Special Enrollment Event.

Seminarian Open Enrollment

Open Enrollment for Seminarians is held during the summer preceding the plan year that runs from August 1st through July 31st. New plan elections for Seminarians who begin studying in the spring semester may be submitted before the commencement of classes. Plan elections must be submitted before the semester in which the Seminarian is enrolling commences.

Seminarians must complete an enrollment form and submit it to the Seminary Group Administrator.

⁷ Employer/Employee cost share information is not provided.

Important note for the Association of Episcopal Seminaries: the medical Plans run on an academic year and the dental and vision plans on a calendar year basis.

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.

New Employees

The effective date of coverage for a new Employee is the first day of the month following the Employee's date of hire. 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. Monday, June 1), coverage for the Employee will commence on the first day of that month (i.e. Monday, June 1), provided that the Plan receives an enrollment form or MLPS submission within 30 days of that date.

If the Employee does not enroll (or is not automatically enrolled by the Participating Group, if applicable) when initially eligible, the Employee must wait for an applicable Significant Life Event or HIPAA Special Enrollment Event to occur, or wait until the next Open 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 he or she is 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 he or she must wait for an applicable Significant Life Event or HIPAA Special Enrollment Event to occur or until the next Open 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 he or she enrolls 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. Paper enrollment forms must be submitted by the Seminary Group Administrator to Client Engagement.

If the Seminarian does not enroll when initially eligible, then he or she 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 Retired Employees

A Pre-65 Retired 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 Retired Employee status* is received by the Plan within 30 days of the retirement date.

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

Once the Pre-65 Retired Employee becomes Medicare-eligible, he or she must actively switch enrollment to the Medicare Supplement Health Plan (MSHP). 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 he or she too must actively switch enrollment to the MSHP. The enrolled Children who are not Disabled may remain in the EHP until the end of the year in which they reach age 30.

If the Pre-65 Retired Employee has a spouse who becomes age 65 and is not actively working, the Post-65 Retired Spouse of the Pre-65 Retired Employee is allowed to enroll in the MSHP provided he or she is enrolled in Medicare Parts A and B. The Pre-65 Retired Employee remains in the EHP. This reverse split is allowed because the Subscriber is a Pre-65 Retired Employee.

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

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

Enrollment in the EHP for Pre-65 Retired 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) Are joining the EHP as part of a new Participating Group

For these limited circumstances, the Pre-65 Retired Employee may enroll in the EHP at the time of a HIPAA Special Enrollment Event or annual open enrollment, and remain in the EHP until such time as he or she becomes Medicare-eligible, at which time the Employee must actively switch enrollment to the MSHP. 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 he or she too must actively switch enrollment to the MSHP.

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

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

Post-65 Retired Employees

The effective date of coverage for the MSHP for a Post-65 Retired Employee is the first day of the month in which he or she turns age 65, provided that he or she is enrolled in Medicare Parts A and B and meets the eligibility requirements of the Plan.

If the Post-65 Retired Employee does not enroll when initially eligible, then he or she must wait for an applicable Significant Life Event or HIPAA Special Enrollment Event to occur, or wait until the next Open 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 Open Enrollment period or until another Significant Life Event or HIPAA Special Enrollment Event occurs.

New Children

A Subscriber's newborn Child is temporarily covered under the Plan for the first 30 days immediately following birth. However, the Subscriber must enroll the new Child for coverage within 30 days of the birth in order for coverage to continue beyond the 30-day period and to ensure claims incurred during the first 30 days are covered. The coverage effective date will be the date of birth. If applicable, monthly contribution rates will change to reflect the new Coverage Tier on the first day of the month following the date of birth. If 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 Open Enrollment period or the occurrence of a subsequent Significant Life Event or HIPAA Special Enrollment Event.

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 Open 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 his/her 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 his/her 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 Open Enrollment period or until a Significant Life Event or HIPAA Special Enrollment Event occurs.

Non-Medicare-eligible Dependents

A Post-65 Retired Employee and his/her Eligible Dependents may split enrollment between the EHP and the MSHP in cases where the Post-65 Retired 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, he or she must actively switch enrollment to the MSHP. The Subscriber's enrolled Children who are not Disabled may continue to participate in the EHP until the end of the year in which they reach age 30.

Disabled Children

If the Dependent Child is Disabled prior to his/her 25th birthday and continues to be Disabled 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.

Satisfactory proof of disability must be submitted to the Plan within 30 days after the end of the month in which the Child reaches age 25. The Plan may require, at any time, a physician's statement certifying the physical or mental disability.

Children of Surviving Spouses of Limited Means

The Children's Health Insurance Program (CHIP)⁸, 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.

⁸ The Children's Health Insurance Program Reauthorization Act of 2009 (CHIPRA or Public Law 111-3) reauthorized the Children's Health Insurance Program (CHIP). CHIPRA finances CHIP through FY 2013

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 his/her 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 his/her 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 7⁹.

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. 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

⁹ The Constitution and Canons of the Episcopal Church, 2012

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, the Member can retain his/her active coverage. If the leave of absence is unpaid, 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 he or she is 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 (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, except if the Child is Disabled 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

Employee/Seminarian

When an Employee or Seminarian enrolled in the EHP dies, his/her 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 enroll in the Extension of Benefits Program will be the first day of the month following the Subscriber's date of death.

Post-65 Retired Employee or Pre-65 Retired Employee

When a Post-65 Retired Employee enrolled in MSHP or a Pre-65 Retired Employee enrolled in the EHP dies, the Surviving Spouse or Surviving Domestic Partner who is also enrolled in the EHP can remain covered until he or she becomes Medicare-eligible, at which time he or she must actively enroll in the MSHP if eligible. His/her enrolled Children may remain in the EHP until the last day of the year in which they turn 30 or later if the Child is Disabled 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 MSHP. Surviving Spouses and Surviving Domestic Partners enrolled in the MSHP at the time of Member's death can remain covered in the MSHP.

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 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 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.

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 last day of the month in which the relationship was officially terminated.

Employees and Seminararians

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

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

The Pre-65 Spouse or Domestic Partner enrolled in the EHP who gets divorced from a Post-65 Retired Employee or Pre-65 Retired Employee can stay enrolled in the EHP. However, if the Spouse or Domestic Partner leaves the EHP, then he or she cannot enroll again with the Plan until he or she becomes eligible for the MSHP. He or she can leave the MSHP and join again at future Open Enrollment periods.

Post-65 Retired Employees or Pre-65 Retired Employees with Dependents in the MSHP

The Spouse or Domestic Partner enrolled in the MSHP who gets divorced from a Post-65 Retired Employee or Pre-65 Retired Employee can stay enrolled in the MSHP. He or she can leave the MSHP and join again at future Open 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 requirements¹⁰. 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, 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 for any reason other than due to attaining age 30 are offered an extension of up to 36 months starting on the first day of the month following the termination event. The extension will end after 36 months for Disabled Children. For non-Disabled Children, the extension will end after 36 months or on the last day of the calendar year in which the Child turns age 30, whichever comes first.
- 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.

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 the extension 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

¹⁰ Under Section 4980B(d) of the Code and Treasury Regulation Section 54.4980 B-2, Q. and A. No. 4.

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. Responses must include a payment to cover the contributions that are due. Otherwise, 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 individual directly, without the involvement of the Group Administrator. 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 Open 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 Medicare-eligible and enrolled
- 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 terminates participation with the Plan to enroll 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
- The date the Plan ceases to exist
- The last day of the calendar year in which a Non-Disabled Dependent Child turns age 30

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 MSHP). 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).

Certificate of Creditable Coverage

HIPAA requires the Plan to provide a Certificate of Creditable Coverage automatically and free of charge when a Member loses coverage under the Plan. The Plan will also provide a Certificate of Creditable Coverage, free of charge upon request by a Member or any time within 24 months after a Member's coverage ends. The Certificate of Creditable Coverage is a document that shows prior periods of coverage under the Plan. In addition to standard identification information, the Certificate will include the date on which coverage under the Plan began and ended.

CIGNA DENTAL PPO NETWORK

The Medical Trust dental plans described in this handbook use the Cigna Dental Participating Provider Organization (PPO) Network (“the network”) to provide dental benefits for you and your eligible dependents.

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

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

You can access the dental provider directory:

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

When you select a participating provider, the Plan pays a greater share of the cost than if you were to select a non-participating provider.

CHOOSING A NETWORK PROVIDER

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

Choice—You can choose any provider participating in the network.

Convenience—Usually, there are no claim forms to file.

Discounts—Your out-of-pocket cost may be lower due to the PPO contracted rate.

CHOOSING AN OUT-OF-NETWORK PROVIDER

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

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

COVERAGE FOR THE BASIC DENTAL AND DENTAL & ORTHODONTIA PPO PLANS

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

Covered Dental Expense means that portion of a dentist's charge that is payable for a service delivered to a covered person provided:

- The service is ordered or prescribed by a dentist
- Is essential for the necessary care of teeth
- The service is within the scope of coverage limitations
- The deductible amount in the schedule has been met
- The maximum benefit in the schedule has not been exceeded
- The charge does not exceed the amount allowed under the Alternate Benefit Provision
- For Class I, II or III, the service is started and completed while coverage is in effect

COVERED DIAGNOSTIC AND PREVENTIVE SERVICES (CLASS I)

- Clinical oral examination – three per person per calendar year
- Palliative (emergency) treatment of dental pain, minor procedures when no other definitive dental services are performed. (Any x-ray taken in connection with such treatment is a separate dental service.)
- X-rays – Complete series – one per person, including panoramic film, in any three calendar years
- Bitewing x-rays – two charges per person per calendar year
- Panoramic (Panorex) x-ray – one per person in any three calendar years
- Other x-rays necessary to diagnose a dental condition, including periapical and occlusal x-rays
- Prophylaxis and Periodontal Prophylaxis (Cleaning) – three per person per calendar year
- Periodontal maintenance procedures (following active therapy)
- Topical application of fluoride (excluding prophylaxis) – Limited to persons less than 19 years old. Two per person per calendar year
- Topical application of sealant, per tooth, on a posterior tooth for a person less than 14 years old – One treatment per tooth in any three calendar years
- Space Maintainers, fixed unilateral – Limited to nonorthodontic treatment

COVERED BASIC RESTORATIONS, ENDODONTICS, PERIODONTICS AND PROSTHODONTIC MAINTENANCE (CLASS II)

- Amalgam filling—one surface
- Composite/resin filling—one surface
- Examinations for consultation purposes
- Lab tests (oral pathology)
- Injections of antibiotic drugs
- Sedative filling restoration for decayed teeth, including pin retention when there is insufficient tooth structure to hold the filling
- Root Canal Therapy—any x-ray, test, laboratory exam or follow-up care is part of the allowance for root canal therapy and not a separate dental service
- Periodontal Scaling and Root Planing—entire mouth
- Adjustments—complete dentures (Any adjustment of or repair to a denture within six months of its installation is not a separate dental service.)
- Tissue conditioning in connection with dentures
- Recementation of crowns, bridges, and dentures
- Simple extractions
- Repair of inlays, onlays, crowns, and bridgework
- Local anesthetic

COVERED MAJOR RESTORATIONS, DENTURES, BRIDGEWORK AND ORAL SURGERY (CLASS III)

- High Noble Metal (gold) or Crown restorations are dental services only when the tooth, as a result of extensive caries or fracture, cannot be restored with amalgam, composite/resin, silicate, acrylic or plastic restoration.
- Crowns
 - Porcelain Fused to High Noble Metal
 - Full Cast, High Noble Metal
 - Three-Fourths Cast, Metallic
- Fixed or Removable Appliances
 - Complete (Full) Dentures, Upper or Lower
- Partial Dentures
 - Lower, Cast Metal Base with Resin Saddles (including any conventional clasps, rests and teeth)
 - Upper, Cast Metal Base with Resin Saddles (including any conventional clasps rests and teeth)
- Overdentures
- Bridge Pontics
 - Cast High Noble Metal
 - Porcelain Fused to High Noble Metal
 - Resin with High Noble Metal

- Retainer Crowns
 - Resin with High Noble Metal
 - Porcelain Fused to High Noble Metal
 - Full Cast High Noble Metal
- Replacement of crowns, bridges, or dentures is only payable if the existing crown, bridge, or denture is at least 5 calendar years old, is not serviceable and cannot be repaired.
- Prosthesis Over Implant – A prosthetic device, supported by an implant or implant abutment is a covered expense. Replacement of any type of prosthesis with a prosthesis supported by an implant or implant abutment is only payable if the existing prosthesis is at least 5 calendar years old, is not serviceable and cannot be repaired.
- Osseous Surgery – Flap entry and closure is part of the allowance for osseous surgery and not a separate dental service.
- Surgical Removal of Erupted Tooth Requiring Elevation of Mucoperiosteal Flap and Removal of Bone and/or Section of Tooth
 - Removal of Impacted Tooth, Soft Tissue
 - Removal of Impacted Tooth, Partially Bony
 - Removal of Impacted Tooth, Completely Bony

Please note that oral surgery may also be covered under your medical plan.

- General Anesthesia – Paid as a separate benefit only when medically or dentally necessary, as determined by Cigna, and when administered in conjunction with complex oral surgical procedures which are covered under this plan.
- I.V. Sedation – Paid as a separate benefit only when medically or dentally necessary, as determined by Cigna, and when administered in conjunction with complex oral surgical procedures which are covered under this plan.
- Inlays – A cast gold filling that is used to replace part of a tooth
- Onlays – A cast gold or porcelain filling that covers one or all of the tooth's cusps

**COVERED ORTHODONTIC SERVICES (CLASS IV)
(APPLIES TO DENTAL & ORTHODONTIA PPO PLAN ONLY)**

Each month of active treatment is a separate dental service. Covered expenses include:

- Orthodontic work-up including x-rays, diagnostic casts and treatment plan and the first month of active treatment including all active treatment and retention appliances
- Continued active treatment after the first month

- Fixed or Removable Appliances - Only one appliance per person for tooth guidance or to control harmful habits
- Study models
- Photos

The total amount payable for all expenses incurred for orthodontics during a person's lifetime will not be more than the orthodontia Maximum shown in the Schedule.

Payments for comprehensive full-banded orthodontic treatment are made in installments. Benefit payments will be made every three months. The first payment is due when the appliance is installed. Later payments are due at the end of each 3-month period. The first installment is 25% of the charge for the entire course of treatment. The remainder of the charge is prorated over the estimated duration of treatment. Payments are only made for services provided while a person is insured. If insurance coverage ends or treatment ceases, payment for the last 3-month period will be prorated.

WHAT'S NOT COVERED

Covered expenses will not include, and no payment will be made for:

- Services performed solely for cosmetic reasons
- Replacement of a lost or stolen appliance
- Replacement of a bridge, crown or denture within five years after the date it was originally installed unless: (a) the replacement is made necessary by the placement of an original opposing full denture or the necessary extraction of natural teeth; or (b) the bridge, crown or denture, while in the mouth, has been damaged beyond repair as a result of an injury received while a person is insured for these benefits
- Any replacement of a bridge, crown or denture which is or can be made useable according to common dental standards
- Procedures, appliances or restorations (except full dentures) whose main purpose is to: (a) change vertical dimension; (b) diagnose or treat conditions or dysfunction of the temporomandibular joint; (c) stabilize periodontally involved teeth; or (d) restore occlusion
- Porcelain or acrylic veneers of crowns or pontics on, or replacing the upper and lower first, second and third molars
- Bite registrations, precision or semiprecision attachments, or splinting
- Instruction for plaque control, oral hygiene, and diet
- Stress breakers

- Myofunctional therapy
- Athletic mouth guards
- Dental services that do not meet common dental standards
- Services that are deemed to be medical services
- Services and supplies received from a hospital
- Travel expenses of a dentist or a covered person
- Expenses for preparing dental reports, itemized bills, or claim forms
- Expenses for telephone calls or broken appointment
- Services for which benefits are not payable according to the "General Limitations" section

GENERAL LIMITATIONS

No payment will be made for expenses incurred for you or any one of your dependents:

- For services rendered by anyone other than a covered dentist
- For complications arising from any noncovered services or treatment
- For, or in connection with, an injury arising out of, or in the course of, any employment for wage or profit
- For, or in connection with, a sickness which is covered under any workers' compensation or similar law
- For charges made by a hospital owned or operated by, or which provides care or performs services for, the United States Government, if such charges are directly related to a military service-connected condition
- Services or supplies received as a result of dental disease, defect, or injury due to an act of war, declared or undeclared
- To the extent that payment is unlawful where the person resides when the expenses are incurred
- For charges which the person is not legally required to pay
- For charges which would not have been made if the person had no insurance
- Expenses incurred for services rendered prior to the date of coverage or after the date the coverage ends under these Plans
- To the extent that billed charges exceed the rate of reimbursement as described in the Schedule of Benefits
- For charges for unnecessary care, treatment, or surgery
- To the extent that you or any of your dependents is in any way paid or entitled to payment for those expenses by or through a public program, other than Medicaid
- For, or in connection with, experimental procedures or treatment methods not approved by the American Dental Association or the appropriate dental specialty society

COVERAGE FOR THE PREVENTIVE DENTAL PPO PLAN

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

Covered Dental Expense means that portion of a dentist's charge that is payable for a service delivered to a covered person provided:

- The service is ordered or prescribed by a dentist
- Is essential for the necessary care of teeth
- The service is within the scope of coverage limitations
- The deductible amount in the schedule has been met
- The maximum benefit in the schedule has not been exceeded
- The charge does not exceed the amount allowed under the Alternate Benefit Provision
- For Class I, II or III, the service is started and completed while coverage is in effect

COVERED PREVENTIVE AND DIAGNOSTIC SERVICES (CLASS I)

- Clinical oral examination—three per person per calendar year
- Palliative (emergency) treatment of dental pain, minor procedures, when no other definitive dental services are performed. (Any x-ray taken in connection with such treatment is a separate dental service.)
- X-rays : Complete series—one per person, including panoramic film, in any three calendar years
- Bitewing x-rays—two charges per person per calendar year
- Panoramic (Panorex) x-ray—one per person in any three calendar years
- Prophylaxis and Periodontal Prophylaxis (Cleaning)— three per person per calendar year
- Topical application of fluoride (excluding prophylaxis)—Limited to persons less than 19 years old. Two per person per calendar year

COVERED BASIC, RESTORATIVE SERVICES (CLASS II)

- Amalgam Filling – one surface
- Composite/Resin Filling, one surface
- Sedative filling restoration for decayed teeth, including pin retention when there is insufficient tooth structure to hold the filling

- Adjustments – Complete Denture. Any adjustment of or repair to a denture within six months of its installation is not a separate dental service
- Simple Extractions
- Necessary repair of dentures or bridgework
- Lab tests (oral pathology)
- Root Canal Therapy—Any x-ray, test, laboratory exam or follow-up care is part of the allowance for root canal therapy and not a separate dental service

COVERED MAJOR SERVICES - MAJOR RESTORATIONS, DENTURES, BRIDGEWORK AND ORAL SURGERY (CLASS III)

- High Noble Metal (gold) or Crown restorations are dental services only when the tooth, as a result of extensive caries or fracture, cannot be restored with amalgam, composite/resin, silicate, acrylic or plastic restoration.
- Crowns
 - Porcelain Fused to High Noble Metal
 - Full Cast, High Noble Metal
 - Three-Fourths Cast, Metallic
- Fixed or Removable Appliances
 - Complete (Full) Dentures, Upper or Lower
- Partial Dentures
 - Lower, Cast Metal Base with Resin Saddles (including any conventional clasps, rests and teeth)
 - Upper, Cast Metal Base with Resin Saddles (including any conventional clasps rests and teeth)
- Bridge Pontics
 - Cast High Noble Metal
 - Porcelain Fused to High Noble Metal
 - Resin with High Noble Metal
- Retainer Crowns
 - Resin with High Noble Metal
 - Porcelain Fused to High Noble Metal
 - Full Cast High Noble Metal
- Prosthesis Over Implant—A prosthetic device, supported by an implant or implant abutment is a covered expense. Replacement of any type of prosthesis with a prosthesis supported by an implant or implant abutment is only payable if the existing prosthesis is at least five calendar years old, is not serviceable and cannot be repaired
- Inlays—A cast gold filling that is used to replace part of a tooth
- Onlays—A cast gold or porcelain filling that covers one or all of the tooth's cusps

COVERED ORTHODONTIA SERVICES (CLASS IV)

Each month of active treatment is a separate dental service. Covered expenses include:

- Orthodontic work-up including x-rays, diagnostic casts, and treatment plan, and the first month of active treatment including all active treatment and retention appliances
- Continued active treatment after the first month
- Fixed or Removable Appliances—Only one appliance per person for tooth guidance or to control harmful habits
- Study models
- Photos

The total amount payable for all expenses incurred for orthodontics during a calendar year will not be more than the orthodontia maximum shown in the Schedule of Benefits.

Payments for comprehensive full-banded orthodontic treatment are made in installments. Benefit payments will be made every three months. The first payment is due when the appliance is installed. Later payments are due at the end of each 3-month period. The first installment is 25% of the charge for the entire course of treatment. The remainder of the charge is prorated over the estimated duration of treatment. Payments are only made for services provided while a person is insured. If insurance coverage ends or treatment ceases, payment for the last 3-month period will be prorated.

WHAT'S NOT COVERED

Covered expenses will not include, and no payment will be made for:

- Services performed solely for cosmetic reasons
- Replacement of a lost or stolen appliance
- Replacement of a bridge, crown or denture within five years after the date it was originally installed unless: (a) the replacement is made necessary by the placement of an original opposing full denture or the necessary extraction of natural teeth; or (b) the bridge, crown or denture, while in the mouth, has been damaged beyond repair as a result of an injury received while a person is insured for these benefits
- Any replacement of a bridge, crown, or denture which is or can be made useable according to common dental standards
- Procedures, appliances or restorations (except full dentures) whose main purpose is to: (a) change vertical dimension; (b) diagnose or treat conditions or dysfunction of the temporomandibular joint; (c) stabilize periodontally involved teeth; or (d) restore occlusion

- Porcelain or acrylic veneers of crowns or pontics on, or replacing the upper and lower first, second, and third molars
- Bite registrations, precision or semiprecision attachments, or splinting
- Topical application of sealant
- Space maintainers
- Injections of antibiotic drugs
- Any periodontal procedure, including scaling and root planing, with the exception of periodontal prophylaxis
- Recementation of crowns, bridges, or dentures
- Instruction for plaque control, oral hygiene, and diet
- Expenses for telephone calls, telephone consultations, or broken appointments
- Expenses for preparing or copying dental reports, itemized bills, or claim forms
- Travel expenses of a dentist or a covered person
- Dental services that do not meet common dental standards
- Expenses incurred for services rendered prior to the date of coverage or after the date coverage ends under this Plan
- General anesthesia
- Intravenous sedation
- Local anesthesia if billed separately
- Overdentures
- Myofunctional therapy
- Oral surgery, except for simple extractions
- Please note that oral surgery may be covered under your medical plan
- Osseous surgery — Flap entry and closure is part of the allowance for osseous surgery and not a separate dental service
- Athletic mouth guards
- Stress breakers
- Services for which benefits are not payable according to the "General Limitations" section

GENERAL LIMITATIONS

No payment will be made for expenses incurred for you or any one of your dependents:

- For, or in connection with, an injury arising out of, or in the course of, any employment for wage or profit

- For or in connection with a sickness which is covered under any workers' compensation or similar law
- For charges made by a hospital owned or operated by or which provides care or performs services for, the United States Government, if such charges are directly related to a military service-connected condition
- Services or supplies received as a result of dental disease, defect, or injury due to an act of war, declared or undeclared
- To the extent that payment is unlawful where the person resides when the expenses are incurred
- For charges which the person is not legally required to pay
- For charges which would not have been made if the person had no insurance
- For services rendered by anyone other than a covered dentist
- To the extent that billed charges exceed the rate of reimbursement as described in the Schedule
- For charges for unnecessary care, treatment or surgery
- To the extent that you or any of your dependents is in any way paid or entitled to payment for those expenses by or through a public program, other than Medicaid
- For or in connection with experimental procedures or treatment methods not approved by the American Dental Association or the appropriate dental specialty society
- For complications arising from any noncovered services or treatment
- Services that are deemed to be medical services
- Services and supplies received from a hospital

DETAILS AND DEFINITIONS

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

ALTERNATE BENEFIT PROVISION

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

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

COINSURANCE

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

CONTRACTED FEE (CIGNA DENTAL PREFERRED PROVIDER)

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

DEDUCTIBLES

Deductibles are expenses to be paid by you or your dependent. Deductibles are in addition to any coinsurance. Once the deductible maximum in the Schedule of Benefits has been reached, you and your family need not satisfy any further dental deductible for the rest of that calendar year.

DENTIST

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

EMERGENCY SERVICES

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

EXPENSE INCURRED

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

- Dentures, crowns, or bridgework—the date they are seeded or cemented
- Root canal therapy—the date the pulp chamber is opened

MAXIMUM REIMBURSABLE CHARGE

The Maximum Reimbursable Charge (MRC) is the lesser of:

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

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

Cigna uses the Ingenix Prevailing Health Care System database to determine the charges made by providers in an area. The database is updated semiannually.

Additional information about the Maximum Reimbursable Charge is available upon request.

PARTICIPATING PROVIDER (CIGNA DENTAL PREFERRED PROVIDER)

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

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

PLAN YEAR

The word “year,” as used in this handbook, refers to the plan year, which is the 12-month period beginning January 1 and ending December 31. All annual benefit maximums and deductibles accumulate during the plan year.

PREDETERMINATION OF BENEFITS

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

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

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

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

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

COORDINATION OF BENEFITS

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

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

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

PLAN

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

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

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

CLOSED PANEL PLAN

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

PRIMARY PLAN

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

SECONDARY PLAN

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

ALLOWABLE EXPENSE

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

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

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

CLAIM DETERMINATION PERIOD

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

REASONABLE CASH VALUE

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

ORDER OF BENEFIT DETERMINATION RULES

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

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

If none of the above rules determines the order of benefits, the plan that has covered you for the longer period of time shall be primary.

EFFECTS ON THE BENEFITS OF THIS PLAN

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

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

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

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

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

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

OTHER IMPORTANT PLAN PROVISIONS

ASSIGNMENT OF BENEFITS

All PPO (“network”) benefits payable by the Plans are automatically assigned to the provider of services or supplies, unless evidence of previous payment is submitted with the claim. All other benefits payable by the Plans may be assigned to the provider of services or supplies at your option. Payments made in accordance with an assignment are made in good faith and release the Plans’ obligation to the extent of the payment. Payments will also be made in accordance with any assignment of rights required by a state Medicaid plan.

REIMBURSEMENT TO THE PLAN

This section applies whenever another party (including your own insurer under an automobile or other policy) is legally responsible or agrees to compensate you or your dependent, by settlement, verdict, or otherwise, for an illness or injury. This section reflects the equitable obligation to reimburse the Plans from any recovery by you, your dependent or representative. If another party is legally responsible or agrees to provide any compensation, you or your dependent (or the legal representatives, estate, heirs, or trusts established on behalf of either you or your dependent) must promptly reimburse the Plans for any dental benefits they paid relating to that illness or injury, up to the full amount of the compensation received from the other party (regardless of how that compensation may be characterized and regardless of whether you or your dependent has been made whole). If the Plans have not yet paid benefits relating to that illness or injury, the Plans may reduce or deny future benefits on the basis of the compensation received or constructively received by you, your dependent, or representative.

In order to secure the rights of the Plans under this section, you or your dependent hereby (1) grant to the Plans a first-priority equitable lien against the proceeds of any full or partial settlement, verdict, or other amounts received by you, your dependent or your representative no matter how those proceeds are captioned or characterized; (2) assign to the Plans any benefits you or your dependent may have under any automobile policy or other coverage, to the extent of the Plans’ claim for reimbursement; and (3) agree that you, your dependent, or representative will hold any compensation in constructive trust for the benefit of the Plans and all their participants who have contributed to the funding of the Plans. No so-called “Fund Doctrine” or “Common Fund Doctrine” or “Attorney’s Fund Doctrine” shall defeat the Plans’ rights. The Plans have a first priority to any recovery from a third party to the extent that benefits have been paid or are payable under the Plans.

This means that the Plan's claim to reimbursement must be paid before any other claim against amounts received from the third party.

You or your dependent must cooperate with the Plans and their agents and must sign and deliver such documents in a timely manner as the Plans or their agents reasonably request to protect the Plans' right of reimbursement. You or your dependent must also provide any relevant information and take such actions as the Plans or their agents reasonably request to assist the Plans in making a full recovery of the reasonable value of the benefits provided. You or your dependent must not take any action that prejudices the Plans' right of reimbursement. If you receive payment as part of a settlement or judgment from any third party as a result of a sickness or injury, and the Plans allege some or all of those funds are due and owed to them, you agree to hold those settlement funds in trust, either in a separate bank account in your name or in your attorney's trust account. You agree that you will serve as a trustee over those funds to the extent of the benefits the Plans have paid. The Plans may reduce or deny future benefits on the basis that you or your dependents have refused to sign and deliver such documents as the Plans or their agents reasonably request to protect the Plans' right of reimbursement.

The reimbursement required under this provision will not be reduced to reflect any costs or attorneys' fees incurred in obtaining compensation, unless separately agreed to, in writing, by the Medical Trust, in the exercise of its sole discretion. If the Plans incur attorneys' fees and costs in order to collect third party settlement funds held by you or your representative, the Plans have the right to recover those fees and costs from you. You may not accept any settlement that does not fully reimburse the Plans, without their prior written approval.

SUBROGATION

This section applies whenever another party (including your own insurer, under an automobile or other policy) is legally responsible or agrees to compensate you or your dependent for your or your dependent's illness or injury and the Plans have paid dental benefits related to that illness or injury.

This section reflects the equitable right of the Plans to restore plan assets to the Plans for the benefit of all participants. The actions of another party caused the Plans to incur expenses they would not normally have incurred, therefore the Plans are entitled to pursue any cause of action or pursue any remedy available to you or your dependents (regardless of how that action may be characterized and regardless of whether you or your dependent have been made whole).

The Plans are subrogated to all of the rights of you or your dependent against any party liable for your or your dependent's illness or injury, to the extent of the reasonable value of the benefits provided to you or your dependent under the Plans. The Plans may assert this right independently of you or your dependent.

You or your dependent is obligated to cooperate with the Plans and their agents in order to protect the Plans' subrogation rights. Cooperation means providing the Plans or their agents in a timely manner with any relevant information requested by them, signing and delivering such documents as the Plans or their agents reasonably request to secure the Plans' subrogation claim, and obtaining the consent of the Plans or their agents before releasing any party from liability for payment of dental expenses.

If you or your dependent enters into litigation or settlement negotiations regarding the obligations of other parties, you or your dependent must not prejudice, in any way, the subrogation rights of the Plans under this section. Please see the "Reimbursement To The Plan" section for your or your dependent's obligations regarding any compensation received or constructively received.

The costs of legal representation of the Plans in matters related to subrogation will be borne solely by the Plans. The costs of legal representation of you or your dependent must be borne solely by you or your dependent.

RECOVERY OF EXCESS PAYMENTS

Whenever payments have been made in excess of the amount necessary to satisfy the provisions of these Plans, the Plans have the right to recover these excess payments from any individual (including yourself), insurance company, or other organization to whom the excess payments were made, or to withhold payment, if necessary, on future benefits until the overpayment is recovered.

If excess payments were made for services rendered to your dependent(s), the Plans have the right to withhold payment on your future benefits until the overpayment is recovered.

Furthermore, whenever payments have been made based on fraudulent information provided by you, the Plans will exercise all available legal rights, including its right to withhold payment on future benefits, until the overpayment is recovered.

RIGHT TO RECEIVE AND RELEASE NECESSARY INFORMATION

Consistent with any privacy requirements under the Health Insurance Portability and Accountability Act of 1996, as amended ("HIPAA") and other applicable law, the Plans may, without the consent of or notice to any person, release to or obtain from any organization or person information needed to implement Plan provisions, including dental information. When you request benefits, you must either furnish or authorize the release of all the information required to implement Plan provisions. Your failure to fully cooperate will result in a denial of the requested benefits, and the Plans will have no further liability for such benefits.

ALTERNATE PAYEE PROVISION

Under normal conditions, all PPO benefits are payable to the provider of services or supplies. All other benefits are payable to you and can only be paid directly to another party upon signed authorization from you. If conditions exist under which a valid release or assignment cannot be obtained, the Plans may make payment to any individual or organization that has assumed the care or principal support for you and is equitably entitled to payment. The Plans may choose to make payments to your separated/divorced spouse, state child support agencies, or Medicaid agencies if required by a qualified medical child support order (QMCSO) or state Medicaid law.

The Plans may also honor benefit assignments made prior to your death in relation to remaining benefits payable by the Plans.

Any payment made by the Plans in accordance with this provision will fully release the Plans of their liability to you.

RELIANCE ON DOCUMENTS AND INFORMATION

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

NO WAIVER

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

DENTIST/PATIENT RELATIONSHIP

These Plans are not intended to disturb the Dentist/patient relationship. Dentists and other health care providers are not agents or delegates of the employer, the Medical Trust, the ECCEBT, or the third-party contract administrator. Nothing contained in these Plans will require you or your dependent to commence or continue dental treatment by a particular provider.

Furthermore, nothing in these Plans will limit or otherwise restrict a Dentist's judgment with respect to the Dentist's ultimate responsibility for patient care in the provision of dental services to you or your dependent.

THE PLAN IS NOT A CONTRACT OF EMPLOYMENT

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

RIGHT TO AMEND OR TERMINATE THE PLAN

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

ADDITIONAL INFORMATION ON COVERED AND EXCLUDED BENEFITS

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

HOW TO FILE A CLAIM

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

CLAIM REMINDERS

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

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

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

The claims address is:

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

HOW TO APPEAL A DENIAL OF BENEFITS

WHEN YOU HAVE A COMPLAINT OR AN APPEAL

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

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

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

START WITH MEMBER SERVICES

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

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

APPEALS PROCEDURE

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

LEVEL ONE APPEAL

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

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

LEVEL Two APPEAL

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

Your written request should include:

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

Please submit this information to:

The Episcopal Church Medical Trust
Attn: Clinical Management
19 E 34th Street
New York, NY 10016

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

Chapter 12

Privacy

Church Pension Group Services Corporation, doing business as the Episcopal Church Medical Trust ("ECMT"), 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 ECMT 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 ECMT 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 health care flexible spending account and any health care or medical services offered under the employee assistance program benefit. This Notice does not apply to benefits offered under the Plans that are not health benefits. Some of the Plans provide benefits through the purchase of insurance. If you are enrolled in an insured Plan, you will also receive a separate notice from that Plan, which applies to your rights under that Plan.

Duties and Obligations of the Plans

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

- maintain the privacy of your PHI;
- provide you with a notice of the Plans' legal duties and privacy practices with respect to your PHI; and
- 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; and
- **As Required By Law.** The Plans will disclose your PHI when required to do so by federal, state or local law. For example, the Plans may disclose your PHI when required by national security laws or public health disclosure laws.

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

- **Treatment.** The Plans may disclose your PHI to your providers for treatment, including the provision of care or the management of that care. For example, the Plans might disclose PHI to assist in diagnosing a medical condition or for pre-certification activities.

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

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

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

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

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

Authorizing Release of Your PHI

To authorize release of your PHI, you must complete a medical information authorization form. An authorization form is available at www.cpg.org or by calling (800) 480-9967. You have the right to limit the type of information that you authorize the Plans to disclose and the persons to whom it should be disclosed. You may revoke your written authorization at any time. 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 its 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 astill@cpq.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 astill@cpq.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 astill@cpq.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. 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 astill@cpq.org for a full explanation of ECMT'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 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
CPG Legal Department
19 East 34th Street
New York, NY 10016
privacy@cpg.org
(212) 592-8365

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)
www.hhs.gov/contactus.html

Effective Date

This Notice is effective as of September 20, 2013.

Changes

Each Plan sponsored by ECMT 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.

Premium Assistance Under Medicaid and the Children’s Health Insurance Program (CHIP)

If you or your children are eligible for Medicaid or CHIP and you are eligible for health coverage from your employer, your State may have a premium assistance program that can help pay for coverage. These States use funds from their Medicaid or CHIP programs to help people who are eligible for these programs, but also have access to health insurance through their employer. If you or your children are not eligible for Medicaid or CHIP, you will not be eligible for these premium assistance programs.

If you or your dependents are already enrolled in Medicaid or CHIP and you live in a State listed below, you can contact your State Medicaid or CHIP office to find out if premium assistance is available.

If you or your dependents are NOT currently enrolled in Medicaid or CHIP, and you think you or any of your dependents might be eligible for either of these programs, you can contact your State Medicaid or CHIP office or dial **1-877-KIDS NOW** or **www.insurekidsnow.gov** to find out how to apply. If you qualify, you can ask the State if it has a program that might help you pay the premiums for an employer-sponsored plan.

Once it is determined that you or your dependents are eligible for premium assistance under Medicaid or CHIP, as well as eligible under your employer plan, your employer must permit you to enroll in your employer plan if you are not already enrolled. This is called a “special enrollment” opportunity, and **you must request coverage within 60 days of being determined eligible for premium assistance**. If you have questions about enrolling in your employer plan, you can contact the Department of Labor electronically at www.askebsa.dol.gov or by calling toll-free 1-866-444-EBSA (3272).

If you live in one of the following States, you may be eligible for assistance paying your employer health plan premiums. The following list of States is current as of July 31, 2013. You should contact your State for further information on eligibility –

ALABAMA – Medicaid	COLORADO – Medicaid
Website: http://www.medicaid.alabama.gov Phone: 1-855-692-5447	Medicaid Website: http://www.colorado.gov/ Medicaid Phone (In state): 1-800-866-3513 Medicaid Phone (Out of state): 1-800-221-3943
ALASKA – Medicaid	
Website: http://health.hss.state.ak.us/dpa/programs/medicaid/ Phone (Outside of Anchorage): 1-888-318-8890 Phone (Anchorage): 907-269-6529	
ARIZONA – CHIP	FLORIDA – Medicaid
Website: http://www.azahcccs.gov/applicants Phone (Outside of Maricopa County): 1-877-764-5437 Phone (Maricopa County): 602-417-5437	Website: https://www.flmedicaidtplrecovery.com/ Phone: 1-877-357-3268
	GEORGIA – Medicaid
	Website: http://dch.georgia.gov/ Click on Programs, then Medicaid, then Health Insurance Premium Payment (HIPP) Phone: 1-800-869-1150

<p align="center">IDAHO – Medicaid and CHIP</p> <p>Medicaid Website: www.accesstohealthinsurance.idaho.gov Medicaid Phone: 1-800-926-2588 CHIP Website: www.medicaid.idaho.gov CHIP Phone: 1-800-926-2588</p>	<p align="center">MONTANA – Medicaid</p> <p>Website: http://medicaidprovider.hhs.mt.gov/clientpages/clientindex.shtml Phone: 1-800-694-3084</p>
<p align="center">INDIANA – Medicaid</p> <p>Website: http://www.in.gov/fssa Phone: 1-800-889-9949</p>	<p align="center">NEBRASKA – Medicaid</p> <p>Website: www.ACCESSNebraska.ne.gov Phone: 1-800-383-4278</p>
<p align="center">IOWA – Medicaid</p> <p>Website: www.dhs.state.ia.us/hipp/ Phone: 1-888-346-9562</p>	<p align="center">NEVADA – Medicaid</p> <p>Medicaid Website: http://dwss.nv.gov/ Medicaid Phone: 1-800-992-0900</p>
<p align="center">KANSAS – Medicaid</p> <p>Website: http://www.kdheks.gov/hcf/ Phone: 1-800-792-4884</p>	
<p align="center">KENTUCKY – Medicaid</p> <p>Website: http://chfs.ky.gov/dms/default.htm Phone: 1-800-635-2570</p>	<p align="center">NEW HAMPSHIRE – Medicaid</p> <p>Website: http://www.dhhs.nh.gov/oii/documents/hippapp.pdf Phone: 603-271-5218</p>
<p align="center">LOUISIANA – Medicaid</p> <p>Website: http://www.lahipp.dhh.louisiana.gov Phone: 1-888-695-2447</p>	<p align="center">NEW JERSEY – Medicaid and CHIP</p> <p>Medicaid Website: http://www.state.nj.us/humanservices/dmahs/clients/medicaid/ Medicaid Phone: 609-631-2392 CHIP Website: http://www.njfamilycare.org/index.html CHIP Phone: 1-800-701-0710</p>
<p align="center">MAINE – Medicaid</p> <p>Website: http://www.maine.gov/dhhs/ofi/public-assistance/index.html Phone: 1-800-977-6740 TTY 1-800-977-6741</p>	
<p align="center">MASSACHUSETTS – Medicaid and CHIP</p> <p>Website: http://www.mass.gov/MassHealth Phone: 1-800-462-1120</p>	<p align="center">NEW YORK – Medicaid</p> <p>Website: http://www.nyhealth.gov/health_care/medicaid/ Phone: 1-800-541-2831</p>
<p align="center">MINNESOTA – Medicaid</p> <p>Website: http://www.dhs.state.mn.us/ Click on Health Care, then Medical Assistance Phone: 1-800-657-3629</p>	<p align="center">NORTH CAROLINA – Medicaid</p> <p>Website: http://www.ncdhhs.gov/dma Phone: 919-855-4100</p>
<p align="center">MISSOURI – Medicaid</p> <p>Website: http://www.dss.mo.gov/mhd/participants/pages/hipp.htm Phone: 573-751-2005</p>	<p align="center">NORTH DAKOTA – Medicaid</p> <p>Website: http://www.nd.gov/dhs/services/medicalserv/medicaid/ Phone: 1-800-755-2604</p>

OKLAHOMA – Medicaid and CHIP	UTAH – Medicaid and CHIP
Website: http://www.insureoklahoma.org Phone: 1-888-365-3742	Website: http://health.utah.gov/upp Phone: 1-866-435-7414
OREGON – Medicaid and CHIP	VERMONT – Medicaid
Website: http://www.oregonhealthykids.gov http://www.hijosaludablesoregon.gov Phone: 1-800-699-9075	Website: http://www.greenmountaincare.org/ Phone: 1-800-250-8427
PENNSYLVANIA – Medicaid	VIRGINIA – Medicaid and CHIP
Website: http://www.dpw.state.pa.us/hipp Phone: 1-800-692-7462	Medicaid Website: http://www.dmas.virginia.gov/rcp-HIPP.htm Medicaid Phone: 1-800-432-5924 CHIP Website: http://www.famis.org/ CHIP Phone: 1-866-873-2647
RHODE ISLAND – Medicaid	WASHINGTON – Medicaid
Website: www.ohhs.ri.gov Phone: 401-462-5300	Website: http://hrsa.dshs.wa.gov/premiumpymt/Apply.shtm Phone: 1-800-562-3022 ext. 15473
SOUTH CAROLINA – Medicaid	WEST VIRGINIA – Medicaid
Website: http://www.scdhhs.gov Phone: 1-888-549-0820	Website: www.dhhr.wv.gov/bms/ Phone: 1-877-598-5820, HMS Third Party Liability
SOUTH DAKOTA - Medicaid	WISCONSIN – Medicaid
Website: http://dss.sd.gov Phone: 1-888-828-0059	Website: http://www.badgercareplus.org/pubs/p-10095.htm Phone: 1-800-362-3002
TEXAS – Medicaid	WYOMING – Medicaid
Website: https://www.gethipptexas.com/ Phone: 1-800-440-0493	Website: http://health.wyo.gov/healthcarefin/equalitycare Phone: 307-777-7531

To see if any more States have added a premium assistance program since July 31, 2013, or for more information on special enrollment rights, you can contact either:

U.S. Department of Labor
Employee Benefits Security Administration
www.dol.gov/ebsa
1-866-444-EBSA (3272)

U.S. Department of Health and Human Services
Centers for Medicare & Medicaid Services
www.cms.hhs.gov
1-877-267-2323, Menu Option 4, Ext. 61565

OMB Control Number 1210-0137 (expires 10/31/2016)

FOR MORE INFORMATION

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

THE EPISCOPAL CHURCH MEDICAL TRUST

www.cpg.org

(800) 480-9967

e-mail: mtcustserv@cpq.org

Monday through Friday, except
holidays, 8:30 a.m.– 8:00 p.m. ET

CIGNA DENTAL

www.cigna.com

(800) 244-6224

Monday through Friday, 8:00 a.m. - 6:00 p.m.

The Plan(s) described in this handbook are sponsored and administered by the Church Pension Group Services Corporation ("CPGSC"), also known as the Episcopal Church Medical Trust (the "Medical Trust"). The 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 handbook contains only a partial description of the Plans intended for informational purposes only. It should not be viewed as a contract, an offer of coverage, or investment, tax, medical, or other advice.

The Church Pension Fund and its affiliates, including but not limited to the Medical Trust, CPGSC and ECCEBT (collectively, "CPG"), retain the right to amend, terminate, or modify the terms of the 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 document carefully to determine which benefits are covered, as well as any applicable exclusions, limitations, and procedures.

CPG does not provide any healthcare services and therefore cannot guarantee any results or outcomes. 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.