

# The Episcopal Church Medical Trust

## Behavioral Health Benefit

This brochure is for members enrolled in the following health plans:

- ✠ Aetna Choice POS II
- ✠ Aetna Select EPO
- ✠ Aetna National HMO
- ✠ CIGNA Open Access Plan (OAP)
- ✠ CIGNA Open Access In-Network Plan (OAP-IN)
- ✠ CIGNA HMO
- ✠ Empire BCBS PPO 90/70
- ✠ Empire BCBS PPO 80/60
- ✠ Empire BCBS PPO 75/50
- ✠ Empire BCBS EPO 90
- ✠ Empire BCBS EPO 80
- ✠ Empire BCBS High Option
- ✠ UnitedHealthcare Choice
- ✠ UnitedHealthcare Choice Plus
- ✠ UnitedHealthcare Choice Plus 80/60

# Introduction

The Episcopal Church Medical Trust (the “Medical Trust”) has prepared this brochure to help you understand your mental health/substance abuse benefits. Please read it carefully. Your benefits are affected by certain limitations and conditions, which require you to be a wise consumer of mental health services and to use only those services you need.

Your emotional and spiritual well-being is vital to the health of the Church. That’s why the Medical Trust has partnered with CIGNA Behavioral Health (CBH). Your mental health/substance abuse benefits will be administered by CBH. CBH will provide clinical support, customer service and behavioral health claims processing for you.

CBH has a nationwide network of providers which includes more than 47,000 independent psychiatrists, psychologists, pastoral counselors and clinical social workers, and more than 4,000 facilities and clinics. CIGNA Behavioral Health and the Episcopal Church Medical Trust share the same basic values of compassionate care for all of our members.

## Employee Assistance Program

The Medical Trust has added the Employee Assistance Program (EAP) to our mental health benefits package. This program, managed by CBH, is available to all members enrolled in any self-insured medical plan administered by the Medical Trust for actively employed members.

EAP services are available 24 hours a day, 7 days a week through the CIGNA Behavioral Health website or by phone. All services are free and confidential. Equipped with many tools, the EAP staff members are trained to provide you with a multitude of services including: help finding daycare services for your children, support for managing stress, information on adoption, assistance in researching nursing homes, etc.

## Other Information

The mental health/substance abuse benefit program (the “Plan”), with the exception of the EAP, is self-funded through the Episcopal Church Clergy and Employees’ Benefit Trust (“ECCEBT”), which is a voluntary employees’ beneficiary association within the meaning of Section 501(c)(9) of the Internal Revenue Code. The EAP portion of the Plan is a fully-insured benefit offered by CBH. The Medical Trust has established the ECCEBT to fund its benefit plans. Reimbursements to covered persons will be based on the provisions of the Plan.

The Medical Trust intends this Plan to be permanent, but since future conditions affecting the Medical Trust or your employer cannot be anticipated or foreseen, the Medical Trust reserves the right to amend, modify, or terminate the Plan in any manner, at any time, which may result in the termination or modification of your coverage. If the Plan is terminated, any Plan assets will be used to pay for eligible expenses incurred prior to the Plan’s termination, and such expenses will be paid as provided under the terms of the Plan prior to its termination.

This brochure contains only a partial, general description of the Plan. It is provided for informational purposes only and should not be viewed as a contract, an offer of coverage, or investment, tax, medical or other advice. In the event that there is a conflict between this brochure and the official Plan documents, the official Plan documents will govern.

## Who Is Eligible

In order to be eligible for mental health/substance abuse benefits covered in this brochure, you must be currently enrolled in a health plan administered by the Episcopal Church Medical Trust and for whom CIGNA Behavioral Health is the mental health/substance abuse benefit administrator.

# Outpatient Mental Health Benefits

When you need to visit your health care provider, the Plan makes it easy. In-network, you pay a \$20 copayment for the office visit. There are no claim forms to fill out.

## Out-of-Network

When you visit an out-of network provider you will be reimbursed for services at 70% of the provider's charge up to a per session maximum reimbursable fee (MRF). If the provider charges you more than the MRF, you are entirely responsible for the amount over the MRF. Please see the chart below.

Provider Type	Individual/Family	Group	Colleague Group
Psychiatrist (MD)	\$130	\$65	\$40
Psychologist (PhD)	\$110	\$55	\$40
Other Licensed Provider*	\$ 90	\$45	\$40

For example, if you see a psychologist for individual therapy, and he/she charges \$200, the plan will reimburse \$110 (70% of \$200 is \$140, but the MRF is \$110). You will be responsible for the remaining charge.

## Preauthorization

Preauthorization is not required for routine outpatient care with an in-network provider for the first 20 visits.

Preauthorization is required for intensive outpatient and face-to-face EAP services. Preauthorization is also required for all out-of-network outpatient treatment.

*\*"Other licensed providers" include licensed clinical social workers, psychiatric nurses, certified addictions counselors, Fellows or Diplomates of the American Association of Pastoral Counselors, and licensed marriage, family, and child therapists. CIGNA Behavioral Health will verify appropriate licensure, experience, and training on a case by case basis.*

## Colleague Groups

Colleague groups facilitated by providers approved by the Medical Trust are covered by CBH. There is no clinical review by the Outpatient Coordinator, however, the provider must complete and return a Provider Application to the Medical Trust. You or your colleague group's facilitator should contact the Medical Trust to request benefits authorization of colleague group services. The colleague group benefit is available to employees or spouses for a family total of 24, 90-minute sessions per year. In addition, employees may use up to 12 of the 24 colleague group sessions for individual consultation.

Once benefits have been authorized, the supplement will cover 70% of the maximum reimbursable fee (MRF) of \$40.00. For example, if you participate in a colleague group and your facilitator charges \$75.00 a session, the plan will reimburse \$40.00 (70% of \$75.00 is \$52.50, but the MRF is \$40.00). You will be responsible for the remaining charge.

Remember to contact the Medical Trust at (800) 806-0478 to access your Colleague Group benefits.

# What's Covered

The following outpatient services are covered based on medical necessity:

- Individual therapy
- Family therapy
- Couples therapy (including pre-marital therapy)
- Group therapy
- Medical management
- Colleague groups (to use this benefit, please call (800) 806-0478)

# What's Not Covered

- Treatment that is experimental, investigational, primarily for research or not in keeping with national standards of practice and not demonstrated through existing peer-reviewed, evidence based scientific literature to be safe and effective for treating or diagnosing the condition or illness for which its use is proposed
- Co-dependency
- Regressive therapy
- Educational, vocational or employment testing, training or services
- Educational therapy or services for learning disabilities or mental retardation
- Autism, except for behavioral therapy provided by eligible behavioral providers as listed in the Plan Description
- Pervasive developmental disorders, except for behavioral therapy provided by eligible behavioral providers as listed in the Plan Description
- Treatment for personal growth and development
- Treatment required by state or federal law to be provided to a child by the school system or school district
- Testing for ADD/ADHD
- Psychological Testing unless completed while in-patient for diagnosis or treatment planning
- Telephonic, e-mail or internet consultations, therapy, or telemedicine
- Neuro-psych testing (see Medical Benefit)
- Aversion therapy
- Bio-feedback, neuro-bio-feedback, hypnotherapy
- Acupuncture, acupressure, aroma therapy, massage therapy, reiki
- Thought field, energy, art or dance therapy
- Custodial care, treatment that is not expected to reduce the disability to the extent necessary to enable the individual to function outside a protected, monitored or controlled environment
- Therapeutic foster care
- Group home
- Three quarter houses
- Wilderness programs
- Residential/therapeutic schools
- Camps
- Court ordered, forensic or custodial evaluations
- Court ordered treatment unless deemed to be medically necessary
- Weight loss programs
- Smoking cessation programs

# Inpatient Mental Health Benefits

To find an in-network facility, contact CIGNA Behavioral Health at (866) 395-7794. You may seek care at an out-of-network facility, but you may have to pay a larger portion of the costs.

Preauthorization is required for inpatient, partial hospitalization, residential, intensive outpatient and face-to-face EAP services. There is a \$150 copayment per admission at an in-network facility. Failure to obtain preauthorization may result in a 50% reduction of covered benefits paid by the Plan.

For emergency admissions, notification must be received within 48 hours of the admission.

## What's Covered

The following inpatient services are covered based on medical necessity:

- Semiprivate room and board
- Private room and board expenses, limited to the cost of a semiprivate room
- Drugs, dressings and other medically necessary supplies

## What's Not Covered

- Sanitarium, rest, or custodial care
- Vocational or occupational training

## How to File a Claim

If you go to an independent behavioral health professional within the CIGNA Behavioral health network, CBH handles all the paperwork and claims forms. If you opt for an out-of-network professional, you will most likely need to file a claim. Additionally, you may have to pay a larger portion of the costs yourself. Call (866) 395-7794 to receive a claim form if you will be submitting claims for reimbursement. Claim forms should be mailed to:

CIGNA Behavioral Health  
P.O. Box 46270  
Eden Prairie, MN 55344

The Plan 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 Plan requests additional information, until the requested information is received by the Plan. The Plan 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 questions regarding the claim, please call (866) 395-7794.

All claims must be received by the Plan within 180 days following the end of the year in which expenses were incurred.

# How to Appeal a Denial of Benefits

If you believe a claim denial or clinical noncertification was improper, the following processes are available:

## Oral Appeal

For an oral appeal of a clinical noncertification or a request for certification involving urgent care, please call (866) 395-7794. Oral appeals will be accepted only for this type of claim denial.

## Written Appeal

Within 180 days of receipt of the notice of the claim denial or clinical noncertification, you may request, in writing, that the Plan conduct a review of the processed claim. All requests for a review of claim denial or clinical noncertification should include a copy of the initial denial letter and any other relevant information (e.g., written comments, documents, articles, or records). The party reviewing the appeal will:

- Review all comments, documents, records, and other information submitted by you.
- Consult with an appropriate health care professional if the claim was denied because it was not considered medically necessary. You may request the name of the health care professional who was consulted.
- Request additional information necessary to review the appeal. You should provide the information as soon as possible.
- Use discretionary authority in making an appeal determination; however, such discretionary authority will be consistent with determination for similarly situated Plan participants.
- Provide notice of the appeal determination in writing, or orally, where appropriate.

Send all written information to:

Central Appeals Unit  
CIGNA Behavioral Health  
P.O. Box 46090  
Eden Prairie, MN 55344

Requests for appeals that do not comply with these procedures will not be considered, except in extraordinary circumstances. You will be notified if the appeal request has not been considered, and you will be allowed to present evidence of why the appeal should be considered.

If you are not satisfied with the Claim Administrator's appeal decision, you may request to have your appeal reviewed by the Plan. The Plan offers this review for covered individuals following the required first level appeal process with the Claim's Administrator. If you wish to pursue a review by the Plan, please send a written request within 60 days of the date of the appeal decision to:

The Episcopal Church Medical Trust  
Attn: Clinical Department  
445 Fifth Avenue  
New York, NY 10016

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

Benefit	In-Network Provider	Out-of-Network Provider
<p><b>Employee Assistance Program (EAP)*</b></p> <p>*The EAP is a fully-insured benefit offered by CBH.</p>	<p>Unlimited telephonic and work/life services</p> <p>Up to 10 face-to-face sessions per issue</p> <p>Deductible: None Copayment: None</p>	<p>N/A</p>
<p>Deductible</p>	<p>None</p>	<p>None</p>
<p>Out-of-Pocket Maximum</p>	<p>None</p>	<p>\$2,100 per person \$6,300 per family</p>
<p><b>Inpatient Mental Health/ Substance Abuse</b> Hospital expenses: room and board, medications, x-rays, lab and physician charges</p>	<p>Plan pays 100% after \$150 copay per admission</p> <p>Annual Day Limit: Unlimited—fully managed</p> <p>Plan coverage reduced to 50% if no precertification</p>	<p>Plan pays 70%</p> <p>Annual Day Limit: Unlimited—fully managed</p> <p>Plan coverage reduced to 50% if no precertification</p>
<p><b>Intensive Outpatient Mental Health/Substance Abuse Program (4:1)</b></p>	<p>Copayment of \$150 per program, payable at admission</p> <p>Annual Limit: Unlimited—fully managed</p> <p>Plan coverage reduced to 50% if no precertification</p>	<p>Plan pays 70%</p> <p>Annual Limit: Unlimited—fully managed</p> <p>Plan coverage reduced to 50% if no precertification</p>
<p><b>Outpatient Mental Health/ Substance Abuse</b></p> <p>Individual/Family</p> <p>Group</p>	<p>No Annual Limit</p> <p>Copayment: \$20/visit</p> <p>Copayment: \$20/group</p>	<p>Plan pays 70% up to the maximum reimbursable fee (MRF) (see Page 3 for list of MRF's)</p>
<p><b>Care Management</b></p> <p>All coverage is subject to medical necessity.</p>	<p>Preauthorization is required for inpatient, partial hospitalization, residential, intensive outpatient and face-to-face EAP services. Failure to obtain it may result in reduced benefit levels paid by your insurer. Preauthorization is required for routine outpatient care with an in-network provider beginning with the 21<sup>st</sup> visit.</p> <p>For emergency admissions, notification must be received within 48 hours of the admission.</p>	<p>Preauthorization is required for outpatient, inpatient, partial hospitalization, residential, intensive outpatient and face-to-face EAP services. Failure to obtain it may result in reduced benefit levels paid by your insurer.</p> <p>For emergency admissions, notification must be received within 48 hours of the admission.</p>

<b>Other Plan Details</b>	
<b>Lab Work</b>	Billed separately. If billed with other charges (e.g. inpatient facility charges) see appropriate rules above
<b>Lab Work</b> ordered by medical provider	Covered by your medical plan.
<b>Emergency Room Facility Charge</b> Primary mental health, alcohol, or substance abuse diagnosis	Covered by your medical plan.
<b>Emergency Room Charges: Facility and Ancillary</b> Behavioral health diagnosis: mental health, alcohol/substance abuse professional services (e.g. initial assessment interview and treatment by physician), lab work, x-rays, detoxification	Covered by your medical plan.
<b>Ambulance</b>  All ambulance transportation, regardless of primary diagnosis, will be covered by your medical plan.	Covered by your medical plan.
<b>Wilderness Program</b>	Individual and group therapies can be reimbursed while provided in a Wilderness Program, but the program itself is an exclusion.
<b>Psychological Testing</b>	Psychological testing can be covered only as part of an inpatient hospitalization.
<b>Halfway House</b>	There is a \$100 copay per admission.

For all Mental Health and Substance Abuse Services, there is a \$5 million lifetime benefit (combined with Medical and Pharmacy benefits) limit.

**About Your Privacy.** Everything you discuss with your counselor or care provider is kept in the strictest confidence in accordance with applicable state and federal laws. Your employer is not notified of your visits or given specific information about your treatment without your written permission. The general health privacy and security standards of the Episcopal Church Medical Trust apply.

# How to Contact Us

Resource	Reason to Contact	Phone Number and Website
CIGNA Behavioral Health	Locate a provider, check on claims, get assistance with any mental health/ substance abuse issues	<b>www.cignabehavioral.com</b> employee ID: episcopal PIN: member (866) 395-7794 24 hours a day, 7 days a week
The Episcopal Church Medical Trust	Eligibility, Colleague Group benefits	<b>www.cpg.org</b> (800) 806-0478 8:30 a.m. - 5:00 p.m. M-F

*Please send correspondence to:*

The Episcopal Church Medical Trust  
Mental Health Benefits  
P.O. Box 2745  
New York, NY 10163

*The Third-Party Contract Administrator*

CIGNA Behavioral Health  
11095 Viking Drive  
Suite 350  
Eden Prairie, MN 55344

*The Plan Sponsor*

Church Pension Group Services Corporation  
455 Fifth Avenue  
New York, NY 10016

*The Plan Network*

CIGNA Behavioral Health  
P.O. Box 46270  
Eden Prairie, MN 55344

*The Plan Administrator*

Church Pension Group Services Corporation  
455 Fifth Avenue  
New York, NY 10016

The plans described in this document (collectively, the “Plans”) are sponsored and administered by 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”), which is a voluntary employees’ beneficiary association within the meaning of section 501(c)(9) of the Internal Revenue Code.

This document contains only a partial, general description of the Plans. It is provided for informational purposes only and should not be viewed as a contract, an offer of coverage, or investment, tax, medical, or other advice. In the event of a conflict between this document and the official plan documents (schedule of benefits, summary plan description, booklet, booklet-certificate), the official plan documents will govern. The Church Pension Fund and CPGSC (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, without notice and for any reason.

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 health care expenses, and plan participants should read the official plan documents carefully to determine which benefits are covered, as well as any applicable exclusions, limitations, and procedures.

All benefits under the Plans are subject to applicable laws, regulations, and policies. Except for the Preventive Dental PPO Plan, the Hearing Aid Benefit, and the Travel Protection Benefit, all such benefits are subject to coordination of benefits. The Plans are subrogated to all of the rights of a plan participant against any party liable for such participant’s illness or injury, to the extent of the reasonable value of the benefits provided to such participant under the Plans. The Plans may assert this right independently of a plan participant, and such participant is obligated to cooperate with CPG in order to protect the Plans’ subrogation rights.

CPG does not provide any health care services and therefore cannot guarantee any results or outcomes. Health care 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.

If you are a plan participant, call the number on your ID card for more information about the Plan in which you are enrolled. All other individuals should call (800) 480-9967.