

Dental Plans Document Handbook

Basic Dental PPO Plan

Dental & Orthodontia PPO Plan

Preventive Dental PPO Plan

Benefits effective as of January 2012

The Episcopal Church Medical Trust

Our Health, Our Members, Our Church



CIGNA

A Business of Caring.



EPISCOPAL CHURCH
MEDICAL TRUST

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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SCHEDULE OF DENTAL BENEFITS

CIGNA Dental

BASIC DENTAL PPO PLAN

Non-Network Annual Deductible: \$50 Individual

\$150 Family

Annual Benefit Maximum: \$1,500 Individual

The following Schedule summarizes amounts you will pay for covered services. When you select a Participating Provider, this Plan pays a greater share of the cost than if you were to select a Non-Participating Provider. Please refer to the “What’s Covered” sections of this Handbook for additional Plan provisions that may affect your benefits.

COVERED SERVICE	YOUR COINSURANCE AMOUNT	NEED TO MEET ANNUAL DEDUCTIBLE?	ADDITIONAL LIMITATIONS AND EXPLANATIONS
Preventive & Diagnostic Services	Network 0%	N/A	Not subject to the annual benefit maximum.
	Non-Network 0%	No	
Basic Restorative Services	Network 15%	N/A	Subject to the annual benefit maximum.
	Non-Network 15%	Yes	
Major Restorative Services	Network 50%	N/A	Subject to the annual benefit maximum.
	Non-Network 50%	Yes	
Orthodontia	Not covered under this Plan.		

NOTES: When services are delivered by a **Participating (Network) Provider**, you are responsible for paying the **Contracted Fee** times the benefit percentage that applies to the class of service, as specified in the Schedule. The Plan is responsible for the balance of the **Contracted Fee**.

When services are delivered by a **Non-Participating (Non-Network) Provider**, you are responsible for paying the **Maximum Reimbursable Charge** times the benefit percentage that applies to the class of service, as specified in the Schedule, plus the balance of the provider’s actual charge.

A Predetermination of Benefits is available on a voluntary basis when extensive dental work in excess of \$200 is proposed.

Benefits paid for participating and non-participating provider services will be applied toward the combined participating and non-participating provider annual benefit maximum.

This benefit summary is provided for informational purposes, is not all-inclusive, and does not constitute an agreement. Additional limitations and explanations, including specific benefit maximums will be provided to eligible, enrolled members in the Plan Document Handbook. In the event of a conflict between this document and the official plan documents, the official plan documents will govern. The Episcopal Church Medical Trust retains the right to amend, terminate or modify the terms of the plan at any time, without notice and for any reason.

Non-Network Annual Deductible: \$25 Individual
 \$75 Family

Annual Benefit Maximum: \$1,500 Individual

Lifetime Orthodontic Maximum: \$1,500 Individual

The following Schedule summarizes amounts you will pay for covered services. When you select a Participating Provider, this Plan pays a greater share of the cost than if you were to select a Non-Participating Provider. Please refer to the “What’s Covered” sections of the Handbook for additional Plan provisions that may affect your benefits.

COVERED SERVICE	YOUR COINSURANCE AMOUNT	NEED TO MEET ANNUAL DEDUCTIBLE?	ADDITIONAL LIMITATIONS AND EXPLANATIONS
Preventive & Diagnostic Services	Network 0%	N/A	Not subject to the annual benefit maximum.
	Non-Network 0%	No	
Basic Restorative Services	Network 15%	N/A	Subject to the annual benefit maximum.
	Non-Network 15%	Yes	
Major Restorative Services	Network 15%	N/A	Subject to the annual benefit maximum.
	Non-Network 15%	Yes	
Orthodontia	Network 50%	N/A	Subject to the lifetime orthodontic maximum.
	Non-Network 50%	Yes	

NOTES: When services are delivered by a **Participating (Network) Provider**, you are responsible for paying the **Contracted Fee** times the benefit percentage that applies to the class of service, as specified in the Schedule. The Plan is responsible for the balance of the **Contracted Fee**.

When services are delivered by a **Non-Participating (Non-Network) Provider**, you are responsible for paying the **Maximum Reimbursable Charge** times the benefit percentage that applies to the class of service, as specified in the Schedule, plus the balance of the provider’s actual charge.

A Predetermination of Benefits is available on a voluntary basis when extensive dental work in excess of \$200 is proposed.

Lifetime maximum applies to both in- and out-of-network benefits.

Benefits paid for participating and non-participating provider services will be applied toward the combined participating and non-participating provider annual benefit maximum.

Orthodontic benefits paid for participating and non-participating provider services will be applied toward the combined participating and non-participating provider lifetime orthodontic maximum.

This benefit summary is provided for informational purposes, is not all-inclusive, and does not constitute an agreement. Additional limitations and explanations, including specific benefit maximums will be provided to eligible, enrolled members in the Plan Document Handbook. In the event of a conflict between this document and the official plan documents, the official plan documents will govern. The Episcopal Church Medical Trust retains the right to amend, terminate or modify the terms of the plan at any time, without notice and for any reason.

SCHEDULE OF DENTAL BENEFITS

CIGNA Dental

PREVENTIVE DENTAL PPO PLAN

Non-Network Annual Deductible: \$0 Individual
\$0 Family

Annual Benefit Maximum: \$1,500 Individual

The following Schedule summarizes amounts you will pay for covered services. When you select a Participating Provider, this Plan pays a greater share of the cost than if you were to select a Non-Participating Provider. Please refer to the “What’s Covered” section of this Handbook for additional Plan provisions that may affect your benefits.

COVERED SERVICE	YOUR COINSURANCE AMOUNT	NEED TO MEET ANNUAL DEDUCTIBLE?	ADDITIONAL LIMITATIONS AND EXPLANATIONS
Preventive & Diagnostic Services	Network & Non-Network 0%	N/A	Not subject to the annual benefit maximum.
Basic Restorative Services	Network & Non-Network 20%	N/A	Subject to the annual benefit maximum.
Major Restorative Services	Network & Non-Network 99%	N/A	Subject to the annual benefit maximum.
Orthodontia	Network & Non-Network 99%	N/A	Subject to the annual benefit maximum.

NOTES: When services are delivered by a **Participating (Network) Provider**, you are responsible for paying the **Contracted Fee** times the benefit percentage that applies to the class of service, as specified in the Schedule. The Plan is responsible for the balance of the **Contracted Fee**.

When services are delivered by a **Non-Participating (Non-Network) Provider**, you are responsible for paying the **Maximum Reimbursable Charge** times the benefit percentage that applies to the class of service, as specified in the Schedule, plus the balance of the provider’s actual charge.

A Predetermination of Benefits is available on a voluntary basis when extensive dental work in excess of \$200 is proposed.

Benefits paid for participating and non-participating provider services will be applied toward the combined participating and non-participating provider annual benefit maximum.

This benefit summary is provided for informational purposes, is not all-inclusive, and does not constitute an agreement. Additional limitations and explanations, including specific benefit maximums will be provided to eligible, enrolled members in the Plan Document Handbook. In the event of a conflict between this document and the official plan documents, the official plan documents will govern. The Episcopal Church Medical Trust retains the right to amend, terminate or modify the terms of the plan at any time, without notice and for any reason.

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. Because the contracted rate results in savings to both you and the Plans, you are reimbursed at a higher level if you use participating providers. Dental PPO providers are also referred to as a “network” or “network providers.” The terms “out-of-network” or “out-of-network” refer to dental care providers that do not participate in the network.

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

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 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

Created in 2009 by an Act of General Convention, the Denominational Health Plan is a program that provides healthcare benefits to eligible employees of The Episcopal Church. The associated Resolution A177 requires that all domestic dioceses, parishes, missions, and other ecclesiastical organizations or bodies subject to the authority of The Episcopal Church join the program and enroll clergy and lay employees who are scheduled to work 1,500 or more compensated hours annually. The Trustees and Officers of the Church Pension Fund administer the program. Benefits are provided through the Medical Trust, which is the sole plan sponsor of such benefits. All affected groups are required to provide healthcare benefits through the Medical Trust no later than January 1, 2013.

Dependent

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

Child

A Subscriber's or Subscriber's Spouse's natural child, stepchild, 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.

Spouse

A lawful husband or wife defined by the State where the Subscriber resides.

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.

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) 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) 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 of the position, and salary range. Priests performing traditional duties as described by the Constitutions and Canons³ 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.

Priest

A person 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.

² http://www.dol.gov/whd/overtime_pay.htm

³ Constitution and Canons of The Episcopal Church

Retired Employee

A former Employee of a Participating Group of the EHP 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, and

(a) is at least 55 years of age, **and**

(b) has five (5) or more years of continuous service with The Episcopal Church, **OR** is a beneficiary of a pension plan sponsored by the Church Pension Fund, **and**

(c) if eligible for Medicare, the Retired Employee can be a former Employee of any Participating Group.

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 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.

Health Insurance Portability and Accountability Act of 1996 (HIPAA)

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

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.

Member

A Subscriber or Dependent.

Open Enrollment

The annual period of time during which Subscribers and other Eligible Individuals may elect and/or change plan options for the following plan year for themselves and their 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, or when a plan option ceases to be available for the upcoming plan year, or when there is a significant change to the existing plan options.

Passive Open Enrollment

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

Participating Group

A diocese, congregation, agency, school, organization, or other body subject to the authority of The Episcopal Church, which has elected to participate in the Plan.

Plan

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 plan options through which Eligible Individuals of The Episcopal Church are provided health benefits. Benefits are provided through the Medical Trust.

Medicare Supplement Health Plan (MSHP)

A program of supplemental medical and dental plan options through which Eligible Individuals of The Episcopal Church are provided health benefits. Benefits 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

An individual who meets the qualifications listed in the eligibility section and is *enrolled in the Plan*.

ELIGIBILITY FOR THE EPISCOPAL HEALTH PLAN (EHP)

While the Participating Group determines eligibility for group-sponsored or group-subsidized benefits, the Medical Trust determines eligibility for the Plans. The employer or Group Administrator is responsible for 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 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 Retired Employee enrolled in the MSHP**
- A Pre-65 Surviving Dependent of a deceased Retired Employee**

**The Dependent must be enrolled under the Subscriber's plan election.*

***The Dependent will be enrolled as a Subscriber; however, eligibility is based on the Retired or deceased 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 year
- A Temporary Employee
- A Seasonal Employee

⁴ As defined in Title III, Canon 14.1, Constitution and Canons of The Episcopal Church, 2009

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

- 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 Retired Employee (or Spouse/Domestic Partner) eligible for Medicare, regardless of whether he or she is actually enrolled in Medicare
- A volunteer

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 first of the month following the date the eligibility determination was provided. The 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 part of the Participating Group for any length of time before s/he can 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.

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 Dependent 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 option 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 option or Coverage Tier except during Open Enrollment, unless there is a Significant Life Event or a HIPAA Special Enrollment Event.

SIGNIFICANT LIFE EVENTS

A Significant Life Event gives a Subscriber the opportunity to make a change to enrollment. The enrollment change must be made within 30 days after 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 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 option

For example, if a Subscriber previously resided in an area in which only the PPO plan was available and then moved to an area where the HMO and PPO are available, the Subscriber may change plans. Conversely, if a Subscriber moved

out of the HMO service area, and was therefore no longer eligible for the HMO plan, the Subscriber may change plans.

- 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

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. The enrollment must be made within 30 days after the event (or 60 days, as described below) and must be consistent with the event. 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 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 eligibility for or loss of eligibility for coverage under a Medicaid Plan or a 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 event occurs.

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 may 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 option.
- If a local managed care plan is elected, additional paper enrollment forms from the local plan option must be submitted to the Plan.
- Seminary administrators must submit paper Enrollment Forms to the Plan instead of using the MLPS website. Forms should be mailed or faxed to Client Engagement.
- Retired Employees who do not receive any contribution assistance from the Participating Group may submit enrollment forms directly to the Plan.

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
- Dissolution of Domestic Partnership Declaration
- 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 of time during which Subscribers of the EHP and MSHP and other Eligible Individuals may elect or change health plan options for the following plan year for themselves and 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 change 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 plan options
- Full contribution rates for each plan option and Coverage Tier⁶
- Options to add or remove 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 option 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.

NEW AUTOMATIC ENROLLMENT REQUIREMENT FOR LARGE EMPLOYERS

Employers with 200 or more Employees under a single Employer Tax Identification Number must comply with the auto enrollment provisions of the Patient Protection and Affordable Care Act⁷ (PPACA), which become effective upon issuance of guidance by the Department of Labor.

⁶ Employer/Employee cost share information is not provided.

⁷ The Patient Protection and Affordable Care Act (PPACA) is a federal law enacted on March 23, 2010 and is also known as healthcare reform.

Employers must track Eligible Employees' election choices and automatically enroll those who did not make a choice (or waive coverage) into a default plan option. The Plan provides MLPS as a tool for Group Administrators to implement this requirement.

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 after 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 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 s/he 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 after that date.

Elections must be received by the Plan no later than 30 days after that date. If s/he does not enroll when initially eligible, then s/he 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 s/he enrolls as a full-time student begins. Elections must be received by the Plan within 30 days after the seminary's published registration deadline for that semester. Paper enrollment forms must be submitted to Client Engagement.

If the Seminarian does not enroll when initially eligible, then s/he must wait for an applicable Significant Life Event or HIPAA Special Enrollment Event to occur or s/he may enroll at the beginning of any subsequent semester and be covered beginning with the first day of the month that semester begins. Enrollment will continue year-round for the duration of the time in seminary, until s/he 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 EHP with no change to the coverage effective date, provided an enrollment form or MLPS submission *confirming continuation of coverage and change to retiree status* is received by the Plan within 30 days after 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 option 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 s/he must wait for an applicable Significant Life Event or HIPAA Special Enrollment Event to occur or until the next Open Enrollment period.

Once the Pre-65 Retired Employee becomes Medicare-eligible, s/he 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 s/he becomes Medicare-eligible, at which time s/he too must actively switch enrollment to the MSHP. The enrolled Child(ren) who are not Disabled may remain in the EHP until the end of the year in which they reach age 30.

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

PRE-65 RETIRED EMPLOYEE, NOT COVERED UNDER THE 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, and remain in the EHP until such time as s/he becomes Medicare-eligible, at which time s/he 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 s/he becomes Medicare-eligible, at which time s/he too must actively switch enrollment to the MSHP. The enrolled Child(ren) 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. If the Pre-65 Retired Employee does not enroll within 30 days after a HIPAA Special Enrollment Event, then s/he must wait until s/he becomes Medicare-eligible, at which time s/he may enroll in the MSHP.

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 after 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. 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 s/he meets the Plan's eligibility requirements and if s/he 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 his/her 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 Retired Employee and his/her Dependents may split enrollment between the EHP and the MSHP in cases where the 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, s/he must actively switch enrollment to the MSHP. The Subscriber's enrolled Child(ren) 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 child(ren) named in the QMCSO.

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

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

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

- 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.

Child(ren) 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, provided the Subscriber's plan offers Dependent coverage. However, Child(ren) 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 Child(ren) and the Subscriber does not enroll the Child(ren), the Participating Group will enroll the Child(ren) 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(ren), the Subscriber may change election and drop coverage for the Child(ren). However, the Subscriber may not drop coverage for the Child(ren) until the other plan's coverage begins. Subscribers may not otherwise drop coverage for Child(ren) 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 inhibition of a Priest in accordance with Title IV, Canon 1⁹.

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 within 30 days of the end date of the leave to increase the Coverage Tier once the Subscriber returns to work.

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 s/he 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

⁹ Constitution and Canons of The Episcopal Church, 2009

- The Participating Group's participation with the Plan terminates
- The last day of the year in which a 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 death date.

Retired Employee

When a Retired Employee enrolled in the EHP or MSHP dies, the Surviving Spouse or Surviving Domestic Partner who is also enrolled in the EHP can remain covered under until s/he becomes Medicare-eligible, at which time s/he 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 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 a 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 Seminarians

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.

Retired Employees with Dependents under age 65

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

Retired Employees with Dependents in the MSHP

The Spouse or Domestic Partner enrolled in the MSHP who gets divorced from a Retired Employee can stay enrolled in the MSHP. S/he 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 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. The maximum extension period depends on what type of termination event applies.

- Employees who are terminated on or after January 1, 2011, 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.
- Dependent Children whose coverage is terminated for any reason 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, 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.

The Plan notifies individuals regarding their eligibility for the extension within 5 business days of a receiving a termination notice from the Group Administrator. The notification includes an enrollment form and an invoice for contributions that are due, and an explanation of the monthly contributions and duration of the extension. If the current plan option 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 forfeited.

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

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.

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.

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
- 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 (30 days notice required)
- The date a Participating Group terminates participation with the 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

IMPORTANT NOTES

REQUIRED MONTHLY CONTRIBUTIONS

The Plan does not pro-rate contribution requirements for any health plan option 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. 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. If a new plan imposes pre-existing condition exclusions, the Certificate may be used to show evidence of prior health coverage in order to offset exclusions under the new 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
- Appliances (i.e. occlusal guards) for the correction of harmful habits, such as grinding the teeth or thumb sucking
- The surgical placement of an implant body or framework of any type; surgical procedures in anticipation of implant placement; any device, index,

or surgical template guide used for implant surgery; treatment or repair of an existing implant; prefabricated or custom implant abutments; removal of an existing implant

- 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)

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
- 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
- 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
- Appliances (i.e. occlusal guards) for the correction of harmful habits, such as grinding the teeth or thumb sucking
- 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
- The surgical placement of an implant body or framework of any type; surgical procedures in anticipation of implant placement; any device, index, or surgical template guide used for implant surgery; treatment or repair of an existing implant; prefabricated or custom implant abutments; removal of an existing implant
- 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 dissatisfied with the level-one decision, you may request a second review of nonurgent claims. To initiate a level-two appeal, follow the same process required for a level-one appeal.

For required pre-service and concurrent care coverage determinations the review will be completed within 15 calendar days and for post service claims, the review will be completed within 30 calendar days. 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. You will be notified in writing of the decision within the time frames above if CIGNA does not approve the requested coverage.

For submitting urgent care appeals at this level, follow the process in Level-One Appeal.

LEVEL THREE APPEAL

If you are not satisfied with CIGNA's first and second level 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 and second level appeal process 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 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.

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

Active Employees
(800) 480-9967
e-mail: mtcustserv@cp.org

Retired Employees
(866) 273-4545
e-mail: mtcustserv@cp.org

Monday through Friday, except holidays,
8:30 a.m.– 7:00 p.m. EST

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 be 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 handbook 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 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, with or without notice, 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 Members should read the official Plan documents carefully to determine which benefits are covered, as well as any applicable exclusions, limitations, and procedures.

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.

