The Episcopal Church Medical Trust

Dental Plan Document Handbook

Basic Dental PPO Plan | Dental & Orthodontia PPO Plan | Preventive Dental PPO Plan

CIGNA
A Business of Caring.

Benefits effective as of January 1, 2008

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. Its purpose is to provide benefits to eligible employees, former employees, and/or their dependents in the event of illness or expenses for various types of dental 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.

ENROLL NOW

If you have questions about any of our plans, please don't hesitate to contact us. We're looking forward to serving you.

For more information, please visit our website at www.cpg.org.

** 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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HOW TO USE THIS HANDBOOK

The Medical Trust has prepared this Handbook to help you understand your benefits in the Basic Dental, Dental & Orthodontia, and Preventive Dental Plans. Please read it carefully. Your benefits are affected by certain limitations and conditions that require you to be a wise consumer of dental services and to use only those services you need. Also, benefits are not provided for certain kinds of treatments or services, even if your dental care provider recommends them.

As used in this Handbook, the word “year” 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. The word “lifetime,” as used in this Handbook, refers to the period of time you or your eligible dependents participate in these Plans or any other plan maintained by the Medical Trust. Any amount you or your eligible dependents have accumulated toward the lifetime benefit maximum amounts of any previous Medical Trust dental plan will be counted toward the benefit maximum amounts of this Plan.

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

This Handbook contains only a partial, general description of the Plans. It is provided for informational purposes only and should not be viewed as a contract, an offer of coverage, or investment, tax, medical, or other advice. There are additional sources of information, such as medical and dental policy, that will be used in making benefit determinations. In the event of a conflict between this Handbook and other official Plan documents, the official Plan documents will govern.

Benefits described in this Handbook are effective as of January 1, 2008.

Important Information

This is not an insured benefit plan. The benefits described in this Handbook are self-funded by the Medical Trust from accumulated assets and are provided directly from the Episcopal Church Clergy and Employees’ Benefit Trust (“ECCEBT”). Payments out of the Plans to dental care providers on behalf of the covered person will be based on the provisions of the Plans. Connecticut General (CIGNA) provides claim administration services to the plan, but CIGNA does not insure the benefits described.

NETWORK BENEFITS

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 "non-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; or
- 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

In-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 in-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.

NOTICE OF PROVIDER DIRECTORY/ NETWORKS

You may access a list of providers who participate in the network by visiting **www.cigna.com**, **www.mycigna.com**, or by calling the toll-free telephone number on your ID card.

Your participating provider network consists of a group of local dental practitioners, of varied specialties as well as general practice, who are contracted with CIGNA.

NON-NETWORK BENEFITS

CHOOSING A NON-NETWORK PROVIDER

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

- You pay an annual Deductible and Coinsurance, (the Maximum Reimbursable Charge (MRC) times the Coinsurance) plus the balance of the provider's actual charge;
- You will usually have to pay the provider when you receive care; and
- You may need to file a claim with CIGNA to be reimbursed by the Plan.

The charts below shows you how costs differ based on whether you choose network or non-network care. It also shows you how your non-network costs differ based on the value of the MRC. These examples are based on the Basic Dental PPO Plan.

Example where the non-network MRC is less than the network Contracted Fee:

	NETWORK	NON-NETWORK
Provider's Charge for Basic Services (for example, a filling)	$500	$500
Network Contracted Fee and Non-Network MRC	Contracted CIGNA Fee: $400	MRC: $300 (80th percentile of all charges made by providers of such service in the geographic area)
Plan Pays	$340 (85% of allowed amount)	$255 (85% of MRC)
You Pay	$60 Coinsurance (15% of allowed amount)	$245 (15% of MRC ($45) plus the $200 difference between the MRC and the provider charge. This example assumes you have satisfied your Deductible.

Example where the non-network MRC is greater than the network Contracted Fee:

	NETWORK	NON-NETWORK
Provider's Charge for Basic Services (for example, a filling)	$500	$500
Network Contracted Fee and Non-Network MRC	Contracted CIGNA Fee: $400	MRC: $450 (80th percentile of all charges made by providers of such service in the geographic area)
Plan Pays	$340 (85% of allowed amount)	$382.50 (85% of MRC)
You Pay	$60 Coinsurance (15% of allowed amount)	$117.50 (15% of MRC ($67.50) plus the $50 difference between the MRC and the provider charge. This example assumes you have satisfied your Deductible.

ELIGIBILITY AND PARTICIPATION

WHO IS ELIGIBLE

The Medical Trust determines eligibility for these Plans. You may not participate in these Plans as both an employee and as a dependent, and your dependents may not participate in these Plans as a dependent of more than one employee. If you are an academic year participant, you cannot participate in these Plans as both a full-time seminary student and as a dependent, and your dependents cannot participate in these Plans as a dependent of more than one full-time seminary student or employee enrolled in these Plans. If you are a retiree, you cannot participate in these Plans as both a retiree and as a dependent, and your dependents cannot participate in the Plans as dependents of more than one retiree or employee.

The Episcopal Church Medical Trust maintains a series of benefit plans for the employees and retirees (and their beneficiaries) of the Protestant Episcopal Church in the United States of America. The Medical Trust funds certain of its benefit plans through a trust fund, known as the Episcopal Church Clergy and Employees' Benefit Trust ("ECCEBT").

As the Medical Trust exclusively serves ecclesiastic societies, dioceses, missionary districts, and other bodies subject to the authority of the church, **the following individuals are eligible for coverage under the Medical Trust Plans:**

- Active clergy and lay employees receiving a W-2 from their employers, who are salaried employees or regularly scheduled to work a minimum of 20 hours per week. Eligibility for Medicare/Medicaid or the receipt of Medicare/Medicaid benefits will not be taken into account in determining eligibility;
- Employees who are on a leave of absence, short-term disability, or long-term disability, and who are not Medicare-eligible;
- Postulants, novices, or professed members of Episcopal Religious Orders. Individuals of the Religious Orders defined in Title III, Canon 24, Section 1, Constitution & Canons 2003 are eligible;
- Retirees who
    - — were employed by the Episcopal Church for five or more continuous years at the time of separation from employment;
    - — were enrolled in a Medical Trust or group-sponsored health plan at the time of retirement;
    - — are eligible to receive a pension from their church employer, if a pension plan was made available by the employer, even if they chose not to begin collecting a benefit at the time of separation; and
    - — are not eligible for any other non-Medical Trust group-sponsored health plan.

ELIGIBILITY AND PARTICIPATION

- Seminarians not covered under the Association of Episcopal Seminaries, interim rectors, priests-in-charge, diocesan-sponsored missioners, and others engaged in official ministry of the diocese. These individuals may be eligible for coverage under the diocese's Medical Trust health care Plans. To request benefits for one of these individuals, a letter should be sent to the Medical Trust. The letter must define the officially recognized status of the person(s) in question, and be signed by the bishop;

Your eligible dependents include:

- Your spouse or your qualifying domestic partner (if applicable to your group);
- Children who are younger than 30 years of age, unmarried, without his or her own dependents, living at home with the parent(s) or enrolled as a full-time student, and not covered under another group health plan or receiving Social Security benefits;*
- Children who, regardless of their age, are physically or mentally disabled and incapable of self-support, provided the disability began before the child reached age 19 (or age 23 if a full-time student). You must submit satisfactory proof of the disability within 30 days after the end of the month in which the child reaches the age limit that is otherwise applicable.

Children eligible for coverage include natural children, stepchildren, legally adopted children or children for whom a petition to the court for adoption has been submitted, and your domestic partner's children (if applicable to your group).

Eligible children may also include recipients under an approved qualified medical child support order (QMCSO).

Note that there may be circumstances in which an individual who is eligible for coverage under a Plan as a dependent does not qualify as your dependent for Federal income tax purposes. In those cases, the cost of providing Plan coverage to that individual will be imputed income to you for Federal income tax purposes.

- Surviving spouses and surviving domestic partners who are not eligible for any other non-Medical Trust group-sponsored health plan.
    - — Surviving spouses and domestic partners who are not enrolled in the Medical Trust at the time of the employee's or retiree's death cannot enroll, unless they are beneficiaries of The Church Pension Fund or the retiree met the lay beneficiary rules.
    - — Surviving spouses and domestic partners (and their dependents) who leave the Medical Trust because they are eligible for coverage through their employer may return to the Medical Trust if they lose their non-Medical Trust coverage, as long as there has been no break in coverage.
- Surviving children who meet the criteria for eligible dependents.

**Verification of status is required for adult children (age 19 and over).*

ELIGIBILITY AND PARTICIPATION

The following individuals are not eligible for coverage:

- Part-time employees working less than 20 hours per week;
- Temporary employees;
- Seasonal employees;
- Part-time students;
- Clergy who were deposed prior to becoming eligible to receive a pension;
- Employees who voluntarily terminate employment prior to becoming eligible to receive a pension; and
- Spouses and dependents who are eligible for other employer group health plans.

GENERAL ENROLLMENT REQUIREMENTS AND ELECTION INFORMATION

You must enroll within 30 days of your employment date, retirement date, or during an open enrollment period. If you also want dependent coverage, you must enroll your eligible dependents at this time. If you do not have any eligible dependents at the time of initial enrollment, but you acquire eligible dependents at a later date, you must enroll the dependent(s) within 30 days of the date you acquire them. To enroll, you must complete and return any enrollment forms required or provided by your employer within the applicable time period. You may be required to obtain and provide your group administrator with a Social Security number for each covered dependent.

SIGNIFICANT LIFE EVENTS

You are allowed to change your enrollment elections during a Plan Year if you have a significant life event. If you have a significant life event, you may change your enrollment decision within 30 days of the significant life event by notifying your group or diocesan administrator and completing and returning any required forms. Your change in enrollment election must be consistent with your significant life event. In other words, you may only change your election if the significant life event causes you, your spouse, or your child to gain or lose eligibility for coverage under this or another plan, and the election change must correspond with the effect on coverage.

A member can change Plan options during the Plan Year as a result of the following qualifying events (provided that the change is consistent with the event):

- Marriage
- Divorce, legal separation, or annulment of marriage
- Death of a spouse or child
- Birth, adoption, or petition to the court for adoption
- Qualification or termination of a domestic partnership (in groups offering domestic partner coverage).
- Termination or commencement of employment by you, your spouse, or your child, including a switch between part-time and full-time, or commencement or return from an unpaid leave of absence

ELIGIBILITY AND PARTICIPATION

- Change in dependent status for your child
- Significant change in cost or a significant curtailment of health coverage for you, your spouse, or your child
- When you, your spouse, or your child becomes entitled to either Medicaid or Medicare
- Return to compensated work where an “active” medical plan benefit applies
- Change in status (e.g., from active to early retiree or retiree, or from retiree or early retiree to active)
- Meeting or exceeding a lifetime limit on benefits.

If your Dentist discontinues participation in the network, you cannot change plans until the next open enrollment period. Open enrollment is the period set aside each year for members to change Plan options, add dependents, or enroll in a Plan option.

All changes to the Plans are effective on the date of the qualifying event, unless otherwise specified. Qualifying events must be reported to the Medical Trust as soon as they occur, but not later than 30 days beyond the onset.

SPECIAL ENROLLMENTS

If you decline coverage under this Plan for yourself or your dependents because of other dental plan coverage, and if such other dental plan coverage is subsequently terminated due to a loss of eligibility for such coverage (loss of eligibility does not include a loss due to failure to pay premiums when due, failure to exhaust COBRA continuation coverage, if elected, or causes such as making a fraudulent claim or misrepresentation) or termination of any employer contributions for such coverage, then you and/or your eligible dependents may enroll in the Plan. A loss of eligibility also may occur, in the case of coverage offered through an HMO, or other arrangement, when an individual no longer resides, lives or works in the service area, and, in the case of group coverage, no other benefit package is available to the individual; when an individual incurs a claim that would meet or exceed a lifetime limit on benefits; and when a plan no longer offers any benefits to similarly-situated individuals.To enroll, you must notify your group or diocesan administrator and complete and return any required forms within 30 days of the loss of the other coverage or termination of employer contributions.

Adopted children and children placed for adoption are covered retroactive to the date of adoption or placement for adoption.

LATE ENROLLMENTS

If you or your dependents are not enrolled within 30 days of your employment date or the earliest date on which coverage can become effective under the Plan, you may enroll for coverage at a later date. For late enrollment, coverage begins on the first day of the month following the date the enrollment requirements are satisfied.

All late enrollees to the dental Plans are required to complete a pre-treatment estimate at their own expense. The pre-treatment form is the ADA Dental Claim Form, which is available at the Dentist's office. An underwriter reviews all Dental Health Statements, and enrollment is subject to approval. The late enrollee and the Medical Trust will be notified as to the decision and the effective date, if applicable.

ELIGIBILITY AND PARTICIPATION

WHEN COVERAGE BEGINS

When the enrollment requirements are met, your coverage begins on the first day of the month following your eligibility date if you are actively at work.

Coverage for your dependents begins the later of when your coverage begins or the first day a dependent becomes eligible, if properly enrolled.

Coverage for retired employees will either continue automatically if the retiree was previously enrolled in a dental Plan option as an active employee and has opted to continue coverage as a retiree, or if the retiree is enrolling for the first time, will begin on the first day of the month following his or her eligibility date, provided the enrollment requirements are met.

WHEN COVERAGE ENDS

Employee/Retiree

Your coverage ends at the earliest of:

- The end of the month in which employment with a participating diocese or group of the Episcopal Church ends;
- For retirees, the end of the month in which the individual ceases to be a retired employee or is no longer in a class of retirees eligible for coverage;
- The end of the month in which contributions cease;
- The end of the month in which the employee is no longer eligible to participate in the Plan;
- The date the Plan ceases to exist;
- The end of the month in which you cease to be a full-time seminarian student in a participating Episcopal seminary (Seminarians only);
- The end of the month in which you become eligible for a non-Medical Trust diocesan-sponsored health plan; or
- The end of the month in which the group terminates coverage with the Medical Trust.

Dependents

Coverage for your dependents ends at the earliest of:

- The date your coverage ends;
- The date contributions cease;
- The end of the month in which a dependent no longer meets the eligibility requirements for any reasons other than age;
- The end of the calendar year in which a dependent child reaches age 30 (except for disabled children);
- The date the Plan ceases to exist;
- The end of the month in which the student is no longer eligible to participate in the Plan (Seminarians only);
- The end of the month in which the dependent or surviving dependent becomes eligible for a non-Medical Trust group-sponsored health plan; or
- The end of the month in which the group terminates coverage with the Medical Trust.

ELIGIBILITY AND PARTICIPATION

SPECIAL SITUATIONS, EXTENSION OF COVERAGE

Death of Employee

Should you die while you are a member of the clergy or a lay employee of the Episcopal Church, your dependents who were covered by the Plan at the time of your death will be eligible for continuing benefit plan coverage with the Medical Trust.

Notify the Medical Trust immediately upon the death of a covered employee, spouse, dependent, or retiree. If a covered employee dies, covered dependents are eligible to continue coverage if all of the following conditions are met:

- The employee was enrolled in a Medical Trust plan at the time of his or her death;
- The dependents were enrolled in the same plan at the time of the employee's death; and
- The dependents have no health coverage available through their own employer. Regardless of whether or not the dependent enrolls in health benefits through his or her employer, eligibility for coverage ceases if the dependent remarries or becomes eligible for health benefits through his or her employer.

Termination of Employment

If you terminate employment, you may elect to continue coverage for up to 18 months following the end of the calendar month in which your termination occurs, if you pay the required monthly contributions in advance. There is no conversion option available at the end of the 18-month extension.

Divorce or Termination of Domestic Partnership

Notify the Medical Trust immediately upon notification of divorce or termination of a domestic partnership. The Medical Trust will assist in determining eligibility for continuation or extension of benefits.

Extension of Dental Benefits

Employees and/or their dependents are eligible for the extension of benefits under the following circumstances:

- Termination of employment (employee and/or dependents are eligible);
- Divorce (dependents are eligible); or
- Graduation from seminary, for seminarians.

The Medical Trust notifies you regarding your eligibility for the extension of benefits upon receipt of a termination form from the group administrator. The notification includes the cost and duration of the medical/dental extended coverage options. Employees and/or dependents can purchase the extension of benefits for up to a 18-months period beginning on their termination date. There can be no break in coverage between termination and enrollment in the extension of benefits.

This extension of benefits is different from the benefits provided under COBRA, as COBRA does not apply to any employee or dependents covered under a dental benefit plan through the Medical Trust.

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 has been reached you and your family need not satisfy any further dental Deductible for the rest of that 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.

DEFINITIONS

MAXIMUM REIMBURSABLE CHARGE

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

- the provider's normal charge for a similar service or supply; or
- 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; and
    - finally, the plan of the spouse of the parent not having custody of the child

COORDINATION OF BENEFITS

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; and
- 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.

OTHER IMPORTANT PLAN PROVISIONS

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 above regarding yours 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.

OTHER IMPORTANT PLAN PROVISIONS

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.

OTHER IMPORTANT PLAN PROVISIONS

NO WAIVER

The failure of the Medical Trust to enforce strictly any term or provision of this 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 Plan 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; and
- 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 do their best to resolve the matter on your initial contact. If they need more time to review or investigate your concern, they 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 after they receive an appeal for a postservice coverage determination. If more time or information is needed to make the determination, they 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.

HOW TO APPEAL A DENIAL OF BENEFITS

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; and
- 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.

GENERAL INFORMATION

Type of Plan

A benefit plan providing group dental benefits.

Name and Address of the Plan Sponsor and Plan Administrator

The Episcopal Church Medical Trust
445 Fifth Avenue
New York, NY 10016
(212) 592-1800

Name and Address of the Designated Agent for Service of Legal Process

The Episcopal Church Medical Trust
445 Fifth Avenue
New York, NY 10016
(212) 592-1800

Name and Address of the Claims Administrator

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

Name and Address of the Independent Review Administrator

The Episcopal Church Medical Trust
445 Fifth Avenue
New York, NY 10016
(212) 592-1800

Method of Funding Benefits

Health benefits are self-funded by the Medical Trust from accumulated assets and are provided directly from the Episcopal Church Clergy and Employees' Benefit Trust ("ECCEBT").

Payments out of the Plans to health care providers on behalf of the covered person will be based on the provisions of the Plans.

COVERAGE AND SCHEDULE OF DENTAL BENEFITS

BASIC DENTAL PPO PLAN

DENTAL & ORTHODONTIA PPO PLAN

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.

CIGNA Dental

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 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% **Non-Network** 0%	 N/A No	Not subject to the annual benefit maximum.
Basic Restorative Services	**Network** 15% **Non-Network** 15%	 N/A Yes	Subject to the annual benefit maximum.
Major Restorative Services	**Network** 15% **Non-Network** 15%	 N/A Yes	Subject to the annual benefit maximum.
Orthodontia	**Network** 50% **Non-Network** 50%	 N/A Yes	Subject to the lifetime orthodontic 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.

Lifetime maximum applies o 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.

BASIC DENTAL AND DENTAL & ORTHODONTIA PPO PLANS

WHAT'S COVERED

When all of the provisions of the Plans are satisfied, the Plans will provide benefits as outlined on the Schedule 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

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 – Only 2 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 – Only one per person, including panoramic film, in any 3 calendar years
- Bitewing x-rays – Only 2 charges per person per calendar year
- Panoramic (Panorex) x-ray – Only one per person in any 3 calendar years
- Other x-rays necessary to diagnose a dental condition, including periapical and occlusal x-rays
- Prophylaxis and Periodontal Prophylaxis (Cleaning) – Only 2 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. Only two per person per calendar year
- Topical application of sealant, per tooth, on a posterior tooth for a person less than 14 years old – Only one treatment per tooth in any 3 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 6 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)

BASIC DENTAL AND DENTAL & ORTHODONTIA PPO PLANS

- 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
  - — Porecelain 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

BASIC DENTAL AND DENTAL & ORTHODONTIA PPO PLANS

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; and
- 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 3 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 5 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

BASIC DENTAL AND DENTAL & ORTHODONTIA PPO PLANS

- 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
- 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 AND SCHEDULE OF DENTAL BENEFITS

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.

PREVENTIVE DENTAL PPO PLAN

WHAT'S COVERED

When all of the provisions of the Plan are satisfied, the Plan will provide benefits as outlined on the Schedule 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 Plan. 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

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 – Only 2 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 – Only one per person, including panoramic film, in any 3 calendar years
- Bitewing x-rays – Only 2 charges per person per calendar year
- Panoramic (Panorex) x-ray – Only one per person in any 3 calendar years
- Prophylaxis and Periodontal Prophylaxis (Cleaning) – Only 2 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 6 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 5 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

PREVENTIVE DENTAL PPO PLAN

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; and
- 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.

Payments for comprehensive full-banded Orthodontic treatment are made in installments. Benefit payments will be made every 3 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 5 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

PREVENTIVE DENTAL PPO PLAN

- 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

PREVENTIVE DENTAL PPO PLAN

- 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

As a participant in the Episcopal Church Medical Trust Basic Dental, Dental & Orthodontia, and Preventive Dental PPO Plans (the "Plans"), you are entitled to certain rights concerning your protected health information under the Health Insurance Portability and Accountability Act (HIPAA). The following describes how health information about you may be used and disclosed and how you may access this information.

The Plans are permitted to make certain types of uses and disclosures of protected health information under applicable law for treatment, payment, and health care operations purposes.

USE AND DISCLOSURE OF INFORMATION TO AND FROM CHURCH PENSION GROUP SERVICES CORPORATION

The Plans may disclose protected health information to Church Pension Group Services Corporation (the "plan sponsor") under limited circumstances. The plans will disclose protected health information to the plan sponsor only upon receipt of a certification by the plan sponsor that the Plan documents have been amended to incorporate and to abide by these privacy provisions.

The Plans may disclose summary health information to the plan sponsor for the purposes of obtaining premium bids, insurance coverage, or modifying, amending, or terminating the Plans.

The Plans may disclose protected health information to carry out plan administration functions that are consistent under applicable law. The Plans may not disclose protected health information to the plan sponsor for the purpose of employment-related actions or decisions or in connection with other benefits or employee benefit plans of the plan sponsor.

A limited number of employees of the plan sponsor will have access to protected health information for the purposes of carrying out plan administration functions in the ordinary course of business. These employees are in the following areas: Human Resources, Information Services, Mailroom/Fax Delivery, Legal Department, Medical Trust Member Services, and Medical Trust Plan Administration.

These employees will only use protected health information for plan administration functions, consistent with the Plans' Privacy Policies and Procedures, the Standards for Privacy of Individually Identifiable Health Information, other applicable federal or state privacy law, and the departments' privacy policies. Should an employee of the plan sponsor not comply with the Plans' Privacy Policies and Procedures, the Standards for Privacy of Individually Identifiable Health Information, or other federal or state privacy law, the employee will be subject to corrective action. The plan sponsor will promptly implement the contingency plans to mitigate any deleterious effect of improper use or disclosure of protected health information by Church Pension Group Services Corporation or the Plans' business associates.

If feasible, the plan sponsor must return or destroy all protected health information received from the Plans that the plan sponsor maintains in any form. The plan sponsor cannot retain copies of such information when it is no longer needed for the purpose for which disclosure was made. If the return or destruction of protected health information is not feasible, the plan sponsor will limit further uses and disclosures to those purposes that make the return or destruction of the information infeasible. The plan sponsor has an obligation under the law to retain records for its plan administrative functions, and will retain the required records, which may or may not contain protected health information, as required under the law. The plan sponsor must report to the Plans any use or disclosure of protected information that is inconsistent with the uses or disclosures provided for of which the plan sponsor becomes aware.

The plan sponsor must make its internal practices, books, and records relating to the use and disclosure of protected health information received from the Plans available to the Secretary of the U.S. Department of Health and Human Services for purposes of determining compliance with the Standards for Privacy of Individually Identifiable Health Information.

USE AND DISCLOSURE OF HEALTH INFORMATION BY THE PLAN

The Plans will not use or disclose protected health information other than as permitted or required by the plan documents or as required by law. For instance, the Plans are permitted to disclose minimum necessary protected health information without your authorization for public health activities, health oversight activities, research, and judicial and administrative proceedings. The Plans are permitted to disclose protected health information to law enforcement officials as required by law. The Plans are also required to disclose protected health information to you or your personal representative to the extent that you have a right of access to the information and to the U.S. Department of Health and Human Services on request for complaint investigation or compliance review.

The Plans' business associates are permitted to use protected health information received from the Plans for the specific activities for which those business associates are contracted. Before receiving your protected health information, the Plans' business associates must agree to the same restrictions and conditions that apply to the Plans and plan sponsor under the Standards for Privacy of Individually Identifiable Health Information and other applicable federal or state privacy laws. The third-party administrator is considered a business associate of the Plans.

ACCESS, AMENDMENT, AND ACCOUNTING OF HEALTH INFORMATION

You have a right to request access to inspect and obtain a copy of your protected health information that the Plans and the Plans' business associates maintain in a designated record set. The Plans have established procedures in its Privacy Policies and Procedures to grant access to your protected health information. The Plans have a right to deny your request for access, and you have the right to request a review of that denial under certain circumstances, pursuant to the provisions of 45 CFR § 164.524.

The designated record set that the Plans maintain includes documentation about enrollment, payment, claims adjudication, or case/health management. To request access to your protected health information, contact the plan sponsor.

You have a right to request that the Plans amend your protected health information that the Plans and the Plans' business associates maintain in a designated record set. The Plans have established procedures in their Privacy Policies and Procedures to allow amendment to your protected health information. The Plans have a right to deny your request for amendment, and you have the right to attach a statement of disagreement, pursuant to the provisions of 45 CFR § 164.526. To request an amendment to your protected health information, contact the plan sponsor.

Pursuant to 45 CFR § 164.528, you have a right to request an accounting of disclosures of your protected health information made by the Plans six years prior to the date on which the accounting is requested, beginning with the effective date of the Standards for Privacy of Individually Identifiable Health Information, which is April 14, 2003.

Example 1: You request an accounting on September 14, 2003. The Plans are obligated to account for disclosures made from April 14, 2003 through September 14, 2003.

Example 2: You request an accounting on September 14, 2010. The Plans are obligated to account for disclosures made from September 14, 2004 through September 14, 2010.

The Plans do not have to account for disclosures made:

- To you;
- To carry out treatment, payment, and health care operations;
- Pursuant to your authorization;
- Incident to a use or disclosure otherwise permitted under the Standards for Privacy of Individually Identifiable Health Information;
- For national security or intelligence purposes;
- As part of a limited data set;
- Prior to April 14, 2003; or
- For other reasons listed in 45 CFR § 164.528.

To request an accounting of disclosures of your protected health information, contact the plan sponsor.

COMPLAINTS

If you believe your privacy rights have been violated, you may complain to the Chief Privacy Officer at Church Pension Group Services Corporation; 445 Fifth Avenue; New York, NY 10016. You also may complain to the Secretary of the Department of Health and Human Services at Hubert H. Humphrey Building; 200 Independence Ave., SW; Washington, D.C. 20201. You will not be retaliated against for filing a complaint.

YOUR HEALTH INFORMATION AND PRIVACY

Your health information is confidential, and your privacy will be protected. You may receive information about treatment alternatives or other health-related benefits and services that may be of interest to you. Your health information also may be used for quality assessment and improvement activities related to your dental benefits. Dental information obtained through administrative services will not be used to make employment and personnel decisions.

NOTE: The following terms, as used in this section, are defined in the Standards for Privacy of Individually Identifiable Health Information (45 CFR Parts 160 and 164): “protected health information,” “business associates,” “personal representative,” “designated record set,” and “limited data set.”

PROVIDER	CONTACT INFORMATION
CIGNA Dental	www.cigna.com (800) 244-6224
The Episcopal Church Medical Trust	www.cpg.org **Active Employees** (800) 480-9967 e-mail: medtrust@cpg.org **Retired Employees** (866) 273-4545 e-mail: mtmedsupp@cpg.org (Monday through Friday, except holidays, 8:30 a.m.– 5:30 p.m. EST)

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

This document contains only a partial, general description of the Plans. It is provided for informational purposes only and should not be viewed as a contract, an offer of coverage, or investment, tax, medical, or other advice. In the event of a conflict between this document and the official plan documents (schedule of benefits, summary plan description, booklet, booklet-certificate), the official plan documents will govern. The Church Pension Fund and CPGSC (collectively, "CPG"), retain the right to amend, terminate or modify the terms of the Plans, as well as any post-retirement health subsidy, at any time, without notice and for any reason.

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

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

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

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

THE EPISCOPAL CHURCH
MEDICAL TRUST

445 Fifth Avenue
New York, NY 10016