Wespath
BENEFITS | INVESTMENTS

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Glenview, Illinois 60025-1604
wespath.org

HealthFlex Benefits Booklet

CIGNA Dental Benefits

- Preferred Provider Organization (PPO) Plan
- Passive PPO 2000

Note: This HealthFlex Benefits Booklet is effective as of January 1, 2020. All prior versions of this Benefits Booklet are Superseded by this document.

a general agency of The United Methodist Church

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Welcome

Wespath has prepared this Benefit Booklet to help you understand your dental benefits, which are administered by Connecticut General Life Insurance Company (CIGNA or the Claims Administrator). Please read it carefully.

HealthFlex Summary Plan Description

You can find a copy of the ***HealthFlex Summary Plan Description*** (SPD) on the Wespath website at **wespath.org**. You also may request a copy from the Wespath Health Team at **1-800-851-2201**. The HealthFlex SPD contains important information about the Plan's eligibility rules, Claims, appeals, cafeteria plan rules, elections and limitations. Please use the HealthFlex SPD together with this Benefit Booklet to fully understand your benefits.

About the Plan

Wespath maintains and administers the Hospitalization and Medical Expense Program, also known as HealthFlex (Plan). The plan is maintained for the benefit of clergy and lay employees (and their Dependents) of The United Methodist Church. The dental plan component of the Plan provides dental benefits for Participants (and their Dependents).

The Plan is a "Church Plan" as defined in Section 414(e) of the Internal Revenue Code of 1986 (Code), as amended, and Section 3(33) of the Employee Retirement Income Security Act of 1974 (ERISA), as amended. The Plan's status as a Church Plan has a significant legal meaning; you can read more about it in the section entitled *Legal Status of the Program*.

Explanation of Terms

You will find terms starting with capital letters throughout this Benefit Booklet. To help you understand your benefits, most of these terms are defined in the *Definitions* Section of this Benefit Booklet.

Plan Sponsor

Your Plan Sponsor is the employer or annual Conference (Conference) through which your coverage under the Plan is coordinated. Your Plan Sponsor has elected to participate in the Plan through an adoption agreement with Wespath. If you have questions about your benefits under the Plan, you may contact your Plan Sponsor or Wespath.

Confidentiality and HIPAA

The privacy of the health records of Plan Participants and their Dependents is protected by specific security and privacy regulations under the Health Insurance Portability and Accountability Act of 1996 (HIPAA). Under HIPAA, Wespath employees and Plan representatives and agents (such as CIGNA and others) may not release Protected Health Information, known as PHI, to a Participant's Plan Sponsor, Spouse, or any other entity (unless required by law) unless the Participant authorizes such release. HIPAA also applies when you want PHI to be shared among health plans and Providers for reasons other than payment or treatment. Wespath's Notice of Privacy Practices describes the Plan's privacy practices and your rights to access your records. The notice is available on the website at **wespath.org**.

Wespath will require your written authorization before sharing your PHI with anyone other than you or your personal representative (that is, your guardian or named representative in a power of attorney). You may be asked to fill out and return authorization forms and to provide verification of information. Please remember that these and other actions are taken to safeguard the privacy of you and your family. Also keep in mind that from time to time employees and agents of Wespath, such as the Claims Administrator, may access PHI, subject to the rules of HIPAA and the privacy policies of Wespath, as part of their day-to-day function of administering the Plan.

Your Responsibility to Provide Accurate Information

Wespath and the Claims Administrator rely on information provided by you when evaluating coverage and benefits under the Plan. All such information, therefore, must be accurate, truthful and complete. Any fraudulent statement, omission or concealment of facts, misrepresentation or incorrect information may result in the denial of a Claim, cancellation or rescission of coverage, or any other legal remedy available to the Plan.

Questions

If you have questions about this Plan or any of the benefit plans administered by Wespath, please visit our website at **wespath.org**. Or you may call the Wespath Health team at **1-800-851-2201**.

Plan Document Controls

If any discrepancy exists between this Benefit Booklet and the terms and conditions set forth in the official plan document of the Hospitalization and Medical Expense Program (HealthFlex Plan Document) or the SPD regarding dental benefits, the terms of the Plan Document and SPD shall govern.

The Schedule

The Schedule is a brief outline of your benefits payable under the Plan. For a full description of each benefit, refer to the appropriate section listed in the Table of Contents.

Important Information About Your Dental Plan

If your Plan Sponsor has elected to provide dental coverage for its Participants, you may have a choice among up to three Benefit Options for dental coverage for yourself and your Dependents. The dental Benefit Options offered under the Plan are:

- CIGNA Dental Preferred Provider Organization (PPO)
- CIGNA Dental Passive PPO 2000

When electing a Benefit Option initially or when changing Benefit Options as described below, the following rules apply:

- If you are in mandatory medical health coverage and you do not waive out of medical, you will automatically be enrolled in dental (if your plan sponsor has elected dental coverage for those not in the HealthFlex Exchange). You may decline dental coverage. However, you cannot waive medical coverage and have dental coverage. The Plan requires that all individuals enrolled in dental must be enrolled in medical coverage. This also applies to HealthFlex Exchange.
  - Mandatory coverage refers to the categories of coverage that a Plan Sponsor must offer to specified persons as described in *The Book of Discipline* and the HealthFlex Hospitalization and Medical Expense Program (HealthFlex), subject to certain exceptions.
- If you have optional medical coverage, you will have the option to enroll in dental coverage (if available). You cannot decline medical coverage and have dental coverage. This also applies to HealthFlex Exchange.
  - Optional coverage refers to the added categories of coverage that a Conference Plan Sponsor elects to offer under the Plan.
- You and your Dependents may enroll for only one of the Benefit Options.
- Your Dependents will be covered only if you are covered and only under the same Benefit Option under which you are covered.

Change in Benefit Option Elected

You may elect to change Benefit Options for yourself and your Dependents during any Open Enrollment Period or Annual Election Period or, in certain circumstances, if you experience a Life Status Event (sometime called a "change of status" event) as described in the SPD.

Notice Regarding Provider Directories and Provider Networks

You can find a listing of Participating Providers on the CIGNA website at **cigna.com** or through links to the CIGNA website on the Benefits Access website (**benefitsaccess.org**) in the "Health Details" section, or by contacting CIGNA or Wespath. Your Participating Provider network consists of a group of local dental practitioners of varied specialties as well as general practice who are employed by or contracted with CIGNA HealthCare or CIGNA Dental Health. HealthFlex dental plans use the CIGNA Advantage PPO network.

Eligibility

General Eligibility

The Plan covers most full-time clergy and employees of participating Plan Sponsors. However, your eligibility depends upon the rules of the Plan, as described in the SPD, and the Adoption Agreement your Plan Sponsor has executed with Wespath. At times, your eligibility may also depend upon certain rules and policies established by your Plan Sponsor or Employer, such as leave of absence policies and retirement policies. Consult the SPD and contact your Plan Sponsor to determine if you are not sure whether you are eligible for coverage in the Plan.

Important Information

This is not an insured employee benefit plan. The benefits described in this Benefit Booklet or any rider, amendment or addendum attached hereto are provided through Benefit Options offered under HealthFlex, a self-insured (self-funded) employee welfare benefit church plan maintained and administered by Wespath, which is responsible for the payment of benefits hereunder. The dental benefits described in this Benefit Booklet are provided through a self-funded employee welfare benefit plan (as defined in §3(1) of ERISA) that is a Church Plan (as defined in §3(33) of ERISA and §414(e) of the Code). As a Church Plan, the Plan is exempt by §4(b)(2) of ERISA from the requirements of Title I of ERISA and the regulations issued by the U.S. Department of Labor. The Plan is administered by Wespath.

Connecticut General (i.e., CIGNA) provides claim administration services to the Plan, but Connecticut General does not insure the benefits described. In the case that this document uses words that might describe an insured plan, because the Plan is not insured by Connecticut General but rather is a self-funded Church Plan, all references to insurance shall be read to indicate that the Plan is self-insured. For example:

- "CIGNA," "CG" and "Insurance Company" shall be deemed to mean "Claims Administrator."
- "Policyholder" shall be deemed to mean "Wespath."
- "Policy" shall be deemed to mean "Plan."
- "Insured" shall be deemed to mean "Covered."
- "Premium" shall be deemed to mean "Required Contribution."
- "Insurance" shall be deemed to mean "Coverage."

Cafeteria Plan

Wespath administers this Plan through a cafeteria plan in accordance with Section 125 of the Internal Revenue Code and Section 125 of the Treasury Regulations. Pursuant to these Cafeteria Plan Regulations, you may agree to a pre-tax salary reduction (such as a flexible spending account, also called a medical reimbursement account) put toward the cost of your coverage. Otherwise you will receive your full taxable earnings as salary. Your elections are limited in certain ways by the cafeteria plan rules, which are explained in detail in the SPD. Please review the SPD for a better understanding of the flexible spending account components of the Plan.

How to File Your Claim

The prompt filing of any required Claim form (Claim Form) will aid in faster payment of your Claim.

You may obtain the required Claim Forms from the Claims Administrator. All fully completed Claim Forms and bills should be sent directly to your servicing CIGNA Claim Office.

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

DENTAL EXPENSES

Your Claim for routine dental care such as cleanings and checkups should be filed as soon as you have incurred Covered Expenses. Itemized copies of your bills should be sent to CIGNA with the Claim Form. If you have any additional bills after the first treatment, file them periodically.

If you are planning extensive dental work, you will need to follow the Predetermination of Benefits procedure when necessary. The term "Predetermination of Benefits" means a review by CIGNA of a Dentist's description of planned treatment and expected charges, including those for diagnostic X-rays. This review should be made whenever extensive dental work is proposed. A predetermination can be submitted by:

1. Checking the appropriate box on the CIGNA dental Claim Form in section 1of the Form, and
2. Submitting that Claim Form and any supporting documentation that substantiates the treatment plan.

The Predetermination of Benefits information should be sent to CIGNA before the dental work is started. If there is a major change in the treatment plan, a revised plan should be sent to CIGNA. (Also see *Predetermination of Benefits* section.)

The expenses that will be included as Covered Expenses will be determined by CIGNA and are subject to the Alternate Benefit Provision. When there has not been a Predetermination of Benefits, CIGNA will determine the expenses that will be included as Covered Expenses at the time the Claim is received.

Predetermination of Benefits **does not guarantee payment**. The estimate of benefits payable may change based on the benefits, if any, for which a person qualifies at the time services are completed. See the *Covered Expenses* section of this booklet for more information about Predetermination of Benefits.

CLAIM REMINDERS
Be sure to use your member ID number and account number when you submit CIGNA's Claim Forms, or when you call the CIGNA Claim office.

- Your account number for dental benefits is **2464058.**
- Your ID number is the same number that is on your ID Card for medical benefits through the Plan.

Prompt filing of any required Claim Forms will speed payment of your Claims.

Warning: Any person who knowingly presents a false or fraudulent Claim for payment of a loss or benefit is guilty of a crime—and may be subject to fines and confinement in prison.

PHYSICAL EXAMINATION
The Claims Administrator, at its own expense, will have the right to examine any person for whom a Claim is pending as it may reasonably require in order to administer that Claim.

NOTICE OF CLAIM
Written notice of Claim must be given to CIGNA within 30 days after the occurrence or start of the Loss on which Claim is based. If notice is not given in that timeframe but you can show that written notice was given as soon as was reasonably possible, the Claim will not be invalidated or reduced.

CLAIM FORMS
When CIGNA receives the notice of Claim, it will send to the Claimant the Claim Forms for filing proof of Loss. If the Claimant does not receive these Claim Forms within 15 days after CIGNA receives notice of the Claim, he or she will be considered to meet the proof of loss requirements if he or she submits written proof of loss within 90 days after the date of loss. This proof must describe the occurrence, character and extent of the loss for which Claim is made.

PROOF OF LOSS
In the event that CIGNA rejects a claim, written proof of Loss must be given to CIGNA within 90 days after the date of the loss for which Claim is made. If written proof of loss is not given in that time but you can show that written notice was given as soon as was reasonably possible, the Claim will not be invalidated or reduced.

Dental Benefits — CIGNA Dental Passive PPO 2000

THE SCHEDULE

The Schedule is a brief outline of your benefits payable under the Plan. For a full description of each benefit, refer to the appropriate section listed in the Table of Contents.

The Passive PPO Benefit Option offers the same level of coverage whether you choose a Participating Provider or a Non-Participating Provider. Greater discounts on services may apply with a Participating Provider.

FOR YOU AND YOUR DEPENDENTS

How the Dental Passive PPO 2000 Benefit Option Works

Class I Preventive Care	Class II Basic Restorative	Class III Major Restorative	Class IV* Orthodontia
• Plan pays 100% • There is no Deductible	• You or your Dependent pays $50 Deductible, up to $150 maximum per family • Plan pays 80% after deductible	• You or your Dependent pays $50 Deductible, up to $150 maximum per family • Plan pays 50% after deductible	• Plan pays 50% • There is no Deductible

** Class IV Orthodontia applies **only** to a Dependent Child less than 19 years of age.*

Maximum Benefit

Class I, II, III	Class IV	Individual Deductible	Family Deductible
Combined Calendar Maximum: • Year 1 $2,000 • Year 2 $2,150 • Year 3 $2,300 • Year 4 $2,450	Lifetime Maximum: $2,000	$50 A person must satisfy this Deductible amount for each Plan Year (calendar year) before Dental Benefits are payable.	$150 After dental Deductibles totaling $150 have been applied in a Plan Year (calendar year) for either: • you and your Dependents, or • your Dependents, your family does not need to satisfy any further dental Deductibles for the rest of that Plan Year.

Dental Benefits — CIGNA Dental Preferred Provider

THE SCHEDULE

The Schedule is a brief outline of your benefits payable under the Plan. For a full description of each benefit, refer to the appropriate section listed in the Table of Contents.

The preferred provider organization (PPO) Benefit Option offered under the Plan includes two options: Participating Provider and Non-Participating Provider. When you select a Participating Provider, this Plan pays a greater share of the cost of Covered Services than if you were to select a Non-Participating Provider.

FOR YOU AND YOUR DEPENDENTS

Emergency Services

The benefit percentage that the Plan will pay for charges for emergency Dental Services provided by a Non-Participating Provider is the same benefit percentage as for charges for services from a Participating Provider. Emergency Dental 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. These services are considered to be emergency care as long as transfer of the covered person to a Participating Provider is precluded because of risk to the Participant's health or because transfer would be unreasonable, given the distance involved in the transfer or the nature of the dental condition.

HOW THE PPO DENTAL BENEFIT OPTION WORKS

Participating Provider

Class I Preventive Care	Class II Basic Restorative	Class III Major Restorative	Class IV* Orthodontia
• Plan pays 100% • There is no Deductible	• You or your Dependent pays $50 Deductible, up to $150 maximum per family • Plan pays 90% after deductible	• You or your Dependent pays $50 Deductible, up to $150 maximum per family • Plan pays 60% after deductible	• Plan pays 50% • There is no Deductible

** Class IV Orthodontia applies **only** to a Dependent Child less than 19 years of age.*

Non-Participating Provider

Class I Preventive Care	Class II Basic Restorative	Class III Major Restorative	Class IV* Orthodontia
• There is no deductible • Plan pays 100%	• You or your Dependent pays $50 Deductible, up to $150 maximum per family • Plan pays 70% after deductible	• You or your Dependent pays $50 Deductible, up to $150 maximum per family • Plan pays 50% after deductible	• Plan pays 50% • There is no deductible.

** Class IV Orthodontia applies **only** to a Dependent Child less than 19 years of age.*

Maximum Benefit

Participating Provider Class I, II, III	Non-Participating Provider Classes I, II, III	Participating Provider Class IV	Non-Participating Provider Class IV
Calendar Year Maximum: • Year 1 $2,000 • Year 2 $2,150 • Year 3 $2,300 • Year 4 $2,450	Calendar Year Maximum: Year 1 $1,000 Year 2 $1,150 Year 3 $1,300 Year 4 $1,450	Lifetime Maximum: $2,000	Lifetime Maximum: $1,000

Deductibles
The Deductibles listed below are expenses to be paid by a Participant or Dependent for the services rendered. These Deductibles are in addition to any other expenses, incurred for which no benefits are payable because of a Co-insurance factor or Co-payment requirement:

Individual Deductible	Family Deductible	Orthodontic Lifetime Deductible
$50 A Participant must satisfy this Deductible amount for each Plan Year before Dental Benefits are payable.	$150 After dental Deductibles totaling $150 have been applied in a Plan Year for either: • you and your Dependents, or your Dependents, your family does not need to satisfy any further Dental deductibles for the rest of the Plan Year.	$50

Simultaneous Accumulation of Amounts
Benefits paid for Participating and Non-Participating Provider services will be applied toward both the Participating and Non-Participating Provider Maximums shown in The Schedule above.

Dental Coverage

FOR YOU AND YOUR DEPENDENTS
If you or any one of your Dependents incurs Covered Expenses, CIGNA will:

- Deduct any dental Deductible that applies from the Covered Expenses first incurred in a Plan Year for a person; and
- Pay for the other Covered Expenses incurred in that Plan Year up to the Maximum Covered Expense determined according to The Schedule and the section in this booklet titled *Dental Services* for each Dental Service, subject to the Alternate Benefit Provision.

The dental Deductible is shown in The Schedule.

Exclusion of Adults
The Plan does ***not*** pay for any Orthodontic services or supplies for any Participant or other Covered Person that is not a Dependent child less than 19 years of age.

The total amount payable for all expenses incurred for Orthodontics for a Dependent child less than 19 years of age during his or her lifetime will not be more than the Orthodontia Maximum shown in The Schedule.

Payments for comprehensive full-banded orthodontic treatments are made in installments. Payment of benefits will be made every 3 months. The first payment becomes payable when the appliance is installed. Later payments are payable at the end of each 3-month period. In determining the first installment, CIGNA assigns 25% of the charge for the entire course of treatment to the appliance. The remainder of such charge is prorated over the estimated duration of such treatment. These payments are made only for services performed while such child is covered. If coverage or treatment of such child ceases, the amount payable for that 3-month period will be prorated.

ORTHODONTIA MAXIMUM BENEFIT PROVISION
The total amount payable for all expenses incurred for Orthodontics for a Covered Person in a Plan Year (calendar year) will not be more than the Maximum Benefit shown in The Schedule.

MAXIMUM BENEFIT PROVISION
The total amount payable for all expenses incurred for a Covered Person in a Plan Year (calendar year) will not be more than the Maximum Benefit shown in The Schedule.

WELLNESS BENEFITS
If you have all recommended preventive care (i.e., two dental cleanings) done in one plan year, your annual dollar maximum will increase the following plan year. This will build your annual dollar maximum for other future services. Year-after-year—as long as you remain enrolled in a HealthFlex dental plan and keep receiving preventive care (i.e., two dental cleanings annually)—your annual dollar maximum will increase each year (up to $2,450 maximum). The increase applies only to family members who complete the required preventive care. The dollar maximum returns to $2,000 after any year when one or both preventive cleanings are not completed.

Covered Expenses

The term Covered Expenses means expenses incurred by or on behalf of you or any one of your Dependents for charges made by a Dentist for the performance of a Dental Service listed in the Dental Services Schedule.

Covered Expenses will include only those expenses incurred when, in the view and discretion of the Claims Administrator, the Dental Service:

- Is performed by or under the direction of a Dentist,
- Is essential for the necessary care of the teeth, and
- Starts and is completed while the person is covered under the Plan.

Any portion of charges for a Dental Service that exceeds the maximum covered expense for that service in the dental services schedule maintained by the Claims Administrator will not be a Covered Expense.

A Dental Service is deemed to start when the actual performance of the service starts, with the following exceptions:

- For fixed bridgework and full or partial dentures, Dental Service is deemed to start when the first impressions are taken and/or abutment teeth are fully prepared.
- For a crown, inlay or onlay, Dental Service is deemed to start on the first date of preparation of the tooth involved.
- For root canal therapy, Dental Service is deemed to start when the pulp chamber of the tooth is opened.

ALTERNATE BENEFIT PROVISION

When more than one covered Dental Service could provide suitable treatment based on common dental standards, CIGNA will determine the covered Dental Service on which the payment will be based and the expenses that will be included as Covered Expenses. Benefits will be provided for treatment rendered in accordance with accepted dental standards for adequate and appropriate care. You and your Dentist are free to apply this benefit payment to the treatment of your choice; however, you are responsible for expenses incurred that exceed Covered Expenses. For this reason, CIGNA strongly recommends the use of *Predetermination of Benefits* (see below) when major Dental Services are needed, so that you and your Dentist know in advance what the Plan will cover before any treatment begins.

PREDETERMINATION OF BENEFITS

The term Predetermination of Benefits means a review by CIGNA of a Dentist's description of planned treatment and expected charges, including those for diagnostic X-rays. This review should be made whenever extensive dental work *is proposed.* The information should be sent to CIGNA *before* the dental work is started. If there is a major change in the treatment plan, a revised plan should be sent to CIGNA.

Review of the proposed treatment is advised whenever the recommended dental work charges exceed $200.

The expenses that will be included as Covered Expenses will be determined by CIGNA and are subject to the *Alternate Benefit Provision*. When there has not been a Predetermination of Benefits, CIGNA will determine the expenses that will be included as Covered Expenses at the time the Claim is received.

Predetermination of benefits does not guarantee payment. The estimate of benefits payable may change based on the benefits, if any, for which a person qualifies at the time services are completed.

Dental Services

Covered Expenses will include expenses incurred for Dental Services listed in this Section. CIGNA may agree to accept, as Covered Expenses, expenses for services not listed here. To be so considered, services should be identified in terms of the American Dental Association Uniform Code on Dental Procedures and Nomenclature or by description, and submitted to CIGNA.

CIGNA Dental Preferred Provider Organization (PPO) Plan—If you or any one of your Dependents, while covered under the Plan, incur Covered Dental Expenses, CIGNA will pay any amount determined as follows:

- The maximum covered expense for any covered service received from a *Participating Provider* is the contracted fee amount subject to the benefit percentage for Participating Providers shown on The Schedule for each class of service.
- The maximum covered expense for any covered service received from a *Non-Participating Provider* is the Reasonable and Customary charge subject to the benefit percentage for Non-Participating Providers shown in The Schedule for each class of service. The Participant or Covered Person must pay the balance up to the Non-Participating Provider's actual charge.

CIGNA Dental Passive PPO Plans—CIGNA will determine the maximum covered expense for Dental Services that it accepts. The maximum covered expense so determined will be consistent with the maximums maintained by CIGNA, and will be available upon request.

Payment of any benefits will be subject to any applicable Deductible, Co-payment or Co-insurance shown in The Schedule and to the maximum benefit provision as determined by CIGNA.

A temporary Dental Service is included in the allowance for the final Dental Service—it is not a separate Dental Service.

CLASS I SERVICES—DIAGNOSTIC AND PREVENTIVE

The following Class I services are Covered Dental Services under the Plan, as described below.

- Clinical Oral Examination: Only two per Covered Person per Plan 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 or Panoramic (Panorex): Only one per Covered Person, including Panoramic film, in any 3 Plan Years.
- Bitewing X-rays: Only two charges per Covered Person per Plan Year.
- Prophylaxis (Cleaning): Only two per Covered Person per Plan Year.
- Periodontal Prophylaxis (Cleaning); Two Maintenance procedures per Plan Year (following active therapy).
- Topical application of fluoride (excluding prophylaxis): Two per Covered Person per Plan Year.
- Topical application of sealant, per tooth, on a posterior tooth for a Covered person: Only two treatments per tooth in a Plan Year.
- Space Maintainers, Fixed Unilateral: Limited to non-orthodontic treatment.

CLASS II SERVICES—BASIC RESTORATIONS, ENDODONTICS, PERIODONTICS, PROSTHODONTIC MAINTENANCE AND ORAL SURGERY

The following Class II services are Covered Dental Services under the Plan, as described below.

- Amalgam Filling: One Surface
- Composite/Resin Filling: One Surface
- Root Canal Therapy: Any X-ray, test, laboratory exam or follow-up care is part of the allowance for root canal therapy—it is not a separate Dental Service.
- Osseous Surgery: Flap entry and closure is part of the allowance for osseous surgery and osseous graft—it is not a separate Dental Service.

Please note: If more than one periodontal surgical service is performed per quadrant, only the one service with the largest maximum covered expense is a Dental Service.

- Periodontal Scaling and Root Planing: Entire mouth
- Adjustments: Complete denture

Please note: Any adjustment of or repair to a denture within 6 months of its installation is not a separate Dental Service.

- Re-cement Bridges or Crowns
- Routine Extractions
- 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: Local anesthetic, analgesic and routine postoperative care for extractions and other oral surgery are part of the allowance for each Dental Service.

- 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 that are covered under this Plan.
- IV 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 that are covered under this Plan.

CLASS III SERVICES—MAJOR RESTORATIONS, DENTURES AND BRIDGEWORK

Please note: High noble metal (gold) or crown restorations are Covered Dental Services only when the tooth, as a result of extensive caries (tooth decay or cavities) or fracture, cannot be restored with amalgam, composite/resin, silicate, acrylic or plastic restoration.

The following Class III services are Covered Dental Services under the Plan, as described below.

- **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)

- **Fixed Appliance**
  - **Bridge Pontics:** Cast high noble metal
  - **Bridge Pontics:** Porcelain fused to high noble metal
  - **Bridge Pontics:** Resin with high noble metal
  - **Retainer Crowns:** Resin with high noble metal
  - **Retainer Crowns:** Porcelain fused to high noble metal
  - **Retainer Crowns:** Full cast high noble metal
- **Implants**
- — Surgical placement of the implant body or framework of any type
- — Any device, index or surgical template guide used for implant surgery
- — Prefabricated or custom implant abutments
- — Removal of an existing implant. (Implant removal is covered only if the implant 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 60 consecutive months old, is not serviceable and cannot be repaired.

CLASS IV SERVICES—ORTHODONTICS

The following Class IV services are Covered Dental Services under the Plan, as described below.

- Each month of active orthodontic treatment is a separate Covered Dental Service.
- Covered orthodontic work-up includes X-rays, diagnostic casts and treatment plan, and first month of active treatment including all active treatment and retention appliances.
- Active treatment is covered per month after the first month.
- Fixed or removable appliances—only one appliance is allowable per Covered Person. These may be used:
  - For tooth guidance
  - To control harmful habits

Expenses Not Covered

Covered Expenses will *not* include, and no payment will be made for, expenses incurred for the following:

- 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*:
  - such replacement is made necessary by the placement of an original opposing full denture or the necessary extraction of natural teeth; or
  - the bridge, crown or denture, while in the mouth, has been damaged beyond repair as a result of an injury received while a Covered Person is covered 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:
  - change vertical dimension;
  - diagnose or treat conditions or dysfunction of the temporomandibular joint;
  - stabilize periodontally involved teeth; or
  - restore occlusion.
- Orthodontic services or supplies for any Covered Person other than a Dependent child younger than 19 years of age.
- Porcelain or acrylic veneers of crown or pontics on or replacing the upper and lower first, second or third molars.
- Bite registrations, precision or semiprecision attachments, or splinting.
- Instruction for plaque control, oral hygiene and diet.
- Dental services that do not meet common dental standards.
- Services that are deemed to be medical services.
- Services and supplies received from a hospital.
- Services for which benefits are not payable according to the *General Limitations* section, below.

In addition, these benefits will be reduced so that the total payment under the items below will not be more than 100% of the charge made for the Dental Service if benefits are provided for that service under:

- this Plan, and
- any medical expense plan (i.e., the medical portion of your group health plan) or prepaid treatment program sponsored or made available by your Plan Sponsor.

General Limitations on Dental Coverage

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

- For or in connection with an injury or sickness arising out of, or in the course of, any employment for wage or profit.
- For or in connection with an injury or sickness which is covered under any workers' compensation or similar law.
- For charges made by a hospital owned or operated by the United States Government:
  - unless there is a legal obligation to pay such charges whether or not there is insurance; or
  - such charges are directly related to a military-service-connected sickness or injury.
- To the extent that payment is unlawful where the Covered Person resides when the expenses are incurred.
- For charges which the Covered Person is not legally required to pay.
- For or in connection with an injury or sickness which is due to war, declared or undeclared.
- For expenses incurred outside the United States or Canada, unless you or your Dependent is a U.S. or Canadian resident and the charges are incurred while traveling on business or for pleasure.
- For charges which you are not obligated to pay, or for which you are not billed, or for which you would not have been billed except that they were covered under this Plan.
- To the extent that charges are more than the Reasonable and Customary Charge or the amount indicated in the schedule of maximum benefits and customary charges maintained by CIGNA.
- For charges for treatment or care that, in the view of the Claims Administrator, is unnecessary care, treatment or surgery.
- To the extent that you or any one 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.

No payment will be made for expenses incurred by you or any one of your Dependents to the extent that benefits are paid or payable for those expenses under the mandatory part of any auto insurance policy written to comply with:

- a "no-fault" insurance law, or
- an uninsured motorist insurance law.

CIGNA will take into account any adjustment option chosen under such part by you or any one of your Dependents.

Coordination of Benefits

This section applies if you or any one of your Dependents is covered under more than one plan and determines how benefits payable from all such plans will be coordinated. You should file all Claims with each plan, including this Plan.

DEFINITIONS

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

Paying Plan

Any of the following that provides benefits or services for medical or 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.
- Coverage under Medicare and other governmental benefits as permitted by law, except
- Medicaid and Medicare supplement policies.
- Medical or dental benefits coverage of group, group-type, and individual automobile contracts.

Each Paying Plan or part of a Paying Plan that has the right to coordinate benefits will be considered a separate Paying Plan.

Closed Panel Plan

A Paying 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 Paying Plan that determines and provides or pays benefits without taking into consideration the existence of any other Paying Plan.

Secondary Plan

A Paying Plan that determines, and may reduce its benefits after taking into consideration, the benefits provided by 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, Co-insurance or Co-payments—that is covered in full or in part by any Paying Plan covering you. When a Paying Plan provides benefits in the form of service s, 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 Paying Plans is not an Allowable Expense.
- If you are covered by two or more Paying Plans that provide coverage for 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 Paying Plan that provides coverage for services or supplies on the basis of reasonable and customary fees and one Paying 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 Co-payment amount, higher Co-insurance percentage, a Deductible and/or a penalty) because you did not comply with Paying Plan provisions or because you did not use a preferred, Participating or network provider, the amount of the reduction is not an Allowable Expense. Such Paying Plan provisions include second surgical opinions and precertification of admissions or services.

Claim Determination Period
A calendar year, but does not include any part of a year during which you are not covered under HealthFlex or any date before this section or any similar provision takes effect.

Reasonable Cash Value
An amount which a duly licensed provider of dental 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 Paying Plan that does not have a coordination of benefits rule consistent with this section shall always be the Primary Plan. If the Paying 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:

- The Paying Plan that covers you as an enrollee or an employee shall be the Primary Plan, and the Paying Plan that covers you as a Dependent shall be the Secondary Plan. If you are a Dependent child whose parents are not divorced or legally separated, the Primary Plan shall be the Paying Plan that covers the parent as an enrollee or employee whose birthday falls first in the calendar year,.
- 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 health care expenses or health coverage, and the Paying Plan for that parent has actual knowledge of the terms of the order, but only from the time of actual knowledge;
  - then, the Paying Plan of the parent with custody of the child;
  - then, the Paying Plan of the Spouse of the parent with custody of the child;
  - then, the Paying Plan of the parent not having custody of the child; and
  - finally, the Paying Plan of the Spouse of the parent not having custody of the child.
- The Paying Plan that covers you as an active employee (or as that employee's Dependent) shall be the Primary Plan, and the Paying Plan that covers you as laid-off or retired employee (or as that employee's Dependent) shall be the Secondary Plan. If the other Paying Plan does not have a similar provision and, as a result, the Paying Plans cannot agree on the order of benefit determination, this paragraph shall not apply.
- The Paying Plan that covers you under a right of continuation that is provided by federal or state law shall be the Secondary Plan, and the Paying Plan that covers you as an active employee or retiree (or as that employee's Dependent) shall be the

Primary Plan. If the other Paying Plan does not have a similar provision and, as a result, the Paying 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 Paying Plan that has covered you for the longer period of time shall be the Primary Plan.

When coordinating benefits with Medicare, this Plan will be the Secondary Plan and determine benefits after Medicare, where permitted by the Social Security Act of 1965, as amended. However, when more than one Paying Plan is secondary to Medicare, the benefit determination rules identified above will be used to determine how benefits will be coordinated.

EFFECT 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 one hundred percent (100%) of the total of all Allowable Expenses.

As each Claim is submitted, the Plan will determine the following:

- The Plan's obligation to provide services and supplies.
- Whether there are any unpaid Allowable Expenses during the Claims Determination Period.

RECOVERY OF EXCESS BENEFITS

If this Plan pays charges for benefits that should have been paid by the Primary Plan, this Plan will have the right to recover such payments.

This Plan will have the right to seek such recovery from any person to, or for whom, or with respect to whom, such services were provided or such payments were made by any insurance company, health care plan or other organization. If CIGNA requests, you shall execute and deliver to CIGNA such instruments and documents as CIGNA determines are necessary to secure the right of payment recovery.

RIGHT TO RECEIVE AND RELEASE INFORMATION

The Plan may, with such consent of the Covered Person as may be necessary, release to or obtain from any other insurer, organization or person, any information, with respect to any person, which the Plan considers necessary in order to coordinate benefits. Any person claiming benefits under this Plan shall furnish to the Plan the information necessary for such purpose.

Right of Reimbursement

The Plan does *not* cover:

1) Expenses for which another party may be responsible as a result of liability for causing or contributing to the injury or illness of you or your Dependent(s).
2) Expenses that are covered under the terms of any automobile medical, automobile no fault, uninsured or underinsured motorist, workers' compensation, government insurance, other than Medicaid, or similar type of insurance or coverage when insurance coverage provides benefits on behalf of you or your Dependent(s).

If you or a Dependent incur dental expenses as described in (1) or (2) above, the Plan and CIGNA shall automatically have a lien upon the proceeds of any recovery by you or your Dependent(s) from such party to the extent of any benefits provided to you or your Dependent(s) by the Plan. You or your Dependent(s) or their representative shall execute such documents as may be required to secure the Plan's rights. CIGNA and the Plan shall be reimbursed the lesser of:

a) the amount actually paid by CIGNA (or the Plan Administrator) under the Plan, or
b) an amount actually received from the third party; at the time that the third party's liability is determined and satisfied; whether by settlement, judgment, arbitration or otherwise.

Payment of Benefits

TO WHOM PAYABLE

All Dental Benefits are payable to you. However, at the option of CIGNA and with the consent of Wespath, all or any part of Dental Benefits may be paid directly to the person or institution on whose charge a Claim is based.

If any person to whom benefits are payable is a minor or, in the opinion of CIGNA, is not able to give a valid receipt for any payment due him or her, such payment will be made to his or her legal guardian. If no request for payment has been made by the legal guardian, CIGNA may, at its option, make payment to the person or institution appearing to have assumed custody and support of the minor or adult.

If you die while any of these benefits remain unpaid, CIGNA may choose to make direct payment to any of your following living relatives: spouse, mother, father, child or children, brothers or sisters; or to the executors or administrators of your estate.

Payment as described above will release CIGNA from all liability to the extent of any payment made.

TIME OF PAYMENT

Benefits will be paid by CIGNA when it receives due proof of Loss. All Claims and indemnities payable under the terms of the Plan shall be paid within 30 days following receipt by CIGNA of due proof of Loss.

RECOVERY OF OVERPAYMENT

When an overpayment has been made by CIGNA or the Plan, CIGNA and the Plan will have the right at any time to:

a) recover that overpayment from the person to whom or on whose behalf overpayment was made; or
b) offset the amount of that overpayment from a future Claim payment.

Termination of Coverage

Termination of Coverage – Employees

Your coverage will cease on the earliest date below:

- The date you cease to be in a Class of Eligible Employees or cease to qualify for the coverage.
- The last day for which you have made any Required Contribution for the coverage.
- The date the Plan, or the dental plan portion thereof, is terminated.
- The date of the calendar month in which your Active Service ends, except as described below.

Temporary Layoff or Leave of Absence

If your Active Service ends due to temporary layoff or leave of absence, your coverage will be continued until the date your Plan Sponsor:

- stops paying Required Contributions for you for a maximum time period of 1 year; or
- otherwise cancels your coverage.

Injury or Sickness

If your Active Service ends due to an injury or sickness, your coverage will be continued while you remain totally and continuously disabled as a result of the injury or sickness. However, the coverage will not continue past the date your Plan Sponsor stops paying Required Contributions for you or otherwise cancels the coverage.

Retirement

If your Active Service ends because you retire, your coverage will be continued until the date on which you or your Plan Sponsor stops paying Required Contributions for you or otherwise cancels the coverage.

Termination of Coverage—Dependents

Coverage for all of your Dependents will cease on the earliest date below:

- The date your coverage ceases.
- The date your dependent ceases to be eligible for coverage as a Dependent.
- The last day for which you have made any Required Contribution for the coverage.

The coverage for any one of your Dependents will cease on the date that Dependent no longer qualifies as a Dependent.

Continuation Coverage

The Continuation Coverage required by federal law (COBRA) does *not* apply to any benefits under this Plan. Because the Plan is a Church Plan, the benefits hereunder are exempt from COBRA continuation requirements pursuant to Internal Revenue Code Section 4980B(d) and Treasury Regulation Section 54.4980 B-2, Q. and A. No. 4.

REQUIREMENTS OF FAMILY AND MEDICAL LEAVE ACT OF 1993

Provisions of the Plan that provide for: (a) continuation of coverage during a leave of absence, and (b) reinstatement of coverage following a return to Active Service, will be administered in accordance with the federal Family and Medical Leave Act of 1993 ("FMLA").

Upon request, your Plan Sponsor will give you detailed information about the Family and Medical Leave Act.

Benefits Extension

DENTAL BENEFITS EXTENSION

An expense incurred in connection with a Dental Service that is completed after a Covered Person's benefits cease will be deemed to be incurred while he or she is covered if:

- For *fixed bridgework and full or partial dentures*, the first impressions are taken and abutment teeth fully prepared while the Covered Person is covered, and the prosthesis is inserted within 3 calendar months after the Covered Person's coverage ceases.
- For *a crown, inlay or onlay*, the tooth is prepared while the Covered Person is covered by the Plan, and the crown, inlay or onlay is installed within 3 calendar months after the Covered Person's coverage ceases.
- For *root canal therapy*, the pulp chamber of the tooth is opened while the Covered Person is covered, and the treatment is completed within 3 calendar months after the Covered Person's coverage ceases.

There is no extension for any Dental Service not shown above.

When You Have a Complaint or an Appeal

Note: The following three pages on *Complaints and Appeals* are provided directly by CIGNA, the Claims Administrator for your dental benefits under HealthFlex.

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.

CIGNA wants you to be 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 complaint regarding a person, a service, the quality of care, or contractual benefits not related to Medical Necessity, you can call our toll-free number and explain your concern to one of our Customer Service representatives. A complaint does not include: a misunderstanding or problem of misinformation that can be promptly resolved by Cigna by clearing up the misunderstanding or supplying the correct information to your satisfaction; or you or your provider's dissatisfaction or disagreement with an adverse determination.

You can also express that complaint in writing. Please call or write to us at the following:

> Customer Services Toll-Free Number or address that appears on your Benefit Identification card, explanation of benefits or claim form.

We will do our best to resolve the matter on your initial contact. If we need more time to review or investigate your complaint, we will send you a letter acknowledging the date on which we received your complaint no later than the fifth working day after we receive your complaint. We will respond in writing with a decision 30 calendar days after we receive a complaint for a post service coverage determination. If more time or information is needed to make the determination, we 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.

If you are not satisfied with the results of a coverage decision, you can start the complaint appeals procedure.

APPEALS PROCEDURE

To initiate an appeal of a complaint resolution decision, you must submit a request for an appeal in writing. 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 to register your appeal by telephone. Call or write to us at the toll-free number or address on your Benefit Identification card, explanation of benefits or claim form.

Your complaint appeal request will be conducted by the Complaint Appeals Committee, which consists of at least three people. Anyone involved in the prior decision may not vote on the Committee. You may present your situation to the Committee in person or by conference call.

We will acknowledge in writing that we have received your request within five working days after the date we receive your request for a Committee review and schedule a Committee review. The Committee review will be completed within 30 calendar days. If more time or information is needed to make the determination, we will notify you in writing to request an extension of up to 15 calendar days and to specify any additional information needed by the Committee to complete the review. You will be notified in writing of the Committee's decision within five working days after the Committee meeting, and within the Committee review time frames above if the Committee does not approve the requested coverage.

When You have an Adverse Determination Appeal

An Adverse Determination is a decision made by Cigna that the health care service(s) furnished or proposed to be furnished to you is (are) not Medically Necessary or clinically appropriate. An Adverse Determination also includes a denial by Cigna of a request to cover a specific prescription drug prescribed by your Dentist. If you are not satisfied with the Adverse Determination, you may appeal the Adverse Determination orally or in writing. You should state the reason why you feel your appeal should be approved and include any information supporting your appeal. We will acknowledge the appeal in writing within five working days after we receive the Adverse Determination Appeal request.

Your appeal of an Adverse Determination will be reviewed and the decision made by a health care professional not involved in the initial decision. We will respond in writing with a decision within 30 calendar days after receiving the Adverse Determination Appeal request.

In addition, your treating Dentist may request in writing a specialty review within 10 working days of our written decision. The specialty review will be conducted by a Dentist in the same or similar specialty as the care under consideration. The specialty review will be completed and a response sent within 15 working days of the request. Specialty review is voluntary. If the specialty reviewer upholds the initial adverse determination and you remain dissatisfied, you are still eligible to request a review by an Independent Review Organization.

Retrospective Review Requirements

Notice of adverse determinations (denials only) of retrospective reviews must be made in writing to the patient within a reasonable period, not to exceed 30 days from the date of receipt.
The term retrospective review is a system in which review of the medical necessity and appropriateness of health care services provided to an enrollee is performed for the first time subsequent to the completion of such health care services. Retrospective review does not include subsequent review of services for which prospective or concurrent reviews for medical necessity and appropriateness were previously conducted.

Independent Review Procedure

If you are not fully satisfied with the decision of Cigna's Adverse Determination appeal process or if you feel your condition is life-threatening, you may request that your appeal be referred to an Independent Review Organization. In addition, your treating Dentist may request in writing that Cigna conduct a specialty review. The specialty review request must be made within 10 days of receipt of the Adverse Determination appeal decision letter. Cigna must complete the specialist review and send a written response within 15 days of its receipt of the request for specialty

review. If the specialist upholds the initial Adverse Determination, you are still eligible to request a review by an Independent Review Organization. The Independent Review Organization is composed of persons who are not employed by Cigna or any of its affiliates. A decision to use the voluntary level of appeal will not affect the claimant's rights to any other benefits under the plan.

There is no charge for you to initiate this independent review process and the decision to use the process is voluntary. Cigna will abide by the decision of the Independent Review Organization. In order to request a referral to an Independent Review Organization, certain conditions apply. The reason for the denial must be based on a Medical Necessity or clinical appropriateness determination by Cigna. Administrative, eligibility or benefit coverage limits or exclusions are not eligible for appeal under this process. You will receive detailed information on how to request an Independent Review and the required forms you will need to complete with every Adverse Determination notice.

The Independent Review Program is a voluntary program arranged by Cigna.

Notice of Benefit Determination on Appeal

Every notice of an appeal decision will be provided in writing or electronically and, if an adverse determination, will include: the specific reason or reasons for the denial decision; reference to the specific plan provisions on which the decision is based; a statement that the claimant is entitled to receive, upon request and free of charge, reasonable access to and copies of all documents, records, and other Relevant Information as defined; and a statement describing any voluntary appeal procedures offered by the Plan and the Claimant's right to bring action in state or federal court ; upon request and free of charge, a copy of any internal rule, guideline, protocol or other similar criterion that was relied upon in making the adverse determination regarding your appeal, and an explanation of the scientific or clinical judgment for a determination that is based on a Medical Necessity, experimental treatment or other similar exclusion or limit.

You also have the right to bring a civil action in state or federal court if you are not satisfied with the decision upon exhaustion of the appeal process. You and the Plan may also have other voluntary alternative dispute resolution options, such as mediation. You may also contact the Plan Administrator.

RELEVANT INFORMATION

Relevant information is any document, record or other information which:

- was relied upon in making the benefit determination;
- was submitted, considered or generated in the course of making the benefit determination, without regard to whether such document, record or other information
- was relied upon in making the benefit determination;
- demonstrates compliance with the administrative processes and safeguards required by federal law in making the benefit determination; or
- constitutes a statement of policy or guidance with respect to the Plan concerning the denied treatment option or benefit for the Claimant's diagnosis, without regard to whether such advice or statement was relied upon in making the benefit determination.

LEGAL ACTION

If you are not satisfied with the outcome of the Appeals Procedure, you may initiate a legal action in state or federal court. However, you may not initiate a legal action against CIGNA, the Plan Administrator, the Plan itself or any other agent of the Plan or your Plan Sponsor, until you have completed the appeal processes. You must exhaust these administrative remedies before you can initiate legal proceedings.

Legal Status of the Plan

NOT INSURANCE

Use of the terms Co-insurance, Co-payment, Deductible and premium in reference to the Plan does not imply that the Claims Administrator or other agents insure the Plan. Similarly, use of such terms does not imply that the Plan provides insurance or that the Plan and Wespath are in the business of insurance. The Plan is offered by Wespath as a self-funded Church Plan only for the benefit of eligible clergy and Employees, and their families, associated with organizations affiliated with Wespath through The United Methodist Church. CIGNA is merely a third-party administrator, in a contractual relationship with the Plan and Wespath, that is not financially responsible for any benefits paid under the Plan.

Although Church Plans are considered employee welfare benefit plans under §3(1) of ERISA, as indicated by §4(b)(2) of ERISA, Title I of ERISA does not apply to Church Plans. Therefore, most regulations issued by the U.S. Department of Labor do not govern the administration of the Plan. In addition, Church Plans are exempt from most state laws regulating insurers, such as state insurance licensing, solvency and funding requirements, by the Church Plan Parity and Entanglement Protection Act of 1999 (Parity Act). Self-insured Church Plans are also not subject to many other state laws and regulations that govern insurers because they are not in the "business of insurance," and the Parity Act, along with certain state laws with respect to Church Plans, removes such plans from state insurance regulation.

INTERPRETATION OF THE PLAN AND BENEFITS

Wespath has sole and exclusive discretion to do all of the following:

- Interpret the provisions and terms of and benefits available under the Plan;
- Interpret the other terms, conditions, limitations and exclusions of the Plan, including the Plan Document, SPD, and the HealthFlex Benefit Booklets and any amendments to such documents; and
- Make factual determinations related to the Plan and the benefits provided thereunder.

Wespath, in its discretion, has delegated some of that authority to the Claims Administrator. Wespath has delegated the authority to adjudicate Claims to the Claims Administrator. Wespath and the Claims Administrator (with Wespath) may delegate this discretionary authority to other persons or entities that provide services in regard to the administration of the Plan.

In certain circumstances, for purposes of overall cost savings or efficiency, Wespath and Claims Administrator may, in their sole discretion, offer benefits for services that would otherwise not be covered services under the Plan. The fact that Wespath or Claims Administrator do so in any particular case shall not in any way be deemed to require them to do so in other similar cases.

FIDUCIARY AND ADMINISTRATIVE DUTIES

As the Plan Administrator, Wespath has an obligation to follow the terms of the Plan document. The Plan document names Wespath as both the administrator and fiduciary of the Plan. An administrator must perform its duties in a manner consistent with the terms of the Plan. A fiduciary must maintain and administer the Plan in the interest of the Plan and its Participants. The fiduciary must perform its duties in a reasonable and prudent manner.

The Plan document grants Wespath the power to delegate fiduciary and non-fiduciary duties and obligations to agents and others.

DUTIES ASSIGNED TO THE PLAN'S CLAIMS ADMINISTRATOR

Under the terms of the administrative services agreements with the Claims Administrator, Wespath has delegated certain administrative duties to CIGNA to process Claims and distribute benefits for the dental coverage under the Plan. Wespath, as the Plan Administrator, pays for most of those benefits through banking arrangements with the Claims Administrator. Wespath may also contractually delegate certain fiduciary duties to the Claims Administrator. Specifically, Wespath may at any time in its discretion through contractual arrangement delegate to CIGNA the fiduciary duties with respect to administering Claims and hearing appeals of Claim denials.

CLERICAL ERROR

If a clerical error or other mistake occurs, that error does not create a right to benefits under the Plan. These errors include, but are not limited to, providing misinformation on eligibility or benefit coverage or entitlements. Oral statements made by the Plan Administrator, the Claims Administrator or any other person shall not serve to amend the Plan. In the event an oral statement conflicts with any term of the Plan, the Plan terms will control. It is your responsibility to confirm the accuracy of statements made by the Plan Administrator or its designees, including the Claims Administrator, in accordance with the terms of this Benefit Booklet and other Plan documents.

NO WAIVER

The failure of Wespath or the Claims Administrator to enforce strictly any term or provision of this Benefit Booklet or the Plan will not be construed as a waiver of such term or provision. Wespath reserves the right to strictly enforce any term or provision of this Benefit Booklet and the Plan at any time.

PHYSICIAN/PATIENT RELATIONSHIP

The Plan is not intended to disturb the physician (Dentist)/patient relationship. Dentists and other providers are not agents or delegates of any employer, Plan Sponsor, Wespath or the Claims Administrator. Nothing contained in this Benefit Booklet or the Plan will require you or your Dependent to commence or continue medical treatment with a particular provider. Furthermore, nothing in this Benefit Booklet or the Plan 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 this Benefit Booklet or the Plan will be construed as a contract or condition of employment between any employer and any Employee. All Employees are subject to discharge to the same extent as if this Benefit Booklet and the Plan had never been adopted.

RIGHT TO AMEND OR TERMINATE PLAN

Wespath reserves the right to amend, modify, or terminate the Plan in any manner, for any reason, at any time, and without prior notification, to the extent permitted by law.

General Information

Type of Plan
An employee welfare benefit Church Plan that provides limited scope group dental benefits.

Name and Address of Plan Administrator
Wespath
1901 Chestnut Ave.
Glenview, IL 60025
(800) 851-2201

Name and Address of Designated Agent for Service of Legal Process
Wespath
1901 Chestnut Ave.
Glenview, IL 60025
(800) 851-2201

Name and Address of Third-Party Claims Administrator for Dental Benefits
Connecticut General Life Insurance Company (CIGNA)
1000 Corporate Center Drive, Suite 500
Franklin, Tennessee 37067
(888) 336-8258

Internal Revenue Service Identification Number
The corporate tax identification number assigned by the Internal Revenue Service to the General Board (Wespath) is 36-2166979.

Plan Year
The Plan Year is the 12-month period beginning January 1 and ending December 31.

For More Information

For more information about:

The HealthFlex Plan
Wespath
1901 Chestnut Avenue
Glenview, IL 60025
wespath.org
(800) 851-2201

Connecticut General Life Insurance Company (CIGNA)
1000 Corporate Center Drive, Suite 500
Franklin, Tennessee 37067
cigna.com
(888) 336-8258

Definitions

ACTIVE SERVICE

You will be considered in Active Service:

- On any of your Plan Sponsor's scheduled work days if you are performing the regular duties of your work on a full-time basis on that day either at your Plan Sponsor's place of business or at some location to which you are required to travel for your Plan Sponsor's business.
- On a day which is not one of your Plan Sponsor's scheduled work days if you were in Active Service on the preceding scheduled work day.

AFFILIATED ORGANIZATION

The term Affiliated Organization means any of the organizations and corporations associated with Wespath through The United Methodist Church, as described in Section 414(e) of the Code, and which participates in the Plan through an adoption agreement with Wespath.

ANNUAL ELECTION PERIOD

The term Annual Election Period means a period of time during which Eligible Persons may make election among Benefit Options for themselves and Dependents under the Plan for the following year. The Plan Administrator will determine the period of time that is the Annual Election Period.

BENEFIT OPTION

Benefit Option means a qualified benefit under §125(f) of the Code that is offered under a cafeteria plan or an option for coverage under an underlying accident or health plan [such as an indemnity option, a PPO option, or a consumer-driven health plan (CDHP) option]. In other words, under the Plan, generally, the PPO, CDHP and high-deductible health plans (HDHPs) for medical benefits with their corresponding prescription drug plans are considered separate Benefit Options, as are the Dental PPO and Passive PPO dental plans, as well as the incentive materials and full-service vision plans.

THE BOOK OF DISCIPLINE

The term *The Book of Discipline* means the body of church law established by Wespath, as amended from time to time.

CHURCH PLAN

An employee benefit plan established and maintained for its employees by a church or by a convention or association of churches as established in §414(e) of the Code and §3(33) of ERISA.

CLAIM

The term Claim means notification in a form acceptable to the Claims Administrator that a service has been rendered or furnished to you. This notification must include full details of the service received, including your name, age, sex, identification number, the name and address of the Provider, an itemized statement of the service rendered or furnished, the date of service, the diagnosis, the Claim charge and any other information which the Claims Administrator may request in connection with services rendered to you.

CLAIMANT
The term Claimant means a person who makes a Claim for benefits under the Plan or who appeals the denial of such a Claim, or such person's representative.

CLAIMS ADMINISTRATOR
For Dental Services provided under the terms of this Benefit Booklet and the Plan, the term Claims Administrator means Connecticut General Life Insurance Company, also called CIGNA or CG.

CODE
The term Code means the Internal Revenue Code of 1986, as amended.

CO-INSURANCE*
The term Co-insurance means the percentage of charges for Covered Expenses that a covered person is required to pay under the Plan.

*** Note:** Use of the term "Co-insurance" in this Benefit Booklet does not imply that Connecticut General Life Insurance Company insures the Plan. The Plan is offered by Wespath on a self-funded basis. Connecticut General Life Insurance Company acts as the third-party contract administrator and is not financially responsible for any benefits paid under the Plan. The Co-insurance amounts are shown on *The Schedule of Dental Benefits.*

CONFERENCE
The term Conference means an Annual Conference, Provisional Conference or Missionary Conference of The United Methodist Church, located in a Jurisdictional Conference in the United States as such entities are defined in *The Book of Discipline*.

CO-PAYMENT
Co-payment, sometimes called a "co-pay," means the first-dollar amount you must pay for certain Covered Dental Services under the Plan that is usually paid at the time the service is performed (e.g., Dentist office visits). Co-payments do not apply to your annual Deductible. Any Co-payment amounts are shown on The Schedule.

COVERED DENTAL SERVICE
The term Covered Dental Service means a service and supply specified in this Benefit Booklet for which benefits will be provided.

COVERED PERSON
The term Covered Person means either the Participant or an enrolled Dependent, but this term applies only while the person is enrolled under the Plan. References to "you" and "your" throughout this Benefit Booklet are references to a Covered Person.

DEDUCTIBLE
The term Deductible means the amount charged for Covered Dental Services that each Covered Person must pay during each Plan Year before the Plan will consider expenses for payment or reimbursement. The individual Deductible applies separately to each Covered Person. A family Deductible applies collectively to all Covered Persons in the same family. When the family Deductible is satisfied, no further Deductible will be applied for any covered family member during the remainder of that Plan Year, except in the case of costs beyond the Maximum Allowance. Deductible amounts are shown on The Schedule.

DENTIST
The term Dentist means a person practicing dentistry or oral surgery within the scope of his or her license. It will also include a physician operating within the scope of the license when he or she performs any of the Dental Services described in this Benefit Booklet.

DEPENDENT
The term Dependent, for all Participants regardless of a Participant's State of residence, means any of the following:

- your lawful Spouse
- a person joined with you in a civil union or state-recognized domestic partnership that is the legal equivalent of marriage, if your Plan Sponsor has elected to extend coverage to such persons. **(Note:** Required Contributions for coverage of a civil union or domestic partner cannot be made on a pre-tax basis, in accordance with federal law; your Plan Sponsor may not use Church funds to pay for such coverage)
- Any child of an eligible Participant from birth through the last day of the month the child attains age 26
- an unmarried child who is mainly dependent on a Participant for financial support and is currently a covered dependent as a result of Michelle's Law
- any unmarried children, without regard to the child's age, who is not self-supporting due to mental or physical impairment as determined by the Plan Administrator. A child who is not self-supporting must be mainly dependent upon the Participant for care and support. This child must have become incapable of self-support either before reaching age 19 or while covered as a Dependent under this Plan or any other health insurance plan.

Proof of the child's condition and dependence may be required by CIGNA 2 months before he or she fails to qualify as stated above or at any reasonable, later time. If proof is not submitted by you within 60 days after receipt of CIGNA's request, the person will no longer qualify as a Dependent. During the next 2 years CIGNA may, from time to time, require proof of the continuation of such condition and dependence. After that, CIGNA may require proof no more than once a year.

A child includes one who is in your custody pursuant to an interim court order of adoption or placement for adoption, whichever comes first, whether or not a final order granting adoption is ultimately issued. It also includes a stepchild who lives with you. It also includes a child living with you for whom you are the legal guardian.

Benefits for a Dependent child or student will continue until last day of the calendar month in which the limiting age is reached.

Anyone who is eligible as an Employee will not be considered as a Dependent. No one may be considered as a Dependent of more than one Employee.

ELIGIBLE PERSON
The term Eligible Person means an Employee of a Plan Sponsor, or other person eligible to become a Participant of the Plan under the terms of the Plan maintained by Wespath who meets the eligibility requirements for this dental care coverage, in accordance with the terms of the Plan as described in the plan document and his or her Plan Sponsor's adoption agreement.

EMPLOYEE
For purposes of this Benefit Booklet, the term Employee means a person who is described as an employee of a church in Sections 414(e)(3) or 7701(a)(20) of the Code, who is a clergyperson serving The United Methodist Church, or who is a common-law employee of Wespath or an Affiliated Organization, including a former Employee who has retired. The term Employee means a full-time employee of the Plan Sponsor. The term does not include Employees who are part-time, seasonal or temporary or who normally work less than 30 hours a week for the Plan Sponsor.

ERISA
The term ERISA means the Employee Retirement Income Security Act of 1974, as amended.

HIPAA
The term HIPAA means the Health Insurance Portability and Accountability Act of 1996 and the regulations promulgated thereunder by the Secretary of the Department of Health and Human Services.

LOSS
The amount a member is claiming under their policy.

MEDICAID
The term Medicaid means a state program of medical aid for needy persons established under Title XIX of the Social Security Act of 1965 as amended.

MEDICARE
The term Medicare means the program of medical care benefits provided under Title XVIII of the Social Security Act of 1965 as amended.

NON-PARTICIPATING PROVIDER
The term Non-Participating Provider means a provider other than a Participating Provider.

OPEN ENROLLMENT PERIOD
The term Open Enrollment Period means a period of time during which eligible persons may enroll themselves and Dependents under the Plan. The Plan Administrator will determine the period of time that is the Open Enrollment Period.

OTHER HEALTH COVERAGE
Under HealthFlex, Other Health Coverage includes a self-insured group health plan; an individual or group health insurance or HMO plan; Parts A and B of Medicare; Medicaid; a health plan for current and former members of the armed forces; a health plan provided through Indian Health Services; a state health benefit risk pool; The Federal Employees Health Program; a plan provided under the Peace Corps Act; a state, county, or municipal public health plan; a State Children's Health Insurance Program (S-CHIP); health coverage provided under a plan established by a foreign country; coverage provided under state or federal health continuation mandates (e.g., COBRA); individual or group health insurance through an association; and an individual or group health conversion plan.

PARTICIPANT
The term Participant means either the primary Participant (i.e., the Employee) or an enrolled Dependent, but this term applies only while such person is enrolled under the Plan. References to "you" and "your" throughout this Benefit Booklet are references to a Participant (also called a Covered Person).

PARTICIPATING PROVIDER
The term Participating Provider means a provider (i.e., a Dentist or other provider) that has entered into an agreement with the Claims Administrator to provide services at a predetermined cost, or a provider or facility that has been designated by the Claims Administrator as a Participating Provider.

The providers qualifying as Participating Providers may change from time to time. A list of the current Participating Providers may be provided by the Claims Administrator.

PLAN
The term Plan means the group health plan component of the Hospitalization and Medical Expense Program, also called HealthFlex, maintained by Wespath on behalf of its Employees and the Employees and other Participants of the organizations and corporations affiliated with Wespath. The Plan is a Church Plan. For the purposes of this Benefit Booklet, the term Plan is generally limited to the portion of the Plan that provides limited scope group dental benefits.

PLAN ADMINISTRATOR
The Plan Administrator is Wespath, on whose behalf CIGNA is providing claim administration services.

PLAN SPONSOR
The term Plan Sponsor means the Affiliated Organization through which an Employee is associated with the Plan.

PLAN YEAR
The Plan Year is the 12-month period beginning January 1 and ending December 31.

REASONABLE AND CUSTOMARY CHARGE

A charge will be considered Reasonable and Customary if:

- it is the normal charge made by the provider for a similar service or supply; and
- it does not exceed the normal charge made by most providers of such services or supplies in the geographic area where the service is received, as determined by CIGNA.

To determine if a charge is Reasonable and Customary, the nature and severity of the injury or sickness being treated will be considered.

Reasonable and Customary Charge information is available from CIGNA upon request.

REQUIRED CONTRIBUTION

Required Contributions include, but are not limited to, premiums for coverage under the Plan, and any other amounts due as a condition of receiving coverage under the Plan. Required Contributions can include portions that Participants must pay and portions that Plan Sponsors must pay.

SPOUSE

The term Spouse, for purposes of the Plan, means a person who is in a marital relationship with a Participant (or with a surviving Spouse) that exists in accordance with the law of the jurisdiction in which the Spouse resides, except that a person who is a "common-law" Spouse shall not be a Spouse for purposes of the Plan. A person who is a Spouse shall still be a Spouse even if the person is geographically or legally separated (but not yet divorced) from the person to whom he or she is married.

WESPATH

Wespath is a general agency of The United Methodist Church.

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