2024 Plan Document Handbook

Delta Dental PPO Plus Premier™
Delta Dental Basic Plan
Delta Dental Comprehensive Plan
Delta Dental Premium Plan

deltadentalins.com

Delta Dental Group No: 22379
Benefits effective as of January 1, 2024

EPISCOPAL CHURCH MEDICAL TRUST

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Introduction

The Episcopal Church Medical Trust (the "Medical Trust") maintains a series of benefit Plans (each a "Plan" and collectively, the "Plans") for the eligible employees (and their Eligible Dependents) of The Episcopal Church. Since 1978, the Plans sponsored by the Medical Trust have served the dioceses, parishes, schools, missionary districts, seminaries, and other institutions subject to the authority of The Episcopal Church. The Medical Trust serves thousands of active employees, retirees, and their Eligible Dependents. The Plans are intended to qualify as "church plans" within the meaning of section 414(e) of the Internal Revenue Code (the "Code") and are exempt from the requirements of the Employee Retirement Income Security Act of 1974, as amended ("ERISA"). When referring to "the Plan" in this handbook, we are referring to the Delta Dental PPO Plus Premier™ plans.

The Medical Trust funds certain of its benefit Plans through a trust fund known as the Episcopal Church Clergy and Employees' Benefit Trust (the "ECCEBT"). The ECCEBT is intended to qualify as a Voluntary Employees' Beneficiary Association (a "VEBA") under section 501(c)(9) of the Code. The purpose of the ECCEBT is to provide Benefits to eligible employees, former employees, and their dependents in the event of illness or expenses for various types of medical care and treatment.

The mission of the Medical Trust is to administer a comprehensive benefit plan while balancing compassion with financial stewardship. This is a unique mission in the world of healthcare benefits, and we believe that our experience and mission to serve The Episcopal Church offers a level of expertise that is unparalleled.

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 *cpg.org* or call Client Services at 800-480-9967.

Benefits described in this Plan Document Handbook are effective as of January 1, 2024. Please note that capitalized terms used in this section but not defined here have the meanings ascribed to such terms in the body of the Plan Document Handbook below.

Chapter 1: Schedule of Benefits

Schedule of Benefits – Delta Dental PPO Plus Premier™ Basic Plan

Plan Sponsor: Church Pension Group Services Corporation dba The Episcopal Church Medical Trust

Group Number: 22379 **Effective Date:** January 1, 2024

Deductibles & Maximums			
	Delta Dental PPO℠ Providers	**Delta Dental Premier® Providers**	**Non-Delta Dental Providers**
Annual Deductible	$0	$0	$0
Annual Maximum	$2,000 per Member per Calendar Year	$1,500 per Member per Calendar Year	$1,000 per Member per Calendar Year
	If a Member switches among types of Providers during a Calendar Year, the Annual Maximum payable for Benefits will be adjusted accordingly. The Annual Maximum payable each year for all services received from all Providers will not exceed the Annual Maximum payable for PPO Providers of $2,000. However, if only Premier Providers are used, the Annual Maximum will not exceed $1,500, and if only Non-Delta Dental Providers are used, the Annual Maximum will not exceed $1,000.		
Annual Maximum waived for	Diagnostic and Preventive Services		

Member Responsibility for Cost Sharing			
Dental Service Category	**Member Responsibility for Cost Sharing when using Delta Dental PPO Providers***	**Member Responsibility for Cost Sharing when using Delta Dental Premier Providers***	**Member Responsibility for Cost Sharing when using Non-Delta Dental Providers***
The Member Responsibility is shown below for the following services:			
Diagnostic and Preventive Services	0%	0%	0%
Basic Services	20%	20%	30%
Major Services	60%	60%	99%

**Reimbursement is based on PPO Contracted Fees for PPO Providers, Premier Contracted Fees for Premier Providers, and Program Allowance for Non-Delta Dental Providers.*

Schedule of Benefits – Delta Dental PPO Plus Premier™ Comprehensive Plan

Plan Sponsor: Church Pension Group Services Corporation dba The Episcopal Church Medical Trust

Group Number: 22379 **Effective Date:** January 1, 2024

Deductibles & Maximums			
	Delta Dental PPO℠ Providers	**Delta Dental Premier® Providers**	**Non-Delta Dental Providers**
Annual Deductible	$0	$0	$100 per Member each Calendar Year $300 per family each Calendar Year
	If a Member switches among types of Providers during a Calendar Year, the maximum Deductible the Member will be responsible for is $100 per Member and $300 per family.		
Lifetime Orthodontic Deductible	$0	$0	$100 per Member per lifetime
	If a Member switches among types of Providers, the maximum Deductible for Orthodontia the Member will be responsible for is $100 per Member.		
Deductibles waived for	Diagnostic and Preventive Services		
Annual Maximum	$2,500 per Member per Calendar Year	$2,000 per Member per Calendar Year	$1,500 per Member per Calendar Year
	If a Member switches among types of Providers during a Calendar Year, the Annual Maximum payable for Benefits will be adjusted accordingly. The Annual Maximum payable each year for all services received from all Providers will not exceed the Annual Maximum payable for PPO Providers of $2,500. However, if only Premier Providers are used, the Annual Maximum will not exceed $2,000, and if only Non-Delta Dental Providers are used, the Annual Maximum will not exceed $1,500.		
Annual Maximum waived for	Diagnostic and Preventive Services		
Lifetime Orthodontic Maximum	$1,500 per Member per lifetime	$1,500 per Member per lifetime	$1,000 per Member per lifetime
	If a Member switches among types of Providers, the Lifetime Orthodontic Maximum will be adjusted accordingly. The Lifetime Orthodontic Maximum payable for all Orthodontic Services received from all Providers will not exceed the Lifetime Orthodontic Maximum payable for PPO Providers of $1,500. However, if only Premier Providers are used, the Lifetime Orthodontic Maximum will not exceed $1,500, and if only Non-Delta Dental Providers are used, the Lifetime Orthodontic Maximum will not exceed $1,000.		
Maximum Takeover Credit	The Plan, as administered by Delta Dental, will receive credit for any amount paid under the Plan Sponsor's previous dental care plan, if applicable, for Orthodontic Services. These amounts will be credited toward the Lifetime Orthodontic Maximum.		

Member Responsibility for Cost Sharing			
Dental Service Category	**Member Responsibility for Cost Sharing when using Delta Dental PPO Provider***	**Member Responsibility for Cost Sharing when using Delta Dental Premier Providers***	**Member Responsibility for Cost Sharing when using Non-Delta Dental Providers***
The Member Responsibility is shown below for the following services:			
Diagnostic and Preventive Services	0%	0%	0%
Basic Services	15%	15%	25%
Major Services	50%	50%	60%
Orthodontic Services	50%	50%	60%

**Reimbursement is based on PPO Contracted Fees for PPO Providers, Premier Contracted Fees for Premier Providers, and Program Allowance for Non-Delta Dental Providers.*

Schedule of Benefits – Delta Dental PPO Plus Premier™ Premium Plan

Plan Sponsor: Church Pension Group Services Corporation dba The Episcopal Church Medical Trust

Group Number: 22379 **Effective Date:** January 1, 2024

Deductibles & Maximums			
	Delta Dental PPO℠ Providers	**Delta Dental Premier® Providers**	**Non-Delta Dental Providers**
Annual Deductible	$0	$0	$50 per Member each Calendar Year $150 per family each Calendar Year
	If a Member switches among types of Providers during a Calendar Year, the maximum Deductible the Member will be responsible for is $50 per Member and $150 per family.		
Lifetime Orthodontic Deductible	$0	$0	$50 per Member per lifetime
	If a Member switches among types of Providers, the maximum Deductible for Orthodontia the Member will be responsible for is $50 per Member.		
Deductibles waived for	Diagnostic and Preventive Services		
Annual Maximum	$3,000 per Member per Calendar Year	$2,500 per Member per Calendar Year	$2,000 per Member per Calendar Year
	If a Member switches among types of Providers during a Calendar Year, the Annual Maximum payable for Benefits will be adjusted accordingly. The Annual Maximum payable each year for all services received from all Providers will not exceed the Annual Maximum payable for PPO Providers of $3,000. However, if only Premier Providers are used, the Annual Maximum will not exceed $2,500, and if only Non-Delta Dental Providers are used, the Annual Maximum will not exceed $2,000.		
Annual Maximum waived for	Diagnostic and Preventive Services		
Lifetime Orthodontic Maximum	$2,000 per Member per lifetime	$2,000 per Member per lifetime	$1,500 per Member per lifetime
	If a Member switches among types of Providers, the Lifetime Orthodontic Maximum will be adjusted accordingly. The Lifetime Orthodontic Maximum payable for all Orthodontic Services received from all Providers will not exceed the Lifetime Orthodontic Maximum payable for PPO Providers of $2,000. However, if only Premier Providers are used, the Lifetime Orthodontic Maximum will not exceed $2,000, and if only Non-Delta Dental Providers are used, the Lifetime Orthodontic Maximum will not exceed $1,500.		
Maximum Takeover Credit	The Plan, as administered by Delta Dental, will receive credit for any amount paid under the Plan Sponsor's previous dental care plan, if applicable, for Orthodontic Services. These amounts will be credited toward the Lifetime Orthodontic Maximum.		

Member Responsibility for Cost Sharing			
Dental Service Category	**Member Responsibility for Cost Sharing when using Delta Dental PPO Providers***	**Member Responsibility for Cost Sharing when using Delta Dental Premier Providers***	**Member Responsibility for Cost Sharing when using Non-Delta Dental Providers***
The Member Responsibility is shown below for the following services:			
Diagnostic and Preventive Services	0%	0%	0%
Basic Services	15%	15%	25%
Major Services	15%	15%	25%
Orthodontic Services	50%	50%	60%

**Reimbursement is based on PPO Contracted Fees for PPO Providers, Premier Contracted Fees for Premier Providers, and Program Allowance for Non-Delta Dental Providers.*

Chapter 2: Eligibility and Enrollment

Individuals who are eligible to participate in the Medical Trust's Episcopal Health Plan (EHP), Small Employer Exception Plan (SEE Plan), or Group Medicare Advantage Plan (GMAP) are eligible for dental coverage under this Plan.* The eligibility criteria for the EHP and SEE Plan (including the definitions of "Eligible Individual" and "Eligible Dependent") are set forth in Chapter 2 of the Plan Document Handbooks for the Medical Trust's medical plans, available at *cpg.org/mtdocs*. The eligibility criteria for the GMAP (including the definitions of "Eligible Individual" and "Eligible Dependent") are set forth in the Medical Trust's Administrative Policy Manual, available at *cpg.org/apm*.

In addition, the other information, terms, and conditions set forth in Chapter 2 of these Plan Document Handbooks (including "Plan Election and Enrollment Guidelines," "Termination of Individual Coverage," and "Extension of Benefits Program") also apply to the Plan. When terms differ between the EHP, SEE Plan, and GMAP, the terms applicable to the Medical Trust medical plan the Eligible Individual is enrolled in (or, if the Eligible Individual is not enrolled in a Medical Trust medical plan, the Medical Trust medical plan for which they are eligible) apply.

A Note on "Active" and "Retiree" Dental Plan Options

The Medical Trust offers dental coverage under the Plan to eligible active employees (as well as eligible seminarians and members of Religious Orders), certain eligible former employees, such as eligible retirees, and their eligible dependents. In general, when an individual enrolls in the GMAP (or another medical plan intended primarily for retirees), if they elect to participate in dental coverage under the Plan, they will be enrolled in a "retiree" dental plan option. The only difference between "active" and "retiree" dental plan options is pricing – the monthly contributions due for "active" plan participation are based on the individual's Participating Group's rates, while the monthly contributions for "retiree" plan participation are the same across all individuals enrolled in the applicable "retiree" dental plan option. There is no difference in Benefits between an "active" dental plan option and the corresponding "retiree" plan option.

** In the case of individuals eligible for the EHP and SEE Plan, their Participating Group (and their employer or former employer, if applicable) must elect to offer dental coverage through the Medical Trust in order for the individual to be eligible for dental coverage.*

Chapter 3: Delta Dental's Networks & Selecting Your Provider

Free Choice of Provider

You may see any Provider for your covered treatment, whether the Provider is a PPO Provider, a Premier Provider, or a Non-Delta Dental Provider. This plan is a PPO plan and the greatest benefits—including out-of-pocket savings—occur when you choose a PPO Provider. To take full advantage of your Benefits, we highly recommend that you verify a Provider's participation status within a Delta Dental network with your dental office before each appointment. Review this section for an explanation of Delta Dental payment procedures to understand the method of payments applicable to your Provider selection and how that may impact your out-of-pocket costs.

Locating a PPO Provider

You may access information through Delta Dental's website at *deltadentalins.com*. You may also call Delta Dental's Customer Service Center and one of Delta Dental's representatives will assist you. Delta Dental can provide you with information regarding a Provider's network participation, specialty, and office location.

Choosing a PPO Provider

A PPO Provider potentially allows the greatest reduction in Members' out-of-pocket expenses since this select group of Providers will provide dental Benefits at a charge that has been contractually agreed upon. Payment for covered services performed by a PPO Provider is based on the Maximum Contract Allowance. PPO Providers have agreed to accept the Maximum Contract Allowance as payment in full for covered services.

It is to your advantage to select PPO Providers because PPO Contracted Fees are typically lower than the Premier Contracted Fees (or the amount charged by Non-Delta Dental Providers). Additionally, the Annual Maximum payable for services received from PPO Providers is higher than the Annual Maximum payable for services from Premier Providers or Non-Delta Dental Providers.

Choosing a Premier Provider

A Premier Provider is a Provider who has contracted with Delta Dental but who has not agreed to the features of the PPO plan. Payment for covered services performed by a Premier Provider is based on the Maximum Contract Allowance. The amount charged by a Premier Provider may be above that accepted by PPO Providers but no more than the Premier Contracted Fee. Premier Providers have agreed to accept contracted fees as payment in full for covered services provided under the Plan. A lower Annual Maximum applies to Premier Providers as compared to PPO Providers.

Choosing a Non-Delta Dental Provider

If a Provider is a Non-Delta Dental Provider, the amount charged to Members may be above that accepted by PPO Providers or Premier Providers, and Members will be responsible for balance billed amounts. Payment for covered services performed by a Non-Delta Dental Provider is based on the Maximum Contract Allowance, and the Member may be balance billed up to the Provider's Submitted Fee.

When you use a Non-Delta Dental Provider, you should also keep the following in mind:

- A higher Deductible (if applicable) and/or rate of Coinsurance may apply.
- A lower Annual Maximum will apply.
- You will usually have to pay the provider when you receive care.
- You may need to file a claim with Delta Dental to be reimbursed by the Plan.
- You may be responsible for balanced billed amounts.

Additional Obligations of PPO and Premier Providers

- The PPO Provider or Premier Provider may accept assignment of Benefits, meaning these Providers will be paid directly by Delta Dental after satisfaction of any applicable Deductible and Coinsurance. The Member does not have to pay all the dental charges while at the dental office and then submit the claim for reimbursement.
- The PPO Provider or Premier Provider will complete the dental Claim Form and submit it to Delta Dental for reimbursement.
- PPO Providers and Premier Providers accept contracted fees as payment in full for covered services and will not balance bill if there is a difference between Submitted Fees and contracted fees.

Chapter 4: Coverage for the Dental Plan

Conditions Under Which Benefits Are Provided

The Plan will pay Benefits for the dental services described under "Services, Limitations, and Exclusions" below, subject to the conditions described in this Plan Document Handbook. The Plan will pay Benefits only for covered services. The Plan will not pay for any services that are in excess of the Limitations or that are excluded by the Exclusions, in each case, as set forth under "Services, Limitations, and Exclusions" below. The Plan covers several categories of dental services when a Provider provides them and when they are necessary and within the standards of generally accepted dental practice. Claims will be processed in accordance with Delta Dental's standard processing policies. The processing policies may be revised at the beginning of a Calendar Year to comply with annual Current Dental Terminology© (CDT) changes made by the American Dental Association and to reflect changes in generally accepted dental practice standards.

Delta Dental will use the processing policies that are in effect at the time the claim is processed. Delta Dental may use dentists (dental consultants) to review treatment plans, diagnostic materials, and/or prescribed treatments to determine generally accepted dental practices and to determine if treatment has a favorable prognosis. Limitations and Exclusions will be applied for the period the person is a Member under the Plan or any prior dental care plan provided by the Medical Trust, or at the time a claim is submitted, as applicable.

If a primary dental procedure includes component procedures that are performed at the same time as the primary procedure, the component procedures are considered to be part of the primary procedure for purposes of determining the Benefit payable under the Plan. Even if the Provider bills separately for the primary procedure and each of its component parts, the total Benefit payable for all related charges will be limited to the maximum Benefit payable for the primary procedure.

Member Coinsurance

Once any applicable Deductible is met, the Plan will pay a percentage of the Maximum Contract Allowance for covered services, as described in the Schedules of Benefits in *Chapter 1*, and you are responsible for paying the balance. What you pay is called your Coinsurance and is part of your out-of-pocket cost. You pay this after any applicable Deductible has been met.

The amount of your Coinsurance will depend on the type of service and the Provider providing the service (*see Chapter 3, "Delta Dental's Networks & Selecting Your Provider"*). Providers are required to collect Coinsurance for covered services. If the Provider discounts, waives, or rebates any portion of the Coinsurance to you, the Plan will instead provide as Benefits only the applicable percentages of the Provider's fees or allowances reduced by the amount of the fees or allowances that are discounted, waived, or rebated.

PPO Providers and Premier Providers have agreed to accept contracted fees as payment in full for covered services. Accordingly, unless you exceed your Annual Maximum or Lifetime Orthodontic Maximum, your only Member responsibility for covered services received from a PPO Provider or Premier Provider should be the applicable Coinsurance. Non-Delta Dental Providers have not agreed to accept the Maximum Contract Allowance as payment in full for covered services; accordingly, in addition to any applicable Deductible and Coinsurance, a Non-Delta Dental Provider may balance bill you for the excess of their Submitted Fee over the Maximum Contract Allowance.

Deductible

Certain plan options under the Plan feature a deductible when you visit a Non-Delta Dental Provider. This is an amount you must pay out of pocket before Benefits are paid. The Deductible amounts are listed in the Schedules of Benefits in *Chapter 1*. Deductibles apply to all Benefits unless otherwise noted. Only the Provider's fees you pay for covered benefits will count toward the Deductible.

Annual Maximum

All plan options under the Plan include an Annual Maximum. An Annual Maximum is the maximum dollar amount the Plan will pay toward the cost of covered dental care in a Calendar Year (excluding the cost of covered diagnostic and preventive services). You are responsible for paying costs above this amount. The Annual Maximum payable is shown in the Schedules of Benefits in *Chapter 1*. You should note that, when receiving services from a PPO Provider, the applicable Annual Maximum will be higher than when receiving services from a Premier Provider (or a Non-Delta Dental Provider).

Lifetime Orthodontic Maximum

All plan options under the Plan that cover Orthodontic Services include a Lifetime Orthodontic Maximum. A Lifetime Orthodontic Maximum is the maximum dollar amount the Plan will pay toward the cost of covered Orthodontic Services. This maximum applies on a lifetime basis and includes any amounts paid for Orthodontic Services under any prior Medical Trust dental plan. You are responsible for paying costs above this amount. The Lifetime Orthodontic Maximum payable is shown in the Schedules of Benefits in *Chapter 1*. You should note that, when receiving services from a PPO Provider or Premier Provider, the applicable Lifetime Orthodontic Maximum will be higher than when receiving services from a Non-Delta Dental Provider.

Pre-Treatment Estimate

Pre-Treatment Estimate requests are not required; however, your Provider may file a Claim Form before beginning treatment, showing the services to be provided to you. Delta Dental will estimate the amount of Benefits payable under the Plan for the listed services. By asking your Provider for a Pre-Treatment Estimate from Delta Dental before you agree to receive any prescribed treatment, you will have an estimate up front of what the Plan will pay and the difference you will need to pay (e.g., any Coinsurance and any excess over the Annual Maximum or Lifetime Orthodontic Maximum, if applicable, or, for a Non-Delta Dental Provider, any excess over the Maximum Contract Allowance). The Benefits will be processed according to the terms of the Plan when the treatment is actually performed. Pre-Treatment Estimates are valid for 365 days, unless other services are received after the date of the Pre-Treatment Estimate (because such other services would count toward your Annual Maximum and may count toward your Lifetime Orthodontic Maximum), or until an earlier occurrence of any one of the following events:

- the date the Plan terminates;
- the date the Plan Sponsor's contract with Delta Dental terminates;
- the date Benefits under the Plan are amended, if the services in the Pre-Treatment Estimate are impacted by the amendment;
- the date your coverage by the Plan ends; or
- the date the Provider's agreement with Delta Dental ends.

A Pre-Treatment Estimate does not guarantee payment. It is an estimate of the amount the Plan will pay if you are enrolled and meet all the requirements of the program at the time the treatment you have planned is completed. A Pre-Treatment Estimate may not take into account any Deductibles, so please remember to figure in your Deductible if necessary.

Wellness Benefits Wellness Benefits are available to help improve the oral health of Members with certain qualifying medical conditions. These benefits are described in more detail under *Wellness Benefits* below.

Other Benefits Delta Dental offers additional benefits to those enrolled in plans it administers, such as the Plan. For more information about these "member perks," visit *www1.deltadentalins.com/memberperks*.

Questions? Contact Delta Dental if you have any questions about your benefits.

Services, Limitations, and Exclusions

Applicable to the Delta Dental Premium Plan and Delta Dental Comprehensive Plan

Description of Dental Services

The Plan will pay the Contract Benefit Level shown in the applicable Schedule of Benefits in *Chapter 1* for the following services (subject to any applicable limitations or exclusions described below):

- **Diagnostic and Preventive Services**

1.	Diagnostic:	procedures to aid the Provider in determining required dental treatment.
2.	Preventive:	cleaning (including scaling in the presence of generalized moderate or severe gingival inflammation-full mouth, and periodontal maintenance), topical application of fluoride solutions, space maintainers.
3.	Sealants:	topically applied acrylic, plastic, or composite materials used to seal developmental grooves and pits in permanent molars for the purpose of preventing decay.

- **Basic Services**

1.	Oral Surgery:	extractions and other surgical procedures (including pre- and post-operative care).
2.	General Anesthesia or IV Sedation:	when administered by a Provider for covered Oral Surgery or selected endodontic and periodontal surgical procedures.
3.	Endodontics:	treatment of diseases and injuries of the tooth pulp.
4.	Periodontics:	treatment of gums and bones supporting teeth.
5.	Palliative:	emergency treatment to relieve pain.
6.	Restorative:	amalgam and resin-based composite restorations (fillings) for treatment of carious lesions (visible destruction of hard tooth structure resulting from the process of decay).
7.	Denture Repairs:	repair to partial or complete dentures, including rebase procedures and relining.
8.	Specialist Consultations:	opinion or advice requested by a general dentist.
9.	Night Guards/ Occlusal Guards:	intraoral removable appliances provided for treatment of harmful oral habits associated with periodontal disease.

- **Major Services**

1.	Crowns and Inlays/Onlays:	treatment of carious lesions (visible decay of the hard tooth structure) when teeth cannot be restored with amalgam or resin-based composites.
2.	Prosthodontics:	procedures for construction of fixed bridges, partial or complete dentures, and the repair of fixed bridges; implant surgical placement and removal; and for implant supported prosthetics, including implant repair and recementation.
3.	Prefabricated Stainless Steel Crowns:	prefabricated stainless steel crowns.

- **Orthodontic Services**
  Procedures performed by a Provider using appliances to treat malocclusion of teeth and/or jaws that significantly interferes with their function.

- **Note on Additional Benefits During Pregnancy**
  When a Member is pregnant, the Plan will pay for additional services to help improve the oral health of the Member during the pregnancy. The additional services each Calendar Year while the Member is covered under the Plan include:
  - one (1) additional oral exam, and
  - either:
    - one (1) additional routine cleaning,
    - one (1) additional periodontal scaling and root planing per quadrant, or
    - one (1) additional periodontal maintenance procedure.

  Written confirmation of the pregnancy must be provided by the Member or their Provider when the claim is submitted.

Limitations

1. Services that are more expensive than the form of treatment customarily provided under accepted dental practice standards are called "Optional Services." Optional Services also include the use of specialized techniques instead of standard procedures.

   Examples of Optional Services include

   a. a crown where a filling would restore the tooth,
   b. an Inlay/Onlay instead of an amalgam restoration, and
   c. an overdenture instead of denture.

   If a Member receives Optional Services, an alternate Benefit will be allowed, which means the Plan will base Benefits on the lower cost of the customary service or standard practice instead of on the higher cost of the Optional Service. The Member will be responsible for the difference between the higher cost of the Optional Service and the lower cost of the customary service or standard procedure (in addition to any Member cost-sharing they would have been responsible for in connection with the lower-cost service).

2. Exam and cleaning limitations:
   a. The Plan will pay for oral examinations (except after-hours exams and exams for observation) and cleanings (including scaling in presence of generalized moderate or severe gingival inflammation-full mouth, periodontal maintenance in the presence of inflamed gums, or any combination thereof) no more than three (3) times in a Calendar Year.
   b. Full mouth debridement is not allowed when performed by the same dentist/dental office on the same day as evaluation procedures.
   c. A full mouth debridement is allowed once in a lifetime when the Member has no history of prophylaxis, scaling and root planing, periodontal surgery, or periodontal maintenance procedures within three (3) years. When allowed, a full mouth debridement counts toward the maintenance frequency in the year provided.
   d. Note that full mouth debridement is covered as a Basic Service and that routine cleanings (including scaling in the presence of generalized moderate or severe gingival inflammation-full mouth), periodontal maintenance, and Procedure Codes that include periodontal maintenance are covered as a Diagnostic and Preventive Service. See *Note on Additional Benefits During Pregnancy* above.
   e. Caries risk assessments are allowed once in 12 months.

3. X-ray limitations:
   a. The Plan will limit the total reimbursable amount to the Provider's Accepted Fee for a complete intraoral series when the fees for any combination of intraoral x-rays in a single treatment series meet or exceed the Accepted Fee for a complete intraoral series.
   b. When a panoramic film is submitted with supplemental film(s), the Plan will limit the total reimbursable amount to the Provider's Accepted Fee for a complete intraoral series.

c. If a panoramic film is taken in conjunction with a complete intraoral series, Delta Dental considers the panoramic film to be included in the complete series.

d. A complete intraoral series and panoramic film are limited to a combined total once every 36 months.

e. Bitewing x-rays are limited to two (2) times in a Calendar Year. Bitewings of any type are disallowed within 12 months of a complete intraoral series unless warranted by special circumstances. Bitewing x-rays are limited to two (2) images for Members under age 10.

f. Image capture procedures are not separately allowable services.

4. Topical application of fluoride solutions is limited to Members under age 19 and is limited to no more than twice in a Calendar Year.

5. Interim caries arresting medicament application is limited to twice per tooth per Calendar Year.

6. Space maintainer limitations:

   a. Space maintainers are limited to the initial appliance and are a covered benefit for a Member to age 19. However, a distal shoe space maintainer-fixed-unilateral is limited to children age eight (8) and younger. A separate/additional space maintainer can be allowed after the removal of a unilateral distal shoe.

   b. Recementation of space maintainer is limited to once per lifetime.

   c. The removal of a fixed space maintainer is considered to be included in the fee for the space maintainer; however, an exception is made if the removal is performed by a different Provider/Provider's office.

7. Pulp vitality tests are allowed once per day when definitive treatment is not performed.

8. Cephalometric x-rays, oral/facial photographic images, and diagnostic casts are covered once per lifetime in conjunction with Orthodontic Services only when Orthodontic Services are a covered benefit. If Orthodontic Services are covered, see Limitations, as age limits may apply. However, 3D x-rays are not a covered benefit.

9. Sealants are limited as follows:

   a. to Members age 15 and under on permanent first and second molars if they are without caries (decay) or restorations on the occlusal surface.

   b. repair or replacement of a Sealant on any tooth within 24 months of its application is included in the fee for the original placement.

10. Specialist Consultations are limited to once per lifetime per Provider and count toward the oral exam frequency. Screenings of patients or assessments of patients reported individually are, when covered, limited to only one (1) in a 12-month period and included if reported with any other examination on the same date of service and Provider office.

11. The Plan will not cover replacement of an amalgam or resin-based composite restorations (fillings) or prefabricated crowns within 24 months of treatment if the service is provided by the same Provider/Provider office. Replacement restorations within 24 months are included in the fee for the original restoration.

12. Protective restorations (sedative fillings) are allowed once per tooth per lifetime when definitive treatment is not performed on the same date of service.

13. Prefabricated crowns are allowed on baby (deciduous) teeth and permanent teeth up to age 16. Replacement restorations within 24 months are included in the fee for the original restoration.

14. Therapeutic pulpotomy is limited to once per lifetime for baby (deciduous) teeth only and is considered palliative treatment for permanent teeth.

15. Pulpal therapy (resorbable filling) is limited to once in a lifetime. Retreatment of root canal therapy by the same Provider/Provider office within 24 months is considered part of the original procedure.

16. Apexification is only benefited on permanent teeth with incomplete root canal development or for the repair of a perforation. Apexification visits have a lifetime limit per tooth of one (1) initial visit, four (4) interim visits, and one (1) final visit to age 19.

17. Retreatment of apical surgery by the same Provider/Provider office within 24 months is considered part of the original procedure.

18. Palliative treatment is covered per visit, not per tooth, and the fee includes all treatment provided other than required x-rays or select Diagnostic procedures.
19. Periodontal limitations:
    a. Benefits for periodontal scaling and root planing in the same quadrant are limited to once in every 24-month period. See *Note on Additional Benefits During Pregnancy* above. No more than two (2) quadrants of scaling and root planing will be covered on the same date of service.
    b. Periodontal surgery in the same quadrant is limited to once in every 36-month period and includes any surgical re-entry or scaling and root planing performed within 36 months by the same Provider/Provider office.
    c. Periodontal services, including bone replacement grafts, guided tissue regeneration, graft procedures, and biological materials to aid in soft and osseous tissue regeneration are only covered for the treatment of natural teeth and are not covered when submitted in conjunction with extractions, periradicular surgery, ridge augmentation, or implants. Guided tissue regenerations and/or bone grafts are not benefited in conjunction with soft tissue grafts in the same surgical area.
    d. Periodontal surgery is subject to a 30-day wait following periodontal scaling and root planing in the same quadrant.
    e. Cleanings (regular and periodontal) and full mouth debridement are subject to a 30-day wait following periodontal scaling and root planing if performed by the same Provider office.
    f. When implant procedures are a covered benefit, scaling and debridement in the presence of inflammation or mucositis of a single implant, including cleaning of the implant surfaces, without flap entry and closure is covered as a Basic Service and are limited to once in a 24-month period.
20. Extractions are covered once in a lifetime, per tooth. The removal of cysts and lesions and incision and drainage procedures are covered once in the same day.
21. [RESERVED]
22. [RESERVED]
23. Frenulectomy and frenuloplasty are only considered in cases of ankyloglossia (tongue-tie) interfering with feeding or speech as diagnosed and documented by a physician or if the frenum is contributing to the presence of a large diastema(s).
24. Crowns and Inlays/Onlays are limited to Members age 12 and older and are covered not more often than once in any 60-month period per tooth except when Delta Dental determines the existing Crown or Inlay/Onlay is not satisfactory and cannot be made satisfactory because the tooth involved has experienced extensive loss or changes to tooth structure or supporting tissues.
25. Core buildup, including any pins, are covered not more than once in any 60-month period.
26. Post and core services are covered not more than once in any 60-month period.
27. Crown repairs are covered not more than twice in any 60-month period. Crowns, Inlays/Onlays, and fixed bridges include repairs for 24 months following installation.
28. Denture Repairs are covered not more than once in any six (6) month period except for fixed Denture Repairs, which are covered not more than twice in any 60-month period.
29. Prosthodontic appliances, implants, and/or implant supported prosthetics that were provided under any plan administered by Delta Dental will be replaced only after 60 months have passed, except when Delta Dental determines that there is such extensive loss of remaining teeth or change in supporting tissue that the existing fixed bridge or denture cannot be made satisfactory. Fixed prosthodontic appliances are limited to Members age 16 and older. Replacement of a prosthodontic appliance and/or implant supported prosthesis not provided under a plan administered by Delta Dental will be made if Delta Dental determines it is unsatisfactory and cannot be made satisfactory. Diagnostic and treatment facilitating aids for implants are considered a part of, and included in, the fees for the definitive treatment. The Plan's payment for implant removal is limited to one (1) for each for each implant site per 60 months whether provided under Delta Dental or any other dental care plan.
30. When a posterior fixed bridge and a removable partial denture are placed in the same arch in the same treatment episode, only the partial denture will be covered.

31. Recementation of Crowns, Inlays/Onlays, or bridges is included in the fee for the Crown, Inlay/Onlay, or bridge when performed by the same Provider/Provider office within six (6) months of the initial placement. After six (6) months, payment will be limited to one (1) recementation in a lifetime by the same Provider/Provider office.
32. The Plan limits payment for dentures to a standard partial or complete denture (Coinsurance applies). A standard denture means a removable appliance to replace missing natural, permanent teeth that is made from acceptable materials by conventional means and includes routine post-delivery care, including any adjustments and relines for the first six (6) months after placement.
    a. Denture rebase is limited to one (1) per arch in a 24-month period and includes any relining and adjustments for six (6) months following placement.
    b. Dentures, removable partial dentures, and relines include adjustments for six (6) months following installation. After the initial six (6) months of an adjustment or reline, adjustments are limited to two (2) per arch in a Calendar Year, and relining is limited to one (1) per arch in a six (6) month period.

       Immediate dentures and immediate removable partial dentures include adjustments for three (3) months following installation. After the initial three (3) months of an adjustment or reline, adjustments are limited to two (2) per arch in a Calendar Year, and relining is limited to one (1) per arch in a six (6) month period.
    c. Tissue conditioning is limited to two (2) per arch in a 12-month period. However, tissue conditioning is not allowed as a separate Benefit when performed on the same day as a denture, reline, or rebase service.
    d. Recementation of fixed partial dentures is limited to once in a lifetime.
33. Limitations on Orthodontic Services:
    a. The maximum amount payable for each Member is shown in the applicable Schedule of Benefits in *Chapter 1*.
    b. Benefits for Orthodontic Services will be provided in periodic payments based on the Member's continuing eligibility.
    c. Benefits are not paid to repair or replace any orthodontic appliance received under this Plan.
    d. Benefits are not paid for orthodontic retreatment procedures.
    e. Orthodontic treatment must be provided by a licensed dentist.
    f. The removal of fixed orthodontic appliances for reasons other than completion of treatment is not a covered benefit.
34. The fees for synchronous/asynchronous teledentistry services are considered inclusive in overall patient management and are not a separately payable service. Teledentistry (i.e., virtual or online) services are covered only when administered in conjunction with procedures and services that are covered under this Plan. Covered dental services delivered through teledentistry are covered to the same extent as services rendered through in-person contact and are subject to the same cost-share, frequency limitations, or any applicable Benefit maximums or lack thereof.
35. Limitations on Night Guards/Occlusal Guard Services:
    a. The replacement of appliances for Night Guards/Occlusal Guards Services is limited to once every 60 months.
    b. A Night Guards/Occlusal Guard adjustment is limited to once in a 12-month period. Limited adjustment is a covered benefit once per quadrant within a 60-month period.

Exclusions

The Plan does not pay Benefits for:

1. Treatment of injuries or illness covered by workers' compensation or employers' liability laws; services received without cost from any federal, state, or local agency, unless this exclusion is prohibited by law.
2. Cosmetic surgery or procedures for purely cosmetic reasons.
3. Maxillofacial prosthetics.
4. Provisional and/or temporary restorations (except an interim removable partial denture to replace extracted anterior permanent teeth during the healing period for children 16 years of age or under). Provisional and/or temporary restorations are not separately payable procedures and are included in the fee for completed service.

5. Services for congenital (hereditary) or developmental (following birth) malformations, including but not limited to cleft palate, upper and lower jaw malformations, enamel hypoplasia (lack of development), fluorosis (a type of discoloration of the teeth), and anodontia (congenitally missing teeth), except those services provided to newborn children for medically diagnosed congenital defects or birth abnormalities.
6. Treatment to stabilize teeth, treatment to restore tooth structure lost from wear, erosion, or abrasion or treatment to rebuild or maintain chewing surfaces due to teeth out of alignment or occlusion. Examples include but are not limited to: equilibration, periodontal splinting, complete occlusal adjustments, and abfraction.
7. Any Single Procedure provided prior to the date the Member became eligible for services under this plan.
8. Prescribed drugs, medication, pain killers, antimicrobial agents, or experimental/investigational procedures.
9. Charges for anesthesia, other than General Anesthesia and IV Sedation administered by a Provider in connection with covered Oral Surgery or selected Endodontic and Periodontal surgical procedures. Local anesthesia and regional/or trigeminal bloc anesthesia are not separately payable procedures.
10. Extraoral grafts (grafting of tissues from outside the mouth to oral tissues).
11. Laboratory processed crowns for Members under age 12.
12. Fixed bridges and removable partials for Members under age 16.
13. Interim implants, endodontic endosseous implants, and extraoral implants.
14. Indirectly fabricated resin-based Inlays/Onlays.
15. Charges by any hospital or other surgical or treatment facility and any additional fees charged by the Provider for treatment in any such facility.
16. Treatment by someone other than a Provider or a person who by law may work under a Provider's direct supervision.
17. Charges incurred for oral hygiene instruction, a plaque control program, a preventive control program (including home care times), dietary instruction, x-ray duplications, cancer screening, or tobacco counseling.
18. Dental practice administrative services including, but not limited to, preparation of claims, any non-treatment phase of dentistry such as provision of an antiseptic environment, sterilization of equipment or infection control, or any ancillary materials used during the routine course of providing treatment, such as cotton swabs, gauze, bibs, masks, or relaxation techniques such as music.
19. Procedures having a questionable prognosis based on a dental consultant's professional review of the submitted documentation.
20. Any tax imposed (or incurred) by a government, state, or other entity in connection with any fees charged for Benefits provided under the Plan; any such tax will be the responsibility of the Member and not a covered benefit.
21. Deductibles, amounts over plan maximums (including any applicable Annual Maximum or Lifetime Orthodontic Maximum) and/or any service not covered under the Plan.
22. Services covered under the Plan but that exceed Benefit limitations or are not in accordance with processing policies in effect at the time the claim is processed.
23. Services for Orthodontic treatment (treatment of malocclusion of teeth and/or jaws), except as provided under the Orthodontic Services section, if applicable.
24. Services for any disturbance of the Temporomandibular (jaw) Joints (TMJ) or associated musculature, nerves, and other tissues.
25. Missed and/or cancelled appointments.
26. Actions taken to schedule and assure compliance with patient appointments, as these actions are inclusive with office operations and are not a separately payable service.
27. Fees for care coordination, as care coordination is considered inclusive in overall patient management and is not a separately payable service.

28. Dental case management, motivational interviewing, and patient education to improve oral health literacy.
29. Non-ionizing diagnostic procedure capable of quantifying, monitoring, and recording changes in structure of enamel, dentin, and cementum.
30. Extra-oral – 2D projection radiographic image and extra-oral posterior dental radiographic image.
31. Diabetes testing.
32. Corticotomy (specialized oral surgery procedure associated with orthodontics).

Services, Limitations, and Exclusions

Applicable to the Delta Dental Basic Plan

Description of Dental Services

The Plan will pay the Contract Benefit Level shown in the applicable Schedule of Benefits in *Chapter 1* for the following services (subject to any applicable limitations or exclusions described below):

- **Diagnostic and Preventive Services**

1.	Diagnostic:	procedures to aid the Provider in determining required dental treatment.
2.	Preventive:	cleaning (including scaling in the presence of generalized moderate or severe gingival inflammation-full mouth, and periodontal maintenance), topical application of fluoride solutions, space maintainers.
3.	Sealants:	topically applied acrylic, plastic, or composite materials used to seal developmental grooves and pits in permanent molars for the purpose of preventing decay.

- **Basic Services**

1.	Oral Surgery:	extractions and other surgical procedures (including pre- and post-operative care).
2.	General Anesthesia or IV Sedation:	when administered by a Provider for covered Oral Surgery or selected endodontic and periodontal surgical procedures.
3.	Endodontics:	treatment of diseases and injuries of the tooth pulp.
4.	Periodontics:	treatment of gums and bones supporting teeth.
5.	Palliative:	emergency treatment to relieve pain.
6.	Restorative:	amalgam and resin-based composite restorations (fillings) for treatment of carious lesions (visible destruction of hard tooth structure resulting from the process of decay).
7.	Denture Repairs:	repair to partial or complete dentures, including rebase procedures and relining.
8.	Specialist Consultations:	opinion or advice requested by a general dentist.
9.	Night Guards/ Occlusal Guards:	intraoral removable appliances provided for treatment of harmful oral habits associated with periodontal disease.

- **Major Services**

1.	Crowns and Inlays/Onlays:	treatment of carious lesions (visible decay of the hard tooth structure) when teeth cannot be restored with amalgam or resin-based composites.
2.	Prosthodontics:	procedures for construction of fixed bridges, partial or complete dentures, and the repair of fixed bridges.
3.	Prefabricated Stainless Steel Crowns:	prefabricated stainless steel crowns.

- **Note on Additional Benefits During Pregnancy**

  When a Member is pregnant, the Plan will pay for additional services to help improve the oral health of the Member during the pregnancy. The additional services each Calendar Year while the Member is covered under the Plan include:

  - one (1) additional oral exam, and
  - either:
    - one (1) additional routine cleaning,
    - one (1) additional periodontal scaling and root planing per quadrant, or
    - one (1) additional periodontal maintenance procedure.

  Written confirmation of the pregnancy must be provided by the Member or their Provider when the claim is submitted.

Limitations

1. Services that are more expensive than the form of treatment customarily provided under accepted dental practice standards are called "Optional Services." Optional Services also include the use of specialized techniques instead of standard procedures.

   Examples of Optional Services include

   a. a crown where a filling would restore the tooth,
   b. an Inlay/Onlay instead of an amalgam restoration, and
   c. an overdenture instead of denture.

   If a Member receives Optional Services, an alternate Benefit will be allowed, which means the Plan will base Benefits on the lower cost of the customary service or standard practice instead of on the higher cost of the Optional Service. The Member will be responsible for the difference between the higher cost of the Optional Service and the lower cost of the customary service or standard procedure (in addition to any Member cost-sharing they would have been responsible for in connection with the lower-cost service).

2. Exam and cleaning limitations:
   a. The Plan will pay for oral examinations (except after-hours exams and exams for observation) and cleanings (including scaling in presence of generalized moderate or severe gingival inflammation-full mouth, periodontal maintenance in the presence of inflamed gums, or any combination thereof) no more than three (3) times in a Calendar Year.
   b. Full mouth debridement is not allowed when performed by the same dentist/dental office on the same day as evaluation procedures.
   c. A full mouth debridement is allowed once in a lifetime when the Member has no history of prophylaxis, scaling and root planing, periodontal surgery, or periodontal maintenance procedures within three (3) years. When allowed, a full mouth debridement counts toward the maintenance frequency in the year provided.
   d. Note that full mouth debridement is covered as a Basic Service and that routine cleanings (including scaling in the presence of generalized moderate or severe gingival inflammation-full mouth), periodontal maintenance, and Procedure Codes that include periodontal maintenance are covered as a Diagnostic and Preventive Service. See *Note on Additional Benefits During Pregnancy* above.
   e. Caries risk assessments are allowed once in 12 months.
3. X-ray limitations:
   a. The Plan will limit the total reimbursable amount to the Provider's Accepted Fee for a complete intraoral series when the fees for any combination of intraoral x-rays in a single treatment series meet or exceed the Accepted Fee for a complete intraoral series.
   b. When a panoramic film is submitted with supplemental film(s), the Plan will limit the total reimbursable amount to the Provider's Accepted Fee for a complete intraoral series.
   c. If a panoramic film is taken in conjunction with a complete intraoral series, Delta Dental considers the panoramic film to be included in the complete series.
   d. A complete intraoral series and panoramic film are limited to a combined total once every 36 months.

e. Bitewing x-rays are limited to two (2) times in a Calendar Year. Bitewings of any type are disallowed within 12 months of a complete intraoral series unless warranted by special circumstances. Bitewing x-rays are limited to two (2) images for Members under age 10.

f. Image capture procedures are not separately allowable services.

4. Topical application of fluoride solutions is limited to Members under age 19 and is limited to no more than twice in a Calendar Year.

5. Interim caries arresting medicament application is limited to twice per tooth per Calendar Year.

6. Space maintainer limitations:

   a. Space maintainers are limited to the initial appliance and are a covered benefit for a Member to age 19. However, a distal shoe space maintainer-fixed-unilateral is limited to children age eight (8) and younger. A separate/additional space maintainer can be allowed after the removal of a unilateral distal shoe.

   b. Recementation of space maintainer is limited to once per lifetime.

   c. The removal of a fixed space maintainer is considered to be included in the fee for the space maintainer; however, an exception is made if the removal is performed by a different Provider/Provider's office.

7. Pulp vitality tests are allowed once per day when definitive treatment is not performed.

8. Cephalometric x-rays, oral/facial photographic images, and diagnostic casts are covered once per lifetime in conjunction with Orthodontic Services only when Orthodontic Services are a covered benefit. If Orthodontic Services are covered, see Limitations, as age limits may apply. However, 3D x-rays are not a covered benefit.

9. Sealants are limited as follows:

   a. to Members age 15 and under on permanent first and second molars if they are without caries (decay) or restorations on the occlusal surface.

   b. repair or replacement of a Sealant on any tooth within 24 months of its application is included in the fee for the original placement.

10. Specialist Consultations are limited to once per lifetime per Provider and count toward the oral exam frequency. Screenings of patients or assessments of patients reported individually are, when covered, limited to only one (1) in a 12-month period and included if reported with any other examination on the same date of service and Provider office.

11. The Plan will not cover replacement of an amalgam or resin-based composite restorations (fillings) or prefabricated crowns within 24 months of treatment if the service is provided by the same Provider/Provider office. Replacement restorations within 24 months are included in the fee for the original restoration.

12. Protective restorations (sedative fillings) are allowed once per tooth per lifetime when definitive treatment is not performed on the same date of service.

13. Prefabricated crowns are allowed on baby (deciduous) teeth and permanent teeth up to age 16. Replacement restorations within 24 months are included in the fee for the original restoration.

14. Therapeutic pulpotomy is limited to once per lifetime for baby (deciduous) teeth only and is considered palliative treatment for permanent teeth.

15. Pulpal therapy (resorbable filling) is limited to once in a lifetime. Retreatment of root canal therapy by the same Provider/Provider office within 24 months is considered part of the original procedure.

16. Apexification is only benefited on permanent teeth with incomplete root canal development or for the repair of a perforation. Apexification visits have a lifetime limit per tooth of one (1) initial visit, four (4) interim visits, and one (1) final visit to age 19.

17. Retreatment of apical surgery by the same Provider/Provider office within 24 months is considered part of the original procedure.

18. Palliative treatment is covered per visit, not per tooth, and the fee includes all treatment provided other than required x-rays or select Diagnostic procedures.

19. Periodontal limitations:
    a. Benefits for periodontal scaling and root planing in the same quadrant are limited to once in every 24-month period. See *Note on Additional Benefits During Pregnancy* above. No more than two (2) quadrants of scaling and root planing will be covered on the same date of service.
    b. Periodontal surgery in the same quadrant is limited to once in every 36-month period and includes any surgical re-entry or scaling and root planing performed within 36 months by the same Provider/Provider office.
    c. Periodontal services, including bone replacement grafts, guided tissue regeneration, graft procedures, and biological materials to aid in soft and osseous tissue regeneration are only covered for the treatment of natural teeth and are not covered when submitted in conjunction with extractions, periradicular surgery, ridge augmentation, or implants. Guided tissue regenerations and/or bone grafts are not benefited in conjunction with soft tissue grafts in the same surgical area.
    d. Periodontal surgery is subject to a 30-day wait following periodontal scaling and root planing in the same quadrant.
    e. Cleanings (regular and periodontal) and full mouth debridement are subject to a 30-day wait following periodontal scaling and root planing if performed by the same Provider office.
    f. When implant procedures are a covered benefit, scaling and debridement in the presence of inflammation or mucositis of a single implant, including cleaning of the implant surfaces, without flap entry and closure is covered as a Basic Service and are limited to once in a 24-month period.
20. Extractions are covered once in a lifetime, per tooth. The removal of cysts and lesions and incision and drainage procedures are covered once in the same day.
21. The following Oral Surgery procedure is not covered: transseptal fiberotomy/supra crestal fiberotomy.
22. The following Oral Surgery procedures are not covered: surgical access of an unerupted tooth, placement of device to facilitate eruption of impacted tooth, and surgical repositioning of teeth.
23. Frenulectomy and frenuloplasty are only considered in cases of ankyloglossia (tongue-tie) interfering with feeding or speech as diagnosed and documented by a physician or if the frenum is contributing to the presence of a large diastema(s).
24. Crowns and Inlays/Onlays are limited to Members age 12 and older and are covered not more often than once in any 60-month period per tooth except when Delta Dental determines the existing Crown or Inlay/Onlay is not satisfactory and cannot be made satisfactory because the tooth involved has experienced extensive loss or changes to tooth structure or supporting tissues.
25. Core buildup, including any pins, are covered not more than once in any 60-month period.
26. Post and core services are covered not more than once in any 60-month period.
27. Crown repairs are covered not more than twice in any 60-month period. Crowns, Inlays/Onlays and fixed bridges include repairs for 24 months following installation.
28. Denture Repairs are covered not more than once in any six (6) month period except for fixed Denture Repairs, which are covered not more than twice in any 60-month period.
29. Prosthodontic appliances that were provided under any plan administered by Delta Dental will be replaced only after 60 months have passed, except when Delta Dental determines that there is such extensive loss of remaining teeth or change in supporting tissue that the existing fixed bridge or denture cannot be made satisfactory. Fixed prosthodontic appliances are limited to Members age 16 and older. Replacement of a prosthodontic appliance not provided under a plan administered by Delta Dental will be made if Delta Dental determines it is unsatisfactory and cannot be made satisfactory.
30. When a posterior fixed bridge and a removable partial denture are placed in the same arch in the same treatment episode, only the partial denture will be covered.
31. Recementation of Crowns, Inlays/Onlays, or bridges is included in the fee for the Crown, Inlay/Onlay, or bridge when performed by the same Provider/Provider office within six (6) months of the initial placement. After six (6) months, payment will be limited to one (1) recementation in a lifetime by the same Provider/Provider office.

32. The Plan limits payment for dentures to a standard partial or complete denture (Coinsurance applies). A standard denture means a removable appliance to replace missing natural, permanent teeth that is made from acceptable materials by conventional means and includes routine post-delivery care, including any adjustments and relines for the first six (6) months after placement.
    a. Denture rebase is limited to one (1) per arch in a 24-month period and includes any relining and adjustments for six (6) months following placement.
    b. Dentures, removable partial dentures, and relines include adjustments for six (6) months following installation. After the initial six (6) months of an adjustment or reline, adjustments are limited to two (2) per arch in a Calendar Year, and relining is limited to one (1) per arch in a six (6) month period.

       Immediate dentures and immediate removable partial dentures include adjustments for three (3) months following installation. After the initial three (3) months of an adjustment or reline, adjustments are limited to two (2) per arch in a Calendar Year, and relining is limited to one (1) per arch in a six (6) month period.
    c. Tissue conditioning is limited to two (2) per arch in a 12-month period. However, tissue conditioning is not allowed as a separate Benefit when performed on the same day as a denture, reline, or rebase service.
    d. Recementation of fixed partial dentures is limited to once in a lifetime.
33. The Plan will not pay for implants (artificial teeth implanted into or on bone or gums), their removal, or other associated procedures, but the Plan will credit the cost of a pontic or standard complete or partial denture toward the cost of the implant associated appliance, i.e., the implant supported crown or denture. The implant appliance is not covered.
34. The fees for synchronous/asynchronous teledentistry services are considered inclusive in overall patient management and are not a separately payable service. Teledentistry (i.e., virtual or online) services are covered only when administered in conjunction with procedures and services that are covered under this Plan. Covered dental services delivered through teledentistry are covered to the same extent as services rendered through in-person contact and are subject to the same cost-share, frequency limitations, or any applicable Benefit maximums or lack thereof.
35. Limitations on Night Guards/Occlusal Guard Services:
    a. The replacement of appliances for Night Guards/Occlusal Guards Services is limited to once every 60 months.
    b. A Night Guards/Occlusal Guard adjustment is limited to once in a 12-month period. Limited adjustment is a covered benefit once per quadrant within a 60-month period.

Exclusions

The Plan does not pay Benefits for:

1. Treatment of injuries or illness covered by workers' compensation or employers' liability laws; services received without cost from any federal, state, or local agency, unless this exclusion is prohibited by law.
2. Cosmetic surgery or procedures for purely cosmetic reasons.
3. Maxillofacial prosthetics.
4. Provisional and/or temporary restorations (except an interim removable partial denture to replace extracted anterior permanent teeth during the healing period for children 16 years of age or under). Provisional and/or temporary restorations are not separately payable procedures and are included in the fee for completed service.
5. Services for congenital (hereditary) or developmental (following birth) malformations, including but not limited to cleft palate, upper and lower jaw malformations, enamel hypoplasia (lack of development), fluorosis (a type of discoloration of the teeth), and anodontia (congenitally missing teeth), except those services provided to newborn children for medically diagnosed congenital defects or birth abnormalities.
6. Treatment to stabilize teeth, treatment to restore tooth structure lost from wear, erosion, or abrasion, or treatment to rebuild or maintain chewing surfaces due to teeth out of alignment or occlusion. Examples include but are not limited to: equilibration, periodontal splinting, complete occlusal adjustments, and abfraction.
7. Any Single Procedure provided prior to the date the Member became eligible for services under this plan.

8. Prescribed drugs, medication, pain killers, antimicrobial agents, or experimental/investigational procedures.
9. Charges for anesthesia, other than General Anesthesia and IV Sedation administered by a Provider in connection with covered Oral Surgery or selected Endodontic and Periodontal surgical procedures. Local anesthesia and regional/or trigeminal bloc anesthesia are not separately payable procedures.
10. Extraoral grafts (grafting of tissues from outside the mouth to oral tissues).
11. Laboratory processed crowns for Members under age 12.
12. Fixed bridges and removable partials for Members under age 16.
13. Interim implants, endodontic endosseous implants, and extraoral implants.
14. Indirectly fabricated resin-based Inlays/Onlays.
15. Charges by any hospital or other surgical or treatment facility and any additional fees charged by the Provider for treatment in any such facility.
16. Treatment by someone other than a Provider or a person who by law may work under a Provider's direct supervision.
17. Charges incurred for oral hygiene instruction, a plaque control program, a preventive control program (including home care times), dietary instruction, x-ray duplications, cancer screening, or tobacco counseling.
18. Dental practice administrative services including, but not limited to, preparation of claims, any non-treatment phase of dentistry such as provision of an antiseptic environment, sterilization of equipment or infection control, or any ancillary materials used during the routine course of providing treatment, such as cotton swabs, gauze, bibs, masks, or relaxation techniques such as music.
19. Procedures having a questionable prognosis based on a dental consultant's professional review of the submitted documentation.
20. Any tax imposed (or incurred) by a government, state, or other entity in connection with any fees charged for Benefits provided under the Plan; any such tax will be the responsibility of the Member and not a covered benefit.
21. Deductibles, amounts over plan maximums (including any applicable Annual Maximum) and/or any service not covered under the Plan.
22. Services covered under the Plan but that exceed Benefit limitations or are not in accordance with processing policies in effect at the time the claim is processed.
23. Services for Orthodontic treatment (treatment of malocclusion of teeth and/or jaws).
24. Services for any disturbance of the Temporomandibular (jaw) Joints (TMJ) or associated musculature, nerves, and other tissues.
25. Missed and/or cancelled appointments.
26. Actions taken to schedule and assure compliance with patient appointments, as these actions are inclusive with office operations and are not a separately payable service.
27. Fees for care coordination, as care coordination is considered inclusive in overall patient management and is not a separately payable service.
28. Dental case management, motivational interviewing, and patient education to improve oral health literacy.
29. Non-ionizing diagnostic procedure capable of quantifying, monitoring, and recording changes in structure of enamel, dentin, and cementum.
30. Extra-oral – 2D projection radiographic image and extra-oral posterior dental radiographic image.
31. Diabetes testing.
32. Corticotomy (specialized oral surgery procedure associated with orthodontics).

Wellness Benefits

Plan Sponsor: Church Pension Group Services Corporation dba The Episcopal Church Medical Trust

Group Number: 22379 **Effective Date:** January 1, 2024

Wellness Benefits are available to help improve the oral health of Members with certain Qualifying Medical Conditions.

Qualifying Medical Conditions

Members with one or more of the following "Qualifying Medical Conditions" will receive Wellness Benefits: cardiovascular (heart) disease, diabetes, cerebrovascular disease (stroke), HIV/AIDS, rheumatoid arthritis, chronic kidney disease, Sjogren's syndrome, lupus, Parkinson's disease, amyotrophic lateral sclerosis, Huntington's disease, opioid misuse and addiction, joint replacement, and cancer.

Wellness Benefits

The information in the table below replaces the coverage for routine cleanings, periodontal maintenance, and periodontal scaling and root planing described under "Services, Limitations, and Exclusions" above.

Service	Member Responsibility for Cost Sharing with PPO and Premier Providers	Member Responsibility for Cost Sharing with Non-Delta Dental Providers	Limitations
Routine Cleaning & Periodontal Maintenance*	0%	0%	Any combination of four (4) each Calendar Year.
Periodontal Scaling & Root Planing	0%	0%	Once every Calendar Year per quadrant with no more than two (2) quadrants covered on the same date of service.

**If a Member is eligible for a pregnancy benefit and is also eligible for the Wellness Benefit, then Wellness Benefits replace the additional pregnancy benefits described under "Services, Limitations and Exclusions," above, except such Members will be entitled to one additional oral exam each Calendar Year while pregnant provided that written confirmation of the pregnancy is submitted.*

All other Benefits, Limitations and Exclusions remain unchanged. Wellness Benefits are subject to applicable Deductibles and Annual Maximums.

Signing up for Wellness Benefits

Sign up online

1. Go to *deltadentalins.com*.
2. Log in to your Online Services account. (If you don't have one, click Register.)
3. Click on the Optional Benefits tab in the left column.
4. Click on Opt In next to the name of the person you want to enroll. You can enroll yourself or a dependent child.
5. Complete and submit the form.

Sign up by phone

Call 888-894-7059 to speak to a Customer Services Representative during regular business hours.

Chapter 5: Definitions

Terms when capitalized in this Plan Document Handbook have defined meanings given in the section below or where indicated elsewhere in this Plan Document Handbook.

Accepted Fee — The amount the attending Provider agrees to accept as payment in full for services rendered.

Annual Maximum — An Annual Maximum is the maximum dollar amount the Plan will pay toward the cost of covered dental care in a Plan Year (excluding the cost of covered diagnostic and preventive services). You are responsible for paying costs above this amount. The Annual Maximum payable is shown in the Schedules of Benefits in *Chapter 1*.

Benefits — Your right to payment for covered health services that are available under the Plan. Your right to Benefits is subject to the terms, conditions, limitations, and exclusions of the Plan, including this Plan Document Handbook and any applicable amendments.

Claim Form — Delta Dental's standard form used to file a claim or request a Pre-Treatment Estimate.

Coinsurance — Once any applicable Deductible is met, the Plan will pay a percentage of the Maximum Contract Allowance for covered services, as described in the Schedules of Benefits in *Chapter 1*, and you are responsible for paying the balance. What you pay is called your coinsurance ("Coinsurance") and is part of your out-of-pocket cost. You pay this after any applicable Deductible has been met.

The amount of your Coinsurance will depend on the type of service and the Provider providing the service (see *Chapter 3: Delta Dental's Networks & Selecting Your Provider*).

Contract Benefit Level — The percentage of the Maximum Contract Allowance that the Plan will pay after any applicable Deductible has been satisfied, as shown in the applicable Schedule of Benefits in *Chapter 1*.

Deductible — A dollar amount that a Member must pay for certain covered services before Delta Dental begins paying Benefits, as shown in the applicable Schedule of Benefits in *Chapter 1*. Deductibles are in addition to any Coinsurance.

Delta Dental — Delta Dental of New York, Inc. and/or another member company of the Delta Dental Plans Association, with respect to certain services.

Delta Dental PPO℠ Provider (PPO Provider)

A Provider who contracts with Delta Dental and agrees to accept the Delta Dental PPO Contracted Fee as payment in full for covered services provided under a PPO dental plan. A PPO Provider also agrees to comply with Delta Dental's administrative guidelines.

Delta Dental PPO Contracted Fee (PPO Contracted Fee)

The fee for a Single Procedure covered under the Plan that a PPO Provider has contractually agreed to accept as payment in full for covered services.

Delta Dental Premier® Provider (Premier Provider)

A Provider who contracts with Delta Dental and agrees to accept the Delta Dental Premier Contracted Fee as payment in full for covered services provided under a plan, but who has not agreed to the features of the PPO plan. A Premier Provider also agrees to comply with Delta Dental's administrative guidelines.

Delta Dental Premier Contracted Fee (Premier Contracted Fee)

The fee for a Single Procedure covered under the Plan that a Premier Provider has contractually agreed to accept as payment in full for covered services.

Eligible Dependent

An individual who meets the definition of an "Eligible Dependent," as described in *Chapter 2: Eligibility and Enrollment*.

Eligible Individual

An individual who meets the definition of an "Eligible Individual," as described in *Chapter 2: Eligibility and Enrollment*.

Identification Card

The card most recently given to you by Delta Dental that shows your member and group ID numbers.

Lifetime Orthodontic Maximum

All plan options under the Plan that cover Orthodontic Services include a Lifetime Orthodontic Maximum. A Lifetime Orthodontic Maximum is the maximum dollar amount the Plan will pay toward the cost of covered Orthodontic Services. This maximum applies on a lifetime basis and includes any amounts paid for Orthodontic Services under any prior Medical Trust dental plan. You are responsible for paying costs above this amount. The Lifetime Orthodontic Maximum payable is shown in the Schedules of Benefits in *Chapter 1*.

Maximum Contract Allowance

The reimbursement under the Plan against which Delta Dental calculates its payment and the Member's financial obligation. Subject to adjustment for extreme difficulty or unusual circumstances, the Maximum Contract Allowance for services provided:

- by a PPO Provider is the lesser of the Provider's Submitted Fee or the Delta Dental PPO Contracted Fee.
- by a Premier Provider is the lesser of the Provider's Submitted Fee or the Delta Dental Premier Contracted Fee.
- by a Non-Delta Dental Provider is the lesser of the Provider's Submitted Fee or the Program Allowance.

Medicaid

A state program of medical aid for needy persons established under Title XIX of the Social Security Act of 1965, as amended.

Medicare

Parts A, B, C, and D of the insurance program established by Title XVIII, United States Social Security Act, as amended by 42 U.S.C. Sections 1394, et seq. and as later amended.

Member

An enrolled Eligible Individual or enrolled Eligible Dependent. As used throughout this Plan Document Handbook, "you" and "your" refer to a Member,

unless otherwise clearly required by context (for example, if context indicates that "you" are not enrolled in the Plan).

My Admin Portal (MAP) — My Admin Portal (MAP) is CPG's online application used by benefits administrators throughout The Episcopal Church to manage employment assignments related to retirement and benefits enrollments.

Non-Delta Dental Provider — A Provider who is not a PPO Provider or a Premier Provider and is not contractually bound to abide by Delta Dental's administrative guidelines.

Participating Group — A diocese, congregation, agency, school, organization, or other body subject to the authority of and/or associated or affiliated with The Episcopal Church, which has elected to participate in the Plan. Also known in My Admin Portal (MAP) as a "Benefits Group."

Plan(s) — The "Plan" refers to the dental plan maintained by the Medical Trust and described in this Plan Document Handbook, for which Delta Dental provides administrative services, and "Plans" collectively refers to the medical and dental plans (i.e., health plans) maintained by the Medical Trust for the benefit of Members, including the Plan. The Plans are intended to qualify as a "church plan" as defined by Section 414(e) of the Code and are exempt from the requirements of ERISA.

Plan Sponsor — The legal entity that has adopted the Plan and has authority regarding its operation, amendment, and termination. **The Plan Sponsor is not Delta Dental. The Plan Sponsor is the Medical Trust**.

Plan Year or Calendar Year — The words "year," "Calendar Year," and "Plan Year," as used in this Plan Document Handbook, refer 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.

Pre-Treatment Estimate — An estimation of the allowable Benefits under the Plan for the services proposed, assuming the person is an eligible Member and subject to the other conditions and assumptions described in *Chapter 4: Coverage for the Dental Plan*.

Procedure Code — The Current Dental Terminology© (CDT) number assigned to a Single Procedure by the American Dental Association.

Program Allowance — The maximum amount the Plan will reimburse for a covered procedure. Delta Dental sets the Program Allowance for each procedure through a review of proprietary data by geographic area. The Program Allowance may vary by the contracting status of the Provider and/or the Program Allowance selected by the Plan Sponsor.

Provider — A person licensed to practice dentistry when and where services (which must be within the scope of such license) are performed. A Provider shall also include a dental partnership, dental professional corporation, or dental clinic.

Single Procedure — A dental procedure that is assigned a separate Procedure Code.

Submitted Fee — The amount that the Provider bills and enters on a claim for a specific procedure.

Chapter 6: Coordination of Benefits

This section applies if a Member is covered under both the Plan and another dental plan. This section determines how benefits payable from all such plans will be coordinated. You should file all claims with each plan.

Delta Dental coordinates the Benefits under the Plan with a Member's benefits under any other group or pre-paid plan or benefit plan designed to fully integrate with other policies. If the Plan is the "primary" plan, the Plan will not reduce Benefits. If the Plan is the "secondary" plan, the Plan may reduce Benefits otherwise payable under the Plan so that the total benefits paid or provided by all plans do not exceed 100% of total allowable expense.

How does Delta Dental determine which plan is the "primary" plan?

1. The plan covering you as an employee (or primary enrolled eligible individual) is primary over a plan covering you as a dependent.
2. The plan covering you as an employee (or primary enrolled eligible individual) is primary over a plan which covers the covered person as a dependent; except that: if the covered person is also a Medicare beneficiary, and as a result of the rule established by Title XVIII of the Social Security Act and implementing regulations, Medicare is:
   a. secondary to the plan covering the covered person as a dependent and
   b. primary to the plan covering the covered person as other than a dependent (e.g., a retired employee), then the benefits of the plan covering the covered person as a dependent are determined before those of the plan covering that covered person as other than a dependent.
3. Except as stated below, when this plan and another plan cover the same child as a dependent of different persons, called parents:
   a. The benefits of the plan of the parent whose birthday falls earlier in a year are determined before those of the plan of the parent whose birthday falls later in that year, but
   b. if both parents have the same birthday, the benefits of the plan which covered one parent longer are determined before those of the plan which covered the other parent for a shorter period of time.
   c. However, if the other plan does not have the birthday rule described above, but instead has a rule based on the gender of the parent, and if, as a result, the plans do not agree on the order of benefits, the rule in the other plan will determine the order of benefits.
4. In the case of a dependent child of legally separated or divorced parents, the plan covering the Member as a dependent of the parent with legal custody, or as a dependent of the custodial parent's spouse (i.e., a stepparent) will be primary over the plan covering the Member as a dependent of the parent without legal custody. If there is a court decree which would otherwise establish financial responsibility for the health care expenses with respect to the child, the benefits of a plan which covers the child as a dependent of the parent with such financial responsibility will be determined before the benefits of any other policy which covers the child as a dependent child.
5. If the specific terms of a court decree state that the parents will share joint custody, without stating that one of the parents is responsible for the healthcare expenses of the child, the plans covering the child will follow the order of benefit determination rules outlined in 3(a) through 3(c), above.
6. The benefits of a plan which covers a covered person as an employee (or non-retired primary enrolled eligible individual) who is neither laid off nor retired are determined before those of a plan which covers that covered person as a laid off or retired employee. The same would hold true if a covered person is a dependent of a person

covered as a retiree and an employee (or primary enrolled eligible individual). If the other plan does not have this rule, and if, as a result, the plans do not agree on the order of benefits, this rule is ignored.

7. If a covered person whose coverage is provided under an extension of benefits or other continuation right is also covered under another plan, the following will be the order of benefit determination:
   a. First, the benefits of a plan covering the covered person as an employee (or primary enrolled eligible individual) (or as that covered person's dependent).
   b. Second, the benefits under the continuation coverage.

   If the other plan does not have the rule described above, and if, as a result, the plans do not agree on the order of benefits, this rule is ignored.
8. If none of the above rules determine the order of benefits, the benefits of the plan which covered you longer are determined before those of the plan which covered you for the shorter term.
9. When determination cannot be made in accordance with the above, the benefits of a plan that is a medical plan covering dental as a benefit shall be primary to a dental-only plan.

Chapter 7: Other Important Plan Provisions

Payment of Benefits; Assignment of Benefits

Payment for services provided by a PPO Provider or Premier Provider will be made directly to the dentist. Any other payments provided by the Plan will be made to you. All Benefits not paid to a PPO Provider or Premier Provider will be payable to you (the Member), or to your estate, or to an alternate recipient as directed by court order, except that if the person is a minor or otherwise not competent to give a valid release (in the opinion of Delta Dental), Benefits may be payable to a person or institution legally supporting the person (or appearing to have assumed such support).

Except as provided above, you may not assign to any party, including, but not limited to, a Provider of healthcare services or items, your right to Benefits under this Plan, nor may you assign any administrative, statutory, or legal rights or causes of action you may have, including, but not limited to, any right to make a claim for Benefits, to request Plan or other documents, to file appeals of denied claims or grievances, or to commence legal action. Any attempt to assign such rights shall be void and unenforceable under all circumstances. Further, Benefits, rights, and interests under the Plan shall not be subject in any manner to any other form of alienation, sale, transfer, assignment, pledge, encumbrance, charge, garnishment, or execution of levy of any kind, either voluntary or involuntary, by any person, and any such attempts shall be void.

By participating in the Plan, you are deemed to authorize Delta Dental to pay any Benefits for services performed by a PPO Provider or a Premier Provider to such Provider. When you authorize the payment of your healthcare Benefits to a Provider, you authorize the payment of the entire amount of the Benefits due on that claim. If a Provider is overpaid because of accepting duplicate payments from you and Delta Dental, it is the Provider's responsibility to reimburse the overpayment to you. You may not interpret or rely upon this discrete authorization or permission to pay any healthcare Benefits to a Provider as the authority to assign any other rights under this policy to any party, including, but not limited to, a Provider of healthcare services or items. No payment by the Plan pursuant to such authorization shall be considered recognition by the Plan of a duty or obligation to pay a provider of services or supplies except to the extent the Plan actually chooses to do so.

To the extent allowed by law, Delta Dental will not accept an assignment to a Non-Delta Dental Provider or facility for any reason, including, but not limited to, an assignment of the right to receive payments. Any payments made by Delta Dental to a Non-Delta Dental Provider or facility does not create a waiver of this section nor grant a Non-Delta Dental Provider rights under the Plan or any applicable law.

When Benefits are paid to you, you are responsible for reimbursing the Non-Delta Dental Provider.

When a Member passes away, Delta Dental may receive notice that an executor of the estate has been established. The executor has the same rights as the Member, and Benefit payments for unassigned claims should be made payable to the executor.

Payment as described above will release the Plan and Delta Dental from all liability to the extent of any payment made.

Alternate Payee Provision

Benefits are generally payable to the Provider of services or supplies. The Plan may choose to make payments to a Member's separated/divorced spouse, state child support agencies, or Medicaid agencies if required by a qualified medical child support order (QMCSO) or state Medicaid law.

Any payment made by the Plan in accordance with this provision will fully release the Plan and Delta Dental of its liability to the Member.

Unclaimed Property

If the Plan cannot provide Benefits to a Member because after a reasonable search, the Plan cannot locate the Member within a period of two (2) years after the payment of Benefits becomes due, such amounts otherwise due to the Member shall be considered "unclaimed property." Unclaimed property amounts will be considered forfeitures that are deemed to occur as of the end of the two-year period. All forfeitures shall be and remain Plan assets, and in no event shall any such forfeiture escheat to, or otherwise be paid to, any governmental unit under any escheat or unclaimed property law.

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 individuals when evaluating coverage and Benefits under the Plan. 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 a Member, an Eligible Individual, a dependent, or another person provides 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 Plan.

No Waiver

The failure of the Medical Trust to enforce strictly any term or provision of the Plan 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 the Plan at any time.

Dentist/Patient Relationship

This Plan is not intended to disturb the dentist/patient relationship. Dentists and other healthcare providers are not agents or delegates of the employer, the Medical Trust, the ECCEBT, or Delta Dental. Any PPO Provider, Premier Provider, or Non-Delta Dental Provider, including any Provider or employee associated with or employed by them, who provides dental services to a Member does so as an independent contractor and shall be solely responsible for dental advice and for performance of dental services, or lack thereof, to the Member. Nothing contained in the Plan will require a Member to commence or continue dental treatment by a particular provider.

Furthermore, nothing in 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 the Member.

The Plan Is Not a Contract of Employment

Nothing contained in the Plan 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 the Plan had never been adopted.

Required Monthly Contributions

The Plan does not prorate contribution requirements for any health plan regardless of the termination date or the effective date. Any monthly contribution rate change will be effective the first day of the month following the change. Contributions for coverage with a retroactive effective date must be paid upon enrollment.

One Type of Coverage

The Plan prohibits two Eligible Individuals who are Members from covering each other as an Eligible Dependent in the same Plan. Therefore, an Eligible Individual who participates in the Plan based on their own eligibility may not be an Eligible Dependent in the same Plan.

A Child of two Members who both work for The Episcopal Church in Participating Groups and are enrolled Eligible Individuals may not be covered as an enrolled Eligible Dependent by virtue of their relationship with both enrolled Eligible Individuals in the same Plan at the same time.

If two Members who are spouses (or domestic partners, if their Participating Groups offer domestic partner benefits) both work for The Episcopal Church in Participating Groups, one of which offers dental benefits and one of which does not, an individual may enroll as an Eligible Individual in a medical Plan and as an Eligible Dependent in a dental Plan, or vice versa.

No Member may be enrolled as an Eligible Individual in more than one medical Plan or more than one dental Plan (or have two or more enrollments in the same medical or dental Plan) at the same time. For example, and without limiting the generality of the foregoing, an employee who works for two Episcopal Employers and who is an Eligible Individual for the EHP by virtue of their employment with each of them cannot be enrolled in the EHP through both of their employers simultaneously.

Plan Sponsor

We maintain contractual relationships with various health plan vendors on Members' behalf. We are the plan sponsor of all Medical Trust health plans.

Plan Administration

The Medical Trust has full discretion and authority to interpret Plan provisions, make factual determinations, and address other issues that may arise. Subject to any right that a Member has to appeal a decision, the Medical Trust determinations are final and binding. To the extent that the Medical Trust delegates administrative authority under the Plan(s) to another party, such as Delta Dental, that party shall act with the same discretion and authority as the Medical Trust.

Right to Amend or Terminate the Plan

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

No Guarantee of Tax Consequences

Although the Plan intends to offer some Benefits on a tax-favored basis, there is no guarantee that any particular tax result will apply. Nothing in this Plan Document Handbook constitutes tax, medical, financial, or legal advice. If you have questions about the tax, financial, or legal consequences of a Benefit, you should consult your personal tax, legal, or financial advisor.

Plan Information and Rights

The Plan(s) described in this Plan Document Handbook are sponsored by the Church Pension Group Services Corporation ("CPGSC"), also known as the Episcopal Church Medical Trust (the "Medical Trust"). The Medical Trust serves only eligible Episcopal employers. The Plans that are self-funded are funded by the Episcopal Church Clergy and Employees' Benefit Trust ("ECCEBT"), a Voluntary Employees' Beneficiary Association within the meaning of section 501(c)(9) of the Code.

This Plan Document Handbook should not be viewed as an offer of coverage, or investment, tax, medical, or other advice. By participating in and accepting benefits from the Plan, you agree to the terms of the Plan set forth in this Plan Document Handbook.

The Plan, and this Plan Document Handbook, are governed by, and the rights and obligations of the Medical Trust, ECCEBT, Delta Dental, and the Members shall be interpreted, construed, and enforced in accordance with the laws of the State of New York without regard to the conflict of law principles thereof.

The Church Pension Fund and its affiliates, including but not limited to the Medical Trust, CPGSC, and ECCEBT (collectively, "CPG"), retain the right to amend, terminate, or modify the terms of the Plan, as well as any post-retirement health subsidy, at any time, for any reason, and unless required by applicable law, without notice.

The Plan is a "church plan" within the meaning of section 3(33) of ERISA and section 414(e) of the Code and is exempt from ERISA. 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. Additionally, the Plan may be exempt from federal and state laws that may otherwise apply to health insurance arrangements. The Plan does not cover all healthcare expenses, and Members should read this document carefully to determine which Benefits are covered, as well as any applicable exclusions, limitations, and procedures.

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

Unauthorized Use of Identification Card

If you permit your Identification Card to be used by someone else, or if you use the card before coverage is in effect or after coverage has ended, you will be liable for payment of any expenses incurred resulting from the unauthorized use. Fraudulent misuse could also result in termination of the coverage. Fraudulent statements on enrollment forms and/or claims for services or payment involving all media (paper or electronic) may invalidate any payment or claims for services and be grounds for voiding the Member's coverage. This includes fraudulent acts to obtain medical services and/or prescription drugs.

Additional Information on Covered and Excluded Benefits

If you would like to receive additional information regarding a specific drug, dental test, device, or procedure that is either a covered or excluded benefit under the Plan, you may contact Delta Dental at 888-894-7059 or via the Internet by logging in to *deltadentalins.com*.

Arbitration

Subject to exhaustion of the procedures set forth in *Chapter 9: How to File a Claim*, a Member who believes that they are entitled to Benefits under the Plan may pursue such claim only and exclusively by submitting the matter to arbitration. Any such arbitration must be commenced no later than one (1)

year after the date the procedures set forth in *Chapter 9: How to File a Claim* are exhausted.

For any controversy, claim, or dispute arising out of or related in any way to the Plan aside from one described in the immediately preceding paragraph, including but not limited to any claims for breach of fiduciary duty, a Member may pursue such controversy, claim, or dispute only and exclusively by submitting the matter to arbitration. Any such arbitration must be commenced no later than two (2) years after the date on which the Member knew or should have known the information that forms the basis of such controversy, claim, or dispute.

In any such arbitration, the parties shall select an arbitrator from a list of names supplied by JAMS, Inc. ("JAMS") in accordance with JAMS's procedures for selection of arbitrators, and the arbitration shall be conducted in accordance with the JAMS Employment Arbitration Rules and Procedures and subject to the JAMS Policy on Employment Arbitration Minimum Standards of Procedural Fairness. The arbitrator's authority shall be governed by the same principles that would apply to such an action in court, including, to the extent applicable, any deferential standard of review applicable to such actions and appropriate limits on discovery beyond the administrative record. In addition, the arbitrator's decision shall be final and binding on all parties and may be enforced in any court of competent jurisdiction. The arbitrator selected must have substantial familiarity with and knowledge of group health plans, preferably with those that are not subject to ERISA.

Waiver of Class, Collective, and Representative Actions

Members must bring any controversy, claim, or dispute in arbitration on an individual basis only, and not on a class, collective, or representative basis, and must waive the right to commence, be a party to, or be an actual or putative class member of any class, collective, or representative action arising out of or relating to the Plan, including, but not limited to, any claims related to the Plan ("class action waiver").

By participating in the Plan or by seeking or receiving any benefit under the Plan, to the fullest extent permitted by law, a Member waives any right to commence, be a party to in any way, recover from, and/or be an actual or putative member or representative of any class, collective, or representative action arising out of or relating to any claim, dispute, or controversy arising out of or relating to the Plan. Notwithstanding anything to the contrary in this Plan, if, for any reason, the waiver of a Member's right to commence, be a party to, recover from, or be an actual or putative member or representative of any class, collective, or representative action within or outside of an arbitration proceeding is found to be unenforceable by a court of competent jurisdiction, the requirement to arbitrate shall no longer apply, and any class, collective, or representative claim shall be filed, litigated, and adjudicated in a court of competent jurisdiction and not in arbitration.

In any arbitration, the Member may not seek or receive any remedy that has the purpose or effect of providing additional benefits or monetary relief to any other Member or beneficiary. Notwithstanding anything to the contrary in this Plan, if, for any reason, a court of competent jurisdiction were to find this restriction on the scope of remedies unenforceable or invalid as to a particular controversy, claim, or dispute, then the requirement to arbitrate shall no longer apply to such controversy, claim, or dispute, and that controversy, claim, or dispute shall be filed, litigated, and adjudicated in a court of competent jurisdiction and not in arbitration.

Chapter 8: Subrogation and Right of Recovery

Definitions

As used throughout this chapter, the term "responsible party" means any party (other than the Plan) actually, possibly, or potentially responsible for making any payment to a covered person due to a covered person's injury, illness, or condition. The term "responsible party" includes the liability insurer of such party or any insurance coverage.

For purposes of this provision, the term "insurance coverage" refers to any coverage providing medical expense coverage or liability coverage including, but not limited to, uninsured motorist coverage, underinsured motorist coverage, personal umbrella coverage, medical payments coverage, workers' compensation coverage, no-fault automobile insurance coverage, or any first party insurance coverage.

For purposes of this provision, a "covered person" includes anyone on whose behalf the Plan pays or provides any Benefit including, but not limited to, the representative of the Member's estate, heir, descendant, a minor Child, a dependent of any Member, or a person entitled to receive any Benefits from the Plan. A "covered person" also includes anyone to whom a Member or a Member's representative transfers or assigns (or purports to transfer or assign) any recovery or right of recovery from a responsible party.

Subrogation

Immediately upon paying or providing any Benefit under this Plan, the Plan shall be subrogated to (i.e., stand in the place of) all rights of recovery a covered person has against any responsible party with respect to any payment made, owed, or potentially owed by the responsible party to a covered person due to a covered person's injury, illness, or condition to the full extent of Benefits provided or to be provided by the Plan.

The right of subrogation means the Plan is, with or without the covered person's consent, entitled to pursue any claims that the covered person may have in order to recover the Benefits paid or payable by the Plan.

Reimbursement

In addition, if a covered person receives any payment from any responsible party or insurance coverage as a result of an injury, illness, or condition, the Plan has the right to recover from, and be reimbursed by, the covered person for all amounts this Plan has paid and will pay as a result of that injury, illness, or condition, up to and including the full amount the covered person receives from any responsible party.

Constructive Trust

By accepting Benefits from the Plan (whether the payment of such Benefits is made to the covered person or made on behalf of the covered person to any Provider), the covered person agrees that if they receive any payment from any responsible party as a result of an injury, illness, or condition, they will serve

as a constructive trustee over the funds that constitute such payment. Failure to hold such funds in trust will be deemed a breach of the covered person's fiduciary duty to the Plan.

Lien Rights

The Plan will automatically have an equitable lien to the extent of Benefits paid by the Plan for treatment of the illness, injury, or condition for which the responsible party is liable. The lien shall be imposed upon any recovery, whether by settlement, judgment, or otherwise, related to treatment for any illness, injury, or condition for which the Plan paid Benefits. The lien may be enforced against any party who possesses funds or proceeds representing the amount of Benefits paid by the Plan, including, but not limited to, the covered person; the covered person's representative or agent; the responsible party; the responsible party's insurer, representative, or agent; and/or any other source possessing funds representing the amount of Benefits paid by the Plan. The lien exists at the time the Plan pays Benefits and, therefore, exists prior to any subsequent filing for bankruptcy.

First-Priority Claim

By accepting Benefits from the Plan (whether the payment of such Benefits is made to the covered person or made on behalf of the covered person to any Provider), the covered person acknowledges that this Plan's recovery rights are a first-priority claim against all responsible parties and are to be paid to the Plan before any other claim for the covered person's damages. Further, this first-priority right to payment is superior to any and all claims, debts, or liens asserted by any medical providers, including, but not limited to, hospitals or emergency treatment facilities, that assert a right to payment from funds payable from or recovered from an allegedly responsible third party and/or insurance carrier. Such superiority shall be notwithstanding anything to the contrary in any agreement between the covered person and such medical provider, whenever such agreement may be entered into, unless the Plan has provided an express written waiver of this provision.

This Plan shall be entitled to full reimbursement on a first-dollar basis from any responsible party's payments, even if such payment to the Plan will result in a recovery to the covered person which is insufficient to make the covered person whole or to compensate the covered person in part or in whole for the damages sustained. The Plan is not required to participate in or pay court costs or attorney fees to any attorney hired by the covered person to pursue the covered person's damage claim.

Applicability to All Settlements and Judgments

The terms of this entire subrogation and right of recovery provision shall apply, and the Plan is entitled to full recovery regardless of whether any liability for payment is admitted by any responsible party and regardless of whether the settlement or judgment received by the covered person identifies the medical Benefits the Plan provided or purports to allocate any portion of such settlement or judgment to payment of expenses other than medical expenses. The Plan is entitled to recover from any and all settlements or judgments, even those designated as pain and suffering, non-economic damages, and/or general damages only.

Cooperation

The covered person shall fully cooperate with the Plan's efforts to recover its Benefits paid. It is the duty of the covered person to notify the Plan within 30 days of the date when any notice is given to any party, including an insurance company or attorney, of the covered person's intention to pursue or investigate a claim to recover damages or obtain compensation due to injury, illness, or condition sustained by the covered person and as soon as reasonably practicable, but in any event within five (5) days, of learning of any settlement

offer, judgment award, or decision regarding such compensation. The covered person and their agents shall provide all information requested by the Plan, Delta Dental, or **their respective** representatives including, but not limited to, completing, signing, and submitting any applications or other forms or statements as the Plan, Delta Dental, or **their respective** representatives may reasonably request and providing all documents related to or filed in personal injury litigation. Failure to provide this information may result in the institution of court proceedings against the covered person. The covered person shall make any court appearances reasonably requested by the Plan.

The covered person will provide the Plan, **Delta Dental,** or **their respective** representatives notice of any recovery the covered person or their agent obtains prior to their receipt of such recovery or, if the covered person or their agent did not learn of the recovery prior to such receipt, within five (5) days after the recovery. The covered person will refrain from any disbursement of settlement proceeds or any other recovery prior to fully satisfying the Plan's subrogation and reimbursement interest.

The covered person shall do nothing to prejudice the Plan's subrogation or recovery interest or to prejudice the Plan's ability to enforce the terms of this Plan provision. This includes, but is not limited to, refraining from making any settlement or recovery that attempts to reduce or exclude the full cost of all Benefits provided by the Plan.

The covered person acknowledges that the Plan has the right to conduct an investigation regarding the injury, illness, or condition to identify any responsible party. The Plan reserves the right to notify the responsible party and their agents of its lien. Agents include, but are not limited to, insurance companies and attorneys.

Failure to Reimburse or Cooperate

In the event of any failure by the covered person to provide reimbursement or failure to appropriately cooperate with the Plan's efforts to recover Benefits paid, the covered person's health benefits may be suspended, until the Plan has fully recovered amounts due hereunder, or terminated.

The Plan retains the option to collect any costs, including court and attorneys' fees incurred by the Plan resulting from its efforts to obtain reimbursement of Benefits paid.

The covered person's failure to cooperate with the Plan or Delta Dental or otherwise to comply with the terms of this Subrogation and Right of Recovery chapter is considered a breach of contract. As such, the Plan has the right to suspend or terminate benefits to the covered person, the covered person's dependents, the enrolled Eligible Individual, or dependents of the enrolled Eligible Individual; deny future benefits; take legal action against the covered person; and/or set off from any future benefits the value of benefits the Plan has paid relating to any sickness, injury, or other medical condition caused or alleged to have been caused by any third party to the extent not recovered by the Plan due to the covered person or the covered person's representative not cooperating with the Plan, Delta Dental, or their respective agents, or otherwise failing to abide by the terms of the Plan, including this Subrogation and Right of Recovery chapter. If the Plan incurs attorneys' fees and costs to collect third-party settlement funds held by the covered person or the covered person's representative, the Plan has the right to recover those fees and costs from the covered person. The covered person will also be required to pay interest on any amounts the covered person holds which should have been returned to the Plan, at the prime rate from time to time published by *The Wall Street Journal*.

The Plan's subrogation and reimbursement rights apply to full and partial settlements, judgments, or other recoveries paid or payable to the covered person or the covered person's representative, estate, heirs, or beneficiaries, no matter how those proceeds are captioned or characterized. Payments include, but are not limited to, economic, non-economic, pecuniary, consortium, and punitive damages. The Plan is not required to help the covered person to pursue their claim for damages or personal injuries, and no amount of associated costs, including attorneys' fees, shall be deducted from the Plan's recovery without the Plan's express written consent. No so-called "Fund Doctrine" or "Common Fund Doctrine" or "Attorney's Fund Doctrine" shall defeat this right.

Regardless of whether the covered person has been fully compensated or made whole, the Plan may collect from the covered person the proceeds of any full or partial recovery that the covered person or their legal representative obtains, whether in the form of a settlement (either before or after any determination of liability) or judgment, no matter how those proceeds are captioned or characterized. Proceeds from which the Plan may collect include, but are not limited to, economic, non-economic, pecuniary, consortium, and punitive damages. No "collateral source" rule, any "Made-Whole Doctrine" or "Make-Whole Doctrine," claim of unjust enrichment, nor any other equitable limitation shall limit the Plan's subrogation or reimbursement rights.

Benefits paid by the Plan may also be benefits advanced.

The Plan's rights to recovery will not be reduced due to the covered person's own negligence, including due to the application of any contributory or comparative negligence defenses.

By participating in and accepting benefits from the Plan, the covered person agrees to assign to the Plan any benefits, claims, or rights of recovery the covered person has under any automobile policy (including but not limited to no-fault benefits, PIP benefits, and/or medical payment benefits), other coverage, or against any third party, to the full extent of the benefits the Plan has paid for the sickness, injury, or other medical condition. By agreeing to provide this assignment in exchange for participating in and accepting benefits, the covered person acknowledges and recognizes the Plan's right to assert, pursue, and recover on any such claim, and the covered person agrees to this assignment voluntarily.

The Plan may, at its option, take necessary and appropriate action to preserve its rights under the provisions of this Subrogation and Right of Recovery chapter, including, but not limited to, providing or exchanging medical payment information with an insurer, the insurer's legal representative, or other third party; filing a reimbursement lawsuit to recover the full amount of medical benefits the covered person receives for the sickness, injury, or other medical condition out of any settlement, judgment, or other recovery from any third party considered responsible; and filing suit in the covered person's name or the covered person's estate's name, which does not obligate the Plan in any way to pay the covered person part of any recovery the Plan might obtain.

The covered person may not accept any settlement that does not fully reimburse the Plan, without its written approval.

In the case of the covered person's death, giving rise to any wrongful death or survival claim, the provisions of this Subrogation and Right of Recovery chapter apply to the covered person's estate, the personal representative of the covered person's estate, and the covered person's heirs or beneficiaries. In the case of the covered person's death, the Plan's right of reimbursement and right

of subrogation shall apply if a claim can be brought on behalf of the covered person or the covered person's estate that can include a claim for past medical expenses or damages.

The obligation to reimburse the Plan is not extinguished by a release of claims or settlement agreement of any kind (other than by a written agreement between the covered person and the Plan).

No allocation of damages, settlement funds, or any other recovery, by the covered person, the covered person's estate, the personal representative of the covered person's estate, the covered person's heirs, the covered person's beneficiaries, or any other person or party, shall be valid if it does not reimburse the Plan for 100% of its interest, unless the Plan provides written consent to such allocation.

The provisions of this Subrogation and Right of Recovery chapter apply to the parent(s), guardian(s), or other representative(s) of a dependent child who incurs a sickness, injury, or other medical condition caused by any third party. If a parent or guardian may bring a claim for damages arising out of a minor's sickness, injury, or other medical condition, the terms of this Subrogation and Right of Recovery chapter shall apply to that claim.

If any third party causes or is alleged to have caused the covered person to suffer a sickness, injury, or other medical condition while the covered person is covered under this Plan, the provisions of this Subrogation and Right of Recovery chapter continue to apply, even after the covered person is no longer covered.

If the covered person's estate, parent, guardian, or conservator asserts a claim against a third party based on the covered person's injury or illness, the covered person's estate, parent, guardian, or conservator and any settlement or judgment recovered by the estate, parent, guardian, or conservator shall be subject to the Plan's liens and other rights to the same extent as if the covered person had asserted the claim against the third party. The Plan may assign its rights to enforce liens and other rights.

Interpretation

In the event that any claim is made that any part of this subrogation and right of recovery provision is ambiguous or questions arise concerning the meaning or intent of any of its terms, the Medical Trust (or its delegate) shall have the sole authority and discretion to resolve all disputes regarding the interpretation of this provision. Any such interpretations shall be final and binding.

Jurisdiction

By accepting Benefits from the Plan (whether the payment of such Benefits is made to the covered person or made on behalf of the covered person to any Provider), the covered person agrees that any court proceeding with respect to this *Chapter 8: Subrogation and Right of Recovery* may be brought in any court of competent jurisdiction as the Plan may elect. By accepting such Benefits, the covered person hereby submits to each such jurisdiction, waiving whatever rights may correspond to them by reason of present or future domicile.

Chapter 9: How to Submit a Claim & How to Appeal a Denial of Benefits

Claims for Benefits must be filed on a standard Claim Form that is available in most dental offices. PPO Providers and Premier Providers will fill out and submit your claims paperwork for you. Some Non-Delta Dental Providers may also provide this service upon request. If you receive services from a Non-Delta Dental Provider who does not provide this service, you can submit your own claim directly to Delta Dental. For more information, please refer to the section titled "Notice of Claim Form," below.

Your dental office should be able to assist you in filling out the Claim Form. Fill out the Claim Form completely and send it to:

Delta Dental
PO Box 2105
Mechanicsburg, PA 17055

Payment Guidelines

Neither the Plan nor Delta Dental pays PPO Providers or Premier Providers any incentive as an inducement to deny, reduce, limit, or delay any appropriate service.

If you or your Provider files a claim for services more than 12 months after the date you received the services, payment may be denied. If the services were received from a Non-Delta Dental Provider, you are still responsible for the full cost. If the payment is denied because your PPO Provider or Premier Provider failed to submit the claim on time, you might not be responsible for that payment. However, if you did not tell your PPO Provider or Premier Provider that you were covered under the Plan at the time you received the service, you may be responsible for the cost of that service.

If you have any questions about any dental charges, processing policies, and/or how your claim is paid, please contact Delta Dental.

Clinical Examination

Before approving a claim, the Plan or Delta Dental will be entitled to receive, to such extent as may be lawful, from any attending or examining Provider, or from facilities in which a Provider's care is provided, such information and records relating to attendance to or examination of, or treatment provided to, you as may be required to administer the claim, or have you be examined by a dental consultant retained by the Plan or Delta Dental, as applicable, at its own expense, in or near your community or residence. Such information and records shall be held confidential.

Notice of Claim Form

Delta Dental will give you or your Provider, on request, a Claim Form to make claim for Benefits. To make a claim, the form should be completed and signed by the Provider who performed the services and by the patient (or the parent

or guardian if the patient is a minor) and submitted to Delta Dental at the address above.

If the form is not furnished by Delta Dental within 15 days after it is requested by you or your Provider, the requirements for claim submission set forth in the next paragraph will be deemed to have been complied with upon the submission to Delta Dental, within the time established in said paragraph for submitting claims, of written proof covering the occurrence, the character, and the extent of the expense for which claim is made. You or your Provider may download a Claim Form from Delta Dental's website.

Written Notice of Claim

Claims must be submitted in writing to Delta Dental within 12 months after the date of service. If it is not reasonably possible to submit a claim in the time required, the claim will not be reduced or denied solely for this reason, provided proof is filed as soon as reasonably possible. In any event, a claim must be submitted no later than one (1) year from such time (unless the claimant was legally incapacitated).

All claims must be submitted to Delta Dental within 12 months of the date the Plan Sponsor's contract with Delta Dental terminates.

Claim Processing Time

Claims payable under the Plan for any service other than a service for which the Plan provides any periodic payment will be processed no later than 30 days after Delta Dental's receipt of the claim. Within this 30-day period, Delta Dental will notify you and your Provider of any additional information needed to process the claim. If Delta Dental requests additional information, the processing timeframe will be delayed until the requested information is received by Delta Dental.

How to Appeal a Denial of Benefits

When You Have a Complaint or 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.

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 a Delta Dental representative. You may also express that concern in writing.

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

Appeals Procedure

Delta Dental will notify you and your Provider if Benefits are denied for services submitted on a Claim Form, in whole or in part, stating the reason(s) for denial.

The Plan has a two-step appeals procedure for coverage decisions.

Level One Appeal

You have at least 180 days after receiving a notice of denial to request an appeal or grievance by writing to Delta Dental giving reasons why you believe

the denial was wrong. You and your Provider may also ask Delta Dental to examine any additional information provided that may support the appeal or grievance.

Send your appeal or grievance to us at the address shown below:

Delta Dental
PO Box 1860
Alpharetta, GA 30023

Delta Dental will send you a written acknowledgment within five (5) days of receipt of the appeal or grievance. Delta Dental will make a full and fair review and may ask for more documents during this review if needed. The review will take into account all comments, documents, records, or other information, regardless of whether such information was submitted or considered initially. If the review is of a denial based in whole or in part on lack of dental necessity, experimental treatment, or clinical judgment in applying the terms of the Plan, Delta Dental shall consult with a dentist who has appropriate training and experience. The review will be conducted for Delta Dental by a person who is neither the individual who made the claim denial that is subject to the review nor the subordinate of such individual. Delta Dental will send the Member a decision within 30 days after receipt of the Member's appeal or grievance.

Level Two Appeal

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

Your written request should include:

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

Please submit this information to:

The Episcopal Church Medical Trust
Attn: Clinical Management
PO Box 2745
New York, NY 10163

You generally will receive a written response to a second-level appeal within 60 days after it is received by the Plan Sponsor. If the Plan Sponsor needs additional time (up to 90 days) to review the second-level appeal, you will be notified of the reason(s) for the delay and the anticipated response date, which may not exceed a total of 150 days from the date the Plan Sponsor receives the appeal.

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

Requirements Relating to Commencing Legal Action

No legal action of any kind related to a Benefit decision may be commenced by you, unless it is commenced within one (1) year of the Plan's final decision on the claim or other request for Benefits. If the Plan decides an appeal is untimely, the Plan's latest decision on the merits of the underlying claim or Benefit request is the final decision date. You must exhaust the Plan's mandatory internal appeals procedure, not including any voluntary level of appeal, before taking legal action of any kind against the Plan. As described in more detail in *Chapter 7: Other Important Plan Provisions*, legal action may be pursued only and exclusively by submitting the matter to arbitration.

Chapter 10: Privacy

Joint Notice of Privacy Practices

This chapter describes how medical information about you may be used and disclosed and how you can get access to this information. Please review it carefully.

Introduction

Church Pension Group Services Corporation, doing business as the Episcopal Church Medical Trust (Medical Trust), is the Plan Sponsor of certain group health plans (each a Plan and together the Plans) that are subject to the Health Insurance Portability and Accountability Act of 1996 and the regulations enacted thereunder (HIPAA).

HIPAA places certain restrictions on the use and disclosure of Protected Health Information (PHI) and requires the Medical Trust to provide this Joint Notice of Privacy Practices (the "Notice") to you. PHI is your individually identifiable health information that is created, received, transmitted, or maintained by the Plans or its business associates, regardless of the form of the information. It does not include employment records held by your employer in its role as an employer. This Notice describes how your PHI may be used and disclosed by the Plans and by employees of the Medical Trust that are responsible for internal administration of the Plans.

It also describes your rights regarding the use and disclosure of such PHI and how you can gain access to it.

What This Notice Applies To

This Notice applies only to health Benefits offered under the Plans. The health Benefits offered under the Plans include, but may not be limited to, medical Benefits, prescription drug Benefits, dental Benefits, the healthcare flexible spending account, and any healthcare or medical services offered under the Employee Assistance Program benefit. This Notice does not apply to Benefits offered under the Plans that are not health Benefits. Some of the Plans provide Benefits through the purchase of insurance. If you are enrolled in an insured Plan, you will also receive a separate notice from that Plan, which applies to your rights under that Plan.

Duties and Obligations of the Plan

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

- Maintain the privacy of your PHI
- Provide you with a notice of the Plans' legal duties and privacy practices with respect to your PHI
- Abide by the terms of the Notice currently in effect

When the Plan May Use and Disclose Your PHI

The following categories describe the ways the Plans are required to use and disclose your PHI without obtaining your written authorization:

- **Disclosures to You.** The Plans will disclose your PHI to you or your personal representative within the legally specified period following a request.
- **Government Audit.** The Plans will make your PHI available to the U.S. Department of Health and Human Services when it requests information relating to the privacy of PHI.
- **As Required by Law.** The Plans will disclose your PHI when required to do so by federal, state, or local law. For example, the Plans may disclose your PHI when required by national security laws or public health disclosure laws.

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

- **Treatment.** The Plans may disclose your PHI to your Providers for treatment, including the provision of care or the management of that care. For example, the Plans might disclose PHI to assist in diagnosing a medical condition or for pre-certification activities.
- **Payment.** The Plans may use and disclose your PHI to pay Benefits. For example, the Plans might use or disclose PHI when processing payments, sending Explanations of Benefits (EOBs) to you, reviewing the medical or dental necessity of services rendered, conducting claims appeals and coordinating the payment of Benefits between multiple medical Plans.
- **Health Care Operations.** The Plans may use and disclose your PHI for Plan operational purposes. For example, the Plans may use or disclose PHI for quality assessment and claim audits.
- **Public Health Risks.** The Plans may disclose your PHI for certain required public health activities (such as reporting disease outbreaks) or to prevent serious harm to you or other potential victims where abuse, neglect, or domestic violence is involved.
- **National Security and Intelligence Activities.** The Plans may disclose your PHI for specialized government functions (such as national security and intelligence activities).
- **Health Oversight Activities.** The Plans may disclose your PHI to health oversight agencies for activities authorized by law (such as audits, inspections, investigations, and licensure).
- **Lawsuits and Disputes.** The Plans may disclose your PHI in the course of any judicial or administrative proceeding in response to a court's or administrative tribunal's order, subpoena, discovery request, or other lawful process.
- **Law Enforcement.** The Plans may disclose your PHI for a law enforcement purpose to a law enforcement official, if certain legal conditions are met (such as providing limited information to locate a missing person).
- **Research.** The Plans may disclose your PHI for research studies that meet all privacy law requirements (such as research related to the prevention of disease or disability).
- **To Avert a Serious Threat to Health or Safety.** The Plans may disclose your PHI to avert a serious threat to the health or safety of you or any other person.

- **Workers' Compensation.** The Plans may disclose your PHI to the extent necessary to comply with laws and regulations related to workers' compensation or similar programs.
- **Coroners, Medical Examiners, and Funeral Directors.** The Plans may disclose your PHI to coroners, medical examiners, or funeral directors for purposes of identifying a decedent, determining a cause of death, or carrying out their respective duties with respect to a decedent.
- **Organ and Tissue Donation.** If you are an organ donor, the Plans may release your PHI to organizations that handle organ procurement or organ, eye, or tissue transplantation or to an organ donation bank, as necessary to facilitate organ or tissue donation and transplantation.
- **Military and Veterans.** If you are a member of the armed forces, the Plans may release your PHI as required by military command authorities.
- **Inmates.** If you are an inmate of a correctional institution or under the custody of a law enforcement official, the Plans may release your PHI to the correctional institution or law enforcement official. This release would be necessary (1) for the institution to provide you with healthcare; (2) to protect your health and safety or the health and safety of others; or (3) for the safety and security of the correctional institution.
- **Business Associates.** The Plans may contract with other businesses for certain Plan administrative services. The Plans may release your PHI to one or more of their business associates for Plan administration if the business associate agrees in writing to protect the privacy of your information.
- **Plan Sponsor.** The Episcopal Church Medical Trust, as sponsor of the Plans, will have access to your PHI for Plan administration purposes. Unless you authorize the Plans otherwise in writing (or your individual identifying data is deleted from the information), your PHI will be available only to the individuals who need this information to conduct these Plan administration activities, but this release of your PHI will be limited to the minimum disclosure required, unless otherwise permitted or required by law.

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

- Most uses and disclosures of psychotherapy notes
- Uses and disclosures of PHI for marketing purposes
- Uses and disclosures that constitute a sale of PHI

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

Authorizing Release of Your PHI

To authorize release of your PHI, you must complete a medical information authorization form. An authorization form is available at *cpg.org* or by calling 800-480-9967. You have the right to limit the type of information that you authorize the Plans to disclose and the persons to whom it should be disclosed. You may revoke your written authorization at any time. The revocation will be followed to the extent action on the authorization has not yet been taken.

Interaction with State Privacy Laws

If the state in which you reside provides more stringent privacy protections than HIPAA, the more stringent state law will still apply to protect your rights. If you have a question about your rights under any particular federal or state law,

please contact the Church Pension Group Privacy Officer. Contact information is included at the end of this Notice.

Fundraising

The Plans may contact you to support their fundraising activities. You have the right to opt out of receiving such communications.

Underwriting

The Plans are prohibited from using or disclosing PHI that is genetic information for underwriting purposes.

Your Rights with Respect to your PHI

You have the following rights regarding PHI the Plans maintain about you:

Right to Request Restrictions. You have the right to request that the Plans restrict their uses and disclosures of your PHI. You will be required to provide specific information as to the disclosures that you wish to restrict and the reasons for your request. The Plans are not required to agree to a requested restriction, but may in certain circumstances. To request a restriction, please write to the Church Pension Group Privacy Officer and provide specific information as to the disclosures that you wish to restrict and the reasons for your request.

Right to Request Confidential Communications. You have the right to request that the Plans' confidential communications of your PHI be sent to another location or by alternative means. For example, you may ask that all EOBs be sent to your office rather than your home address. The Plans are not required to accommodate your request unless your request is reasonable and you state that the ordinary communication process could endanger you. To request confidential communications, please submit a written request to the Church Pension Group Privacy Officer.

Right to Inspect and Copy. You have the right to inspect and obtain a copy of the PHI held by the Plans. However, access to psychotherapy notes, information compiled in reasonable anticipation of or for use in legal proceedings, and under certain other, relatively unusual circumstances, may be denied. Your request should be made in writing to the Church Pension Group Privacy Officer. A reasonable fee may be imposed for copying and mailing the requested information. You may contact the Medical Trust Plan Administration at *jservais@cpg.org* for a full explanation of the Medical Trust's fee structure.

Right to Amend. You have the right to request that the Plans amend your PHI or record if you believe the information is incorrect or incomplete. To request an amendment, you must submit a written request to the Medical Trust Plan Administration at *jservais@cpg.org*. Your request must list the specific PHI you want amended and explain why it is incorrect or incomplete and be signed by you or your authorized representative. All amendment requests will be considered carefully. However, your request may be denied if the PHI or record that is subject to the request:

- Is not part of the medical information kept by or for the Plans
- Was not created by or on behalf of the Plans or its third-party administrators, unless the person or entity that created the information is no longer available to make the amendment
- Is not part of the information that you are permitted to inspect and copy; or
- Is accurate and complete

Right to an Accounting of Disclosures. You have the right to receive information about when your PHI has been disclosed to others. Certain exceptions apply to this rule. For example, a Plan does not need to account for disclosures made to you or with your written authorization, or for disclosures

that occurred more than six years before your request. To request an accounting of disclosures, you must submit your request in writing to the Medical Trust Plan Administration at *jservais@cpg.org* and indicate in what form you want the accounting (e.g., paper or electronic). Your request must state a time period of no longer than six years and may not include dates before your coverage became effective. The Medical Trust Plan Administration will then notify you of any additional information required for the accounting request. A Plan will provide you with the date on which a disclosure was made, the name of the person or entity to whom PHI was disclosed, a description of the PHI that was disclosed, the reason for the disclosure and certain other information. If you request this accounting more than once in a 12-month period, you may be charged a reasonable, cost-based fee for responding to these additional requests. You may contact Medical Trust Plan Administration at *jservais@cpg.org* for a full explanation of the Medical Trust's fee structure.

Breach Notification. You have the right to receive a notification from the Plans if there is a breach of your unsecured PHI.

Right to a Paper Copy of This Notice. You are entitled to get a paper copy of this Notice at any time, even if you have agreed to receive it electronically. To obtain a paper copy of this Notice, please contact the Church Pension Group Privacy Officer.

If You Are a Person in the European Union, the Following Provisions Will Also Be Applicable to You: For the purposes of the General Data Protection Regulation 2016/679 (the "GDPR"), the Data Controller is Church Pension Group Services Corporation registered in the State of Delaware in the United States with a registered address at 19 East 34th Street, New York, NY 10016.

You can request further information from our Privacy Officer at *privacy@cpg.org*.

In addition to your rights with respect to your PHI addressed above, you may have additional or overlapping rights under the GDPR. GDPR rights regarding your PHI include the following:

- You may access and export a copy of PHI;
- You may request deletion of, and update to PHI;
- You have the right to be informed about any automated decision-making of PHI including the significance and consequences of such processing for you;
- You may also object to or restrict the Plans' use of PHI. For example, you can object at any time to the Plans' use of PHI for direct marketing purposes.
- Where you believe that the Plans have not complied with its obligations under this Privacy Policy or the applicable law, you have the right to make a complaint to an EU Data Protection Authority;
- If the Plans obtained your consent to use your PHI, you may withdraw that consent at any time.

Data Retention

We only retain PHI collected for a limited time period as long as we need it to fulfill the purposes for which have initially collected it, unless otherwise required by law.

Data Transfers

We maintain servers in the United States and Canada, and your information may be processed on servers located in the United States and Canada. Data protection laws vary among countries, with some providing more protection than others. Regardless of where your information is processed, we apply the same protections described in this policy.

If You Believe Your Privacy Rights Have Been Violated

If you believe your privacy rights have been violated by any Plan, you may file a complaint with the Church Pension Group Privacy Officer and with the Secretary of the U.S. Department of Health and Human Services.

All complaints must be filed in writing. You will not be retaliated against for filing a complaint. To contact the Church Pension Group Privacy Officer:

Privacy Officer

The Church Pension Group
19 East 34th Street
New York, NY 10016
212-592-8365
privacy@cpg.org

To contact the Secretary of the U.S. Department of Health and Human Services:

U.S. Department of Health and Human Services
Office for Civil Rights
200 Independence Avenue, SW
Washington, DC 20201
202-619-0257 | 800-368-1019 (toll-free)
https://www.hhs.gov/about/contact-us/index.html

Effective Date

This Notice is effective as of August 29, 2018.

Changes

Each Plan sponsored by the Medical Trust reserves the right to change the terms of this Notice and information practices and to make the new provisions effective for all PHI it maintains, including any PHI it currently maintains as well as PHI it receives or holds in the future, as permitted by applicable law. Any material amendment to the terms of this Notice, and these information practices will be provided to you via mail or electronically with your prior written consent.

More Information

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

The Episcopal Church Medical Trust

cpg.org
800-480-9967
Email: *mtcustserv@cpg.org*
Monday to Friday, 8:30 AM to 8:00 PM ET

Delta Dental

deltadentalins.com
888-894-7059

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