



# HealthFlex Benefits Booklet

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## CIGNA Dental Benefits

- Traditional Dental
- Preferred Provider Organization Plan

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## Welcome

The General Board of Pension and Health Benefits of The United Methodist Church, Incorporated in Illinois (General Board) has prepared this Benefit Booklet to help you understand your dental benefits which are administered by Connecticut General Life Insurance Company (CIGNA, CG or the Claims Administrator). Please read it carefully.

## About the Plan

The General Conference of The United Methodist Church established a welfare benefit program for clergy and lay employees effective January 1, 1961. The Hospitalization and Medical Expense Program, also known as HealthFlex (Program), is maintained for the benefit of clergy and lay employees (and their Dependents) of The United Methodist Church. The dental plan component of the Program provides dental benefits for Participants.

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

## Serving The United Methodist Church

The General Conference established the General Board to supervise and administer the employee benefit plans of The United Methodist Church. The General Board, in accordance with the provisions of *The Book of Discipline*, performs its duties for the supervision and administration of the Program, and fulfills its responsibilities in the spirit of the Church’s mandate for inclusiveness and racial and social justice.

## Explanation of Terms

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

## Plan Sponsor

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

## Confidentiality and HIPAA

The privacy of the health records of Program Participants and their Dependents is protected by specific security and privacy regulations under the Health Insurance Portability and Accountability Act of 1996 (HIPAA). Under HIPAA, General Board employees and Program

representatives and agents (such as CIGNA and others) may not release Protected Health Information, known as PHI, to a Participant's Plan Sponsor, Spouse, or any other entity (unless required by law) unless the Participant authorizes such release. HIPAA also applies when you want PHI to be shared among health plans and Providers for reasons other than payment or treatment. The General Board's Notice of Privacy Practices describes the Program's privacy practices and your rights to access your records. The notice is available on the Web site, [www.gbophb.org](http://www.gbophb.org).

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

## Your Responsibility to Provide Accurate Information

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

## Questions

If you have questions about this Program or any of the benefit plans administered by the General Board, please do not hesitate to contact us. The General Board welcomes you to your dental coverage under HealthFlex and looks forward to serving you.

For more information, please visit our Web site at [www.gbophb.org](http://www.gbophb.org). Or you may call the General Board Health team at 1-800-851-2201.

## Plan Document Controls

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

## The Schedule

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

## Important Information About Your Dental Plan

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

- ◆ CIGNA Dental HMO (Rocky Mountain Conference only)
- ◆ CIGNA Dental Preferred Provider, and
- ◆ CIGNA Traditional Dental.

Details of the benefits under the latter two of the Benefit Options are described in separate sections and Schedules of this Benefit Booklet. CIGNA Dental HMO benefits are described in the benefit summary available on the HealthFlex Web site and through information available from CIGNA.

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

- ◆ You and your Dependents may enroll for only one of the Benefit Options.
- ◆ Your Dependents will be covered only if you are covered and only under the same Benefit Option under which you are covered.

### **CHANGE IN BENEFIT OPTION ELECTED**

You may elect to change Benefit Options for yourself and your Dependents during any Open Enrollment Period or Annual Election Period or, in certain circumstances, if you experience a Change of Status event described below in the section about the Cafeteria Plan Regulations.

### **EFFECTIVE DATE OF CHANGE IN BENEFIT OPTION**

If you are changing Benefit Options during an Open Enrollment Period or Annual Election Period, you and your Dependents will become covered under the Benefit Option elected on the first day of the Plan Year that follows such Open Enrollment Period or Annual Election Period. If you are allowed to make an election change due to a Change of Status event the effective date of such change will be the first day of the month that follows the month in which you make the election.

### **NOTICE REGARDING PROVIDER DIRECTORIES AND PROVIDER NETWORKS**

If your Benefit Option under the Program utilizes a network of Providers, you can find a separate listing of Participating Providers on the CIGNA Web site at <http://www.cigna.com> or through links to the CIGNA Web site on the HealthFlex Web site or by contacting CIGNA or the General Board. Your Participating Provider network consists of a group of local dental practitioners, of varied specialties as well as general practice, who are employed by or contracted with CIGNA HealthCare or CIGNA Dental Health.

## Notice of Federal Requirements Uniformed Services Employment and Reemployment Rights Act of 1994 (USERRA)

The Uniformed Services Employment and Reemployment Rights Act of 1994 (USERRA) sets requirements for continuation of group health plan coverage and reemployment in regard to military leaves of absence. These requirements apply to medical and dental coverage for you and

your Dependents. They do not apply to any life, short-term or long-term disability or accidental death & dismemberment coverage.

**CONTINUATION OF COVERAGE DURING USERRA LEAVE**

For leaves of fewer than 31 days, coverage will continue as described in the Termination section regarding Leaves of Absence.

For leaves of 31 days or more, you may continue coverage for yourself and your Dependents as follows:

Because your Plan Sponsor is not subject to COBRA, you may continue benefits, by paying the Required Contribution to your Plan Sponsor, until the earliest of the following:

- ◆ 24 months from the last day of employment with the Plan Sponsor;
- ◆ the day after you fail to apply or return to work; and
- ◆ the date the Program, or the dental benefit portion thereof, is terminated.

The Program or your Plan Sponsor may charge you and your Dependents up to 102% of the total Required Contribution (in the case of USERRA-type continuation coverage the Required Contribution for coverage can include both the Participant portion of any premium or contribution and the Plan Sponsor portion). Your coverage will end as of the first day of any month in which you fail to remit any Required Contributions for coverage.

**REINSTATEMENT OF BENEFITS (APPLICABLE TO ALL BENEFIT OPTIONS)**

If your coverage ends during the leave because you do not elect USERRA continuation coverage and you are reemployed by your current Plan Sponsor, coverage for you and your Dependents may be reinstated if: 1) you gave your Plan Sponsor advance written or verbal notice of your military service leave; and 2) the duration of all military leaves while you are employed with your current Plan Sponsor does not exceed five years.

You and your Dependents will be subject to only the balance of a pre-existing condition exclusion (PCE) or waiting period that was not yet satisfied before the leave began. However, if an injury or sickness occurs or is aggravated during the military leave, full Program limitations will apply.

Any 63-day break in coverage rule regarding credit for time accrued toward a PCE waiting period will be waived.

**TIME FRAMES FOR REQUESTING REEMPLOYMENT**

When a leave ends, you must report your intent to return to work as follows:

- ◆ for leaves of fewer than 31 days or for a fitness exam, by reporting to your Plan Sponsor by the next regularly scheduled work day following eight hours of travel time;
- ◆ for leaves of 31 days to 180 days, by submitting an application to your Plan Sponsor within 14 days; and
- ◆ for leaves of more than 180 days, by submitting an application to your Plan Sponsor within 90 days.

Consult your Plan Sponsor for more details regarding your rights and your Plan Sponsor's obligations for reemployment under USERRA.

## Notice of Federal Requirements

If your income does not exceed 100% of the official poverty line and your liquid assets are at or below twice the Social Security income level, the state may decide to pay contributions for this coverage instead of for Medicaid, if it is cost-effective.

## Important Information

This is not an insured employee benefit plan. The benefits described in this Benefit Booklet or any rider, amendment or addendum attached hereto are provided through Benefit Options offered under the Hospitalization and Medical Expense Program, also called HealthFlex (the "Program"), a self-insured, or self-funded, employee welfare benefit church plan maintained and administered by the General Board of Pension and Health Benefits of The United Methodist Church, Incorporated in Illinois (General Board), which is responsible for the payment of benefits hereunder. The dental benefits described in this Benefit Booklet are provided through a self-funded employee welfare benefit plan (as defined in §3(1) of ERISA) that is a Church Plan (as defined in §3(33) of ERISA and §414(e) of the Code). As a Church Plan, The Program is exempt by §4(b)(2) of ERISA from the requirements of Title I of ERISA and the regulations issued by the U.S. Department of Labor. The Program is administered by the General Board. Connecticut General provides claim administration services to the Program, but Connecticut General does not insure the benefits described. In the case that this document uses words that might describe an insured plan, because the Program is not insured by Connecticut General but rather is a self-funded Church Plan, all references to insurance shall be read to indicate that the Program is self-insured. For example, references to "CG" and "Insurance Company," shall be deemed to mean "Claims Administrator" and "Policyholder" shall be deemed to mean the "General Board" and "Policy" to mean "Program" and "Insured" to mean "Covered" and "Premium" to mean "Required Contribution" and "Insurance" shall be deemed to mean "Coverage."

## Effect of Cafeteria Plan Regulations on this Plan

The Plan Administrator administers this Program as a cafeteria plan in accordance with Section 125 of the Internal Revenue Code and Section 125 of the Treasury Regulations. Pursuant to these Cafeteria Plan Regulations, you may agree to a pre-tax salary reduction put toward the cost of your coverage. Otherwise you will receive your full taxable earnings as salary.

**Provisions in this Benefit Booklet that appear to allow for enrollment or coverage changes not consistent with the Cafeteria Plan Regulations are superseded by this section.**

### COVERAGE ELECTIONS

According to the Cafeteria Plan Regulations, you are generally allowed to enroll for or change coverage, each Plan Year, during the Open Enrollment and Annual Election Period, typically in each November that precedes the applicable Plan Year. However, exceptions are allowed if you request a change in coverage within 30 days of the following:

- ◆ the date you meet Special Enrollment criteria under federal requirements as described in §9801(f) of the Code (see *HIPAA Special Enrollment* events below under *Change in Status Events*); or
- ◆ the date you meet the criteria shown in the following section entitled *Change of Status Events*.

#### CHANGE IN STATUS EVENTS

Change in Status Events include:

- ◆ Marital status changes (e.g., marriage, divorce, legal separation).
- ◆ Changes in the number of Dependents (e.g., an increase through birth or adoption or a decrease through death).
- ◆ A Dependent ceases to qualify as a Dependent under the Program, i.e., becomes ineligible, or regains eligibility (e.g., reaches a limiting age, ceases to be a full-time student).
- ◆ Change in employment<sup>1</sup> status of a Participant or Dependent that affects eligibility for the underlying benefit plan (e.g., changing from full-time to part-time employment, commencement or return from an unpaid leave of absence).
- ◆ HIPAA Special Enrollment events (see below).
- ◆ Change in residence<sup>2</sup> that affects eligibility (e.g., moving out of the coverage area for a managed care option).

For example, if you previously resided in an area in which only the PPO Benefit Option was available and you moved into an area where both the PPO Benefit Option and a Program-affiliated dental HMO Benefit Option were available to you, and as a result you were to gain access to that dental HMO Benefit Option, you could change your election for dental Benefit Option coverage under the Program. Note, though, that in this circumstance you will *not* have incurred a Change of Status for flexible spending account purposes. So, in such circumstance, you could change your election from the PPO Benefit Option to an available Program-related dental HMO Benefit Option, but you could not change your health care flexible spending account election. Similarly, if you move out of that dental HMO Benefit Option service area, and are therefore no longer eligible for that dental HMO Benefit Option, you will have incurred a Change of Status for purposes of your dental Benefit Option.

Any changes in elections based upon a Change of Status Event must be **on account of** and **consistent with** such Change in Status Event. For example, when a Participant acquires a new Dependent, the election change for that Change of Status event would be to add coverage for that Dependent, not to drop coverage for other Dependents.

In certain other limited circumstances a Participant may make changes to his or her elections; these additional Change in Status Events are:

- ◆ Judgment, decree or order (i.e., a qualified medical child support order).
- ◆ Medicare entitlement (or loss of such entitlement).
- ◆ Mid-year Program changes (e.g., significant changes in the cost of coverage or significant curtailment of coverage during a Program Year).

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<sup>1</sup> Appointment changes within a Conference, other than appointment to non-salaried statuses and compensation changes alone are not considered Change of Status events.

<sup>2</sup> Changes in residence that affect eligibility for certain coverage options do not qualify as Change of Status events for flexible spending accounts.

- ◆ Certain required circumstances under the Family and Medical Leave Act where applicable to your employer.

#### **HIPAA SPECIAL ENROLLMENT**

If an eligible person declines coverage under the Program, he or she cannot make an election of HealthFlex coverage until the next Open Enrollment Period and coverage would not begin until the subsequent Plan Year. In addition, the eligible person must indicate on the *HealthFlex Enrollment/Change Form* whether he or she has Other Health Coverage. Other Health Coverage information is important because under federal law, if an eligible person has given this written notice and subsequently loses that Other Health Coverage, he or she may, in certain situations, be able to enroll for coverage under the Program at the time he or she loses Other Health Coverage.

The situations in which an Eligible Person may be able to enroll for HealthFlex coverage upon the loss of Other Health Coverage or in which Participants may make changes to certain elections are called Special Enrollment events and are as follows:

- ◆ An Eligible Person declines coverage under HealthFlex because he or she (or his or her Spouse or Dependent) has Other Health Coverage or COBRA or other continuation coverage, then he or she (or his or her Spouse or Dependent) lose the Other Health Coverage because he or she is no longer eligible (e.g., through an employment status change, divorce, change of residence (only if it causes a loss of access to a managed care option and no other option is available under the Other Health Coverage), loss of student status, limiting age, etc.) or because the employer failed to pay the required premium or he or she exhausts the COBRA or other continuation coverage.
- ◆ An Eligible Person declines coverage under HealthFlex for his or her Spouse or Dependent because the Spouse or Dependent has Other Health Coverage or has COBRA or other continuation coverage, then such Spouse or Dependent loses the Other Health Coverage because he or she is no longer eligible (e.g., through an employment status change, divorce, death of a spouse etc.) or because the employer failed to pay the required premium or the Spouse or Dependent exhausts the COBRA or other continuation coverage period.
- ◆ An Eligible Person gains a new Dependent due to marriage, birth, adoption, or placement for adoption or legal guardianship.
- ◆ An Eligible Person declines coverage under HealthFlex for himself or herself (or for his or her Spouse or Dependent) because he or she (or his or her Spouse or Dependent) has Other Health Coverage, then the Eligible Person (or his or her Spouse or Dependent) reaches a lifetime limit for all benefits under the Other Health Coverage, or an Eligible Person declines HealthFlex coverage for his or her Spouse or Dependent because the Spouse or Dependent has Other Health Coverage, then he or she reaches a lifetime limit for all benefits under the Other Health Coverage.
- ◆ The Program (or the plan of an Eligible Person's Spouse or Dependent) no longer offers a Benefit Option to an entire class of similarly situated individuals that includes the Eligible Person.

In order to enroll in the Program as a result of a Special Enrollment event, you, or the Spouse or Dependent involved, must be otherwise eligible for coverage under the Program.

## HealthFlex Benefits Booklet

### CIGNA Dental Benefits

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If a Participant or Eligible Person does not experience a Change of Status Event, he or she is not permitted to change his or her elections at any time during the Plan Year.

### How to File Your Claim

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

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

CIGNA HealthCare Service Center  
P.O. Box 188036  
Chattanooga, TN 37422-8036

### **DENTAL EXPENSES**

The first dental Claim should be filed as soon as you have incurred Covered Expenses. Itemized copies of your bills should be sent with the Claim Form. If you have any additional bills after the first treatment, file them periodically.

You should follow the *Predetermination of Benefits* procedure when necessary. The term *Predetermination of Benefits* means a review by CG of a Dentist's description of planned treatment and expected charges, including those for diagnostic x-rays. This review should be made whenever extensive dental work is proposed. A predetermination can be submitted by: 1) checking the appropriate box on the CG dental Claim Form in section one of the Form, and 2) submitting that Claim Form and any supporting documentation that substantiates the treatment plan. The information should be sent to CG before the dental work is started. If there is a major change in the treatment plan, a revised plan should be sent to CG.

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

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

### **CLAIM REMINDERS**

- ◆ Be sure to use your member ID number and account number when you submit CG's Claim Forms, or when you call the CG Claim office.
- ◆ Your account number for dental benefits is 2464058 and your ID number is the same number that is on your ID Card for medical benefits through the Program.
- ◆ Prompt filing of any required Claim Forms speeds payment of your Claims.

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

#### **NOTICE OF CLAIM**

Written notice of Claim must be given to CG within 30 days after the occurrence or start of the loss on which Claim is based. If notice is not given in that time, the Claim will not be invalidated or reduced if it is shown that written notice was given as soon as was reasonably possible.

#### **CLAIM FORMS**

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

#### **PROOF OF LOSS**

Written proof of loss must be given to CG within 90 days after the date of the loss for which Claim is made. If written proof of loss is not given in that time, the Claim will not be invalidated or reduced if it is shown that written proof of loss was given as soon as was reasonably possible.

#### **PHYSICAL EXAMINATION**

The Plan Administrator, at its own expense, will have the right to examine any person for whom a Claim is pending as it may reasonably require.

## **Eligibility**

#### **IN GENERAL**

You may not participate in this Program as an Employee and as a Dependent, and your Dependents may not participate in this Program as a Dependent of more than one Employee.

In addition, eligibility for Medicaid or the receipt of Medicaid benefits will not be taken into account in determining eligibility.

#### **ELIGIBILITY FOR PARTICIPANT COVERAGE**

You will become eligible for coverage on the day you complete the applicable waiting period if:

- ◆ You are in a Class of Eligible Participants (you have satisfied the eligibility requirements of both the Program and the adoption agreement of your Plan Sponsor), and
- ◆ A *HealthFlex Enrollment/Change Form* is submitted and signed within 30 days of the eligible event, or
- ◆ You are an eligible retired Participant or Dependent of a retiree.

If you were previously insured or covered under a group health plan and your insurance or coverage ceased, you must satisfy the applicable waiting period to become covered again. Contact your Plan Sponsor for waiting period information.

**Initial Participant Group:** You are in the Initial Participant Group if you and your Dependents are covered, or you and your Dependents are new enrollees on the effective date of this Benefit Booklet. You are also considered part of the Initial Participant Group on the effective date your Plan Sponsor joins the Program if you are covered with the Plan Sponsor at that time the Plan Sponsor joins the Program.

**New Participant Group:** You are in the New Participant Group if you are not in the Initial Participant Group.

You are not eligible to participate in this Program if you are:

- ◆ A part-time lay Employee regularly scheduled to work less than 30 hours per week;
- ◆ A clergy Employee appointed ¼ time or less;
- ◆ A temporary Employee;
- ◆ A seasonal Employee;
- ◆ A clergy Employee whose Conference relationship has been severed by such means as honorable location, withdrawal to unite with another denomination, surrender of ministerial credentials or surrender of the local pastor license prior to becoming eligible to receive a pension;
- ◆ An Employee who voluntarily terminates prior to becoming eligible to receive a pension; or
- ◆ Residing outside of the United States for more than six continuous months at a time.

#### **ELIGIBILITY FOR DEPENDENT COVERAGE**

Your Dependent will become eligible for coverage on the later of:

- ◆ The day you become an eligible covered Participant, or
- ◆ The day you acquire the eligible Dependent.

#### **WAITING PERIOD**

- ◆ **Initial Participant Group:** None
- ◆ **New Participant Group:** Contact your Plan Sponsor for details regarding your Waiting Period.

#### **CLASSES OF ELIGIBLE PARTICIPANTS**

Each Participant as defined by your Plan Sponsor.

#### **EFFECTIVE DATE OF YOUR COVERAGE**

You will become covered on the date you elect the coverage by completing an approved *HealthFlex Enrollment/Change Form* with your Plan Sponsor, if applicable, so long as the Plan Administrator receives such *HealthFlex Enrollment/Change Form* from your Plan Sponsor within 30 days of the date you became eligible, but you will in no event become covered earlier than the date you become eligible. If you are a Late Entrant (see below), your coverage will not become effective until the Plan Administrator agrees to cover you under the Program.

You will become covered on your first day of eligibility, following your election, if you are in Active Service on the date, or if you are not in Active Service on that date due to your health status.

*It is the responsibility of the Plan Sponsor to provide all completed enrollment materials to the General Board within 30 days of an Employee's eligibility date. Failure by Plan Sponsors to perform this duty under the Program may subject Employees to adverse consequences under the terms of the Program.*

#### **EFFECTIVE DATE OF DEPENDENT COVERAGE**

Coverage for your Dependents will become effective on the date you elect it by completing an approved *HealthFlex Enrollment/Change Form* with your Plan Sponsor, if applicable, so long as the Plan Administrator receives such *HealthFlex Enrollment/Change Form* from your Plan Sponsor within 30 days of the date you became eligible, but no earlier than the day you become eligible for Dependent coverage. All of your Dependents as defined herein will be included. Your Dependent will not be denied enrollment for coverage due to health status.

Your Dependents will be covered only if you are covered under the Program.

#### **EMPLOYEE COVERAGE**

The benefits under this Program are offered to you as an Employee. To be covered, you may have to pay part of the cost. The portion of the cost of coverage that you might be required to pay is your Required Contribution. If you do not pay Required Contributions on a timely basis as required by the Program and your Plan Sponsor, the General Board can terminate your coverage.

#### **LATE ENTRANT – EMPLOYEE**

You are a Late Entrant if you elect the coverage more than 30 days after you become eligible.

#### **DEPENDENT COVERAGE**

For your Dependents to be covered, you might have to pay part of the cost of Dependent coverage. The portion of the cost of coverage that you must pay for coverage of your Dependents is also considered a Required Contribution. If you do not pay Required Contributions on a timely basis as required by the Program and your Plan Sponsor, the General Board can terminate your coverage.

#### **LATE ENTRANT – DEPENDENT**

You are a Late Entrant for Dependent Coverage if you elect that coverage more than 30 days after you become eligible for it.

### **Requirements of the Omnibus Budget Reconciliation Act of 1993 (OBRA '93)**

**The group health plan coverage requirements in this section do not apply to any benefits for loss of life, dismemberment or loss of income.**

Any other provisions in this Benefit Booklet that provide for: 1) the definition of an adopted child and the effective date of eligibility for coverage of that child, and 2) eligibility requirements for a child for whom a court order for medical support is issued; are superseded by these provisions required by the federal Omnibus Budget Reconciliation Act of 1993, where applicable.

**A. ELIGIBILITY FOR COVERAGE UNDER A QUALIFIED MEDICAL CHILD SUPPORT ORDER**

If a Qualified Medical Child Support Order is issued for your child, that child will be eligible for coverage as required by the order and you will not be considered a Late Entrant for Dependent coverage.

You must notify your Plan Sponsor and elect coverage for that child, and yourself if you are not already enrolled, within 31 days of the Qualified Medical Child Support Order being issued.

**Qualified Medical Child Support Order**

A Qualified Medical Child Support Order is a judgment, decree or order (including approval of a settlement agreement) or administrative notice, which is issued pursuant to a state domestic relations law (including a community property law), or to an administrative process, which provides for child support or provides for group health plan benefit coverage to such child and relates to benefits under the Program, and satisfies all of the following:

- ◆ the order recognizes or creates a child's right to receive group health benefits for which a Participant or beneficiary is eligible;
- ◆ the order specifies your name and last known address, and the child's name and last known address, except that the name and address of an official of a State or political subdivision may be substituted for the child's mailing address;
- ◆ the order provides a description of the coverage to be provided or the manner in which the type of coverage is to be determined;
- ◆ the order states the period to which it applies; and
- ◆ if the order is a National Medical Support Notice completed in accordance with the Child Support Performance and Incentive Act of 1998, such Notice meets the requirements above.

The Qualified Medical Child Support Order may not require the Program to provide coverage for any type or form of benefit or option not otherwise provided under the Program.

**Payment of Benefits**

Any payment of benefits in reimbursement for Covered Expenses paid by the child, the child's custodial parent or legal guardian, shall be made to the child, the child's custodial parent or legal guardian, or a State official whose name and address have been substituted for the name and address of the child.

**B. COVERAGE ELIGIBILITY FOR ADOPTED CHILDREN**

Any child under the age of 18 who is adopted by you, including a child who is placed with you for adoption, will be eligible for Dependent Coverage upon the date of placement with you. A child will be considered placed for adoption when you become legally obligated to support that child, totally or partially, prior to that child's adoption.

If a child placed for adoption is not adopted, all coverage under the Program ceases when the placement ends, and will not be continued.

## Dental Benefits - CIGNA Traditional Dental

### THE SCHEDULE

For You and Your Dependents

### How the Traditional Dental Benefit Option Works

Class I Preventive Care	Class II Basic Restorative	Class III Major Restorative	Class IV* Orthodontia
<ul style="list-style-type: none"> <li>• Program pays 100%</li> <li>• There is no Deductible</li> </ul>	<ul style="list-style-type: none"> <li>• You or your Dependent pays \$50 Deductible</li> <li>• Program pays 80%</li> </ul>	<ul style="list-style-type: none"> <li>• You or your Dependent pays \$50 Deductible</li> <li>• Program pays 50%</li> </ul>	<ul style="list-style-type: none"> <li>• Program pays 50%</li> <li>• There is no Deductible</li> </ul> <p>Subject to 12-months waiting period, see below.</p>

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

**Important Note:** The Program requires that a Participant and Dependent be covered for 12 consecutive months before Class IV Orthodontia benefits will be considered Covered Expenses.

### Maximum Benefit

Class I, II, III	Class IV	Individual Deductible	Family Deductible
Combined Calendar Maximum: \$2,000	Lifetime Maximum: \$2,000	\$50  A person must satisfy this Deductible amount for each Plan Year (calendar year) before Dental Benefits are payable.	\$150  After dental Deductibles totaling \$150 have been applied in a Plan Year (calendar year) for either: <ul style="list-style-type: none"> <li>• you and your Dependents, or</li> <li>• your Dependents, then your family need not satisfy any further dental Deductibles for the rest of that Plan Year.</li> </ul>

## Dental Benefits - CIGNA Dental Preferred Provider

### THE SCHEDULE

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

### For You and Your Dependents

**Emergency Services** – The benefit percentage that the Program will pay for charges for emergency Dental Services provided by a Non-Participating Provider is the same benefit percentage as for charges for services from a Participating Provider. Emergency Dental Services are required immediately to either alleviate pain or to treat the sudden onset of an acute dental condition. These are usually minor procedures performed in response to serious symptoms, which temporarily relieve significant pain, but do not effect a definitive cure, and which, if not rendered, will likely result in a more serious dental or medical complication. These services are considered to be emergency care as long as transfer of the covered person to a Participating Provider is precluded because of risk to the Participant’s health or because transfer would be unreasonable, given the distance involved in the transfer or the nature of the dental condition.

### How the PPO Dental Benefit Option Works

#### Participating Provider

Class I Preventive Care	Class II Basic Restorative	Class III Major Restorative	Class IV* Orthodontia
<ul style="list-style-type: none"> <li>• Program pays 100%</li> <li>• There is no Deductible</li> </ul>	<ul style="list-style-type: none"> <li>• You or your Dependent pays \$50 Deductible</li> <li>• Program pays 90%</li> </ul>	<ul style="list-style-type: none"> <li>• You or your Dependent pays \$50 Deductible</li> <li>• Program pays 60%</li> </ul>	<ul style="list-style-type: none"> <li>• Program pays 50%</li> <li>• There is no Deductible</li> </ul> Subject to 12-months waiting period, see below.

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

**Important Note:** The Program requires that a Participant and Dependent be covered for 12 consecutive months before Class IV Orthodontia benefits will be considered Covered Expenses.

**Non-Participating Provider**

Class I Preventive Care	Class II Basic Restorative	Class III Major Restorative	Class IV* Orthodontia
Program pays 100%	Program pays 70%	Program pays 50%	<ul style="list-style-type: none"> <li>• Program pays 50%</li> <li>• Your Dependent Child age 18 and under will pay a \$50 Lifetime Deductible</li> </ul> Subject to 12-months waiting period, see below.

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

**Important Note:** The Plan requires that a Participant and Dependent be covered for 12 consecutive months before Class IV Orthodontia benefits will be considered Covered Expense

**Maximum Benefit**

Participating Provider Class I, II, III	Non-Participating Provider Classes I, II, III	Participating Provider Class IV	Non-Participating Provider Class IV
Calendar Year Maximum: \$2,000	Calendar Year Maximum: \$1,000	Lifetime Maximum: \$2,000	Lifetime Maximum: \$1,000

**Deductibles**

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

Individual Deductible	Family Deductible	Orthodontic Lifetime Deductible
\$50  A Participant must satisfy this Deductible amount for each Plan Year before Dental Benefits are payable.	\$150  After dental Deductibles totaling \$150 have been applied in a Plan Year for either: <ul style="list-style-type: none"> <li>• you and your Dependents, or</li> <li>• your Dependents, your family need not satisfy any further Dental deductibles for the rest of the Plan Year.</li> </ul>	\$50

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

## Dental Coverage

### **FOR YOU AND YOUR DEPENDENTS**

If you or any one of your Dependents incurs Covered Expenses, CG will:

- ◆ deduct any dental Deductible that applies from the Covered Expenses first incurred in a Plan Year (calendar year) for a person; and
- ◆ pay for the other Covered Expenses incurred in that Plan Year (calendar year) up to the Maximum Covered Expense determined according to The Schedule and the section entitled Dental Services below for each Dental Service, subject to the Alternate Benefit Provision.

The dental Deductible is shown in The Schedule.

### **MISSING TEETH LIMIT**

The amount payable is 50% of the amount otherwise payable for first replacement of teeth that are missing when a person becomes covered for these benefits.

After a person has been continuously covered under the Program for these benefits for 24 months, this limit will no longer apply.

The Missing Teeth Limit will not apply to any person who is a member of the Initial Employee Group.

### **ORTHODONTIA PROVISION**

The Program requires you to be covered for 12 consecutive months before CG or the Program will consider Class IV Orthodontia benefits to be Covered Expenses.

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

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

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

**ORTHODONTIA MAXIMUM BENEFIT PROVISION**

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

**MAXIMUM BENEFIT PROVISION**

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

**Covered Expenses**

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

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

- ◆ is performed by or under the direction of a Dentist,
- ◆ is essential for the necessary care of the teeth, and
- ◆ starts and is completed while the person is covered under the Program.

Any portion of charges for a Dental Service that exceeds the Maximum Covered Expense shown for that service in the Dental Services Schedule will not be a Covered Expense.

A Dental Service is deemed to start when the actual performance of the service starts except that:

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

**ALTERNATE BENEFIT PROVISION**

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

**PREDETERMINATION OF BENEFITS**

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

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

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

## Dental Services

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

**CIGNA Traditional Dental** – CG will determine the Maximum Covered Expense for Dental Services that it accepts. The Maximum Covered Expense so determined will be consistent with the maximums listed.

**CIGNA Dental Preferred Provider** – If you or any one of your Dependents, while covered under the Program, incurs Covered Dental Expenses, CG will pay any amount determined as follows:

- ◆ The Maximum Covered Expense for any covered service received from a Participating Provider is the Contracted Fee Amount subject to the benefit percentage for Participating Providers shown on The Schedule for each class of service. The Maximum Covered Expense for any covered service received from a Non-Participating Provider is the Reasonable and Customary charge subject to the benefit percentage for Non-Participating Providers shown in The Schedule for each class of service. The Participant or Co-covered Person must pay the balance up to the Non-Participating Provider's actual charge.

Payment of any benefits will be subject to any applicable deductibles and maximum benefits shown in The Schedule.

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

### **CLASS I SERVICES – DIAGNOSTIC AND PREVENTIVE**

- ◆ Clinical Oral Examination: Only two per person per Plan Year (calendar year).
- ◆ Palliative (emergency) treatment of dental pain, minor procedures, when no other definitive Dental Services are performed. (Any x-ray taken in connection with such treatment is a separate Dental Service.)
- ◆ X-rays – Complete Series: Only one per Covered Person, including Panoramic film, in any three Plan Years (calendar years).
- ◆ Bitewing X-rays: Only two charges per Covered Person per Plan Year (calendar year).

- ◆ Panoramic (Panorex) X-ray: Only one per Covered Person in any 3 Plan Years (calendar years).
- ◆ Prophylaxis (Cleaning): Only two per Covered Person per Plan Year (calendar year).
- ◆ Periodontal maintenance procedures (following active therapy), Periodontal Prophylaxis.
- ◆ Topical application of fluoride (excluding prophylaxis): Limited to Covered Persons less than 19 years old. Only one per Covered Person per Plan Year (calendar year).
- ◆ Topical application of sealant, per tooth, on a posterior tooth for a Covered person less than 14 years old: Only one treatment per tooth in any 3 Plan Year (calendar years).
- ◆ Space Maintainers, Fixed Unilateral: Limited to nonorthodontic treatment.

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

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

If more than one periodontal surgical service is performed per quadrant only the one with the largest Maximum Covered Expense is a Dental Service.

- ◆ Periodontal Scaling and Root Planing: Entire Mouth
- ◆ Adjustments: Complete Denture

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

- ◆ Recement Bridge
- ◆ Routine Extractions

Surgical Removal of Erupted Tooth Requiring Elevation of Mucoperiosteal Flap and Removal of Bone and/or Section of Tooth

- ◆ Removal of Impacted Tooth, Soft Tissue
- ◆ Removal of Impacted Tooth, Partially Bony
- ◆ Removal of Impacted Tooth, Completely Bony

Local anesthetic, analgesic and routine postoperative care for extractions and other oral surgery are part of the allowance for each Dental Service.

- ◆ General Anesthesia: Paid as a separate benefit only when medically or dentally necessary, as determined by CG, and when administered in conjunction with complex oral surgical procedures which are covered under this Program.
- ◆ I.V. Sedation: Paid as a separate benefit only when medically or dentally necessary, as determined by CG, and when administered in conjunction with complex oral surgical procedures which are covered under this Program.

**CLASS III SERVICES – MAJOR RESTORATIONS, DENTURES AND BRIDGEWORK**

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

**Crowns**

- ◆ Porcelain fused to high noble metal
- ◆ Full cast, high noble metal
- ◆ Three-fourths cast, metallic

**Fixed or Removable Appliances**

- ◆ Complete (full) dentures, upper or lower

**Partial Dentures**

- ◆ Lower, cast metal base with resin saddles (including any conventional clasps, rests and teeth)
- ◆ Upper, cast metal base with resin saddles (including any conventional clasps rests and teeth)

**Bridge Pontics:** Cast high noble metal

**Bridge Pontics:** Porcelain fused to high noble metal

**Bridge Pontics:** Resin with high noble metal

**Retainer Crowns:** Resin with high noble metal

**Retainer Crowns:** Porcelain fused to high noble metal

**Retainer Crowns:** Full cast high noble metal

**CLASS IV SERVICES – ORTHODONTICS**

Each month of active treatment is a separate Dental Service.

Orthodontic work-up including x-rays, diagnostic casts and treatment plan and first month of active treatment including all active treatment and retention appliance

Active treatment per month after the first month.

Fixed or removable appliances—only one appliance per Covered Person

- ◆ For tooth guidance
- ◆ To control harmful habits

**Expenses Not Covered**

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

- ◆ Services performed solely for cosmetic reasons.
- ◆ Replacement of a lost or stolen appliance.
- ◆ Replacement of a bridge, crown or denture within five years after the date it was originally installed unless: 1) such replacement is made necessary by the placement of an original opposing full denture or the necessary extraction of natural teeth; or 2) the bridge, crown or denture, while in the mouth, has been damaged beyond repair as a result of an injury received while a Covered Person is covered for these benefits.

## HealthFlex Benefits Booklet

### CIGNA Dental Benefits

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- ◆ Any replacement of a bridge, crown or denture which is or can be made useable according to common dental standards.
- ◆ Procedures, appliances or restorations (except full dentures) whose main purpose is to:  
1) change vertical dimension, 2) diagnose or treat conditions or dysfunction of the temporomandibular joint, 3) stabilize periodontally involved teeth, or 4) restore occlusion.
- ◆ Orthodontic services or supplies for any Covered Person other than a Dependent child less than 19 years of age.
- ◆ Orthodontic services or supplies for any Covered Person during the first 12 months of coverage under the Program.
- ◆ Porcelain or acrylic veneers of crown or pontics on or replacing the upper and lower first, second and third molars.
- ◆ Bite registrations; precision or semiprecision attachments; or splinting.
- ◆ A surgical implant of any type including any prosthetic device attached to it.
- ◆ Instruction for plaque control, oral hygiene and diet.
- ◆ Dental services that do not meet common dental standards.
- ◆ Services that are deemed to be medical services.
- ◆ Services and supplies received from a hospital.
- ◆ Services for which benefits are not payable according to the “General Limitations” section.

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

- ◆ this Program, and
- ◆ any medical expense plan or prepaid treatment program sponsored or made available by your Plan Sponsor.

### General Limitations on Dental Coverage

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

- ◆ For or in connection with an injury or sickness arising out of, or in the course of, any employment for wage or profit.
- ◆ For or in connection with an injury or sickness which is covered under any workers’ compensation or similar law.
- ◆ For charges made by a hospital owned or operated by the United States Government:  
1) unless there is a legal obligation to pay such charges whether or not there is insurance, or 2) such charges are directly related to a military-service-connected sickness or injury.
- ◆ To the extent that payment is unlawful where the Covered Person resides when the expenses are incurred.
- ◆ For charges which the Covered Person is not legally required to pay.
- ◆ For or in connection with an injury or sickness which is due to war, declared or undeclared.
- ◆ For expenses incurred outside the United States or Canada, unless you or your Dependent is a U.S. or Canadian resident and the charges are incurred while traveling on business or for pleasure.
- ◆ For charges which you are not obligated to pay or for which you are not billed or for which you would not have been billed except that they were covered under this Program.
- ◆ To the extent that they are more than the Reasonable and Customary Charge or the amount indicated in the Schedule.

- ◆ For charges for treatment or care that, in the view of the Claims Administrator, is unnecessary care, treatment or surgery.
- ◆ To the extent that you or any one of your Dependents is in any way paid or entitled to payment for those expenses by or through a public program, other than Medicaid.
- ◆ For or in connection with experimental procedures or treatment methods not approved by the American Dental Association or the appropriate dental specialty society.

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

- ◆ a “no-fault” insurance law, or
- ◆ an uninsured motorist insurance law.

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

## Coordination of Benefits

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

### **DEFINITIONS**

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

### **PAYING PLAN**

Any of the following that provides benefits or services for medical or dental care or treatment:

- ◆ Group insurance and/or group-type coverage, whether insured or self-insured which neither can be purchased by the general public, nor is individually underwritten, including closed panel coverage.
- ◆ Coverage under Medicare and other governmental benefits as permitted by law, excepting Medicaid and Medicare supplement policies.
- ◆ Medical or dental benefits coverage of group, group-type, and individual automobile contracts.

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

### **CLOSED PANEL PLAN**

A Paying Plan that provides medical or dental benefits primarily in the form of services through a panel of employed or contracted providers, and that limits or excludes benefits provided by providers outside of the panel, except in the case of emergency or if referred by a provider within the panel.

**PRIMARY PLAN**

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

**SECONDARY PLAN**

A Paying Plan that determines, and may reduce its benefits after taking into consideration, the benefits provided or paid by the Primary Plan. A Secondary Plan may also recover from the Primary Plan the Reasonable Cash Value of any services it provided to you.

**ALLOWABLE EXPENSE**

A necessary, reasonable and customary service or expense, including Deductibles, coinsurance or co-payments, that is covered in full or in part by any Paying Plan covering you. When a Paying Plan provides benefits in the form of services, the Reasonable Cash Value of each service is the Allowable Expense and is a paid benefit.

Examples of expenses or services that are not Allowable Expenses include, but are not limited to the following:

- ◆ An expense or service or a portion of an expense or service that is not covered by any of the Paying Plans is not an Allowable Expense.
- ◆ If you are covered by two or more Paying Plans that provide services or supplies on the basis of reasonable and customary fees, any amount in excess of the highest reasonable and customary fee is not an Allowable Expense.
- ◆ If you are covered by one Paying Plan that provides services or supplies on the basis of reasonable and customary fees and one Paying Plan that provides services and supplies on the basis of negotiated fees, the Primary Plan's fee arrangement shall be the Allowable Expense.
- ◆ If your benefits are reduced under the Primary Plan (through the imposition of a higher co-payment amount, higher coinsurance percentage, a deductible and/or a penalty) because you did not comply with Paying Plan provisions or because you did not use a preferred, Participating or network provider, the amount of the reduction is not an Allowable Expense. Such Paying Plan provisions include second surgical opinions and precertification of admissions or services.

**CLAIM DETERMINATION PERIOD**

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

**REASONABLE CASH VALUE**

An amount which a duly licensed provider of dental care services usually charges patients and which is within the range of fees usually charged for the same service by other health care providers located within the immediate geographic area where the health care service is rendered under similar or comparable circumstances.

**ORDER OF BENEFIT DETERMINATION RULES**

A Paying Plan that does not have a coordination of benefits rule consistent with this section shall always be the Primary Plan. If the Paying Plan does have a coordination of benefits rule

consistent with this section, the first of the following rules that applies to the situation is the one to use:

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

If none of the above rules determines the order of benefits, the Paying Plan that has covered you for the longer period of time shall be the Primary Plan.

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

#### **EFFECT ON THE BENEFITS OF THIS PROGRAM**

If this Program is the Secondary Plan, this Program may reduce benefits so that the total benefits paid by all Plans during a Claim Determination Period are not more than one hundred percent (100%) of the total of all Allowable Expenses.

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

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

#### **RECOVERY OF EXCESS BENEFITS**

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

This Program will have the right to seek such recovery from any person to, or for whom, or with respect to whom, such services were provided or such payments were made by any insurance company, healthcare plan or other organization. If we request, you shall execute and deliver to us such instruments and documents as we determine are necessary to secure the right of recovery.

**RIGHT TO RECEIVE AND RELEASE INFORMATION**

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

**Right of Reimbursement**

The Program does not cover:

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

If you or a Dependent incur dental expenses as described in (1) and (2) above, the Program and Connecticut General shall automatically have a lien upon the proceeds of any recovery by you or your Dependent(s) from such party to the extent of any benefits provided to you or your Dependent(s) by the Program. You or your Dependent(s) or their representative shall execute such documents as may be required to secure the Program's rights. Connecticut General and the Program shall be reimbursed the lesser of: a) the amount actually paid by CG (or the Plan Administrator) under the Program, or b) an amount actually received from the third party; at the time that the third party's liability is determined and satisfied; whether by settlement, judgment, arbitration or otherwise.

**Payment of Benefits**

**TO WHOM PAYABLE**

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

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

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

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

**TIME OF PAYMENT**

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

**RECOVERY OF OVERPAYMENT**

When an overpayment has been made by CG, CG will have the right at any time to: (a) recover that overpayment from the person to whom or on whose behalf it was made; or (b) offset the amount of that overpayment from a future Claim payment.

## Termination of Coverage

**TERMINATION OF COVERAGE – EMPLOYEES**

Your coverage will cease on the earliest date below:

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

**TEMPORARY LAYOFF OR LEAVE OF ABSENCE**

If your Active Service ends due to temporary layoff or leave of absence, your coverage will be continued until the date your Plan Sponsor: (a) stops paying Required Contributions for you for a maximum time period of one year; or (b) otherwise cancels your coverage.

**INJURY OR SICKNESS**

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

**RETIREMENT**

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

**TERMINATION OF COVERAGE – DEPENDENTS**

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

- ◆ The date your coverage ceases.
- ◆ The date you cease to be eligible for Dependent Coverage.

- ◆ The last day for which you have made any Required Contribution for the coverage.
- ◆ The date Dependent coverage is canceled.

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

#### **CONTINUATION COVERAGE**

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

#### **REQUIREMENTS OF FAMILY AND MEDICAL LEAVE ACT OF 1993**

Any provisions of the Program that provide for: (a) continuation of coverage during a leave of absence; and (b) reinstatement of coverage following a return to Active Service; are modified by the following provisions of the federal Family and Medical Leave Act of 1993 (“FMLA”), where applicable:

##### **A. Continuation of Dental Coverage During Leave**

Your dental coverage will be continued during a leave of absence if:

that leave qualifies as a leave of absence under the FMLA; and  
you are an eligible Employee under the terms of that Act.

The cost of your dental coverage during such leave must be paid, whether entirely by your Plan Sponsor or in part by you and your Plan Sponsor.

##### **B. Reinstatement of Canceled Coverage Following Leave**

Upon your return to Active Service following a leave of absence that qualifies under the FMLA, any canceled coverage (health, life or disability) will be reinstated as of the date of your return.

You will not be required to satisfy any eligibility or benefit waiting period or the requirements of any Pre-existing Condition Limitation or Exclusion to the extent that they had been satisfied prior to the start of such leave of absence.

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

## **Benefits Extension**

#### **DENTAL BENEFITS EXTENSION**

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

- ◆ For fixed bridgework and full or partial dentures, the first impressions are taken and/or abutment teeth fully prepared while he is covered and the prosthesis inserted within three calendar months after his coverage ceases.

- ◆ For a crown, inlay or onlay, the tooth is prepared while he is covered and the crown, inlay or onlay installed within three calendar months after his coverage ceases.
- ◆ For root canal therapy, the pulp chamber of the tooth is opened while he is covered and the treatment is completed within three calendar months after his coverage ceases.

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

## When You Have a Complaint or an Appeal

For the purposes of this section, any reference to “you,” “your” or “Member” also refers to a representative or provider designated by you to act on your behalf, unless otherwise noted.

We want you to be satisfied with the care you receive. That is why we have established a process for addressing your concerns and solving your problems.

### **START WITH MEMBER SERVICES**

We are here to listen and help. If you have a concern regarding a person, a service, the quality of care, or contractual benefits, you can call the toll-free number on your explanation of benefits (EOB), or Claim Form and explain your concern to one of CIGNA’s Member Services representatives. You can also express that concern in writing.

We will do our best to resolve the matter on your initial contact. If we need more time to review or investigate your concern, we will get back to you as soon as possible, but in any case within 30 days.

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

### **APPEALS PROCEDURE**

The Program has a two-step appeals procedure. To initiate an appeal, you must submit a request for a review in writing to the Plan Administrator (the General Board) within 180 days of receipt of a denial notice (i.e., on an EOB). You should state the reason why you feel your Claim should be approved and include any information supporting your Claim. Write the Plan Administrator at the address in the *General Information* section of this Benefit Booklet. The Plan Administrator will promptly consider your Claim and notify you in writing of the Plan Administrator’s decision regarding the Claim for benefits. You then have 90 days from the date of the notice of denial from the General Board in which to submit an appeal. The denial notice from the General Board will generally contain a *Notice of Intermediate Appeal*. Be sure to read any such *Notice of Intermediate Appeal* carefully and follow the time frames set out therein.

### **LEVEL ONE APPEAL**

Your appeal will be reviewed and the decision made by someone not involved in the initial decision. Appeals involving medical necessity or clinical appropriateness will be considered by a health care professional.

You may appeal the initial decision by submitting to the Appeals Intermediary documentation that supports your Claim, such as additional facts or information tending to dispute the Claims

Administrator's or the Plan Administrator's interpretation of the Program or the facts upon which the Claims Administrator or Plan Administrator based its Claim denial decision. The Appeals Intermediary shall only consider those issues and supporting documents that are submitted with the *Notice*, except by its leave or discretion. The appeal must be filed on such forms as may be required from time to time by the General Board.

For level one appeals, the Appeals Intermediary will hold a hearing of the appeal within 60 days of the receipt of the *Notice* and all supporting documentation. You may, upon request filed with the *Notice*, request to delay the hearing for up to 45 days. The Appeals Intermediary will respond to you in writing with a decision within 30 calendar days after the hearing has been held. If more time or information is needed to make the determination, the Program will notify you in writing within the initial 60 days to request an extension of up to 45 calendar days and to specify any additional information needed to complete the review. You, or your duly authorized representative, may present your situation to the Appeals Intermediary in person or by telephone conference call. If you choose to appear at the hearing in person, you will be wholly responsible for all costs associated with such appearance.

#### **LEVEL TWO APPEAL**

If you are dissatisfied with the Program's level one appeal decision, you may request a second review. To initiate a level two appeal, follow the instructions that are included with the letter you receive from the Appeals Intermediary informing you of the results of the first level appeal. The second level appeal is an appeal to a committee of the Board of Directors of the General Board (Committee). Anyone involved in the first level appeal decision may not vote on the Committee. For appeals involving medical necessity or clinical appropriateness the Committee will consult with at least one appropriate health care professional, e.g., a Dentist, in the same or similar specialty as the care under consideration, as determined by the Committee. You may present your situation to the Committee in person or by telephone conference call. If you choose to appear at the hearing in person, you will be wholly responsible for all costs associated with such appearance.

#### **NOTICE OF BENEFIT DETERMINATION ON APPEAL**

Every notice of a determination on appeal will be provided in writing or electronically, if you have reasonable access to electronic communication media and you request that such communications be made electronically, and, if an adverse determination, will include: 1) the specific reason or reasons for the adverse determination; 2) reference to the specific Program provisions on which the determination is based; 3) a statement that the Claimant is entitled to receive, upon request and free of charge, reasonable access to and copies of all documents, records, and other Relevant Information as defined below; 4) a statement describing any voluntary appeal procedures offered by the Program and the Claimant's right to bring action in state or federal court; and 5) upon request and free of charge, a copy of any internal rule, guideline, protocol or other similar criterion that was relied upon in making the adverse determination regarding your appeal, and an explanation of the scientific or clinical judgment for a determination that is based on a medical necessity, experimental treatment or other similar exclusion or limit.

You also have the right to bring a civil action in state or federal court if you are not satisfied with the decision upon exhaustion of the appeal process. You and the Program may have other

voluntary alternative dispute resolution options such as mediation. You may also contact the Plan Administrator.

**RELEVANT INFORMATION**

Relevant information is any document, record or other information which: 1) was relied upon in making the benefit determination; 2) was submitted, considered or generated in the course of making the benefit determination, without regard to whether such document, record, or other information was relied upon in making the benefit determination; 3) demonstrates compliance with the administrative processes and safeguards required by federal law in making the benefit determination; or 4) constitutes a statement of policy or guidance with respect to the Program concerning the denied treatment option or benefit for the Claimant's diagnosis, without regard to whether such advice or statement was relied upon in making the benefit determination.

**LEGAL ACTION**

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

**Legal Status of the Program**

**NOT INSURANCE**

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

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

**INTERPRETATION OF THE PROGRAM AND BENEFITS**

The General Board has sole and exclusive discretion to do all of the following:

- ◆ Interpret the provisions and terms of and benefits available under the Program;

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

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

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

#### **METHOD OF FUNDING BENEFITS**

Dental benefits are self-funded or self-insured from accumulated assets and are provided directly from the General Board. The General Board may purchase excess risk insurance coverage, often called stop-loss coverage, which is intended to reimburse the General Board for certain losses incurred and paid under the Program by the General Board. Such excess risk coverage, if any, is not part of the Program; it does not imply that the General Board or the Program is in the business of insurance nor does it render the Program subject to state insurance regulations. Payments out of the Program to health care providers on behalf of the Participants will be based on the provisions of the Program.

#### **FIDUCIARY AND ADMINISTRATIVE DUTIES**

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

The plan document grants the General Board the power to delegate fiduciary and non-fiduciary duties and obligations to agents and others.

#### **DUTIES ASSIGNED TO THE PROGRAM'S CLAIMS ADMINISTRATOR**

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

**CLERICAL ERROR**

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

**NO WAIVER**

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

**PHYSICIAN/PATIENT RELATIONSHIP**

The Program is not intended to disturb the physician (Dentist)/patient relationship. Dentists and other providers are not agents or delegates of any employer, Plan Sponsor, the General Board or the Claims Administrator. Nothing contained in this Benefit Booklet or the Program will require you or your Dependent to commence or continue medical treatment by a particular provider. Furthermore, nothing in this Benefit Booklet or the Program will limit or otherwise restrict a Dentist's judgment with respect to the Dentist's ultimate responsibility for patient care in the provision of Dental Services to you or your Dependent.

**THE PLAN IS NOT A CONTRACT OF EMPLOYMENT**

Nothing contained in this Benefit Booklet or the Program will be construed as a contract or condition of employment between any employer and any Employee. All Employees are subject to discharge to the same extent as if this Benefit Booklet and the Program had never been adopted.

**RIGHT TO AMEND OR TERMINATE PROGRAM**

The General Board reserves the right to amend, modify, or terminate the Program in any manner, for any reason, at any time, and without prior notification.

**General Information**

**TYPE OF PLAN**

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

**NAME AND ADDRESS OF THE PLAN ADMINISTRATOR**

General Board of Pension and Health Benefits of  
The United Methodist Church, Incorporated in Illinois  
1201 Davis Street  
Evanston, IL 60201  
(847) 869-4550

**NAME AND ADDRESS OF THE DESIGNATED AGENT FOR SERVICE OF LEGAL PROCESS**

General Board of Pension and Health Benefits of  
The United Methodist Church, Incorporated in Illinois  
1201 Davis Street  
Evanston, Illinois 60201  
(847) 869-4550

**NAME AND ADDRESS OF THE THIRD-PARTY CLAIMS ADMINISTRATOR FOR DENTAL BENEFITS**

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

**INTERNAL REVENUE SERVICE IDENTIFICATION NUMBER**

The corporate tax identification number assigned by the Internal Revenue Service to the General Board is 36-2166979.

**PLAN YEAR**

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

**METHOD OF FUNDING BENEFITS**

Dental benefits are self-funded or self-insured from accumulated assets and are provided directly from the General Board. The General Board may purchase excess risk insurance coverage, often called stop-loss coverage, which is intended to reimburse the General Board for certain losses incurred and paid under the Plan by the General Board. Such excess risk coverage, if any, is not part of the Program; it does not render the Program subject to state insurance regulations. Payments out of the Plan to dental care Providers on behalf of the Covered Person will be based on the provisions of the Program.

**FOR MORE INFORMATION**

Here are some additional resources, should you have any questions after reviewing all of the information in this Benefit Booklet.

For more information about:

**THE HEALTHFLEX PLAN:**

General Board of Pension and Health Benefits of The United Methodist Church  
1201 Davis Street  
Evanston, IL 60201  
[www.gbophb.org](http://www.gbophb.org)  
(800) 851-2201

**CONNECTICUT GENERAL LIFE INSURANCE COMPANY**

1000 Corporate Center Drive, Suite 500  
Franklin, Tennessee 37067  
[www.cigna.com](http://www.cigna.com)  
(888) 336-8258

## Definitions

### **ACTIVE SERVICE**

You will be considered in Active Service:

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

### **AFFILIATED ORGANIZATION**

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

### **ANNUAL ELECTION PERIOD**

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

### **BENEFIT OPTION**

Benefit Option means a qualified benefit under §125(f) of the Code that is offered under a cafeteria plan or an option for coverage under an underlying accident or health plan (such as an indemnity option, an HMO option, or a PPO option). In other words, under the Program, generally, the HMO, PPO, EPO, OOA, Medicare HMO, Medicare Companion, Mental Health HMO and Mental Health PPO plans for medical benefits with their corresponding prescription drug plans are considered separate Benefit Options, as are the Indemnity, PPO and HMO dental plans, and the incentive materials and full-service vision plans.

### ***THE BOOK OF DISCIPLINE***

The term The Book of Discipline means the body of church law established by the General Conference of The United Methodist Church, as amended from time to time.

### **CHURCH PLAN**

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

### **CLAIM**

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

**CLAIMANT**

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

**CLAIMS ADMINISTRATOR**

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

**CODE**

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

**COINSURANCE\***

The term Coinsurance means the percentage of charges for Covered Expenses that a covered person is required to pay under the Program.

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

**CONFERENCE**

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

**CO-PAYMENT**

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

**COVERED DENTAL SERVICE**

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

**COVERED PERSON**

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

**DEDUCTIBLE**

The term Deductible means the amount of charges for Covered Dental Services each Covered Person must pay during each Plan Year before the Program will consider expenses for payment or reimbursement. The individual Deductible applies separately to each Covered Person. A family Deductible applies collectively to all Covered Persons in the same family. When the family Deductible is satisfied, no further Deductible will be applied for any covered family

member during the remainder of that Plan Year, except in the case of costs beyond the Maximum Allowance. Deductible amounts are shown on The Schedule.

**DENTIST**

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

**DEPENDENT**

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

- ◆ your lawful Spouse, and
- ◆ any unmarried child of yours who is:
  - less than 19 years old;
  - 19 years but less than 25 years old, enrolled in school as a full-time student and primarily supported by you. However, if the full-time student graduates prior to age 25, coverage will end the last day of the third month after graduation from college, university or post high school (the month in which graduation occurs is counted in these three months); and
  - 19 or more years old and incapable of self-sustaining employment by reason of mental or physical handicap. Proof of the child's condition and dependence may be required by CG two months before he fails to qualify as stated above or at any reasonable, later time. If proof is not submitted by you within 60 days after receipt of CG's request, the person will no longer qualify as a Dependent. During the next two years CG may, from time to time, require proof of the continuation of such condition and dependence. After that, CG may require proof no more than once a year.

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

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

Anyone who is eligible as an Employee will not be considered as a Dependent.

No one may be considered as a Dependent of more than one Employee.

**ELIGIBLE PERSON**

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

**EMPLOYEE**

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

**ERISA**

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

**GENERAL BOARD**

The term General Board means the General Board of Pension and Health Benefits of The United Methodist Church, Incorporated in Illinois.

**HIPAA**

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

**MEDICAID**

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

**MEDICARE**

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

**NON-PARTICIPATING PROVIDER**

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

**OPEN ENROLLMENT PERIOD**

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

**OTHER HEALTH COVERAGE**

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

**PARTICIPANT**

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

**PARTICIPATING PROVIDER**

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

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

**PLAN ADMINISTRATOR**

The Plan Administrator of the Plan is the General Board of Pension and Health Benefits of The United Methodist Church, Incorporated in Illinois, or its designee, on whose behalf CG is providing claim administration services.

**PLAN SPONSOR**

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

**PLAN YEAR**

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

**PROGRAM**

The term Program means the group health plan component of the Hospitalization and Medical Expense Program maintained by the General Board on behalf of its Employees and the Employees and other Participants of the organizations and corporations affiliated with the General Board. The Plan is a Church Plan. For the purposes of this Benefit Booklet the term Program is generally limited to the portion of the Program that provides limited scope group dental benefits. The Program may also be referred to as the Plan from time to time.

**REASONABLE AND CUSTOMARY CHARGE**

A charge will be considered Reasonable and Customary if:

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

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

Reasonable and Customary Charge information is available upon request.

**REQUIRED CONTRIBUTION**

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

**SPOUSE**

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

**Notice**

The plan described in this document (the Plan) is maintained and administered by the General Board of Pension and Health Benefits of The United Methodist Church, Incorporated in Illinois (General Board). The Plan is self-funded (or self-insured).

This document contains only a partial, general description of the Plan. It is provided for informational purposes only and should not be viewed as a contract, an offer of coverage, or investment, tax, medical or other advice. In the event of any conflict between this Benefit Booklet and the official plan documents (schedule of benefits, benefit grids, summary plan description, or plan document), the official plan documents will govern.

The General Board and its affiliates, retain the right to amend, terminate or modify the terms of the Plan, as well as any post-retirement health subsidy, at any time, without notice and for any reason.

The Plan is a Church Plan within the meaning of section 3(33) of the Employee Retirement Income Security Act and section 414(e) of the Internal Revenue Code. Not all Plans are available in all areas of the United States. The Plans do not cover all dental care expenses, and Participants should read the official plan documents carefully to determine which benefits are covered, as well as any applicable exclusions, limitations, and procedures.

All benefits under the Plan are subject to applicable laws, regulations, and policies. All benefits are subject to coordination of benefits provisions. The Plans are subrogated to all of the rights of a Plan Participant against any party liable for such Participant’s Sickness or Injury, to the extent of the reasonable value of the benefits provided to such Participant under the Plan. The Plan may assert this right independently of a Plan Participant, and such Participant is obligated to cooperate with the General Board in order to protect the Plan’s subrogation rights.

The General Board does not provide any health or dental care Services and therefore cannot guarantee any results or outcomes. Health and dental care Providers and vendors are independent contractors in private practice and are neither employees nor agents of the General Board or

## HealthFlex Benefits Booklet

### CIGNA Dental Benefits

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Connecticut General Life Insurance Company. The availability of any particular Provider cannot be guaranteed, and Provider network composition is subject to change.

If you are a Plan Participant, call the number customer service center number (800) 851-2201 for more information about the Plan in which you are enrolled.

Services provided by Connecticut General Life Insurance Company are administrative claims payment services only; Connecticut General Life Insurance Company does not assume any financial risk or obligation with respect to Claims.