

SCHEDULE OF DENTAL BENEFITS

CIGNA Dental

BASIC DENTAL PPO PLAN

Non-Network Annual Deductible: \$50 Individual

\$150 Family

Annual Benefit Maximum: \$1,500 Individual

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

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

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

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

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

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

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

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

Annual Benefit Maximum: \$1,500 Individual

Lifetime Orthodontic Maximum: \$1,500 Individual

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

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

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

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

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

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

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

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

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SCHEDULE OF DENTAL BENEFITS

CIGNA Dental

PREVENTIVE DENTAL PPO PLAN

Non-Network Annual Deductible: \$0 Individual

\$0 Family

Annual Benefit Maximum: \$1,500 Individual

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

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

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

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

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

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

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