

Vanderbilt University

PREPAID DENTAL SERVICES

EFFECTIVE DATE: January 1, 2004

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3308928

This document printed in December, 2003 takes the place of any documents previously issued to you which described your benefits.

Printed in U.S.A.



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CIGNA HealthCare



CIGNA HealthCare



The following pages describe your dental plan offered by Connecticut General.



*Home Office: Bloomfield, Connecticut
Mailing Address: Hartford, Connecticut 06152*

CONNECTICUT GENERAL LIFE INSURANCE COMPANY

a CIGNA company (called CG) certifies that it covers certain Employees for the benefits provided by the following policy(s):

POLICYHOLDER: Vanderbilt University

GROUP POLICY(S) - COVERAGE

3308928-003 PREPAID DENTAL SERVICES

EFFECTIVE DATE 01/01/2004

NOTICE

Any benefits in this certificate will apply to an Employee only if: a) he has elected that benefit; and b) he has a "Final Confirmation Letter," with his name, which shows his election of that benefit.

This certificate describes the main features of the coverage. It does not waive or alter any of the terms of the policy(s). If questions arise, the policy(s) will govern.

This certificate takes the place of any other issued to you on a prior date which described the coverage.

.....
Corporate Secretary

CER7V37



Certificate of Prepaid Dental Services

Connecticut General Life Insurance Company

1. Description of Coverage

Covered Persons covered by this Certificate, which is issued under a Group Contract of Prepaid Dental Services, are entitled to the services under this Dental Plan in accordance with the Patient Charge Schedule described in Section 5. Certain services are subject to the Patient Charge as listed in the Schedule. No cash payments or other indemnity shall be paid by Connecticut General or CIGNA Dental Health to any Covered Person or to any Provider with the exception of any payment to or on behalf of a Covered Person pursuant to Sections 6(a) and 13 hereof, and with the exception of any payment due a Network General Dentist pursuant to his or her contract with CIGNA Dental Health.

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2. Definitions

Capitalized terms in this Contract, unless otherwise defined, shall have the meanings set forth below.

Connecticut General - Connecticut General Life Insurance Company.

Covered Persons - Subscribers and their enrolled Dependents.

Dental Plan - Prepaid dental care services to be provided pursuant to this Contract.

Dependent -
Your spouse or your Domestic Partner; and

- all your unmarried children from birth to 25 years of age and any children 25 years of age or older who are incapable of self-support because of mental or physical disability if the disability existed prior to their reaching the age of 25.

Children must live with you in a regular parent-child relationship and depend upon you for more than 50 percent of their support. If a court approved "Qualified Medical Child Support Order" is provided within 31 days of the date issued, the requirement that the child reside with the employee will be waived. They must be children of the employee by birth, legal guardianship or custody, legal adoption or placement in anticipation of adoption, the employee's stepchildren, or the children of the employee's certified Domestic Partner. Vanderbilt University may require copies of any legal papers issued to establish a person as your dependent. Only copies of actual court documents issued by the respective courts will be considered acceptable documentation.

For an incapacitated Dependent, evidence of his or her reliance on the Subscriber shall be furnished to CIGNA Dental Health, on behalf of Connecticut General, in the form CIGNA Dental Health requests within 31 days after said Dependent attains the age of 25 and, thereafter, not more frequently than annually.

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Domestic Partner -

A Certified Domestic Partner is defined as a person of the same sex that is not related by blood. The partner must be at least 21 years of age, not legally married to anyone else, nor have another domestic partner. This person must be currently in a committed relationship of six months or more duration and reside in a common household sharing joint responsibility for the household. Certification must be obtained through the Office of the Director of Benefits, Human Resources.

Domestic Partner coverage cannot be transferred to states in which such coverage has been disapproved by regulatory authorities.

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Group - Employer, labor union or other organization that executes this Contract for managed dental services on your behalf.

Patient Charge Schedule - List of services covered under your Dental Plan and how much they cost you.

Patient Charges - Payments made by Covered Persons directly to a Network General Dentist or Network Specialist for certain dental procedures, as set forth in the applicable Patient Charge Schedule.

Premiums - Fees that the Group must remit to CIGNA Dental Health, on behalf of Connecticut General, for Covered Persons each calendar month during the term of this Contract.

Network General Dentist - Licensed dentist who has executed a contract with CIGNA Dental Health under which he or she agrees to provide prepaid dental care services to Covered Persons in accordance with the applicable Patient Charge Schedule.

Network Specialist - Licensed dentist who is not a Network General Dentist, but one who has executed a contract with CIGNA Dental Health under which he or she agrees to provide specialized dental services, for which he is qualified, to Covered Persons upon approved referral.

Subscriber/You - Eligible faculty or staff member or member of the Group who is enrolled in the Dental Plan and who has paid all applicable Premiums, if any.

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3. Eligibility

The effective date of coverage of the Group under the Dental Plan shall be the first day of the month following receipt of appropriate Premiums by CIGNA Dental Health, on behalf of Connecticut General. Subscribers will become eligible for coverage after active service with the group for the appropriate waiting period as designated in the Pre-Contract Application.

Dependents may be enrolled in the Dental Plan at the time you enroll, during open enrollment, or within 31 days of becoming eligible due to a life status change such as marriage, birth or adoption.

A newly born child is automatically covered during the first 31 days of life. If you wish to continue coverage beyond the first 31 days, your baby needs to be enrolled in the Dental Plan and you need to begin to pay Premiums during that period.

4. Premiums

In consideration of services to be provided, Premiums will be paid to Connecticut General in accordance with the rate schedule attached to or set forth in the Pre-Contract Application. The Group will contribute a portion of such fees and the Subscriber shall pay the balance, if any.

Under the Family and Medical Leave Act of 1993, you may be eligible to continue coverage during certain leaves of absence from work. During such leaves, you will be responsible for paying your Group the portion of the Premium, if any, which you would have been responsible for if you had not taken the leave.

5. Covered Services and Patient Charge Schedule

Services under the Group Contract will be provided according to the Patient Charge Schedule. Certain services are subject to a Patient Charge as listed in the Schedule. Patient Charges listed on the Patient Charge Schedule of the Dental Plan will be reviewed and may be adjusted on an annual basis. Patient Charges shall then be in effect for a minimum of one year.

6. Emergencies

An emergency is a dental problem that causes acute pain or requires immediate treatment.

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- (a) Emergency Care Away From Home - If an emergency arises while you are more than 50 miles away from home or unable to contact your Network General Dentist, covered services performed by any general dentist for diagnosis and relief of pain will be reimbursed up to a total of \$50.00, per incident, less applicable Patient Charges. This reimbursement will

be made after you submit appropriate reports and x-rays to CIGNA Dental Health.

- (b) Emergency Care After Hours - There is a Patient Charge listed on your Patient Charge Schedule for emergency care rendered after regularly scheduled office hours. This charge will be in addition to other applicable Patient Charges.

7. Services Not Covered Under Your Dental Plan

The Dental Plan does not cover services related to the following:

- (A) Services not listed on the Patient Charge Schedule; nor
- (B) Services provided by a non-Network General Dentist or a non-Network Specialist without CIGNA Dental Health's prior approval (except in emergencies, as described in Section 6); nor
- (C) injuries as to which benefits exist under worker's compensation, occupational disease, or a similar law or act; nor
- (D) conditions as to which dental treatment is provided by a federal or state government agency or is provided without cost to the Group or any Covered Person by any political subdivision or governmental authority, or a public program other than Medicaid; nor
- (E) any injury arising out of any condition which is intentionally self-inflicted; nor
- (F) declared or undeclared war or act thereof; nor
- (G) service in the armed forces of any country or international authority; nor
- (H) cosmetic dentistry or dental surgery performed without functional or pathological need, (dentistry or dental surgery performed solely to improve appearance); nor
- (I) prescription drugs, sedation or general anesthetic; nor
- (J) procedures, appliances or restorations whose main purpose is to: (a) change vertical dimension; or (b) diagnose or treat conditions or dysfunctions of the temporomandibular joint except as specified in the Patient Charge Schedule; nor
- (f) fixed prosthodontic, removable prosthodontic and root canal treatment in progress which was initiated prior to the effective date of the Covered Person's CIGNA Dental Health coverage; nor
- (L) replacement of lost or stolen appliances; nor
- (M) replacement of fixed prosthodontic and removable prosthodontic appliances that are rendered non-functional due to patient abuse, misuse or neglect; nor

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- (N) any procedure or service associated with the placement or prosthodontic restoration of a dental implant; nor
- (O) any procedure considered to be experimental in nature.
- (P) Hospitalization, including any associated incremental charges for dental services performed in a hospital.
- (Q) Services to the extent Covered Person is compensated for them under any group medical plan, no-fault auto insurance policy, or insured motorist policy.

8. Limitations on Covered Services

The services included in the Dental Plan are limited to the extent set forth herein.

- (A) Frequency - The frequency of certain covered services such as cleanings, is limited as shown on the applicable Patient Charge Schedule.
- (B) Specialty Care - Payment authorization is required for coverage of services by a Network Specialist.
- (C) Pediatric Dentistry - Coverage for a referral to a Pediatric Dentist ends on your child's 7th birthday; however, exceptions for medical reasons may be considered on an individual basis. Your Network General Dentist will provide care after your child's 7th birthday.
- (D) Oral Surgery - The surgical removal of an impacted wisdom tooth is not covered if the tooth is not diseased or if the removal is only for orthodontic reasons.

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9. Charges for Broken Appointments

All Covered Persons shall pay the charge set forth in the Patient Charge Schedule for each appointment broken with less than twenty-four (24) hours' notice to the Network General Dentist. The broken appointment fee will not be charged if CIGNA Dental Health determines that the Covered Person was unable to provide such notice through no fault of his or her own.

10. Facilities

Except as otherwise provided in Sections 8(B) and 13 hereof, all dental services to be rendered to Covered Persons shall be performed by Network General Dentists at individual facilities. These facilities are operated by independent General Dentists for the provision of ordinary and customary dental treatment at locations convenient to the Subscriber. Family members must be treated at the same dental facility, unless otherwise extended by your Group's Agreement.

Transfers between participating facilities, for any reason, can be arranged through the CIGNA Dental Health administrative office and will be effective on the first of the month following

the processing of the request. There will be no charge to the Subscriber for such transfers in excess of the outstanding balance due to the Network General Dentist, if any.

11. Method of Treatment; Confidentiality

The services to be provided under this Certificate shall be provided in accordance with recognized standards of sound dental practice. CIGNA Dental Health, on behalf of Connecticut General, shall impose no restrictions as to methods of diagnosis or treatment. The private dentist-patient relationship shall be maintained between Subscribers and Network General Dentists, and CIGNA Dental Health will not disclose the contents of any records, charts, files or other data pertaining to the condition of Covered Persons without their prior written authorization.

12. Application

No statement by a Subscriber in his or her application shall void his or her coverage under the Group Contract or shall be used in any legal proceeding, unless such application, or an exact copy, is included in or attached to this Certificate. No agent or representative of Connecticut General, including CIGNA Dental Health, is authorized to change this Certificate or the Group Contract or to waive any provision of this Certificate or the Group Contract.

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13. Specialty Referrals

When specialized dental care services are required by a Covered Person, a Network General Dentist must initiate the referral process. CIGNA Dental Health shall review the specialty referral request and authorize payment to an endodontist, oral surgeon, orthodontist, pedodontist, and/or periodontist for specialty treatment listed, according to the applicable Patient Charge Schedule.

Treatment by the Network Specialist must be initiated within ninety (90) days from issuance of CIGNA Dental Health authorization, and the Covered Person's coverage must be in effect when treatment is rendered. Covered Persons shall be liable for the applicable Patient Charges in effect on the date the procedure is initiated, as indicated in the applicable Patient Charge Schedule, including fees for any dental services rendered but not listed in the Patient Charge Schedule for the Group.

In the event CIGNA Dental Health determines that a Network Specialist is not available, the CIGNA Dental Health Professional Relations Department will arrange a visit to a non-participating specialist. In all cases, the Covered Person shall remain responsible only for Patient Charges, as listed in the applicable Patient Charge Schedule.



14. Responsibility for Service

Dental services hereunder will be provided in accordance with recognized standards of sound dental practice through contracts with Network General Dentists and Network Specialists. CIGNA Dental Health shall not be obligated to cover any dental service listed in the applicable Patient Charge Schedule other than through Network General Dentists or Network Specialists, unless prior authorization has been granted.

15. Dual Coverage

You or your Dependents may have other dental coverage through your spouse's employer or other sources. In that case, applicable coordination of benefit rules described below will apply:

Coordination of Services and Benefits

Applicability - This Coordination of Benefits (COB) provision applies when a Covered Person has health care coverage under more than one Plan. ("Plan" is defined below.)

If a Covered Person is covered by this Contract and another Plan, the Order of Benefit Determination Rules described below determine whether this Contract or the other Plan is Primary. The benefits of this Contract:

- 1. shall not be reduced when, under the Order of Benefit Determination Rules, this Contract is Primary; but

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- 2. may be reduced for the Reasonable Cash Value of any service provided under this Contract that may be recovered from another Plan when, under the Order of Benefit Determination Rules, the other Plan is Primary. (The above reduction is described in the subsection below entitled "Effect on the Benefits of this Contract.")

Definitions. "Plan" means this Contract or any of the following which provides benefits or services for, or because of, dental care or treatment:

- 1. Group insurance or group-type coverage, whether insured or uninsured. This includes prepayment or group practice coverage.
- 2. Coverage under a governmental plan or coverage required or provided by law. This does not include a state plan under Medicaid (Title XIX of the United States Social Security Act, as amended from time to time). It also does not include any plan when, by law, its benefits are excess to those of any private insurance program or other non-governmental program.
- 3. Dental benefits coverage of all group and group-type contracts.

"Plan" does not include coverage under individual policies or contracts. Each contract or other arrangement for coverage under subparagraphs 1, 2, or 3 above is a separate Plan. Also, if an arrangement has two parts and COB rules apply only to one of the two, each of the parts is a separate Plan.

"Primary" means that a Plan's benefits are to be provided or paid without considering any other Plan's benefits. (The Order of Benefit Determination Rules below determine whether a Plan is Primary or Secondary to another Plan.)

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"Secondary" means that a Plan's benefits may be reduced and it may recover the Reasonable Cash Value of the services it provided from the Primary Plan. (The Order of Benefit Determination Rules below determine whether a Plan is Primary or Secondary to another Plan.)

"Allowable Expense" means a necessary, reasonable, and customary item of expense for dental care, when the item of expense is covered at least in part by one or more Plans covering the person for whom the claim is made.

- 1. When a Plan provides benefits in the form of services, the Reasonable Cash Value of each service rendered is an Allowable Expense and a benefit paid.
- 2. When benefits are reduced under a Primary Plan because a Covered Person does not comply with the Plan provisions, the amount of such reduction will not be considered an Allowable Expense.

"Claim Determination Period" means a calendar year. However, it does not include any part of a year during which a Covered Person has no coverage under this Plan, or any part of a year before the date this COB provision or a similar provision takes effect.

"Reasonable Cash Value" means 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 dental care providers located within the immediate geographic area where the dental care service is rendered under similar or comparable circumstances.

Order of Benefit Determination Rules. When a Covered Person receives services through this Plan or is otherwise entitled to claim benefits under this Plan, and the services or benefits are a basis for a claim under another Plan, this Plan shall be Secondary and the other Plan shall be Primary, unless:

- 1. The other Plan has rules coordinated its benefits with those of this Plan; and
- 2. both the other Plan's rules and this Plan's rules, as stated below, require that this Plan's benefits be determined before those of the other Plan. This Plan determines its Order of Benefits using the first of the following rules that applies:



1. The Plan under which the Covered Person is an employee shall be Primary.
2. If the Covered Person is not an employee under a Plan, then the Plan which covers the Covered Person's parent (as an employee) whose birthday occurs earlier in a calendar year shall be Primary.

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NOTE: The word "birthday" as used in this subparagraph refers only to month and day in a calendar year, not to the year in which the person was born. To aid in the interpretation of this paragraph, the following example is given: If a Covered Person's mother has a birthday on January 1 and the Covered Person's father has a birthday on January 2, the Plan which covers the Covered Person's mother would be Primary.

3. If two or more Plans cover a Covered Person as a dependent child of divorced or separated parents, benefits for the Covered Person shall be determined in the following order:
 - a. First, the Plan of the parent with custody of the child;
 - b. Then, the Plan of the spouse of the parent with custody of the child; and
 - c. Finally, the Plan of the parent not having custody of the child.
4. Notwithstanding subparagraph 3 above, if the specific terms of a court decree state that one of the parents is responsible for the health care expenses of the child, and the entity obligated to pay or provide the benefits of the Plan of that parent has actual knowledge of those terms, the benefits of that Plan shall be Primary. This subparagraph 4 does not apply with respect to any Claim Determination Period or Plan year in which benefits are paid or provided before the entity has that actual knowledge.
5. The benefits of a Plan which covers a Covered Person as an employee (or as that employee's dependent) shall be determined before those of a Plan which covers that Covered Person as a laid-off or retired employee (or as that employee's dependent). If the other Plan does not have this provision and if, as a result, the Plans do not agree on the order of benefit determination, this paragraph shall not apply.
6. If a Covered Person whose coverage is provided under a right of continuation pursuant to federal or state law is also covered under another Plan, the benefits of the Plan covering the Covered Person as an employee (or as that employee's dependent) shall be determined before those of a Plan under continuation coverage. If the other Plan does not have this provision and if, as a result, the Plans do not agree on the order of benefit determination, this paragraph shall not apply.

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7. If one of the Plans which covers a Covered Person is issued out of the state whose laws govern this Contract and determines the order of benefits based upon the gender of a parent, and as a result, the Plans do not agree on the order of benefits determination, the Plan with the gender rules shall determine the order of benefits.
8. If none of the above rules determines the order of benefits, the Plan which has covered the Covered Person for the longer period of time shall be Primary.

Effect on the benefits of this Plan. This subsection applies when, in accordance with the Order of Benefit Determination Rules, this Plan is Secondary to one or more other Plans. In that event, the benefits of this Plan may be reduced under this subsection. Such other Plan or Plans are referred to as "the other Plans" in the subparagraphs below.

This Plan may reduce benefits payable or may recover the Reasonable Cash Value of services provided when the sum of:

1. The benefits that would be payable for the Allowable Expenses under this Plan, the absence of this COB provision; and
2. The benefits that would be payable for the Allowable Expenses under the other Plans, in the absence of provisions with a purpose like that of this COB provision, whether or not claim is made, exceeds those Allowable Expenses in a Claim Determination Period. In that case, the benefits of this Plan will be reduced, or the Reasonable Cash Value of any services provided by this Plan may be recovered from the other Plan, so that they and the benefits payable under the other Plans do not total more than those Allowable Expenses.

When the benefits of this Plan are reduced as described above, each benefit is reduced in proportion. It is then charged against any applicable benefit limit of this Plan.

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Recovery of Excess Benefits. In the event a service or benefit is provided by CIGNA Dental Health which is not required by this Contract, or if it has provided a service or benefit which should have been paid by the Primary Plan, that service or benefit shall be considered an excess benefit. CIGNA Dental Health shall have the right to recover to the extent of the excess benefit. If the excess benefit is a service, recovery shall be based upon the Reasonable Cash Value for that service. If the excess benefit is a payment, recovery shall be based upon the actual payment made. Recovery may be sought from among one or more of the following, as CIGNA Dental Health shall determine: any person to, or for, or with respect to whom, such services were provided or such payments were made; any insurance company; health care plan or other organization. This right of recovery shall be CIGNA Dental Health's alone and at its sole discretion. If determined necessary by CIGNA Dental Health, the Covered Person (or his or her legal representative if a minor or legally



incompetent), upon request, shall execute and deliver to CIGNA Dental Health such instruments and papers required and do whatever else is necessary to secure CIGNA Dental Health's rights hereunder.

Medicare Benefits. Except as otherwise provided by applicable federal law, the services and benefits under this Plan for Covered Persons aged sixty-five (65) and older, or for Covered Persons otherwise eligible for Medicare payments, shall not duplicate any services or benefits to which such Covered Persons are eligible under Parts A or B of the Medicare Act. Where Medicare is the responsible payor, all amounts payable pursuant to the Medicare program for services and benefits provided hereunder to Covered Persons are payable to and shall be retained by CIGNA Dental Health. Covered Persons enrolled in Medicare shall cooperate with and assist CIGNA Dental Health in its efforts to obtain reimbursement from Medicare or the Covered Person in such instances.

Rights to Receive and Release Information. CIGNA Dental Health may, without consent of or notice to any Covered Person, release to or obtain from any person or organization or governmental entity any information with respect to the administering of this Section. A Covered Person shall provide to CIGNA Dental Health any information it requests to implement this provision.

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16. Grievance Procedure

Almost all controversies can be solved on a personal level by the Network General Dentist and his/her staff. In addition, the CIGNA Dental Health's Professional Relations Department is able to solve problems and act as liaison between the Covered Person and the Facility.

A Covered Person can contact CIGNA Dental Health either by telephone or by mail regarding questions about their treatment plan or case process. The Professional Relations Department is staffed with experienced individuals who can help to further explain the treatment plan rationale, charges for certain services or any other question about the Dental Plan.

1. If the problem concerns quality of care, a CIGNA Dental Health local dental director will be consulted for appropriate resolution. The director's decision shall be final if he/she rules in favor of the Covered Person; however, if the director decides against the Covered Person, an appointment can be arranged with a mutually-agreed-upon dentist for a second opinion, at CIGNA Dental Health's expense. Resolution should be within two weeks, providing appointment time is available. The final decision will be made by a CIGNA Dental Health regional dental director based upon independent analysis of the recommendation of both the local dental director and the consulting dentist.

2. If the problem concerns plan definitions or limitations, or Provider/patient relationship, the Dental Administrator will be consulted. A written or verbal response will be provided within fifteen (15) working days.

If the Covered Person is not satisfied with CIGNA Dental Health's decision, a grievance committee composed of three members (the "Committee") will be established within three months of initial notification to CIGNA Dental Health by the Covered Person. If the grievance is of a strictly professional nature, concerning the qualifications of or treatment provided by a Network General Dentist, all three members shall be dentists. In all cases, the Committee shall include:

1. a representative appointed by CIGNA Dental Health;
2. a representative appointed by the Covered Person; and
3. a mutually-agreed-upon representative of the dental community, who shall preside over the Committee.

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The parties to each side of this controversy will bear the cost of his/her own expenses. Both parties shall share, on an equal basis, the expenses of the third member presiding over the Committee.

Notwithstanding any other provision in this Section, all parties reserve the right, after the Committee has reached a final decision, to pursue all available remedies through courts of competent jurisdiction with respect to any claims arising from professional treatment performed by a Network General Dentist.

17. Grace Period

The Grace Period for the payment of Premiums by the Group and by the Subscriber shall be twenty (20) days. If at the expiration of this Grace Period the Group has not paid amounts due, then the entire Dental Plan shall terminate as of the last day of the month for which payment is due. If at the expiration of the Grace Period any Subscriber has not paid amounts due, then the Subscriber's coverage and coverage for his or her Dependents under the Dental Plan shall cease as of the last day of the month for which payment is due. Upon such expiration, terminated Covered Persons shall be liable for the cost of services received during the Grace Period, unless the Group failed to remit dollars previously deducted on behalf of a Subscriber.

18. Reinstatement

If any Subscriber defaults in making any payment, subsequent acceptance of a payment by Connecticut General or CIGNA Dental Health shall reinstate coverage only with respect to services to be provided after such acceptance.

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19. Termination

Except as provided in the Extension of Benefits provisions, coverage under this Contract shall terminate as follows:

- (1) For a Covered Person(s), effective the first day of the month following the:
 - (a) date the Subscriber ceases employment with the Group;
 - (b) date the Covered Person disenrolls from CIGNA Dental Health;
 - (c) upon no less than thirty (30) days' notice by CIGNA Dental Health after an opportunity to change Network General Dentists at least once, due to permanent breakdown of the dentist-patient relationship with the Covered Person, as determined by CIGNA Dental Health.
 - (d) upon notification by CIGNA Dental Health to the Covered Person, due to misuse of dental services and/or Facilities.
- (2) For a Dependent(s), effective the last day of the month when the Dependent ceases to meet the definition of Dependent (unless otherwise specified in the Pre-Contract Application).
- (3) For a Group, in case of non-payment of Premiums, after thirty (30) days' written notice, but the Group shall remain liable for Premiums accrued during this thirty (30) day period.

CIGNA Dental Health, on behalf of Connecticut General, will provide written notice within a reasonable time to the Group of any termination or breach of contract by or inability to perform of any contracting Network General Dentist if CIGNA Dental Health, on behalf of Connecticut General, determines that Covered Persons may be materially and adversely affected hereby.

20. Extension of Benefits

Coverage for completion of a dental procedure which was begun before termination from the Dental Plan (except for orthodontic treatment), which required two or more visits on separate days to a Facility, shall be extended for ninety (90) days after termination of the Covered Person's coverage under this Contract, unless the date of termination by CIGNA Dental Health was due to non-payment of Premiums.

In the case of orthodontic treatment, if the orthodontist has agreed to or is receiving monthly payments, extension of coverage shall be sixty (60) days after termination of the Covered Person's coverage under the Contract.

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If the orthodontist has agreed to or is receiving quarterly payments, coverage will be extended to the end of the calendar

quarter or sixty (60) days after termination of the Covered Person's coverage under this Contract, whichever is later.

21. Continuation of Coverage

- (A) Continuation for Subscribers and Dependents - If a Subscriber's coverage would otherwise cease due to a reduction in work hours or termination of employment for any reason other than gross misconduct, the Subscriber may continue coverage upon payment of the required Premium to the Group. A Subscriber must elect to continue coverage within sixty (60) days from the later of:
 - (a) the date the coverage would otherwise cease; or
 - (b) the date he or she receives notice of the right to continue coverage. A Subscriber's coverage will not be continued by CIGNA Dental Health, on behalf of Connecticut General, beyond the earliest of the following dates:
 - (1) eighteen (18) months from the date the Subscriber's work hours are reduced or his or her employment terminates, whichever may occur first;
 - (2) the date coverage ends due to the Subscriber's failure to make timely payment of the required Premium;
 - (3) the date the Subscriber becomes covered as an employee under another group dental service plan;
 - (4) the date the Subscriber becomes eligible for Medicare; or
 - (5) the date the Group Contract cancels.

Subscriber may also continue coverage for his or her Dependents, subject to the above provisions, provided: (a) the Subscriber has elected to continue such coverage for himself or herself as outlined above; and (b) that Dependent was enrolled for such coverage on the day before the Subscriber's work hours were reduced or his or her employment terminated. Coverage for Dependents will cease on the earliest of the following dates:

- (1) the date the Subscriber's coverage ceases;
 - (2) the date the Dependent becomes eligible for Medicare; or
 - (3) the date the Dependent becomes covered as an employee under another group dental service plan.
- (B) Continuation for Dependents - If a Dependent's coverage would otherwise cease due to:
 - (1) the Subscriber's death;
 - (2) the Subscriber's eligibility for Medicare;
 - (3) divorce or legal separation; or
 - (4) with respect to a Dependent child, failure to continue to qualify as a Dependent;

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The Dependent's coverage may be continued upon payment of the required pre-payment fee to the Group. A Dependent must elect to continue coverage within sixty (60) days from the later of: (a) the date the coverage would otherwise cease; or (b) the date the Dependent receives notice of the right to continue coverage. A Dependent's coverage will not be continued by CIGNA Dental Health, on behalf of Connecticut General beyond the earliest of the following dates:

- (1) thirty-six (36) months from the date of (1), (2), (3) or (4) above, whichever may occur first;
 - (2) the date coverage ends due to failure to make timely payment of the required Premium;
 - (3) the date the Dependent becomes eligible for Medicare;
 - (4) the date the Dependent becomes covered as an employee under another group dental service plan;
 - (5) with respect to a former spouse, the date the former spouse becomes covered as a dependent spouse under another group dental service plan; or
 - (6) the date the Group Contract cancels.
- (C) A Dependent whose coverage is being continued under (A) is not entitled to continue coverage under (B).

The provisions of the conversion privilege described in Section 21 hereof may apply following termination of the continuation of coverage.

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22. Conversions

Any Subscriber who terminates his employment with the Group, or any Dependent who ceases to be eligible for coverage under this Contract because of the termination of a Subscriber's employment, may obtain coverage under an individual dental plan issued by CIGNA Dental Health, on behalf of Connecticut General, at the prevailing conversion rates of CIGNA Dental Health for the standard conversion benefit plan. Any Dependent who ceases to be eligible for coverage under the Group Contract because of his or her dissolution of marriage with a Subscriber or because of age limitations also may obtain coverage under an individual dental plan issued by CIGNA Dental Health, on behalf of Connecticut General. Written application for the individual dental plan must be made, and the first premium paid to CIGNA Dental Health, acting on behalf of Connecticut General, not later than the latter of (a) thirty-one (31) days after termination of coverage under the Dental Plan (or sixty (60) days in the event that termination of coverage was due to dissolution of marriage) or (b) fifteen (15) days after the Subscriber or Dependent has been given written notice of the existence of the conversion privilege, but in no event later than sixty (60) days after such termination.

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Your Rights Under Federal Law

As a participant in your CIGNA Dental plan, you are entitled to certain rights and protections provided under federal laws. This is a summary of those laws and the things you need to know.

Please call Member Services at 1-800-367-1037 if you have any questions. The hearing impaired may call the state TTY toll-free relay service listed in their local telephone directory.



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I. Employee Retirement Income Security Act of 1974 (ERISA)

The following complies with federal law effective July 1, 2002. Provisions of the laws of your state may supersede.

What Is ERISA?

ERISA is a federal law which governs different aspects of health and welfare plans including:

- Summary Plan Descriptions;
- Claim payment;
- Appeals procedures; and
- Reporting requirements.

Although most plans are subject to ERISA, some plans which are exempt include: (1) tax-exempt church employee groups; (2) state, local and federal government employee groups; (3) trust and association plans not funded by employers and plans maintained outside the U.S. for non resident aliens. Exempt plans may also choose to be subject to ERISA. To be sure your plan is subject to ERISA, you should check with your Plan Administrator.

If your plan is subject to ERISA, you are afforded the following rights:

ERISA Entitles You to Receive Information About Your Plan and Benefits

- to examine all documents governing the Plan at the Plan Administrator's office and at other specified locations, such as work sites and union halls, including insurance contracts and collective-bargaining agreements, and a copy of the latest annual report (Form 5500 Series) filed by the Plan with the U.S. Department of Labor and available at the Public Disclosure Room of the Pension and Welfare Benefit Administration. This is available at no charge.
- to obtain, upon written request to the Plan Administrator, copies of all documents governing the Plan. There may be a charge for copies.
- to receive a summary of the Plan's annual financial report. The Plan Administrator is required by law to furnish each participant with a copy of this Summary Annual Report.

ERISA Allows You and/or Your Dependent(s) to Continue Group Dental Plan Coverage

- Continue dental care coverage for yourself, your spouse or your dependents if there is a loss of coverage under the Plan as a result of a qualifying event. You or your Dependents may have to pay for such coverage.

- Reduction or elimination of exclusionary periods of coverage for preexisting conditions under your group dental plan. You should be provided a certificate of creditable coverage, free of charge, from your group dental plan or issuer when you lose coverage under the Plan, when you become entitled to elect federal continuation coverage, when your federal continuation coverage ceases, if you request it before losing coverage, or if you request it up to 24 months after losing coverage, you may be subject to a preexisting condition exclusion for 12 months (18 months for late enrollees) after your enrollment date in your coverage.

ERISA Requires Prudent Actions by Plan Fiduciaries

In addition to creating rights for Plan participants ERISA imposes duties upon the people responsible for the operation of the employee benefit Plan. The people who operate your Plan, called "fiduciaries" of the Plan, have a duty to do so prudently and in the interest of you and other Plan participants and beneficiaries. No one, including your Employer, your union, or any other person, may fire you or otherwise discriminate against you in any other way to prevent you from obtaining a welfare benefit or exercising your rights under ERISA. If your claim for a welfare benefit is denied or ignored, in whole or in part, you have the right to know why this was done, to obtain copies of documents relating to the decision without charge, and to appeal any denial, all within certain time schedules.

ERISA Allows You to Enforce Your Rights

Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request a copy of Plan documents or the latest annual report from the Plan and do not receive them within 30 days, you may file suit in a federal court. In such a case, the court may require the Plan Administrator to provide the materials and pay you up to \$110 a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the administrator. If you have a claim for benefits which is denied or ignored in whole or in part, you may file suit in a state or federal court.

In addition, if you disagree with the Plan's decision or lack thereof concerning the qualified status of a domestic relations order or a medical child support order you may file suit in federal court. If it should happen that plan fiduciaries misuse the Plan's money, or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor, or you may file suit in federal court. The court will decide who should pay court costs and legal fees. If you are successful the court may order the person you have sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees, for example, if it finds your claim is frivolous.



ERISA Requires Disclosures About Your Plan

If your Plan is an ERISA plan, your Plan Administrator is required to include the following information in the Summary Plan Description:

- the name of the Plan;
- the name, address, zip code and business telephone number of the sponsor of the Plan;
- Employer Identification Number (EIN);
- the name, address, zip code and business telephone number of the Plan Administrator;
- the name, address and zip code of the person designated as agent for the service of legal process;
- the cost of the Plan; and
- the Plan's fiscal year ending date.

The Plan Sponsor Has The Right to Modify, Amend or Terminate Your Plan

The Employer as Plan Sponsor reserves the right to, at any time, change or terminate benefits under the Plan, to change or terminate the eligibility of classes of Employees to be covered by the Plan, to amend or eliminate any other plan term or condition and to terminate the whole Plan or any part of it. The procedure by which benefits may be changed or terminate, by which the eligibility of classes of Employees may be changed or terminated, or by which part or all of the Plan may be terminated, is contained in the Employer's Plan Document, which is available for inspection and copying from the Plan Administrator. No consent of any participant is required to terminate, modify, amend or change the Plan.

Effect of Plan Termination

Termination of the Plan together with termination of the insurance policy(s) which funds the Plan benefits will have no adverse effect on any benefits to be paid under the policy(s) for any covered dental expenses incurred prior to the date that policy(s) terminates. Likewise, any extension of benefits under the policy(s) due to your or your Dependent's total disability which began prior to and has continued beyond the date the policy(s) terminates will not be affected by the Plan termination. Rights to purchase limited amounts of dental insurance to replace part of the benefits lost because the policy(s) terminated may arise under the terms of the policy(s). A subsequent Plan termination will not effect the extension of benefits and rights under the policy(s).

Your coverage under the Plan's insurance policy(s) will end on the earliest of the following dates:

- the last day of the calendar month in which you leave Active Service;

- the date you are no longer in an eligible class; if the Plan is contributory, the date you cease to contribute; or
- the date the policy(s) terminates.

See your Plan Administrator to determine if any extension of benefits or rights are available to you or your Dependents under this policy(s). No extension of benefits or rights will be available solely because the Plan terminates.

Funding of the Plan

The Employee is responsible for the full cost of the plan. Premiums are paid through payroll deductions and in some instances through direct billing. The cost of dental care coverage is subject to change at any time.

Claim Determination Procedures Under ERISA:

Procedures Regarding Medical Necessity Determinations

In general, dental services and benefits must be medically necessary to be covered under the Plan. The procedures for determining the medical necessity vary, according to the type of service and benefit requested, and the type of dental plan. Medical necessity determinations are made on either a preservice, concurrent, or postservice basis, as described below. When services or benefits are determined not to be medically necessary, you or your representative will receive a written description of the adverse determination. Appeals procedures are described in your plan booklet, in your provider's network participation documents and in the determination notices.

Preservice Medical Necessity Determinations

Certain services require prior authorization in order to be covered. This prior authorization is called a "preservice medical necessity determination." When you or your representative request a required medical necessity determination prior to care, we will notify you or your representative of the determination within 15 days after receiving the request. However, if more time is needed due to matters beyond our control, we will notify you or your representative within 15 days after receiving your request. This notice will include the date a determination can be expected, which will be no more than 30 days after receipt of the request. If more time is needed because necessary information is missing from the request, the notice will also specify what information is needed, and you or your representative must provide the specified information to us within 45 days after receiving the notice. The determination period will be suspended on the date we send such a notice of missing information, and the determination will resume on the date you or your representative responds to the notice.

If the determination periods above would (a) seriously jeopardize your life or health, your ability to regain maximum function, or (b) in the opinion of a Dentist with knowledge of



your health condition, cause you severe pain which cannot be managed without the requested services, we will make the preservice determination on an expedited basis. Our Dental reviewer, in consultation with the treating Dentist, will decide if an expedited appeal is necessary. We will notify you or your representative of an expedited determination within 72 hours after receiving the request. However, if necessary information is missing from the request, we will notify you or your representative within 24 hours after receiving the request to specify what information is needed. You or your representative must provide the specified information to us within 48 hours after receiving the notice. We will notify you or your representative of the expedited benefit determination within 48 hours after you or your representative responds to the notice. Expedited determinations may be provided orally, unless you or your representative requests written notification.

Postservice Medical Necessity And Postservice Claims Determinations

When your or your representative requests a medical necessity determination after services have been rendered or requests payment for services which have been rendered, we will notify you or your representative of the determination within 30 days after receiving the request. However, if more time is needed to make a determination due to matters beyond our control, we will notify you or your representative within 30 days after receiving the request. This notice will include the date a determination can be expected, which will be no more than 45 days after receipt of the request.

If more time is needed because necessary information is missing from the request, the notice will also specify what information is needed, and you or your representative must provide the specified information to us within 45 days after receiving the notice. The determination period will be suspended on the date we send such a notice of missing information, and the determination will resume on the date you or your representative responds to the notice.

Notice of Adverse Determination

Every notice of an adverse benefit determination will be provided in writing or electronically, and will include all of the following that pertain to the determination:

- the specific reason or reasons for the adverse determination;
- reference to the specific plan provisions on which the determination is based;
- a description of any additional material or information necessary to perfect the claim and an explanation of why such material or information is necessary;
- a description of the Plan’s review procedures and the time limits applicable, including the statement of a claimant’s

rights to bring a civil action under section 502(a) of ERISA following an adverse determination on appeal;

- 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 claim, 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;
- in the case of a claim involving urgent care, a description of the expedited review process applicable to such claim.

Assistance With Your Questions

If you have any questions about your Plan, you should contact your Plan Administrator. If you have any questions about this statement or about your rights under ERISA, or if you need assistance in obtaining documents from the Plan Administrator, you should contact the nearest office of the Pension and Welfare Benefits Administration, U.S. Department of Labor, listed in your telephone directory or the Division of Technical Assistance and Inquiries, Pension and Welfare Benefits Administration, U.S. Department of Labor, 200 Constitution Avenue, N.W., Washington, D.C. 20210. You may also obtain certain publications about your rights and responsibilities under ERISA by calling the publications hotline of the Pension and Welfare Benefits Administration.

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

What Is USERRA?

USERRA sets requirements for continuation and reinstatement of your and/or your Dependent’s dental coverage and reemployment in regard to military leaves of absence. Leaves are as follows:

For leaves of less than 31 days, coverage will continue as described in the “Termination” section of your plan booklet or certificate.

For leaves of 31 days or more, you may continue coverage in accordance with the federal continuation requirements called COBRA. If your Employer is not subject to COBRA, you may continue benefits, by paying the required premium to your Employer, until the earliest of:

- 18 months from the last day of employment with the Employer;
- the day after you fail to apply or return to work; or
- the date the policy cancels.



Your Employer may charge you and your Dependents up to 102% of the total premium.

Following continuation of dental coverage per COBRA (see COBRA requirements) or USERRA requirements, you may convert to a plan of coverage as outlined in your plan booklet or certificate.

USERRA Allows You to Reinstate Your Benefits

If your coverage ends during the leave because you do not elect COBRA or an available conversion plan at the expiration of COBRA and you are reemployed by your current Employer, coverage for you and your Dependent(s) may be reinstated if:

- you gave your Employer advance written or verbal notice of your military leave; and
- the duration of all military leaves while you are employed with your current Employer does not exceed five years.

You and your Dependent(s) will be subject to only the balance of a preexisting condition limitation 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 plan limitations will apply. Any 63-day break in coverage regarding credit for time accrued toward a preexisting condition imitation waiting period will be waived.

USERRA Sets Timeframes for Requesting Reemployment

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

- for leaves of less than 31 days or for a fitness exam by reporting to your Employer by the next regularly scheduled work day following 8 hours of travel time;
- for leaves of 31 days or more but less than 181 days by submitting an application to your Employer within 14 days; and
- for leaves of more than 181 days, by submitting an application to your Employer within 90 days.

Consult your Employer for more details regarding your rights and your Employer’s obligations for reemployment. This section will be superseded in whole or in part by any richer state-required provision shown in your plan booklet or certificate.

III. Requirements of the Family and Medical Leave Act of 1993 (FMLA)

Any provisions of the policy that provide for continuation of insurance during a leave of absence and reinstatement of coverage following a leave of absence is superceded by the FMLA provisions below.

What Is FMLA?

In general, FMLA provides an entitlement of up to 12 weeks of job-protected (state laws may allow more time), unpaid leave during any 12 months for:

- the birth and care of the Employee’s child or placement for adoption or foster care of a child with the Employee;
- to care for an immediate family member (spouse, child, parent) who has a serious health condition; or
- for the Employee’s own serious health condition.

Continuation of Dental Insurance During Leave

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

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

The cost of your dental insurance during such leave of absence must be paid by you.

Reinstatement of Canceled Insurance Following Leave

Upon your return to Active Service following a leave of absence that qualifies under FMLA, any canceled insurance (health, dental, 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 requirement of any Preexisting Condition Limitation to the extent that they have been satisfied prior to start of such leave of absence. Your Employer will give you detailed information about FMLA if you choose to take a leave of absence.

IV. Continuation Required by the Consolidated Omnibus Budget Reconciliation Act (COBRA)

The Continuation required by federal law does not apply for any benefits for loss of life, dismemberment or loss of income and is only available for certain groups. Please contact your Plan Administrator concerning COBRA eligibility under your Plan.

What Is COBRA?

COBRA is a federal law that enables you or your Dependent to continue dental insurance if coverage would cease due to a reduction of your work hours or your termination of employment (other than for gross misconduct). Federal law also enables your Dependents to continue dental insurance if their coverage ceases due to your death, divorce or legal separation, or with respect to a Dependent child, failure to continue to qualify as a Dependent. Continuation must be elected in accordance with the rules of your Employer’s group



plan(s) and is subject to federal law, regulations and interpretations.

Employees and Dependents Continuation Provision

If you or your Dependent’s insurance would otherwise cease because of a reduction in the number of hours you work or your termination of employment for any reason other than gross misconduct, you or your Dependent may continue insurance upon payment of the required premium to the Employer. You and your Dependents must elect to continue insurance within 60 days from the later of:

- the date the reduction of your work hours are reduced or your termination of employment;
- the date the notice of the right to continue insurance is sent; or
- the date the insurance would otherwise cease.

You must pay the first premium within 45 days from the date you elect to continue coverage. Such insurance will not be continued by us for you and/or your Dependents, as applicable, beyond the earliest of the following dates:

- 18 months from the date your work hours are reduced or your employment terminates, whichever may occur first;
- the date the policy cancels;
- the date coverage ends due to your failure to pay the required subsequent premium within 30 days of the due date;
- the date your Dependent ceases to qualify as an eligible Dependent;
- after you elect to continue this insurance, the date you first become entitled to Medicare, and for your Dependent, the date he first becomes entitled to Medicare;
- after you elect to continue this insurance, for you, the date you first become covered under another group dental plan, unless you have a condition for which the new plan limits or excludes coverage, in which case coverage will continue until the earliest of any other point above.

Dependent Continuation Provision

If dental insurance for your Dependents would otherwise cease because of:

1. your death;
2. divorce or legal separation; or
3. with respect to a Dependent child, failure to continue to qualify as a Dependent, such insurance may be continued upon payment of the required premium to the Employer. In the case of 2. or 3. above, you or your Dependent must notify your Employer within 60 days of such event. In addition, a Dependent must elect to continue insurance

within 60 days from the later of: (a) the date the insurance would otherwise cease; or (b) the date notice of the right to continue insurance is sent.

We will not continue the dental insurance of a Dependent beyond the earliest of the following dates:

- 36 months from the date of 1., 2. or 3. above, whichever occurs first;
- the date coverage ends due to failure to pay the required subsequent premium within 30 days of the due date;
- after the Dependent elects to continue this insurance, the date the Dependent first becomes entitled to Medicare;
- the date the policy cancels; or
- after the Dependent elects to continue this insurance, the date the Dependent first becomes covered under another group dental plan, unless the Dependent has a condition for which the new plan limits or excludes coverage, in which case coverage will continue until the earliest of any other point above.

Subsequent Events Affecting Dependent Coverage

If, within the initial 18-month continuation period, your Dependent would lose coverage because of an event described in 1., 2., or 3. above, or because of your coverage loss due to your subsequent entitlement to Medicare, after you have continued your Dependent’s coverage due to your employment termination or reduction in work hours, your Dependent may continue coverage for up to 36 months from the date of loss of employment or reduction in work hours.

If your employment ends or your work hours are reduced within 18 months after your entitlement to Medicare, your covered Dependent may continue coverage for up to 36 months from the date you become entitled to Medicare.

If your employment ends or your work hours are reduced more than 18 months after your entitlement to Medicare, your covered Dependent may continue coverage for up to 18 months from the date your employment or your work hours are reduced.

Disabled Individuals Continuation Provisions

If you or your Dependent is disabled before or within the first 60 days of continuation of coverage which follows termination of employment or a reduction in work hours, the disabled person may continue dental insurance for up to an additional 11 months beyond the 18-month period.

If you or your Dependents who are not disabled elect to continue coverage, such family members of the disabled person may extend coverage for up to an additional 11 months, if they otherwise remain eligible, and notice of disability is provided as described in b., below.

To be eligible you or your Dependent must:



- a. be declared disabled as of a day before or during the first 60 days of continuation, under Title II or XVI by the Social Security Administration; and
- a. notify the Plan Administrative of the Social Security Administration’s determination within 60 days following the determination and within the initial 18-month continuation period, and provide the Plan Administrator with a copy of the determination.

Termination of coverage for all covered persons during the additional 11 months will occur if the disabled person is found by the Social Security Administration to be no longer disabled. Termination for this reason will occur on the first day of the month beginning more than 30 days after the date of the final determination.

All reasons for termination described above which apply to the initial 18 months will also apply to all or any covered persons for any additional months of coverage.

Effect of Employer Chapter 11 Proceedings on Retiree Coverage

If you are covered as a retiree, and a proceeding under USC Chapter 11, bankruptcy for the Employer results in a substantial loss of coverage for you or your Dependents within one year before or after such proceeding, coverage will continue until: (a) for you, your death; and (b) for your Dependent surviving spouse or Dependent child, up to 36 months from your death.

Payment of Premium

COBRA plans may require the payment of an amount that does not exceed 102% of the applicable premium, except the Plan may require payment of up to 150% of the applicable premium for any extended period of continuation coverage for a covered person who is disabled. The additional 48% may only be applied to the premium for the rating category that includes the disabled individual, and only for the additional 11 months.

Applicable premium is determined as follows:

- if the Employee alone elects to continue coverage, the Employee will be charged the active Employee rate;
- if a Dependent spouse alone elects to continue coverage, the spouse will be charged the active Employee rate;
- if a Dependent child or children elect to continue coverage without a parent also electing the continuation, each child will be charged the active Employee rate;
- if the entire family elects to continue coverage, they will be charged the family rate;
- if the Schedule of Premium Rates is set up on a step-rate basis, the active rate basis that fits the individuals who elect to continue his coverage is the rate that will be

charged. If only children elect to continue coverage, each child will be charged the Employee Only rate.

If payment of premium is made within the grace period in an amount not significantly less than the amount the plan requires to be paid, the amount must be deemed to satisfy the plan’s requirement. However, you must be notified and allowed at least 30 days after the notice is provided for payment to be made.

Providing Notification of Status to Providers During the Grace Period

If, after you elect to continue coverage, dental care provider contacts your Plan to confirm coverage for a period for which premium has not yet been received, the Plan must give a complete and accurate response.

Notification Requirements

Your Employer should send your initial notification of coverage continuation rights as required by federal law when:

- when the Plan first becomes subject to federal continuation requirements;
- when you are hired; and
- when you add a spouse as a Dependent for benefits under the Plan. Receipt of this certificate may serve as such notice.

If you become eligible to continue coverage per federal law, your Employer must send you notification within 14 days. If the Plan has a Plan Administrator, the Employer must notify the Plan Administrator within 30 days. The Plan Administrator must notify you within 14 days, thereafter.

If eligibility to continue coverage is due to divorce, legal separation or a Dependent child losing eligibility for coverage under the Plan, you or your Dependent spouse must notify your Employer within 60 days of such event. Your Employer must notify you of the right to continue coverage within 14 days after receipt of notification of such event.

Conversion Available Following Continuation

If you or your Dependent’s continuation ends due to the expiration of the maximum 18-, 29- or 36- month continuation period whichever applies, you or your Dependent may be entitled to convert to the insurance on accordance with dental conversion benefit then available to Employees and their Dependents.

Interaction With Other Continuation Benefits

A person who is eligible to continue insurance under both federal law and state law may continue the insurance, upon payment of any required premium, for a period of time not to exceed the longer of: (1) the continuation required by federal



law; or (2) any other continuation of insurance provided in your plan booklet or certificate.

Newly Acquired Dependents

If, while your insurance is being continued under the continuation required by federal law provisions, you acquire a new Dependent, such Dependent will be eligible for this continuation provided:

- the required premium is paid; and
- we are notified of your newly acquired Dependent in accordance with the terms of the policy.

If your death, divorce or legal separation subsequently occurs for your newly acquired Dependent spouse, such spouse will not be entitled to continue his insurance. However, your Dependent child will be able to continue his insurance.

If your child who is born, adopted or placed for adoption as a newly acquired Dependent subsequently fails to continue to qualify as a Dependent, coverage would only be continued as stated in the Dependent Continuation Provision above.

V. Notice of requirements of the Omnibus Budget Reconciliation of 1993 (OBRA '93)

What is OBRA?

OBRA requires that any group dental plan which provides coverage for Dependent children of plan participants, must provide benefits to Dependent children placed with participants for adoption under the same terms and conditions as apply in the case of dependent children who are "natural" children of participants under the plan. OBRA also provides eligibility for dependents under Qualified Medical Child Support Orders.

These coverage requirements do not apply to any benefits for loss of life, dismemberment or loss of income. Any other provisions in your plan booklet or certificate that provide for:

- the definition of an adopted child and the effective date of eligibility for coverage of that child; and
- eligibility requirements for a child for whom a court order for medical support is issued are superceded by these provisions required by OBRA '93, as amended.

What is a 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 health benefit coverage to such child and relates to benefits under the group health plan 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 policy to provide coverage for any type or form of benefit or option not otherwise provided under the policy, except an order may require a plan to comply with state laws regarding child dental care coverage.

When Your Natural Child is Eligible for Coverage

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 will not be considered a late entrant for dependent insurance. You must notify your Employer 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.

When Your Adopted/Placed for Adoption Child is Eligible for Coverage

Any child under the age of 18 who is adopted by you, including child who is placed for adoption, will be eligible for Dependent Insurance upon the date of placement with you. A child will be considered placed for adoption when you become legally obligated to support your child, totally or partially, prior to that child's adoption. If the child placed for adoption is not adopted, all coverage ceases when the placement ends and will not be continued.

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.

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