

Vanderbilt University

CIGNA DENTAL PPO

EFFECTIVE DATE: January 1, 2008

DPPO 2008
3308928

This document printed in April, 2008 takes the place of any documents previously issued to you which described your benefits.

Printed in U.S.A.

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Home Office: Bloomfield, Connecticut

Mailing Address: Hartford, Connecticut 06152

CONNECTICUT GENERAL LIFE INSURANCE COMPANY

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

POLICYHOLDER: Vanderbilt University

GROUP POLICY(S) — COVERAGE

3308928 - DENT1 CIGNA DENTAL PREFERRED PROVIDER INSURANCE

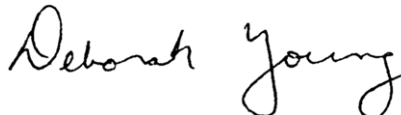
EFFECTIVE DATE: January 1, 2008

NOTICE

Any insurance 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 insurance. 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 insurance.



Deborah Young, Corporate Secretary

Explanation of Terms

You will find terms starting with capital letters throughout your certificate. To help you understand your benefits, most of these terms are defined in the Definitions section of your certificate.

The Schedule

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



How To File Your Claim

The prompt filing of any required claim form will result in faster payment of your claim.

You may get the required claim forms from your Benefit Plan Administrator. All fully completed claim forms and bills should be sent directly to your servicing CG Claim Office.

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 must follow the Predetermination of Benefits procedure when it is necessary for dental forms.

CLAIM REMINDERS:

- BE SURE TO USE YOUR MEMBER ID AND ACCOUNT NUMBER WHEN YOU FILE CG'S CLAIM FORMS, OR WHEN YOU CALL YOUR CG CLAIM OFFICE.

YOUR MEMBER ID IS THE ID SHOWN ON YOUR BENEFIT IDENTIFICATION CARD.

YOUR ACCOUNT NUMBER IS THE 7-DIGIT POLICY NUMBER SHOWN ON YOUR BENEFIT IDENTIFICATION CARD.

- PROMPT FILING OF ANY REQUIRED CLAIM FORMS RESULTS IN FASTER 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.

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Accident and Health Provisions

Claims

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 Policyholder for the claimant, the claim forms which it uses for filing proof of loss. If the claimant does not get these claim forms within 15 days after CG receives notice of claim, he will be considered to meet the proof of loss requirements of the policy if he 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

CG, at its own expense, will have the right to examine any person for whom claim is pending as often as it may reasonably require.

Legal Actions

Where CG has followed the terms of the policy, no action at law or in equity will be brought to recover on the policy until at least 60 days after proof of loss has been filed with CG. No action will be brought at all unless brought within 3 years after the time within which proof of loss is required.

GM6000 CLA43V6

Eligibility – Effective Date

Dental Benefits

Employee Group is Defined as Either:

Initial Employee Group: You are in the initial Employee Group if you are employed in a class of employees on the date that class of employees becomes a Class of Eligible Employees as determined by your Employer; or

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

Eligibility Waiting Period

All full-time faculty and full-time regular exempt staff are eligible for coverage immediately. All other full-time regular employees are eligible 90 days after the first day of employment.

Eligibility for Employee Insurance

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

- you are in a Class of Eligible Employees; and
- you are an eligible, full-time Employee; and
- you normally work at least 30 hours a week.

Classes of Eligible Employees

Each Employee excluding Texas residents as reported to the insurance company by your Employer.



GM6000 ELI261 M

Employee Insurance

This plan is offered to you as an Employee. To be insured you may have to pay the cost.

Effective Date of Your Insurance

You will become insured on the date you become eligible for the plan.

If you are not in Active Service on the date you would otherwise become insured, you will become insured on the date you return to Active Service.

Change in Status

If you experience a Change in Status as defined by Section 125 of the Internal Revenue Code Regulations you may:

- elect, cancel or change your dental insurance benefits; and/or
- add or delete eligible Dependents to your dental insurance.

Late Entrant - Employee

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

Your Employer will not allow you to enroll for dental insurance until the next Open Enrollment period unless: you qualify for a Change in Status as defined by Section 125; your benefit election is consistent with the Change in Status; and the benefit election occurs no later than 30 days following the Change in Status.

GM6000 ELI262 M

Eligibility for Employee Insurance if Your Previous Dental Insurance Ceased

You are eligible to elect this insurance if:

- you were previously insured by CG or another carrier and your insurance ceased; or
- your insurance ceased because you were no longer employed in a Class of Eligible Employees.

You will be subject to the applicable Waiting Periods for Major Treatment incorporated in this plan. Evidence of a period of continuous dental insurance coverage immediately preceding this dental insurance plan will be credited to the Waiting Periods for Major Treatment.

Rules for Reentry into the Dental Insurance Plan

Reentry into the dental insurance plan is defined to mean that you were previously enrolled for CG dental insurance, you subsequently disenrolled from the plan and later would like to reenroll for CG dental insurance.

Your Employer will allow you to reenter the dental insurance plan at Open Enrollment or anytime you experience a Change

in Status as defined by Section 125. In either case, you will be subject to the applicable Waiting Periods for Major Treatment incorporated in this plan. Evidence of a period of continuous dental insurance coverage immediately preceding this dental insurance plan will be credited to the Waiting Periods for Major Treatment.

GM6000 ELI263

Eligibility for Dependent Insurance

You are eligible for Dependent Insurance:

- the day you become eligible for yourself; or
- the day you acquire your first Dependent.

Dependent Insurance

For your Dependents to be insured, you may have to pay the cost.

Effective Date of Dependent Insurance

Insurance for your Dependents will become effective on the date you elect it by signing an approved payroll deduction form, but no earlier than the day you become eligible for Dependent Insurance. All of your Dependents as defined will be included.

Rules for Reentry into the Dental Insurance Plan

Reentry into the dental insurance plan is defined to mean that your Dependents were previously enrolled for CG dental insurance, then subsequently disenrolled from the plan and later would like to reenroll for CG dental insurance.

Your Employer will allow your Dependents to reenter the dental insurance plan at Open Enrollment or anytime they experience a Change in Status as defined by Section 125. In either case, your Dependents will be subject to the applicable Waiting Periods for Major Treatment incorporated in this plan. Evidence of a period of continuous dental insurance coverage immediately preceding this dental insurance plan will be credited to the Waiting Periods for Major Treatment.

GM6000 ELI264 M



CIGNA Dental Preferred Provider Insurance

The Schedule

For You and Your Dependents

The Dental Benefits Plan offered by your Employer includes Participating and Non-Participating Providers. If you select a Participating Provider, your cost will be less than if you select a Non-Participating Provider.

Emergency Services

The Benefit Percentage payable for Emergency Services charges made by a Non-Participating Provider is the same Benefit Percentage as for Participating Provider Charges. Dental Emergency 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.

Deductibles

Deductibles are expenses to be paid by you or your Dependent. Deductibles are in addition to any Coinsurance. Once the Deductible maximum in The Schedule has been reached you and your family need not satisfy any further dental deductible for the rest of that year.

Participating Provider Payment

Participating Provider services are paid based on the Contracted Fee agreed upon by the provider and CG.

Non-Participating Provider Payment

Non-Participating Provider services are paid based on the Maximum Reimbursable Charge. For this plan, the Maximum Reimbursable Charge is calculated at the 90th percentile of all provider charges in the geographic area.

Simultaneous Accumulation of Amounts

Expenses incurred for either Participating or non-Participating Provider charges will be used to satisfy both the Participating and non-Participating Provider Deductibles shown in the Schedule.

Benefits paid for Participating and non-Participating Provider services will be applied toward both the Participating and non-Participating Provider maximum shown in the Schedule.



BENEFIT HIGHLIGHTS	PARTICIPATING PROVIDER	NON-PARTICIPATING PROVIDER
Classes I, II, III Combined Calendar Year Maximum		\$1,500
Class IV Lifetime Maximum		\$1,000
Calendar Year Deductible		
Individual		\$50 per person
Family Maximum		Not Applicable
Class I		
Preventive Care	100%	100%
Class II		
Basic Restorative	80% after plan deductible	80% after plan deductible
Class III		
Major Restorative	Refer to the section of the Schedule below	Refer to the section of the Schedule below
Class IV		
Orthodontia	50% after plan deductible	50% after plan deductible
Class IV Orthodontia applies only to a Dependent Child less than 19 years of age.		

YEARS OF PARTICIPATION	PARTICIPATING PROVIDER CLASS III COINSURANCE	NON-PARTICIPATING PROVIDER CLASS III COINSURANCE
Year 1	10% after plan deductible	10% after plan deductible
Year 2	25% after plan deductible	25% after plan deductible
Year 3 or more	50% after plan deductible	50% after plan deductible



Dental Benefits

Waiting Periods for Major Treatment – Initial Employee Group and New Employee Group

You may access your Employee dental benefit insurance once you have satisfied the waiting periods.

- there is no waiting period for Class I, Class II and Class III services;

If the plan contains Orthodontic benefits then:

- after one calendar year of coverage Employee dental benefits will increase to include Class IV procedures.

You may be asked to provide evidence of the prior coverage applied to satisfy applicable waiting periods.

This waiting period will not apply to any person who is a member of the Initial Employee group.

GM6000 DEN147 M

Waiting Periods for Major Treatment – Dependents

The Dependent waiting period is calculated separately from the Employee waiting period. Satisfaction of the Dependent waiting period begins when the eligible Employee enrolls for Dependent insurance.

A Dependent may access dental benefit insurance once they have satisfied the following waiting periods.

- there is no waiting period for Class I, Class II and Class III services;

If the plan contains Orthodontic benefits then:

- after one calendar year of coverage, Dependent dental benefits will increase to include Class IV procedures;

Dependents may be asked to provide evidence of the prior coverage applied to satisfy applicable waiting periods.

GM6000 DEN146 M

Class III Coinsurance – Employees and Dependents

Your plan includes a progressive increase of coinsurance benefit payable for Class III services according to the years you participate in the dental plan, as shown in The Schedule.

You and your Dependents will receive the benefit level for Class III services applicable to your years of participation.

GM6000 DEN146 M

Covered Dental Expense

Covered Dental Expense means that portion of a Dentist’s charge that is payable for a service delivered to a covered person provided:

- the service is ordered or prescribed by a Dentist;
- is essential for the Necessary care of teeth;

- the service is within the scope of coverage limitations;
- the deductible amount in The Schedule has been met;
- the maximum benefit in The Schedule has not been exceeded;
- the charge does not exceed the amount allowed under the Alternate Benefit Provision;
- for Class I, II or III the service is started and completed while coverage is in effect, except for services described in the “Benefits Extension” section.

GM6000 DEN160

Alternate Benefit Provision

If more than one covered service will treat a dental condition, payment is limited to the least costly service provided it is a professionally accepted, necessary and appropriate treatment.

If the covered person requests or accepts a more costly covered service, he or she is responsible for expenses that exceed the amount covered for the least costly service. Therefore, CG recommends Predetermination of Benefits before major treatment begins.

Predetermination of Benefits

Predetermination of Benefits is a voluntary review of a Dentist’s proposed treatment plan and expected charges. It is not preauthorization of service and is not required.

The treatment plan should include supporting pre-operative x-rays and other diagnostic materials as requested by CG’s dental consultant. If there is a change in the treatment plan, a revised plan should be submitted.

CG will determine covered dental expenses for the proposed treatment plan. If there is no Predetermination of Benefits, CG will determine covered dental expenses when it receives a claim.

Review of proposed treatment is advised whenever extensive dental work is recommended (when charges exceed \$500).

Predetermination of Benefits is not a guarantee of a set payment. Payment is based on the services that are actually delivered and the coverage in force at the time services are completed.

GM6000 DEN161M

Missing Teeth Limitation

The amount payable for the replacement of teeth that are missing when a person first becomes insured is 50% of the amount payable for the replacement of teeth that are extracted after a person has dental coverage.

This payment limitation no longer applies after 24 months of continuous coverage.

This limitation will not apply to any person who is a member



of the Initial Employee group.

GM6000 DEN165M

Covered Services

The following section lists covered dental services, if service is not listed there is no coverage.

CG may agree to cover expenses for a service not listed. To be considered, the service should be identified using the American Dental Association Uniform Code of Dental Procedures and Nomenclature, or by description and then submitted to CG.

GM6000 DEN166V2

Dental PPO – Participating and Non-Participating Providers

Payment for a service delivered by a Participating Provider is the Contracted Fee, times the benefit percentage that applies to the class of service, as specified in the Schedule.

The covered person is responsible for the balance of the Contracted Fee.

Payment for a service delivered by a non-Participating Provider is the Maximum Reimbursable Charge times the benefit percentage that applies to the class of service, as specified in the Schedule.

The covered person is responsible for the balance of the provider's actual charge.

GM6000 DES426

Class I Services – Diagnostic And Preventive Dental Services

Bitewing x-rays - 2 sets in any calendar year. Limited to a maximum of 4 films per set.

Clinical oral evaluation – Only 2 per calendar year.

Prophylaxis (Cleaning) - 2 prophylaxis or periodontal maintenance procedures per calendar year.

Topical application of fluoride (excluding prophylaxis) - Limited to persons less than 19 years old. Only 1 per person per calendar year.

Topical application of sealant, per tooth, on an unrestored permanent bicuspid or molar tooth for a person less than 14 years old - Only 1 treatment per tooth per lifetime.

Space Maintainers - Limited to nonorthodontic treatment for prematurely removed or missing teeth for a person less than 14 years old.

GM6000 DES429 M

Class II Services – Diagnostic Services

Complete mouth survey or panoramic x-rays - only 1 in any 3 calendar year period. For benefit determination purposes, a

full mouth series will be determined to include bitewings and 10 or more periapical x-rays.

Individual periapical x-rays - A maximum of 4 periapical x-rays which are not performed in conjunction with an operative procedure are payable in any calendar year.

Intraoral occlusal x-rays - Limited to 2 films in any calendar year.

Fillings

Amalgam Restorations - Multiple restorations on one surface will be paid as a single filling. Benefits for replacement of an existing amalgam restoration are only payable if at least a calendar year has passed since the existing amalgam was placed.

Silicate Restorations - Benefits for the replacement of an existing silicate restoration are only payable if at least a calendar year has passed since the existing filling was placed.

Composite Resin Restorations - Restorations which involve either the mesial or distal surface are considered single surface restorations unless the incisal angle is also involved. Benefits for the replacement of an existing composite restoration are payable only if at least a calendar year has passed since the existing filling was placed. Benefits for composite resin restorations on bicuspid and molar teeth will be based on the benefit for the corresponding amalgam restoration.

GM6000 DES430

Pin Retention - Covered only in conjunction with amalgam or composite restoration. Payable one time per restoration regardless of the number of pins used.

Oral Surgery, Routine Extractions

Routine Extraction - Includes an allowance for local anesthesia and routine postoperative care.

Root Removal - Exposed Roots - Includes an allowance for local anesthesia and routine postoperative care.

Miscellaneous Services

Palliative (emergency) Treatment of Dental Pain – Minor Procedures - paid as a separate benefit only if no other service, except x-rays, is rendered during the visit.

GM6000 DES431

Class III Services – Diagnostic Procedures

Histopathologic Examinations - Payable only if the surgical biopsy is also covered under this plan.

Denture Adjustments, Rebasing and Relining

Denture Adjustments – Only covered 1 time in any calendar year, and only if performed more than one calendar year after the insertion of the denture.

Relining Dentures, Rebasing Dentures – Limited to relining or rebasing done more than one calendar year after the initial



insertion, and then not more than one time in any 3 calendar year period.

Tissue Conditioning - maxillary or mandibular – Payable only if at least one calendar year has elapsed since the insertion of a full or partial denture and only once in any 3 calendar year period.

Repairs To Crowns and Inlays

Recent Inlays - No limitation.

Recent Crowns - No limitation.

Repairs to Crowns - Limited to repairs performed more than one calendar year after initial insertion.

Repairs To Dentures and Bridges

Repairs to Full and Partial Dentures - Limited to repairs performed more than one calendar year after initial insertion.

Recent Fixed Partial Denture - Limited to repairs performed more than one calendar year after initial insertion.

Fixed Partial Denture Repair, by Report - Limited to repairs performed more than one calendar year after initial insertion.

GM6000 DES432

Inlays, Onlays and Crowns

Inlays and Onlays – Covered only when the tooth cannot be restored by an amalgam or composite filling due to major decay or fracture, and then only if more than 5 calendar years have elapsed since the last placement.

Crowns – Covered only when the tooth cannot be restored by an amalgam or composite filling due to major decay or fracture, and then only if more than 5 calendar years have elapsed since the last placement. For persons under 16 years of age, benefits for crowns on vital teeth are limited to Resin or Stainless Steel Crowns.

Benefits for crowns are based on the amount payable for nonprecious metal substrate.

Stainless Steel Crowns, Resin Crowns – Covered only when the tooth cannot be restored by filling and then only 1 time in a 3 calendar year period. Limited to persons under the age of 16.

Post and Core (in conjunction with a crown or inlay) – Covered only for endodontically treated teeth with total loss of tooth structure.

GM6000 DES433

Endodontic Procedures

Therapeutic Pulpotomy - Payable for deciduous teeth only.

Root Canal Therapy, Primary Tooth (excluding final restoration) - Includes all preoperative, operative and postoperative x-rays, bacteriological cultures, diagnostic tests, local anesthesia and routine follow-up care.

Root Canal Therapy – Permanent Tooth – Includes all preoperative, operative and postoperative x-rays, bacteriological cultures, diagnostic tests, local anesthesia and routine follow-up care.

Root Canal Therapy, Retreatment – by Report - Covered only if more than 2 calendar years have passed since the original endodontic therapy and only if necessity is confirmed by professional review.

Apexification – Includes all preoperative, operative and postoperative x-rays, bacteriological cultures, diagnostic tests, local anesthesia and routine follow-up care. A maximum of 3 visits per tooth are payable.

Apicoectomy – Includes all preoperative, operative and postoperative x-rays, bacteriological cultures, diagnostic tests, local anesthesia and routine follow-up care.

Retrograde Filling (per root) – Includes all preoperative, operative and postoperative x-rays, bacteriological cultures, diagnostic tests, local anesthesia and routine follow-up care. Not separately payable on the same date and tooth as an Apicoectomy.

Root Amputation (per root) – Includes all preoperative, operative and postoperative x-rays, bacteriological cultures, diagnostic tests, local anesthesia and routine follow-up care.

Hemisection – Fixed bridgework replacing the extracted portion of a hemisected tooth is not covered. Procedure includes local anesthesia and routine postoperative care.

GM6000 DES434

Minor Periodontal Procedures

Periodontal Scaling and Root Planing (if not related to periodontal surgery) – Per Quadrant - Limited to 1 time per quadrant of the mouth in any 3 calendar year period. Not separately payable if performed on the same treatment plan as prophylaxis.

Periodontal Maintenance Procedures Following Active Therapy – Payable only if at least 6 months have passed since the completion of active periodontal surgery. Only 1 periodontal maintenance procedure or adult prophylaxis is payable in any 6-month period. This procedure includes an allowance for an exam and scaling and root planing.

Major Periodontal Surgery

Gingivectomy – Only one periodontal surgical procedure is covered per area of the mouth in any 3 calendar year period.

Gingival Flap Procedure Including Root Planing – Only 1 periodontal surgical procedure is covered per area of the mouth in any 3 calendar year period.

Clinical Crown Lengthening – Hard Tissue – No limitation.

Mucogingival Surgery – Per Quadrant – only 1 periodontal surgical procedure is covered per area of the mouth in any 3 calendar year period.



Osseous Surgery – only 1 periodontal surgical procedure is covered per area of the mouth in any 3 calendar year period.

Bone Replacement Graft – First Site Quadrant.

Bone Replacement Graft – Each Additional Site in Quadrant.

Guided Tissue Regeneration – Resorbable Barrier – per Site, per Tooth - Only 1 periodontal surgical procedure is covered per area of the mouth in any 3 calendar year period. Not payable as a discrete procedure if performed during the same operative session in the same site as osseous surgery.

GM6000 DES435

Pedicle Soft Tissue Graft – No limitation.

Free Soft Tissue Graft (including donor site surgery) – No limitation.

Subepithelial Connective Tissue Graft Procedure (including donor site surgery) – No limitation.

Distal or Proximal Wedge Procedure (when not performed in conjunction with surgical procedures in the same anatomical area) – No limitation.

Oral Surgery - Surgical Extractions

Surgical Extraction – (except for the removal of impacted teeth) – Includes an allowance for local anesthesia and routine postoperative care

Surgical Removal of Residual Tooth Roots (Cutting Procedure) – Includes an allowance for local anesthesia and routine postoperative care.

Other Oral Surgery

Tooth Transplantation (includes reimplantation from one site to another and splinting and/or stabilization) – Includes an allowance for local anesthesia and routine postoperative care.

Surgical Exposure of Impacted or Unerupted Tooth to Aid Eruption – Includes an allowance for local anesthesia and routine postoperative care.

Biopsy of Oral Tissue – Includes an allowance for local anesthesia and routine postoperative care.

Alveoloplasty – Includes an allowance for local anesthesia and routine postoperative care.

Vestibuloplasty – Includes an allowance for local anesthesia and routine postoperative care. Only payable when performed primarily to facilitate insertion of a removable denture.

Radical Excision of Reactive Inflammatory Lesions (Scar Tissue or Localized Congenital Lesions) – Includes an allowance for local anesthesia and routine postoperative care.

Removal of Odontogenic Cyst or Tumor – Includes an allowance for local anesthesia and routine postoperative care.

GM6000 DES436

Removal of Exostosis – Maxilla or Mandible – Includes an allowance for local anesthesia and routine postoperative care.

Incision and Drainage – Includes an allowance for local anesthesia and routine postoperative care.

Osseous, Osteoperiosteal, or Cartilage Graft of the Mandible or Facial bones – Autogenous or Nonautogenous, by Report – Includes an allowance for local anesthesia and routine postoperative care. Only payable when performed primarily to facilitate insertion of a removable denture.

Frenectomy (Frenulectomy, Frenotomy), Separate Procedure – Includes an allowance for local anesthesia and routine postoperative care.

Excision of Hyperplastic Tissue – Per Arch - Includes an allowance for local anesthesia and routine postoperative care.

Excision of Pericoronal Gingiva – Includes an allowance for local anesthesia and routine postoperative care.

Synthetic Graft – Mandible or Facial Bones, by Report – Includes an allowance for local anesthesia and routine postoperative care. Only payable when performed primarily to facilitate insertion of a removable denture.

Surgical Extraction of Impacted Teeth

Surgical Removal of Impacted Tooth – Soft Tissue – The benefit includes an allowance for local anesthesia and routine postoperative care.

Surgical Removal of Impacted Tooth – Partially Bony – The benefit includes an allowance for local anesthesia and routine postoperative care.

Surgical Removal of Impacted Tooth – Completely Bony – The benefit includes an allowance for local anesthesia and routine postoperative care.

Removal of Impacted Tooth; Completely Bony, with Unusual Surgical Complications – The benefit includes an allowance for local anesthesia and routine postoperative care.

GM6000 DES437

Prosthetics

Full dentures – There are no additional benefits for personalized dentures or overdentures or associated procedures. CG will not pay for any denture until it is accepted by the patient. Limited to one time per arch per 7 calendar years. Partial dentures – There are no additional benefits for precision or semiprecision attachments. The benefit for a partial denture includes any clasps and rests and all teeth. CG will not pay for any denture until it is accepted by the patient. Limited to one partial denture per arch per 7 calendar years unless there is a necessary extraction of an additional functioning natural tooth.

Add tooth to existing partial denture to replace newly extracted Functional Natural Tooth – Only if more than a calendar year has elapsed since the insertion of the partial denture.



Complete and partial overdentures – There are no additional benefits for precision or semiprecision attachments. The benefit for a partial denture includes any clasps and rests and all teeth. CG will not pay for any denture until it is accepted by the patient. Limited to one partial denture per arch per 7 calendar years unless there is a necessary extraction of an additional functioning natural tooth.

Post and core (in conjunction with a fixed bridge) – Covered only for endodontically treated teeth with total loss of tooth structure.

GM6000 DES438

Fixed Partial Dentures (Nonprecious Metal Pontics, Retainer Crowns and Metallic Retainers) – Benefits will be considered for the initial replacement of a Necessary Functioning Natural Tooth extracted while the person was covered under the plan.

Replacement: Benefits for the replacement of an existing bridge are payable only if the existing bridge is at least 7 calendar years old, is not serviceable, and cannot be repaired.

Benefits for retainer crowns and pontics are based on the amount payable for nonprecious metal substrates.

Cast Metal Retainer for Resin Bonded Fixed Bridge – Benefits will be considered for the initial replacement of a Necessary Functioning Natural Tooth extracted while the person was covered under the plan.

Replacement: Benefits are based on the amount payable for nonprecious metal substrates. Benefits for the replacement of an existing resin bonded bridge are payable only if the existing resin bonded bridge is at least 7 calendar years old, is not serviceable, and cannot be repaired.

Anesthesia and IV Sedation

General Anesthesia – Paid as a separate benefit only when medically or dentally necessary and when administered in conjunction with complex oral surgical procedures which are covered under this plan.

I. V. Sedation - Paid as a separate benefit only when medically or dentally necessary and when administered in conjunction with complex oral surgical procedures which are covered under this plan.

GM6000 DES442

Class IV Services - Orthodontics

Each month of active treatment is a separate Dental Service.

Covered Orthodontic Treatment

- cephalometric x-rays;
- full mouth or panoramic x-rays taken in conjunction with an orthodontic treatment plan;
- diagnostic casts (i.e., study models) for orthodontic evaluation;

surgical exposure of impacted or unerupted tooth for orthodontic purposes;

fixed or removable orthodontic appliances for tooth movement and/or tooth guidance.

Orthodontia Provision

The total amount payable for all expenses incurred for Orthodontics during a Dependent child's lifetime will not be more than the Orthodontia Maximum shown in The Schedule. Benefits are payable under this plan only for active Orthodontic Treatment and for the Orthodontic services on the list of Dental Services for dependent children who are under age 19 on the date the Orthodontic Treatment is started.

No benefits are payable for retention in the absence of full active Orthodontic Treatment.

Charges will be considered, subject to other plan conditions, as follows:

- 25% of the total case fee will be considered as being incurred on the date the initial active appliance is placed;
- the remainder of the total case fee will be divided by the number of months for the total treatment plan and the resulting portion will be considered to be incurred on a monthly basis until the plan maximum is paid, treatment is completed or eligibility ends. Payments will be made quarterly.

GM6000 DES459

Replacement Provisions For Orthodontic Coverage

Coverage will be provided if Orthodontic Treatment was Started while your Dependent child was covered for Orthodontic benefits under the prior carrier's plan and:

- Orthodontic Treatment is continued under this plan; and
- proof that the Maximum Benefit under this plan was not equaled or exceeded by the benefits paid or payable under the previous plan is submitted to CG;

In this case the Maximum Benefit for the Dependent child will be calculated determining:

- the lesser of the Maximum Benefit of this plan and the maximum benefit of the replacement plan; and
- subtracting the benefit paid or payable by the prior plan from the amount in the bullet above. The remainder of the benefit is payable under this plan.

In no event will the Dependent child receive more in Orthodontic benefits than the amount which the Dependent child would have received had the prior plan remained in effect.

GM6000 DES460



Expenses Not Covered

Covered Expenses do not include expenses incurred for:

- procedures which are not included in the list of Covered Dental Expenses.
- procedures which are not necessary and which do not have uniform professional endorsement.
- procedures for which a charge would not have been made in the absence of coverage or for which the covered person is not legally required to pay.
- any procedure, service, supply or appliance, the sole or primary purpose of which relates to the change or maintenance of vertical dimension.
- procedures, appliances or restorations whose main purpose is to diagnose or treat jaw joint problems, including dysfunction of the temporomandibular joint and craniomandibular disorders, or other conditions of the joints linking the jawbone and skull, including the complex muscles, nerves and other tissues related to that joint.
- the alteration or restoration of occlusion.
- the restoration of teeth which have been damaged by erosion, attrition or abrasion.
- bite registration or bite analysis.
- any procedure, service, or supply provided primarily for cosmetic purposes. Facings, repairs to facings or replacement of facings on crowns or bridge units on molar teeth shall always be considered cosmetic.

GM6000 DEN175

- the surgical placement of an implant body or framework of any type; surgical procedures in anticipation of implant placement; any device, index or surgical template guide used for implant surgery; treatment or repair of an existing implant; prefabricated or custom implant abutments; removal of an existing implant.
- crowns, inlays, cast restorations, or other laboratory prepared restorations on teeth unless the tooth cannot be restored with an amalgam or composite resin filling due to major decay or fracture.
- core build-ups.
- replacement of a partial denture, full denture, or fixed bridge or the addition of teeth to a partial denture unless:
 - (a) replacement occurs at least 7 calendar years after the initial date of insertion of the current full or partial denture; or
 - (b) the partial denture is less than 7 calendar years old, and the replacement is needed due to a necessary extraction of an additional functioning natural tooth while the person is covered under this plan (alternate benefits of

adding a tooth to an existing appliance may be applied); or

- (c) replacement occurs at least 7 calendar years after the initial date of insertion of an existing fixed bridge (if the prior bridge is less than 7 calendar years old, and replacement is needed due to an additional Necessary extraction of a functioning natural tooth while the person is covered under this plan. Benefits will be considered only for the pontic replacing the additionally extracted tooth).
- The removal of only a permanent third molar will not qualify an initial or replacement partial denture, full denture or fixed bridge for benefits.

GM6000 DEN179

- the replacement of crowns, cast restoration, inlay, onlay or other laboratory prepared restorations within 7 calendar years of the date of insertion.
- The replacement of a bridge, crown, cast restoration, inlay, onlay or other laboratory prepared restoration regardless of age unless necessitated by major decay or fracture of the underlying Natural Tooth.
- replacement of a partial denture or full denture which can be made serviceable or is replaceable.
- replacement of lost or stolen appliances.
- replacement of teeth beyond the normal complement of 32.
- prescription drugs.
- any procedure, service, supply or appliance used primarily for the purpose of splinting.
- athletic mouth guards.
- myofunctional therapy.
- precision or semiprecision attachments.
- denture duplication.
- separate charges for acid etch.
- labial veneers (laminare).
- treatment of jaw fractures and orthognathic surgery.
- charges for sterilization of equipment, disposal of medical waste or other requirements mandated by OSHA or other regulatory agencies and infection control.
- charges for travel time; transportation costs; or professional advice given on the phone.
- procedures performed by a Dentist who is a member of the covered person's family (the covered person's family is limited to spouse, siblings, parents, children, grandparents, and the spouse's siblings and parents), except in the case of a dental emergency and no other Dentist is available.
- temporary, transitional or interim dental services.



- any procedure, service or supply not reasonably expected to correct the patient’s dental condition for a period of at least 3 calendar years, as determined by CG.
- diagnostic casts, diagnostic models, or study models.
- any charge for any treatment performed outside of the United States other than for Emergency Treatment (any benefits for Emergency Treatment which is performed outside of the United States will be limited to a maximum of (\$100 - \$200) per calendar year period);
- oral hygiene and diet instruction; broken appointments; completion of claim forms; personal supplies (e.g., water pick, toothbrush, floss holder, etc.); duplication of x-rays and exams required by a third party;
- any charges, including ancillary charges, made by a hospital, ambulatory surgical center or similar facility;
- services for which benefits are not payable according to the "General Limitations" section.

GM6000 DEN182

General Limitations

Dental Benefits

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

- for or in connection with an injury arising out of, or in the course of, any employment for wage or profit;
- for or in connection with a Sickness which is covered under any workers' compensation or similar law;
- for charges made by a Hospital owned or operated by or which provides care or performs services for, the United States Government, if such charges are directly related to a military-service-connected condition;
- services or supplies received as a result of dental disease, defect or injury due to an act of war, declared or undeclared;
- to the extent that payment is unlawful where the person resides when the expenses are incurred;
- for charges which the person is not legally required to pay;
- for charges which would not have been made if the person had no insurance;
- to the extent that billed charges exceed the rate of reimbursement as described in the Schedule;
- for charges for unnecessary care, treatment or surgery;
- to the extent that you or any 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.

GM6000 GEN312V4

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.

Coverage under this Plan plus another Plan will not guarantee 100% total reimbursement.

Definitions

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

Plan

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

- (1) 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.
- (2) Governmental benefits as permitted by law, excepting Medicaid, Medicare and Medicare supplement policies.
- (3) Medical benefits coverage of group, group-type, and individual automobile contracts.

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

Closed Panel Plan

A Plan that provides medical or dental benefits primarily in the form of services through a panel of employed or contracted providers, and which 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 Plan that determines and provides or pays benefits without taking into consideration the existence of any other Plan.

Secondary Plan

A 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.

GM6000 MOB1

v5



Reasonable Cash Value

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

Order of Benefit Determination Rules

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

- (1) The Plan that covers a person as an enrollee or an employee shall be the Primary Plan and the Plan that covers that person as a Dependent shall be the Secondary Plan;
- (2) For a Dependent child whose parents are not divorced or legally separated, the Primary Plan shall be the Plan which covers the parent whose birthday falls first in the calendar year;
- (3) For the Dependent of divorced or separated parents, benefits for the Dependent shall be determined in the following order:
 - (a) first, if a court decree states that one parent is responsible for the child's healthcare expenses or health coverage and the Plan for that parent has actual knowledge of the terms of the order, but only from the time of actual knowledge;
 - (b) then, the Plan of the parent with custody of the child;
 - (c) then, the Plan of the spouse of the parent with custody of the child;
 - (d) then, the Plan of the noncustodial parent of the child, and
 - (e) finally, the Plan of the spouse of the parent not having custody of the child.

GM6000 MOB2

- (4) The Plan that covers you as an active employee (or as that employee's Dependent) shall be the Primary Plan and the Plan that covers you as laid-off or retired employee (or as that employee's Dependent) shall be the secondary Plan. If the other Plan does not have a similar provision and, as a result, the Plans cannot agree on the order of benefit determination, this paragraph shall not apply.
- (5) The Plan that covers you under a right of continuation which is provided by federal or state law shall be the Secondary Plan and the Plan that covers you as an active employee or retiree (or as that employee's Dependent) shall be the Primary Plan. If the other Plan

does not have a similar provision and, as a result, the Plans cannot agree on the order of benefit determination, this paragraph shall not apply.

- (6) If one of the Plans that covers you is issued out of the state whose laws govern this Policy, 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 benefit determination, the Plan with the gender rules shall determine the order of benefits.

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

Effect on the Benefits of This Plan

If this Plan is the Secondary Plan, the benefits that would be payable under this Plan in the absence of Coordination will be reduced by the benefits payable under all other Plans for the expense covered under this Plan.

When a Plan provides benefits in the form of services, the Reasonable Cash Value of each service rendered will be considered both an expense incurred and a benefit payable.

GM6000 MOB3V5

Recovery of Excess Benefits

If CG pays charges for services and supplies that should have been paid by the Primary Plan, CG will have the right to recover such payments.

CG will have sole discretion 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

CG, without consent or notice to you, may obtain information from and release information to any other Plan with respect to you in order to coordinate your benefits pursuant to this section. You must provide us with any information we request in order to coordinate your benefits pursuant to this section. This request may occur in connection with a submitted claim; if so, you will be advised that the "other coverage" information, (including an Explanation of Benefits paid under the Primary Plan) is required before the claim will be processed for payment. If no response is received within 90 days of the request, the claim will be denied. If the requested information is subsequently received, the claim will be processed.

GM6000 MOB4



Expenses For Which A Third Party May Be Liable

This policy does not cover expenses for which another party may be responsible as a result of having caused or contributed to the Injury or Sickness. If you incur a Covered Expense for which, in the opinion of CG, another party may be liable:

1. CG shall, to the extent permitted by law, be subrogated to all rights, claims or interests which you may have against such party and shall automatically have a lien upon the proceeds of any recovery by you from such party to the extent of any benefits paid under the Policy. You or your representative shall execute such documents as may be required to secure CG's subrogation rights.
2. Alternatively, CG may, at its sole discretion, pay the benefits otherwise payable under the Policy. However, you must first agree in writing to refund to CG the lesser of:
 - a. the amount actually paid for such Covered Expenses by CG; or
 - b. the amount you actually receive from the third party for such Covered Expenses;at the time that the third party's liability is determined and satisfied, whether by settlement, judgment, arbitration or award or otherwise.

GM6000 CCP7

CCL7

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 Policyholder, all or any part of them may be paid directly to the person or institution on whose charge 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.

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.

GM6000 POB12

PMT135V16

Miscellaneous

If you are a CIGNA Dental plan member as well as a member of a CIGNA medical plan, you may be eligible for additional dental benefits during certain episodes of care. For example, certain frequency limitations for dental services may be relaxed for pregnant women, diabetics or those with cardiac disease. Please review your plan enrollment materials for details.

GM6000 POB8

Termination of Insurance

Employees

Your insurance will cease on the earliest date below:

- the last day of the calendar month you cease to be in a Class of Eligible Employees or cease to qualify for the insurance.
- the last day for which you have made any required contribution for the insurance.
- the date the policy is canceled.
- the last day of the calendar month in which your Active Service ends except as described below.

Any continuation of insurance must be based on a plan which precludes individual selection.

Temporary Layoff or Leave of Absence

If your Active Service ends due to temporary layoff or leave of absence, your insurance will be continued until the date your Employer: (a) stops paying premium for you; or (b) otherwise cancels your insurance. However, your insurance will not be continued for more than 60 days past the date your Active Service ends.

Injury or Sickness

If your Active Service ends due to an Injury or Sickness, your insurance will be continued while you remain totally and continuously disabled as a result of the Injury or Sickness. However, your insurance will not continue past the date your Employer stops paying premium for you or otherwise cancels the insurance.

GM6000 TRM23V3



Dependents

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

- the last day of the calendar month your insurance ceases.
- the last day of the calendar month you cease to be eligible for Dependent Insurance.
- the last day for which you have made any required contribution for the insurance.
- the last day of the calendar month Dependent Insurance is canceled.

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

GM6000

TRM309

Dental Benefits Extension

An expense incurred in connection with a Dental Service that is completed after a person's benefits cease will be deemed to be incurred while he is insured if:

- for fixed bridgework and full or partial dentures, the first impressions are taken and/or abutment teeth fully prepared while he is insured and the prosthesis inserted within 3 calendar months after his insurance ceases.
- for a crown, inlay or onlay, the tooth is prepared while he is insured and the crown, inlay or onlay installed within 3 calendar months after his insurance ceases.
- for root canal therapy, the pulp chamber of the tooth is opened while he is insured and the treatment is completed within 3 calendar months after his insurance ceases.

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

GM6000 BE6

BEX131V7

Federal Requirements

The following pages explain your rights and responsibilities under federal laws and regulations. Some states may have similar requirements. If a similar provision appears elsewhere in this booklet, the provision which provides the better benefit will apply.

FDRL1

V2

Notice of Provider Directory/Networks

Notice Regarding Provider Directories and Provider Networks

If your Plan utilizes a network of Providers, you will automatically and without charge, receive a separate listing of Participating Providers.

You may also have access to determine which providers participate in the network by visiting www.cigna.com;

mycigna.com or by calling the toll-free telephone number on your ID card.

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.

FDRL32M

Qualified Medical Child Support Order (QMCSO)

A. Eligibility for Coverage Under a QMCSO

If a Qualified Medical Child Support Order (QMCSO) 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 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 QMCSO being issued.

B. Qualified Medical Child Support Order Defined

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 health benefit coverage to such child and relates to benefits under the group health plan, and satisfies all of the following:

1. the order recognizes or creates a child's right to receive group health benefits for which a participant or beneficiary is eligible;
2. 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;
3. the order provides a description of the coverage to be provided, or the manner in which the type of coverage is to be determined;
4. the order states the period to which it applies; and
5. 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 QMCSO may not require the health insurance policy to provide coverage for any type or form of benefit or option not otherwise provided under the policy, except that an order may require a plan to comply with State laws regarding health care coverage.



C. Payment of Benefits

Any payment of benefits in reimbursement for Covered Expenses paid by the child, or 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.

FDRL2

VI

Effect of Section 125 Tax Regulations on This Plan

Your Employer has chosen to administer this Plan in accordance with Section 125 regulations of the Internal Revenue Code. Per this regulation, you may agree to a pretax salary reduction put toward the cost of your benefits. Otherwise, you will receive your taxable earnings as cash (salary).

A. Coverage Elections

Per Section 125 regulations, you are generally allowed to enroll for or change coverage only before each annual benefit period. However, exceptions are allowed if your Employer agrees and you enroll for or change coverage within 30 days of the following:

- the date you meet the Special Enrollment criteria described above; or
- the date you meet the criteria shown in the following Sections B through F.

B. Change of Status

A change in status is defined as:

- (a) change in legal marital status due to marriage, death of a spouse, divorce, annulment or legal separation;
- (b) change in number of Dependents due to birth, adoption, placement for adoption, or death of a Dependent;
- (c) change in employment status of Employee, spouse or Dependent due to termination or start of employment, strike, lockout, beginning or end of unpaid leave of absence, including under the Family and Medical Leave Act (FMLA), or change in worksite;
- (d) changes in employment status of Employee, spouse or Dependent resulting in eligibility or ineligibility for coverage;
- (e) change in residence of Employee, spouse or Dependent to a location outside of the Employer’s network service area; and
- (f) changes which cause a Dependent to become eligible or ineligible for coverage.

C. Court Order

A change in coverage due to and consistent with a court order of the Employee or other person to cover a Dependent.

D. Medicare or Medicaid Eligibility/Entitlement

The Employee, spouse or Dependent cancels or reduces coverage due to entitlement to Medicare or Medicaid, or enrolls or increases coverage due to loss of Medicare or Medicaid eligibility.

E. Change in Cost of Coverage

If the cost of benefits increases or decreases during a benefit period, your Employer may, in accordance with plan terms, automatically change your elective contribution.

When the change in cost is significant, you may either increase your contribution or elect less-costly coverage. When a significant overall reduction is made to the benefit option you have elected, you may elect another available benefit option. When a new benefit option is added, you may change your election to the new benefit option.

F. Changes in Coverage of Spouse or Dependent Under Another Employer’s Plan

You may make a coverage election change if the plan of your spouse or Dependent: (a) incurs a change such as adding or deleting a benefit option; (b) allows election changes due to Special Enrollment, Change in Status, Court Order or Medicare or Medicaid Eligibility/Entitlement; or (c) this Plan and the other plan have different periods of coverage or open enrollment periods.

FDRL5

Eligibility for Coverage 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 Insurance 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 health coverage ceases when the placement ends, and will not be continued.

The provisions in the “Exception for Newborns” section of this document that describe requirements for enrollment and effective date of insurance will also apply to an adopted child or a child placed with you for adoption.

FDRL6



Federal Tax Implications for Dependent Coverage

Premium payments for Dependent health insurance are usually exempt from federal income tax. Generally, if you can claim an individual as a Dependent for purposes of federal income tax, then the premium for that Dependent's health insurance coverage will not be taxable to you as income. However, in the rare instance that you cover an individual under your health insurance who does not meet the federal definition of a Dependent, the premium may be taxable to you as income. If you have questions concerning your specific situation, you should consult your own tax consultant or attorney.

FDRL7

Group Plan Coverage Instead of Medicaid

If your income does not exceed 100% of the official poverty line and your liquid resources are at or below twice the Social Security income level, the state may decide to pay premiums for this coverage instead of for Medicaid, if it is cost effective. This includes premiums for continuation coverage required by federal law.

FDRL10

Requirements of Medical Leave Act of 1993 (FMLA)

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

A. Continuation of Health Insurance During Leave

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

- that leave qualifies as a leave of absence under the Family and Medical Leave Act of 1993; and
- you are an eligible Employee under the terms of that Act.

The cost of your health insurance during such leave must be paid, whether entirely by your Employer or in part by you and your Employer.

B. Reinstatement of Canceled Insurance Following Leave

Upon your return to Active Service following a leave of absence that qualifies under the Family and Medical Leave Act of 1993, any canceled insurance (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 to the extent that they had been satisfied prior to the start of such leave of absence.

Your Employer will give you detailed information about the Family and Medical Leave Act of 1993.

FDRL13

Uniformed Services Employment and Re-Employment Rights Act of 1994 (USERRA)

The Uniformed Services Employment and Re-employment Rights Act of 1994 (USERRA) sets requirements for continuation of health coverage and re-employment in regard to an Employee's military leave of absence. These requirements apply to medical and dental coverage for you and your Dependents.

A. Continuation of Coverage

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

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

You may continue benefits by paying the required premium to your Employer, until the earliest of the following:

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

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

Following continuation of health coverage per USERRA requirements, you may convert to a plan of individual coverage according to any "Conversion Privilege" shown in your certificate.

B. Reinstatement of Benefits (applicable to all coverages)

If your coverage ends during the leave of absence because you do not elect USERRA or an available conversion plan at the expiration of USERRA and you are reemployed by your current Employer, coverage for you and your Dependents may be reinstated if (a) you gave your Employer advance written or verbal notice of your military service leave, and (b) the duration of all military leaves while you are employed with your current Employer does not exceed 5 years.

You and your Dependents will be subject to only the balance of a Pre-Existing Condition Limitation (PCL) 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 rule regarding credit for time accrued toward a PCL waiting period will be waived.

If your coverage under this plan terminates as a result of your eligibility for military medical and dental coverage and your



order to active duty is canceled before your active duty service commences, these reinstatement rights will continue to apply.

FDRL58

Claim Determination Procedures Under ERISA Procedures Regarding Medical Necessity Determinations

In general, health services and benefits must be Medically Necessary to be covered under the plan. The procedures for determining Medical Necessity vary, according to the type of service or benefit requested, and the type of health plan.

You or your authorized representative (typically, your health care provider) must request Medical Necessity determinations according to the procedures described below, in the Certificate, and in your provider's network participation documents as applicable.

When services or benefits are determined to be not Medically Necessary, you or your representative will receive a written description of the adverse determination, and may appeal the determination. Appeal procedures are described in the Certificate, in your provider's network participation documents, and in the determination notices.

Concurrent Medical Necessity Determinations

When an ongoing course of treatment has been approved for you and you wish to extend the approval, you or your representative must request a required concurrent Medical Necessity determination at least 24 hours prior to the expiration of the approved period of time or number of treatments. When you or your representative requests such a determination, CG will notify you or your representative of the determination within 24 hours after receiving the request.

Postservice Medical Necessity Determinations

When you or your representative requests a Medical Necessity determination after services have been rendered, CG 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 CG's control CG 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. The determination period will be suspended on the date CG sends such a notice of missing information, and the determination period will resume on the date you or your representative responds to the notice.

FDRL35

Postservice Claim Determinations

When you or your representative requests payment for services which have been rendered, CG will notify you of the

claim payment determination within 30 days after receiving the request. However, if more time is needed to make a determination due to matters beyond CG's control, CG 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 within 45 days after receiving the notice. The determination period will be suspended on the date CG sends such a notice of missing information, and 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: (1) the specific reason or reasons for the adverse determination; (2) reference to the specific plan provisions on which the determination is based; (3) a description of any additional material or information necessary to perfect the claim and an explanation of why such material or information is necessary; (4) a description of the plan's review procedures and the time limits applicable, including a statement of a claimant's rights to bring a civil action under section 502(a) of ERISA following an adverse benefit determination on appeal; (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 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; and (6) in the case of a claim involving urgent care, a description of the expedited review process applicable to such claim.

FDRL36

COBRA Continuation Rights Under Federal Law

For You and Your Dependents

What is COBRA Continuation Coverage?

Under federal law, you and/or your Dependents must be given the opportunity to continue health insurance when there is a "qualifying event" that would result in loss of coverage under the Plan. You and/or your Dependents will be permitted to continue the same coverage under which you or your Dependents were covered on the day before the qualifying event occurred, unless you move out of that plan's coverage area or the plan is no longer available. You and/or your Dependents cannot change coverage options until the next open enrollment period.



When is COBRA Continuation Available?

For you and your Dependents, COBRA continuation is available for up to 18 months from the date of the following qualifying events if the event would result in a loss of coverage under the Plan:

- your termination of employment for any reason, other than gross misconduct, or
- your reduction in work hours.

For your Dependents, COBRA continuation coverage is available for up to 36 months from the date of the following qualifying events if the event would result in a loss of coverage under the Plan:

- your death;
- your divorce or legal separation; or
- for a Dependent child, failure to continue to qualify as a Dependent under the Plan.

Who is Entitled to COBRA Continuation?

Only a “qualified beneficiary” (as defined by federal law) may elect to continue health insurance coverage. A qualified beneficiary may include the following individuals who were covered by the Plan on the day the qualifying event occurred: you, your spouse, and your Dependent children. Each qualified beneficiary has their own right to elect or decline COBRA continuation coverage even if you decline or are not eligible for COBRA continuation.

The following individuals are not qualified beneficiaries for purposes of COBRA continuation: domestic partners, same sex spouses, grandchildren (unless adopted by you), stepchildren (unless adopted by you). Although these individuals do not have an independent right to elect COBRA continuation coverage, if you elect COBRA continuation coverage for yourself, you may also cover your Dependents even if they are not considered qualified beneficiaries under COBRA. However, such individuals’ coverage will terminate when your COBRA continuation coverage terminates.

FDRL20

V1

Secondary Qualifying Events

If, as a result of your termination of employment or reduction in work hours, your Dependent(s) have elected COBRA continuation coverage and one or more Dependents experience another COBRA qualifying event, the affected Dependent(s) may elect to extend their COBRA continuation coverage for an additional 18 months (7 months if the secondary event occurs within the disability extension period) for a maximum of 36 months from the initial qualifying event. The second qualifying event must occur before the end of the initial 18 months of COBRA continuation coverage or within the disability extension period discussed below. Under no circumstances will COBRA continuation coverage be

available for more than 36 months from the initial qualifying event. Secondary qualifying events are: your death; your divorce or legal separation; or, for a Dependent child, failure to continue to qualify as a Dependent under the Plan.

Disability Extension

If, after electing COBRA continuation coverage due to your termination of employment or reduction in work hours, you or one of your Dependents is determined by the Social Security Administration (SSA) to be totally disabled under title II or XVI of the SSA, you and all of your Dependents who have elected COBRA continuation coverage may extend such continuation for an additional 11 months, for a maximum of 29 months from the initial qualifying event.

To qualify for the disability extension, all of the following requirements must be satisfied:

1. SSA must determine that the disability occurred prior to or within 60 days after the disabled individual elected COBRA continuation coverage; and
2. A copy of the written SSA determination must be provided to the Plan Administrator within 60 calendar days after the date the SSA determination is made AND before the end of the initial 18-month continuation period.

If the SSA later determines that the individual is no longer disabled, you must notify the Plan Administrator within 30 days after the date the final determination is made by SSA. The 11-month disability extension will terminate for all covered persons on the first day of the month that is more than 30 days after the date the SSA makes a final determination that the disabled individual is no longer disabled.

All causes for “Termination of COBRA Continuation” listed below will also apply to the period of disability extension.

Medicare Extension for Your Dependents

When the qualifying event is your termination of employment or reduction in work hours and you became enrolled in Medicare (Part A, Part B or both) within the 18 months before the qualifying event, COBRA continuation coverage for your Dependents will last for up to 36 months after the date you became enrolled in Medicare. Your COBRA continuation coverage will last for up to 18 months from the date of your termination of employment or reduction in work hours.

FDRL21

Termination of COBRA Continuation

COBRA continuation coverage will be terminated upon the occurrence of any of the following:

- the end of the COBRA continuation period of 18, 29 or 36 months, as applicable;
- failure to pay the required premium within 30 calendar days after the due date;
- cancellation of the Employer’s policy with CIGNA;



- after electing COBRA continuation coverage, a qualified beneficiary enrolls in Medicare (Part A, Part B, or both);
- after electing COBRA continuation coverage, a qualified beneficiary becomes covered under another group health plan, unless the qualified beneficiary has a condition for which the new plan limits or excludes coverage under a pre-existing condition provision. In such case coverage will continue until the earliest of: (a) the end of the applicable maximum period; (b) the date the pre-existing condition provision is no longer applicable; or (c) the occurrence of an event described in one of the first three bullets above; or
- any reason the Plan would terminate coverage of a participant or beneficiary who is not receiving continuation coverage (e.g., fraud).

FDRL22

VI

Employer's Notification Requirements

Your Employer is required to provide you and/or your Dependents with the following notices:

- An initial notification of COBRA continuation rights must be provided within 90 days after your (or your spouse's) coverage under the Plan begins (or the Plan first becomes subject to COBRA continuation requirements, if later). If you and/or your Dependents experience a qualifying event before the end of that 90-day period, the initial notice must be provided within the time frame required for the COBRA continuation coverage election notice as explained below.
- A COBRA continuation coverage election notice must be provided to you and/or your Dependents within the following timeframes:
 - (a) if the Plan provides that COBRA continuation coverage and the period within which an Employer must notify the Plan Administrator of a qualifying event starts upon the loss of coverage, 44 days after loss of coverage under the Plan;
 - (b) if the Plan provides that COBRA continuation coverage and the period within which an Employer must notify the Plan Administrator of a qualifying event starts upon the occurrence of a qualifying event, 44 days after the qualifying event occurs; or
 - (c) in the case of a multi-employer plan, no later than 14 days after the end of the period in which Employers must provide notice of a qualifying event to the Plan Administrator.

How to Elect COBRA Continuation Coverage

The COBRA coverage election notice will list the individuals who are eligible for COBRA continuation coverage and inform you of the applicable premium. The notice will also include instructions for electing COBRA continuation coverage. You must notify the Plan Administrator of your election no later than the due date stated on the COBRA

election notice. If a written election notice is required, it must be post-marked no later than the due date stated on the COBRA election notice. If you do not make proper notification by the due date shown on the notice, you and your Dependents will lose the right to elect COBRA continuation coverage. If you reject COBRA continuation coverage before the due date, you may change your mind as long as you furnish a completed election form before the due date.

Each qualified beneficiary has an independent right to elect COBRA continuation coverage. Continuation coverage may be elected for only one, several, or for all Dependents who are qualified beneficiaries. Parents may elect to continue coverage on behalf of their Dependent children. You or your spouse may elect continuation coverage on behalf of all the qualified beneficiaries. You are not required to elect COBRA continuation coverage in order for your Dependents to elect COBRA continuation.

FDRL23

How Much Does COBRA Continuation Coverage Cost?

Each qualified beneficiary may be required to pay the entire cost of continuation coverage. The amount may not exceed 102% of the cost to the group health plan (including both Employer and Employee contributions) for coverage of a similarly situated active Employee or family member. The premium during the 11-month disability extension may not exceed 150% of the cost to the group health plan (including both employer and employee contributions) for coverage of a similarly situated active Employee or family member. For example:

If the Employee alone elects COBRA continuation coverage, the Employee will be charged 102% (or 150%) of the active Employee premium. If the spouse or one Dependent child alone elects COBRA continuation coverage, they will be charged 102% (or 150%) of the active Employee premium. If more than one qualified beneficiary elects COBRA continuation coverage, they will be charged 102% (or 150%) of the applicable family premium.

When and How to Pay COBRA Premiums

First payment for COBRA continuation

If you elect COBRA continuation coverage, you do not have to send any payment with the election form. However, you must make your first payment no later than 45 calendar days after the date of your election. (This is the date the Election Notice is postmarked, if mailed.) If you do not make your first payment within that 45 days, you will lose all COBRA continuation rights under the Plan.

Subsequent payments

After you make your first payment for COBRA continuation coverage, you will be required to make subsequent payments of the required premium for each additional month of coverage. Payment is due on the first day of each month. If



you make a payment on or before its due date, your coverage under the Plan will continue for that coverage period without any break.

Grace periods for subsequent payments

Although subsequent payments are due by the first day of the month, you will be given a grace period of 30 days after the first day of the coverage period to make each monthly payment. Your COBRA continuation coverage will be provided for each coverage period as long as payment for that coverage period is made before the end of the grace period for that payment. However, if your payment is received after the due date, your coverage under the Plan may be suspended during this time. Any providers who contact the Plan to confirm coverage during this time may be informed that coverage has been suspended. If payment is received before the end of the grace period, your coverage will be reinstated back to the beginning of the coverage period. This means that any claim you submit for benefits while your coverage is suspended may be denied and may have to be resubmitted once your coverage is reinstated. If you fail to make a payment before the end of the grace period for that coverage period, you will lose all rights to COBRA continuation coverage under the Plan.

FDRL24

V2

You Must Give Notice of Certain Qualifying Events

If you or your Dependent(s) experience one of the following qualifying events, you must notify the Plan Administrator within 60 calendar days after the later of the date the qualifying event occurs or the date coverage would cease as a result of the qualifying event:

- Your divorce or legal separation;
- Your child ceases to qualify as a Dependent under the Plan; or
- The occurrence of a secondary qualifying event as discussed under “Secondary Qualifying Events” above (this notice must be received prior to the end of the initial 18- or 29-month COBRA period).

(Also refer to the section titled “Disability Extension” for additional notice requirements.)

Notice must be made in writing and must include: the name of the Plan, name and address of the Employee covered under the Plan, name and address(es) of the qualified beneficiaries affected by the qualifying event; the qualifying event; the date the qualifying event occurred; and supporting documentation (e.g., divorce decree, birth certificate, disability determination, etc.).

Newly Acquired Dependents

If you acquire a new Dependent through marriage, birth, adoption or placement for adoption while your coverage is being continued, you may cover such Dependent under your COBRA continuation coverage. However, only your newborn or adopted Dependent child is a qualified beneficiary and may continue COBRA continuation coverage for the remainder of the coverage period following your early termination of COBRA coverage or due to a secondary qualifying event. COBRA coverage for your Dependent spouse and any Dependent children who are not your children (e.g., stepchildren or grandchildren) will cease on the date your COBRA coverage ceases and they are not eligible for a secondary qualifying event.

FDRL25

V1

Trade Act of 2002

The Trade Act of 2002 created a new tax credit for certain individuals who become eligible for trade adjustment assistance and for certain retired Employees who are receiving pension payments from the Pension Benefit Guaranty Corporation (PBGC) (eligible individuals). Under the new tax provisions, eligible individuals can either take a tax credit or get advance payment of 65% of premiums paid for qualified health insurance, including continuation coverage. If you have questions about these new tax provisions, you may call the Health Coverage Tax Credit Customer Contact Center toll-free at 1-866-628-4282. TDD/TYY callers may call toll-free at 1-866-626-4282. More information about the Trade Act is also available at www.doleta.gov/tradeact/2002act_index.asp.

In addition, if you initially declined COBRA continuation coverage and, within 60 days after your loss of coverage under the Plan, you are deemed eligible by the U.S. Department of Labor or a state labor agency for trade adjustment assistance (TAA) benefits and the tax credit, you may be eligible for a special 60 day COBRA election period. The special election period begins on the first day of the month that you become TAA-eligible. If you elect COBRA coverage during this special election period, COBRA coverage will be effective on the first day of the special election period and will continue for 18 months, unless you experience one of the events discussed under “Termination of COBRA Continuation” above. Coverage will not be retroactive to the initial loss of coverage. If you receive a determination that you are TAA-eligible, you must notify the Plan Administrator immediately.

Interaction With Other Continuation Benefits

You may be eligible for other continuation benefits under state law. Refer to the Termination section for any other continuation benefits.

FDRL26



ERISA Required Information

The name of the Plan is:

The Group Dental Care Plan for Faculty and Staff
for Vanderbilt University

The name, address, ZIP code and business telephone number
of the sponsor of the Plan is:

Vanderbilt University
Suite 500
2525 West End Avenue
Nashville TN 37235
(615) 322-8330

Employer Identification Number (EIN)	Plan Number
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62-0476822	507
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The name, address, ZIP code and business telephone number
of the Plan Administrator is:

Employer named above

The name, address and ZIP code of the person designated as
agent for the service of legal process is:

Employer named above

The office designated to consider the appeal of denied claims
is:

The CG Claim Office responsible for this Plan

The cost of the Plan is shared by Employee and Employer.

The Plan's fiscal year ends on 12/31.

The preceding pages set forth the eligibility requirements and
benefits provided for you under this Plan.

Plan Type

The plan is a healthcare benefit plan.

Collective Bargaining Agreements

You may contact the Plan Administrator to determine whether
the Plan is maintained pursuant to one or more collective
bargaining agreements and if a particular Employer is a
sponsor. A copy is available for examination from the Plan
Administrator upon written request.

FDRL27M

Discretionary Authority

The Plan Administrator delegates to CG the discretionary
authority to interpret and apply plan terms and to make factual
determinations in connection with its review of claims under
the plan. Such discretionary authority is intended to include,
but not limited to, the determination of the eligibility of
persons desiring to enroll in or claim benefits under the plan,
the determination of whether a person is entitled to benefits
under the plan, and the computation of any and all benefit
payments. The Plan Administrator also delegates to CG the

discretionary authority to perform a full and fair review, as
required by ERISA, of each claim denial which has been
appealed by the claimant or his duly authorized representative.

Plan Modification, Amendment and Termination

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
terminated, by the which the eligibility of classes of
employees may be changed or terminated, or by which part of
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 designated by the
Employer. No consent of any participant is required to
terminate, modify, amend or change the Plan.

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 medical expenses incurred prior to the date
that policy(s) terminates. Likewise, any extension of benefits
under the policy(s) due to you 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 life and
medical 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 affect 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;
- 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.

Statement of Rights

As a participant in the plan you are entitled to certain rights
and protections under the Employee Retirement Income
Security Act of 1974 (ERISA). ERISA provides that all plan
participants shall be entitled to:

FDRL28



Receive Information About Your Plan and Benefits

- examine, without charge, at the Plan Administrator's office and at other specified locations, such as worksites and union halls, all documents governing the plan, including insurance contracts and collective bargaining agreements and 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 Employee Benefits Security Administration.
- obtain, upon written request to the Plan Administrator, copies of documents governing the Plan, including insurance contracts and collective bargaining agreements, and a copy of the latest annual report (Form 5500 Series) and updated summary plan description. The administrator may make a reasonable charge for the copies.
- receive a summary of the Plan's annual financial report. The Plan Administrator is required by law to furnish each person under the Plan with a copy of this summary financial report.

Continue Group Health Plan Coverage

- continue health care coverage for yourself, your spouse or 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. Review this summary plan description and the documents governing the Plan on the rules governing your federal continuation coverage rights.
- reduction or elimination of exclusionary periods of coverage for preexisting conditions under your group health plan, if you have creditable coverage from another plan. You should be provided a certificate of creditable coverage, free of charge, from your group health plan or health insurance 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. Without evidence of creditable 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.

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 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 you have a 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.

FDRL29

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 a 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.

Assistance with Your Questions

If you have any questions about your plan, you should contact the 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 Employee Benefits Security Administration, U.S. Department of Labor listed in your telephone directory or the Division of Technical Assistance and Inquiries, Employee Benefits Security 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 Employee Benefits Security Administration.

FDRL59

Notice of an Appeal or a Grievance

The appeal or grievance provision in this certificate may be superseded by the law of your state. Please see your explanation of benefits for the applicable appeal or grievance procedure.

GM6000

NOT90



The Following Will Apply To Residents of Tennessee

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

Start with Member Services

We are here to listen and help. If you have a concern regarding a person, a service, the quality of care, or contractual benefits, you can call our toll-free number and explain your concern to one of our Customer Service representatives. You can also express that concern in writing. Please call or write to us at the following:

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

We will do our best to resolve the matter on your initial contact. If we need more time to review or investigate your 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.

Appeals Procedure

CG has a two step appeals procedure for coverage decisions. To initiate an appeal, you must submit a request for an appeal in writing within 365 days of receipt of a denial notice. You should state the reason why you feel your appeal should be approved and include any information supporting your appeal. If you are unable or choose not to write, you may ask to register your appeal by telephone. Call or write to us at the toll-free number or address on your Benefit Identification card, explanation of benefits or claim form.

GM6000 APL498V1

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.

For level-one appeals, we will respond in writing with a decision within 30 calendar days after we receive an appeal for a postservice coverage determination. If more time or information is needed to make the determination, we will

notify you in writing to request an extension of up to 15 calendar days and to specify any additional information needed to complete the review.

GM6000 APL500

Level-Two Appeal

If you are dissatisfied with our level-one appeal decision, you may request a second review. To start a level-two appeal, follow the same process required for a level-one appeal.

Most requests for a second review will be conducted by the Appeals Committee, which consists of at least three people. Anyone involved in the prior decision may not vote on the Committee. For appeals involving Medical Necessity or clinical appropriateness, the Committee will consult with at least one Dentist reviewer in the same or similar specialty as the care under consideration, as determined by CG's Dentist reviewer. You may present your situation to the Committee in person or by conference call.

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

GM6000 APL502

Appeal to the State of Tennessee

You have the right to contact the Department of Commerce and Insurance for assistance at any time. The Commissioner's Office may be contacted at the following address and telephone number:

Tennessee Department of Commerce and Insurance
500 James Robertson Parkway
Nashville, TN 37423
800-342-4029

GM6000 APL503

V2

Notice of Benefit Determination on Appeal

Every notice of a determination on appeal will be provided in writing or electronically and, if an adverse determination, will include: (1) the specific reason or reasons for the adverse determination; (2) reference to the specific plan 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; (4) a statement describing any voluntary appeal procedures offered by the



plan and the claimant's right to bring an action under ERISA section 502(a); (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 under Section 502(a) of ERISA if you are not satisfied with the decision on review. You or your plan may have other voluntary alternative dispute resolution options such as Mediation. One way to find out what may be available is to contact your local U.S. Department of Labor office and your State insurance regulatory agency. You may also contact the Plan Administrator.

Relevant Information

Relevant Information is any document, record, or other information which (a) was relied upon in making the benefit determination; (b) 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; (c) demonstrates compliance with the administrative processes and safeguards required by federal law in making the benefit determination; or (d) constitutes a statement of policy or guidance with respect to the plan concerning the denied treatment option or benefit or the claimant's diagnosis, without regard to whether such advice or statement was relied upon in making the benefit determination.

Legal Action

If your plan is governed by ERISA, you have the right to bring a civil action under Section 502(a) of ERISA if you are not satisfied with the outcome of the Appeals Procedure. In most instances, you may not initiate a legal action against CG until you have completed the Level-One and Level-Two Appeal processes. If your Appeal is expedited, there is no need to complete the Level-Two process prior to bringing legal action.

GM6000 APL504

Definitions

Active Service

You will be considered in Active Service:

- on any of your Employer'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 Employer's place of business or at some location to which you are required to travel for your Employer's business.

- on a day which is not one of your Employer's scheduled work days if you were in Active Service on the preceding scheduled work day.

DFS1

Chewing Injury

Chewing injury means an injury which occurs during the act of chewing or biting. The injury may be caused by biting on a foreign object not expected to be a normal constituent of food; by parafunctional (i.e., abnormal) habits such as chewing on eyeglass frames or pencils; or biting down on a suddenly dislodged or loose dental prosthesis.

DFS1471

Coinsurance

The term Coinsurance means the percentage of charges for Covered Expenses that an insured person is required to pay under the Plan.

DFS17

Contracted Fee - CIGNA Dental Preferred Provider

The term Contracted Fee refers to the total compensation level that a provider has agreed to accept as payment for dental procedures and services performed on an Employee or Dependent, according to the Employee's dental benefit plan.

DFS1217

Covered Dental Injury

Covered Dental injury means all damage to a covered person's mouth due to an accident caused by an External Force, and all complications arising from that damage. The term Covered Dental injury does not include damage to teeth, dental appliances or prosthetic devices which results from chewing or biting food or other substances. A Chewing injury is not a Covered Dental injury.

DFS1473

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 the policy.

DFS24

Dependent

1. Your spouse or certified domestic partner. (Certified domestic partner is a person of the same sex that is not related by blood. The partner must not be under 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 with the employee. Certification of domestic partnership must be obtained



through the Office of the Director of Benefits, Human Resources.)

2. Your unmarried children from birth to 25 years of age. Children must live with you in a regular parent-child relationship, or reside in a custodial institution for medical reasons or another monitored environment (endorsed by a physician on an annual basis) for medical or behavioral reasons, and depend upon you for more than 70 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.
3. Any unmarried children 25 years of age or older who are incapable of self-support because of mental or physical disability, if the disability existed, and is documented with Vanderbilt's Office of Benefits Administration, prior to their reaching the age of 25. Children must live with you in a regular parent-child relationship, or reside in a custodial institution for medical reasons or reside in another monitored environment (endorsed by a physician on an annual basis) for medical or behavioral reasons, and depend upon you for more than 70 percent of their support. 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. The Plan Administrator or its designee must approve the continuation of coverage for this child.

The University reserves the right to audit dependents and 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 as acceptable documentation.

DFS1717 M

Employee

The term Employee means a full-time employee of the Employer. The term does not include employees who are part-time or temporary or who normally work less than 30 hours a week for the Employer.

DFS211

Employer

The term Employer means the Policyholder and all Affiliated Employers.

DFS212

External Force

External Force means any sudden, unexpected impact from outside the oral cavity.

DFS1472

Functioning Natural Tooth

Functioning Natural Tooth means a Natural Tooth which is performing its normal role in the mastication (i.e., chewing) process in the covered person's upper or lower arch and which is opposed in the covered person's other arch by another natural tooth or prosthetic (i.e., artificial) replacement.

DFS1469

Handicapping Malocclusion

Handicapping Malocclusion means a malocclusion which severely interferes with the ability of a person to chew food, as determined by CG.

DFS1477

Maximum Reimbursable Charge - Dental

The Maximum Reimbursable Charge is the lesser of:

1. the provider's normal charge for a similar service or supply; or
2. the policyholder-selected percentile of all charges made by providers of such service or supply in the geographic area where it is received.

To determine if a charge exceeds the Maximum Reimbursable Charge, the nature and severity of the Injury or Sickness may be considered.

CG uses the Ingenix Prevailing Health Care System database to determine the charges made by providers in an area. The database is updated semiannually.

The percentile used to determine the Maximum Reimbursable Charge is listed in the Schedule.

Additional information about the Maximum Reimbursable Charge is available upon request.

GM6000 DFS1814V1

(DEN)

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.

DFS192

Medically Necessary and/or Dentally Necessary

Services provided by a Dentist or Physician as determined by CG are medically/dentally necessary if they are:

1. required for the diagnosis and/or treatment of the particular dental condition or disease; and
2. consistent with the symptom or diagnosis and treatment of the dental condition or disease; and



3. commonly and usually noted throughout the medical/dental field as proper to treat the diagnosed dental condition or disease; and
4. the most fitting level or service which can safely be given to you or your Dependent.

A: (1) diagnosis, (2) treatment and (3) service with respect to a dental condition or disease, is not Medically/Dentally Necessary if made, prescribed or delivered solely for convenience of the patient or provider.

DFS1467

Medicare

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

DFS149

Natural Tooth

Natural Tooth means any tooth or part of a tooth that is organic and formed by the natural development for the body (i.e., not manufactured). Organic portions of a tooth include the crown enamel and dentin, the root cementum and dentin, and the enclosed pulp (nerve).

DFS1468

Necessary

Necessary means a procedure, service or supply which is required by, and appropriate for, treatment of the covered person's dental condition according to broadly accepted standards of care, as determined by CG in consultation with our dental consultant.

DFS1474

Orthodontic Treatment

Orthodontic Treatment means the corrective movement of the teeth through the alveolar bone by means of an active appliance to correct a handicapping malocclusion of the mouth.

DFS1476

Participating Provider - CIGNA Dental Preferred Provider

The term Participating Provider means: a dentist, or a professional corporation, professional association, partnership, or other entity which is entered into a contract with CG to provide dental services at predetermined fees.

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

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