

**Guidestone Financial
Resources of the Southern
Baptist Convention**

Choice Dental Plan

CIGNA DENTAL CHOICE

EFFECTIVE DATE: January 1, 2011

CN020
3172000

This document printed in December, 2010 takes the place of any documents previously issued to you which described your benefits.

Printed in U.S.A.

Intended For GuideStone Participant Use Only

Table of Contents

Certification.....	4
Important Notices	6
How To File Your Claim	6
Accident and Health Provisions.....	7
Eligibility – Effective Date.....	7
Waiting Period.....	7
Employee Insurance	8
Dependent Insurance	8
Important Information about Your Dental Plan	8
CIGNA Dental Choice	9
The Schedule	9
Covered Dental Expense	10
CIGNA Dental Choice – Contracted Providers.....	10
Expenses Not Covered	12
General Limitations	13
Dental Benefits	13
Coordination of Benefits.....	13
Expenses For Which A Third Party May Be Liable.....	15
Payment of Benefits	15
Termination of Insurance.....	16
Employees	16
Dependents	16
Dental Benefits Extension.....	16
Federal Requirements	17
Qualified Medical Child Support Order (QMCSO)	17
Coverage of Students on Medically Necessary Leave of Absence.....	17
Eligibility for Coverage for Adopted Children.....	18
Federal Tax Implications for Dependent Coverage.....	18
Group Plan Coverage Instead of Medicaid.....	18
Requirements of Medical Leave Act of 1993 (as amended) (FMLA)	18
Uniformed Services Employment and Re-Employment Rights Act of 1994 (USERRA).....	18
Notice of an Appeal or a Grievance	19
When You Have a Complaint or an Adverse Determination Appeal	19
Definitions.....	21

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

CONNECTICUT GENERAL LIFE INSURANCE COMPANY

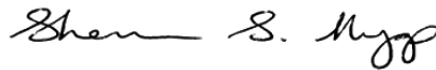
a CIGNA company (called CG) certifies that it insures certain Employees for the benefits provided by the following policy(s):

POLICYHOLDER: Guidestone Financial Resources of the SBC

GROUP POLICY(S) — COVERAGE
3172000 – DENT1 CIGNA DENTAL CHOICE

EFFECTIVE DATE: January 1, 2011

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.



Shermona Mapp, Corporate Secretary

CER7V21

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.

Intended For GuideStone Participant Use Only



Important Notices

IMPORTANT NOTICE

To obtain information or make a complaint:

You may call Connecticut General Life Insurance Company at the following toll-free telephone numbers for information or to make a complaint.

FOR DENTAL INSURANCE QUESTIONS 1-800-244-6224

You may contact the Texas Department of Insurance to obtain information on companies, coverages, rights or complaints at

1-800-252-3439

You may write the Texas Department of Insurance
P.O. Box 149104

Austin, TX 78714-9104

FAX # (512) 475-1771

Web: <http://www.tdi.state.tx.us>

E-mail: ConsumerProtection@tdi.state.tx.us

PREMIUM OR CLAIM DISPUTES: Should you have a dispute concerning your premium or about a claim you should contact the agent or the company first. If the dispute is not resolved, you may contact the Texas Department of Insurance.

ATTACH THIS NOTICE TO YOUR POLICY: This notice is for information only and does not become a part or condition of the attached document.

GM6000

NOT3V28

AVISO IMPORTANTE

Para obtener información o para someter una queja:

Usted puede llamar a Connecticut General Life Insurance Company a los siguientes números de teléfono para llamadas gratuitas si desea obtener información o someter una queja.

PARA PREGUNTAS ACERCA DEL SEGURO DENTAL 1-800-244-6224

Usted puede comunicarse Departamento de Seguros de Texas para obtener información sobre compañías, cobertura, derechos o quejas al

1-800-252-3439

Usted puede escribir al Departamento de Seguros de Texas
P.O. Box 149104

Austin, TX 78714-9104

FAX # (512) 475-1771

Web: <http://www.tdi.state.tx.us>

E-mail: ConsumerProtection@tdi.state.tx.us

DISPUTAS SOBRE PRIMAS O RECLAMOS: Si usted tiene una disputa con respecto a su prima o sobre un reclamo, usted debe comunicarse primero con el agente o la compañía. Si la disputa no se resuelve, usted puede entonces comunicarse con el Departamento de Seguros de Texas.

ADJUNTE ESTE AVISO A SU POLIZA: Este aviso es sólo para información y no se convierte en parte o condición del documento adjunto.

GM6000

NOT3V29

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.

GM6000 CI 8

CLA14V10

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

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 20 hours per week hours a week.

If you were previously insured and your insurance ceased, you must satisfy the waiting period to become insured again. If your insurance ceased because you were no longer employed in a Class of Eligible Employees, you are not required to satisfy any waiting period if you again become a member of a Class of Eligible Employees within one year after your insurance ceased.

Eligibility for Dependent Insurance

You will become eligible for Dependent insurance on the later of:

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

Waiting Period

Initial Employee Group: None.

New Employee Group: Any applicable waiting period as specified by your Employer

Classes of Eligible Employees

Class 1 – An active Employee earning wages from a church or ministry organization that is eligible to utilize products and services made available by or through Guidestone Financial Resources of the Southern Baptist Convention (“Guidestone”) working at least 20 hours per week.

Class 2 - A seminary student of a seminary or Bible college affiliated with the Southern Baptist Convention.

Class 3 - A volunteer assigned by the North American Mission Board to serve in the Mission Service Corps.

Class 4 - A volunteer assigned by the International Mission Board to serve in the International Service Corps.

Class 5 - A chaplain credentialed and endorsed by the North American Mission Board. You must not be eligible for other Dental coverage.

Class 6 - A full-time vocational evangelist who meets Guidestone’s criteria.

Class 7 - A retiree from a church, agency or institution affiliated with the Southern Baptist Convention who meets Guidestone’s criteria.



Class 8 - Surviving Dependents previously covered as dependents of a participating Employee.

GM6000 EL 2

V-32
ELI6

Employee Insurance

This Plan is offered to you as an Employee. To be insured, you will have to pay part of the cost.

Effective Date of Your Insurance

You will become insured on the date you elect the insurance by signing an approved payroll deduction form, but no earlier than the date you become eligible. If you are a Late Entrant, your insurance will not become effective until CG agrees to insure you.

You will become insured on your first day of eligibility, following your election, if you are in Active Service on that date, or if you are not in Active Service on that date due to your health status. However, you will not be insured for any loss of life, dismemberment or loss of income coverage until you are in Active Service.

Late Entrant - Employee

You are a Late Entrant if:

- you elect the insurance more than 30 days after you become eligible;
- you declined coverage during your initial enrollment period by signing a Declination of Coverage form provided by your Employer; or
- you again elect it after you cancel your payroll deduction.

CG may require evidence of good health to be provided at your expense if you are a Late Entrant.

GM6000 EF 1

ELI7V86

Dependent Insurance

For your Dependents to be insured, you will have to pay part of the cost of Dependent Insurance.

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.

If you are a Late Entrant for Dependent Insurance, the insurance for each of your Dependents will not become effective until CG agrees in writing to insure that Dependent.

Your Dependents will be insured only if you are insured.

Late Entrant – Dependent

You are a Late Entrant for Dependent Insurance if:

- you elect that insurance more than 30 days after you become eligible for it; or
- you again elect it after you cancel your payroll deduction.

CG may require evidence of your Dependent's good health at your expense if you are a Late Entrant.

GM6000 EF 2

V-1
ELI10

Important Information about Your Dental Plan

When you elected Dental Insurance for yourself and your Dependents, you elected one of the two options offered:

- **CIGNA Dental Care; or**
- **CIGNA Dental Choice.**

Details of the benefits under each of the options are described in separate certificates/booklets.

When electing an option initially or when changing options as described below, the following rules apply:

- **You and your Dependents may enroll for only one of the options, not for both options.**
- **Your Dependents will be insured only if you are insured and only for the same option.**

Change in Option Elected

If your plan is subject to Section 125 (an IRS regulation), you are allowed to change options only at Open Enrollment or when you experience a "Life Status Change."

If your plan is not subject to Section 125 you are allowed to change options at any time.

Consult your plan administrator for the rules that govern your plan.

Effective Date of Change

If you change options during open enrollment, you (and your Dependents) will become insured on the effective date of the plan. If you change options other than at open enrollment (as allowed by your plan), you will become insured on the first day of the month after the transfer is processed.

GM6000 DEN198V6



CIGNA Dental Choice

The Schedule

For You and Your Dependents

If you or your Dependent receive services from a Contracted Dentist, payment for a covered procedure will be based on a percentage of the Contracted Fee agreed upon by CG and the Contracted Dentist. The insured must pay the balance up to the Contracted Fee amount.

If you or your Dependent receive services from a non-Contracted Dentist, payment for a covered procedure will be based on a percentage of the Maximum Reimbursable Charge. The insured must pay the balance up to the provider's actual charge.

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.

Benefit Payment

Services of a Contracted Dentist are paid based on the Contracted Fee agreed upon by the provider and CG. Services of a non-Contracted Dentist are 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.

BENEFIT HIGHLIGHTS

Classes I, II, III, IX Calendar Year Maximum	\$1,200
Class IV Lifetime Maximum	\$1,000
Calendar Year Deductible	
Individual	\$50 per person
Family Maximum	Not Applicable
Class I	
Preventive Care	90%, no deductible
Class II	
Basic Restorative	70% after plan deductible
Class III	
Major Restorative	50% after plan deductible
Class IV	
Orthodontia	50%, no deductible
Class IX	
Implants	50% after plan deductible



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, III or IX the service is started and completed while coverage is in effect, except for services described in the “Benefits Extension” section.

GM6000 DEN160

v2

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 \$300).

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 DEN161

Missing Teeth Limitation

There is no payment for replacement of teeth that are missing when a person first becomes insured.

GM6000 DEN163

Covered Services

The following section lists covered dental services. 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

CIGNA Dental Choice – Contracted Providers

Payment for a service delivered by a Contracted 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-Contracted Provider is the Maximum Reimbursable Charge (calculated at the 90th percentile), 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 DES285V1

(TX)

Benefit Waiting Periods for Certain Services

Repairs, Re-cementing of Fixed partials (Bridges), Inlays, Onlays or Crowns.....	None
Accidental Non-Chewing Injury.....	None
All Services under Endodontics (includes root canal therapy)	6 months
Stainless Steel/Plastic Crowns.....	6 months
Relines, Rebases, Denture Adjustment.....	6 months



Complex Oral Surgery.....	12 months
All Services under Minor and Major Periodontics ...	12 months
Crowns/Inlays/Onlays/Labial Veneers	24 months
Dentures (Partial or Complete).....	24 months
Orthodontia.....	12 months

Class I Services – Diagnostic And Preventive

Clinical oral examination – Only 2 per person per calendar year.

Palliative (emergency) treatment of dental pain, minor procedures, when no other definitive Dental Services are performed. (Any x-ray taken in connection with such treatment is a separate Dental Service.)

Bitewing x-rays – Only 1 charge per person per calendar year.

Prophylaxis (Cleaning) – Only 2 per person per calendar year.

Topical application of fluoride (excluding prophylaxis) – Limited to persons less than 14 years old. Only one per person per calendar year.

Topical application of sealant, per tooth, on a posterior tooth for a person less than 16 years old – Only one treatment per tooth.

Space Maintainers, fixed unilateral – Limited to non-orthodontic treatment for a person less than 16 years old. Includes adjustments within 6 months if installation.

GM6000 DES297V5

Class II Services – Basic Restorations, X-rays, And Minor Oral Surgery

X-rays:

- Complete Series – once every 60 months
- Panoramic – once every 60 months (may also be payable in connection with the removal of impacted teeth)
- Other X-Rays

New fillings; replacement fillings

Simple extractions, removal of exposed roots, incision and drainage

Certain lab tests, pain treatment, therapeutic drug Injections

GM6000 DES298

V7

Class III Services - Major Restorations, Endodontics, Periodontics, Prosthodontic Maintenance, Oral Surgery, Dentures and Bridgework

Root Canal Therapy – Any x-ray, test, laboratory exam or follow-up care is part of the allowance for root canal therapy and not a separate Dental Service.

All Endodontic services.

Crowns

Note: Crown restorations are Dental Services only when the tooth, as a result of extensive caries or fracture, cannot be restored with amalgam, composite/resin, silicate, acrylic or plastic restoration.

Porcelain Fused to High Noble Metal

Full Cast, High Noble Metal

Three-Fourths Cast, Metallic

Removable Appliances

Complete (Full) Dentures, Upper or Lower

Partial Dentures

Lower, Cast Metal Base with Resin Saddles (including any conventional clasps, rests and teeth)

Upper, Cast Metal Base with Resin Saddles (including any conventional clasps rests and teeth)

Fixed Appliances

Bridge Pontics - Cast High Noble Metal

Bridge Pontics - Porcelain Fused to High Noble Metal

Bridge Pontics - Resin with High Noble Metal

Retainer Crowns - Resin with High Noble Metal

Retainer Crowns - Porcelain Fused to High Noble Metal

Retainer Crowns - Full Cast High Noble Metal

Prosthesis Over Implant – A prosthetic device, supported by an implant or implant abutment is a Covered Expense.

Replacement of any type of prosthesis with a prosthesis supported by an implant or implant abutment is only payable if the existing prosthesis is at least 5 calendar years old, is not serviceable and cannot be repaired.

Periodontal maintenance procedures (following active therapy), Periodontal Prophylaxis.

Osseous Surgery – Flap entry and closure is part of the allowance for osseous surgery and not a separate Dental Service.

Periodontal Scaling and Root Planing – Entire Mouth

Adjustments – Complete Denture

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

Recement Bridge

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

Removal of Impacted Tooth, Soft Tissue

Removal of Impacted Tooth, Partially Bony

Removal of Impacted Tooth, Completely Bony



Local anesthetic, analgesic and routine postoperative care for extractions and other oral surgery procedures are not separately reimbursed but are considered as part of the submitted fee for the global surgical procedure.

General Anesthesia – Paid as a separate benefit only when Medically or Dentally Necessary, as determined by CG, and when administered in conjunction with complex oral surgical procedures which are covered under this plan.

I. V. Sedation – Paid as a separate benefit only when Medically or Dentally Necessary, as determined by CG, and when administered in conjunction with complex oral surgical procedures which are covered under this plan.

GM6000 DES302V5

Class IV Services - Orthodontics

Each month of active treatment is a separate Dental Service.

Covered Expenses include:

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

Continued active treatment after the first month.

Fixed or Removable Appliances - Only one appliance per person for tooth guidance or to control harmful habits.

The total amount payable for all expenses incurred for Orthodontics during a person’s lifetime will not be more than the Orthodontia Maximum shown in the Schedule.

Payments for comprehensive full-banded Orthodontic treatment are made in installments. Benefit payments will be made every 3 months. The first payment is due when the appliance is installed. Later payments are due at the end of each 3-month period. The first installment is 25% of the charge for the entire course of treatment. The remainder of the charge is prorated over the estimated duration of treatment. Payments are only made for services provided while a person is insured. If insurance coverage ends or treatment ceases, payment for the last 3-month period will be prorated.

GM6000 DES462

Class IX Services – Implants

Covered Dental Expenses include: the surgical placement of the implant body or framework of any type; any device, index, or surgical template guide used for implant surgery; prefabricated or custom implant abutments; or removal of an existing implant. Implant removal is covered only if the implant is not serviceable and cannot be repaired.

GM6000 DES461

Expenses Not Covered

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

- services performed solely for cosmetic reasons, except for the treatment of congenital defects in a newborn child;
- replacement of a lost or stolen appliance;
- replacement of a bridge, crown or denture within 5 years after the date it was originally installed unless: (a) the replacement is made necessary by the placement of an original opposing full denture or the necessary extraction of natural teeth; or (b) the bridge, crown or denture, while in the mouth, has been damaged beyond repair as a result of an injury received while a person is insured for these benefits;
- any replacement of a bridge, crown or denture which is or can be made useable according to common dental standards;
- procedures, appliances or restorations (except full dentures) whose main purpose is to: (a) change vertical dimension; (b) diagnose or treat conditions or dysfunction of the temporomandibular joint; (c) stabilize periodontally involved teeth; or (d) restore occlusion;
- porcelain or acrylic veneers of crowns or pontics on, or replacing the upper and lower first, second and third molars;
- bite registrations; precision or semiprecision attachments; or splinting;

GM6000 DEN185

- instruction for plaque control, oral hygiene and diet;
- dental services that do not meet common dental standards;
- services that are deemed to be medical services;
- services and supplies received from a Hospital;
- services for which benefits are not payable according to the "General Limitations" section.

GM6000 DEN186



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.

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 that limits or excludes benefits provided by providers outside of the panel, except in the case of emergency or if referred by a provider within the panel.

Primary Plan

The 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 COB11

v7

Allowable Expense

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

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

- (1) An expense or service or a portion of an expense or service that is not covered by any of the Plans is not an Allowable Expense.
- (2) If you are covered by two or more Plans that provide services or supplies on the basis of reasonable and customary fees, any amount in excess of the highest reasonable and customary fee is not an Allowable Expense.



Claim Determination Period

A calendar year, or that part of a calendar year in which the person has been covered under this Plan.

GM6000 COB12V4

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 by other health care providers located within the immediate geographic area where the health care service is rendered under similar or comparable circumstances.

Order of Benefit Determination Rules

A 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 you as an enrollee or an employee shall be the Primary Plan and the Plan that covers you as a Dependent shall be the Secondary Plan;
- (2) If you are 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 as an enrollee or employee;
- (3) If you are 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 parent not having custody of the child, and
 - (e) finally, the Plan of the spouse of the parent not having custody of the child.

GM6000 COB13

- (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, this Plan may reduce benefits so that the total benefits paid by all Plans during a Claim Determination Period are not more than 100% of the total of all Allowable Expenses.

The difference between the amount that this Plan would have paid if this Plan had been the Primary Plan, and the benefit payments that this Plan had actually paid as the Secondary Plan, will be recorded as a benefit reserve for you. CG will use this benefit reserve to pay any Allowable Expense not otherwise paid during the Claim Determination Period.

GM6000 COB14

v7

As each claim is submitted, CG will determine the following:

- (1) CG's obligation to provide services and supplies under this policy;
- (2) whether a benefit reserve has been recorded for you; and
- (3) whether there are any unpaid Allowable Expenses during the Claims Determination Period.

If there is a benefit reserve, CG will use the benefit reserve recorded for you to pay up to 100% of the total of all Allowable Expenses. At the end of the Claim Determination Period, your benefit reserve will return to zero and a new benefit reserve will be calculated for each new Claim Determination Period.



Recovery of Excess Benefits

If CG pays charges for benefits that should have been paid by the Primary Plan, or if CG pays charges in excess of those for which we are obligated to provide under the Policy, CG will have the right to recover the actual payment made or the Reasonable Cash Value of any services.

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 made by any insurance company, healthcare plan or other organization. If we request, you must 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 COB15

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

Clinical research has established an association between dental disease and complications of some medical conditions, such as the conditions noted below:

If you are a CIGNA Dental plan member and you have one or more of the conditions listed below, you may apply for 100% reimbursement of your network copayment or network coinsurance for certain periodontal or caries-protection



procedures (up to the applicable plan maximum reimbursement levels and annual plan maximums).

For members with diabetes, cerebrovascular or cardiovascular disease:

- periodontal scaling and root planing (sometimes referred to as “deep cleaning”)
- periodontal maintenance

For members who are pregnant:

- periodic, limited and comprehensive oral evaluation
- periodontal evaluation
- periodontal maintenance
- periodontal scaling and root planing (sometimes referred to as “deep cleaning”)
- treatment of inflamed gums around wisdom teeth
- an additional cleaning during pregnancy
- palliative (emergency) treatment – minor procedure

For members with chronic kidney disease or going to or having undergone an organ transplant or undergoing head and neck Cancer Radiation:

- topical application of fluoride
- topical fluoride varnish
- application of sealant
- periodontal scaling and root planing (sometimes referred to as “deep cleaning”)
- periodontal maintenance

Please refer to the plan enrollment materials for further details.

GM6000 POB8 V6

Termination of Insurance

Employees

Your insurance will cease on the earliest date below:

- the date you cease to be in a Class of Eligible Employees or cease to qualify for the insurance.
- the last day for which you have made any required contribution for the insurance.
- the date the policy is canceled.
- the date 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, the insurance will not continue past the date your Employer stops paying premium for you or otherwise cancels the insurance.

Retirement

If your Active Service ends because you retire, your insurance will be continued until the date on which your Employer stops paying premium for you or otherwise cancels the insurance.

GM6000 TRM15V44

Dependents

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

- the date your insurance ceases.
- the date you cease to be eligible for Dependent Insurance.
- the last day for which you have made any required contribution for the insurance.
- the date 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

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

V1

Coverage of Students on Medically Necessary Leave of Absence

If your Dependent child is covered by this plan as a student, as defined in the Definition of Dependent, coverage will remain active for that child if the child is on a medically necessary leave of absence from a postsecondary educational institution (such as a college, university or trade school.)

Coverage will terminate on the earlier of:

- a) The date that is one year after the first day of the medically necessary leave of absence; or
- b) The date on which coverage would otherwise terminate under the terms of the plan.

The child must be a Dependent under the terms of the plan and must have been enrolled in the plan on the basis of being a student at a postsecondary educational institution immediately before the first day of the medically necessary leave of absence.

The plan must receive written certification from the treating physician that the child is suffering from a serious illness or injury and that the leave of absence (or other change in enrollment) is medically necessary.



A “medically necessary leave of absence” is a leave of absence from a postsecondary educational institution, or any other change in enrollment of the child at the institution that: (1) starts while the child is suffering from a serious illness or condition; (2) is medically necessary; and (3) causes the child to lose student status under the terms of the plan.

FDRL76

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 and liquid resources do not exceed certain limits established by law, 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.

FDRL75

Requirements of Medical Leave Act of 1993 (as amended) (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, as amended, 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, as amended; 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, as amended, 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, as amended.

FDRL74

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. They do not apply to any Life, Short-term or Long-term Disability or Accidental Death & Dismemberment coverage you may have.



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.

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 Texas

When You Have a Complaint or an Adverse Determination 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.

When You Have a Complaint

We are here to listen and help. If you have a complaint regarding a person, a service, the quality of care, or contractual benefits not related to Medical Necessity, you can call our toll-free number and explain your concern to one of our Customer Service representatives. A complaint does not include: (a) a misunderstanding or problem of misinformation that can be promptly resolved by CG by clearing up the misunderstanding or supplying the correct information to your satisfaction; or (b) you or your provider's dissatisfaction or disagreement with an adverse determination. You can also express that complaint 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 complaint, we will send you a letter acknowledging the date on which we received your complaint no later than the fifth working day after we receive your complaint. We will respond in writing with a decision 30 calendar days after we receive a complaint 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 APL484

v1

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

Complaint Appeals Procedure

To initiate an appeal of a complaint resolution decision, you must submit a request for an appeal in writing. 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 APL485

v1

Your complaint appeal request will be conducted by the Complaint Appeals Committee, which consists of at least three people. Anyone involved in the prior decision may not vote on the Committee. You may present your situation to the Committee in person or by conference call.

We will acknowledge in writing that we have received your request within five working days after the date we receive your request for a Committee review and schedule a Committee review. 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 APL486

v1

When You have an Adverse Determination Appeal

An Adverse Determination is a decision made by CG that the health care service(s) furnished or proposed to be furnished to you is (are) not Medically Necessary or clinically appropriate. An Adverse Determination also includes a denial by CG of a request to cover a specific prescription drug prescribed by your Dentist. If you are not satisfied with the Adverse Determination, you may appeal the Adverse Determination orally or in writing. You should state the reason why you feel your appeal should be approved and include any information supporting your appeal. We will acknowledge the appeal in writing within five working days after we receive the Adverse Determination Appeal request.

Your appeal of an Adverse Determination will be reviewed and the decision made by a health care professional not involved in the initial decision. We will respond in writing with a decision within 30 calendar days after receiving the Adverse Determination Appeal request.

In addition, your treating Dentist may request in writing a specialty review within 10 working days of our written decision. The specialty review will be conducted by a Dentist in the same or similar specialty as the care under consideration. The specialty review will be completed and a response sent within 15 working days of the request. Specialty review is voluntary. If the specialty reviewer upholds the initial adverse determination and you remain dissatisfied, you are still eligible to request a review by an Independent Review Organization.

GM6000 APL487

v2

Independent Review Procedure

If you are not fully satisfied with the decision of CG's Adverse Determination appeal process or if you feel your condition is life-threatening, you may request that your appeal be referred to an Independent Review Organization. In addition, your treating Dentist may request in writing that CG conduct a specialty review. The specialty review request must be made within 10 days of receipt of the Adverse Determination appeal decision letter. CG must complete the specialist review and send a written response within 15 days of its receipt of the request for specialty review. If the specialist upholds the initial Adverse Determination, you are still eligible to request a review by an Independent Review Organization. The Independent Review Organization is composed of persons who are not employed by CG or any of its affiliates. A decision to use the voluntary level of appeal will not affect the claimant's rights to any other benefits under the plan.

There is no charge for you to initiate this independent review process and the decision to use the process is voluntary. CG



will abide by the decision of the Independent Review Organization.

In order to request a referral to an Independent Review Organization, certain conditions apply. The reason for the denial must be based on a Medical Necessity or clinical appropriateness determination by CG. Administrative, eligibility or benefit coverage limits or exclusions are not eligible for appeal under this process. You will receive detailed information on how to request an Independent Review and the required forms you will need to complete with every Adverse Determination notice.

The Independent Review Program is a voluntary program arranged by CG.

Appeal to the State of Texas

You have the right to contact the Texas Department of Insurance for assistance at any time for either a complaint or an Adverse Determination appeal. The Texas Department of Insurance may be contacted at the following address and telephone number:

Texas Department of Insurance
333 Guadalupe Street
P.O. Box 149104
Austin, TX 78714-9104
1-800-252-3439

GM6000 APL488

V2

Notice of Benefit Determination on Appeal

Every notice of an appeal decision will be provided in writing or electronically and, if an adverse determination, will include: (1) the specific reason or reasons for the denial decision; (2) reference to the specific plan provisions on which the decision 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 under Federal Law

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 Complaint or Adverse Determination Appeal process. If your Complaint is expedited, there is no need to complete the Complaint Appeal process prior to bringing legal action.

GM6000 APL489

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

Charges

The term Charges means actual billed charges; except when the Contracted Dentist has contracted directly or indirectly with CG for a different amount. If the Contracted Dentist has



contracted to receive payment on a basis other than fee-for-service amount then "charges" will be calculated based on a CG determined fee schedule or on a CG determined percentage of actual billed charges.

DFS1405

CIGNA Dental Health (herein referred to as CDH)

CDH is a wholly-owned subsidiary of CIGNA Corporation that, on behalf of CG, contracts with Participating General Dentists for the provision of dental care. CDH also provides management and information services to Policyholders and Participating Dental Facilities.

DFS592

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 Dentist

The term Contracted Dentist 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 Dentists qualifying as Contracted Dentists may change from time to time. A list of the current Contracted Dentists will be provided by your Employer.

GM6000 DEF3

DFS2104

Contracted Fee

The term Contracted Fee refers to:

- the total compensation level that a Contracted Dentist 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.

GM6000 DEF1

DFS2103

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

Dependents are:

- your lawful spouse; and
- any unmarried child of yours who is
 - less than 26 years old;
 - 26 or more years old and primarily supported by you and incapable of self-sustaining employment by reason of mental or physical handicap. Proof of the child's condition and dependence must be submitted to CG within 31 days after the date the child ceases to qualify above. During the next two years CG may, from time to time, require proof of the continuation of such condition and dependence. After that, CG may require proof no more than once a year.

A child includes your natural child, stepchild, or legally adopted child, or the child for whom you are the legal guardian, or the child who is the subject of a lawsuit for adoption by you, or the child who is supported pursuant to a court order imposed on you (including a qualified medical child support order) or your grandchild who is your Dependent for federal income tax purposes at the time of application.

Benefits for a Dependent child will continue until the last day before your Dependent's birthday, in the year in which the limiting age is reached.

An Employee may be covered as a Dependent on another Employee's plan if both are employed by different Employers.

Dependents may be covered under more than one Employee if both Employees are employed by different Employers.

GM6000 DFS2100

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 20 hours per week hours a week for the Employer.

DFS211



Employer

The term Employer means the Policyholder and all Affiliated Employers.

DFS212

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

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