Conseco Services LLC

PREPAID DENTAL SERVICES
(For Illinois Residents)

EFFECTIVE DATE: June 1, 2009

CN002
2472746

This document printed in June, 2009 takes the place of any documents previously issued to you which described your benefits.

Printed in U.S.A.

Table of Contents

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: Conseco Services LLC

GROUP POLICY(S) — COVERAGE
2472746 - DHMO PREPAID DENTAL SERVICES

EFFECTIVE DATE: June 1, 2009

NOTICE

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

This certificate describes the main features of the coverage. It does not waive or alter any of the terms of the policy(s). If questions arise, the policy(s) will govern.
This certificate takes the place of any other issued to you on a prior date which described the coverage.

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.

Certificate of Prepaid Dental Services

Connecticut General Life Insurance Company

1. Description of Coverage

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

2. Definitions

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

Connecticut General - Connecticut General Life Insurance Company.

Adverse Determination - a decision by CIGNA Dental Health not to authorize payment for certain limited specialty care procedures on the basis of necessity or appropriateness of care. To be considered clinically necessary, the treatment or service must be reasonable and appropriate and meet the following requirements:

a. be consistent with the symptoms, diagnosis or treatment of the condition present;

b. conform to commonly accepted standards throughout the dental field;

c. not be used primarily for the convenience of the member or provider of care; and

d. not exceed the scope, duration, or intensity of that level of care needed to provide safe and appropriate treatment.

Requests for payment authorization that are declined by CIGNA Dental Health based upon the above criteria will be the responsibility of the member at the Dentist's Usual Fees. A licensed Dentist will make any such denial.

CIGNA Dental Health - The CIGNA Dental Health organization that provides dental benefits in your state as listed on the face page of this Booklet

Contract Fees - The fees contained in the Network Specialty Care Dentist agreement with CIGNA Dental Health.

Covered Persons - Subscribers and their enrolled Dependents.

Covered Services - The dental procedures listed on your Patient Charge Schedule.

Dental Office - Your selected office of Network General Dentist(s).

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

Dependent - Spouse; Domestic Partner; unmarried son/daughter (including newborn and adopted children), stepson/stepdaughter of a Subscriber; or member of the Subscriber's household resulting from a court order or placement by an administrative agency, who is: (a) less than 26 years old; or (b) between the ages of 26 and 30, who is an Illinois resident, served as a member of the active or reserve components of any of the branches of the Armed Forces of the United States, and has received a release or discharge other than a dishonorable discharge. The eligible dependent shall submit to CG a form approved by the Illinois Department of Veterans' Affairs stating the date on which the dependent was released from service; or (c) of any age if he or she is and continues to be both: (1) incapable of self-sustaining employment due to mental retardation or physical handicap; and (2) reliant upon the Subscriber or other care providers for lifetime care and supervision. The term "other care providers" is defined as a Community Integrated Living Arrangement, group home, supervised apartment, or other residential services licensed or certified by the Department of Mental Health and Developmental Disabilities, the Department of Public Health, or the Department of Public Aid. For a Dependent who falls into category (c), hereof, evidence of his or her reliance on the Subscriber shall be furnished to CIGNA Dental Health, on behalf of Connecticut General, in the form CIGNA Dental Health requests within 31 days after said Dependent attains the age of 26 and, thereafter, not more frequently than annually.

Domestic Partner -

1. A person of the same or opposite sex who:
   a. shares your permanent residence;
   b. has resided with you for no less than one year;
   c. is no less than 18 years of age;
   d. is financially interdependent with you and has proven such interdependence by providing documentation of at least two of the following arrangements: common ownership of real property or a common leasehold interest in such property, common ownership of a motor vehicle, a joint bank account or a joint credit account, designation as a beneficiary for life

insurance or retirement benefits or under your partner's will, assignment of durable power of attorney or health care power of attorney, or such other proof as is considered by CIGNA Dental Health to be sufficient to establish financial interdependency under the circumstances of your particular case;

e. is not your blood relative any closer than would be prohibited for a legal marriage; and

f. has signed jointly with you a notarized affidavit in form and content satisfactory to CIGNA Dental Health which shall be made available to CIGNA Dental Health upon request; or

2. A person of the same or opposite sex who has registered jointly with you as Domestic Partners with a governmental entity pursuant to a state or local law authorizing such registration and who has signed jointly with you a notarized affidavit of such registration which can be made available to CIGNA Dental Health upon request.

The above definition applies so long as neither you nor your Domestic Partner hereunder:

a. has signed a Domestic Partner affidavit or declaration with any other person within twelve months prior to designating each other as Domestic Partners hereunder;

b. is currently legally married to another person; or

c. has any other Domestic Partner, spouse or spouse equivalent of the same or opposite sex.

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

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

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

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

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

Network Dentist - A licensed dentist who has signed an agreement with CIGNA Dental Health to provide general dentistry or specialty care services to you. The term when used includes both Network General Dentists and Network Specialty Dentists.

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

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

Service Area - The geographical area designated by CIGNA Dental Health within which it shall provide benefits and arrange for dental care services.

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

Usual Fee - The customary fee that an individual dentist most frequently charges for a given dental service.

3. Eligibility

To enroll in the Dental Plan, you and your Dependents must be able to seek treatment for Covered Services within a CIGNA Dental Health Service Area. Other eligibility requirements are determined by your Group.

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

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

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

4. Premiums

Your Group sends a monthly fee to CIGNA Dental Health for members participating in the Dental Plan. The amount and terms of this fee are set forth in your Group Contract. You

may contact your Benefits Representative for information regarding any part of this fee to be withheld from your salary or to be paid by you to the Group.

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

5. Covered Services and Patient Charge Schedule

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

CIGNA Dental Health will give written notice to your Group of any change in Patient Charges at least 45 days prior to such change. You will be responsible for the Patient Charges listed on the Patient Charge Schedule that is in effect on the date a procedure is started.

There are no deductibles and no annual dollar limits for services covered by your Dental Plan.

Your Network General Dentist should tell you about Patient Charges for Covered Services, the amount you must pay for non-Covered Services and the Dental Office's payment polices. Timely payment is important. It is possible that the Dental Office may add late charges to overdue balances.

Network General Dentists are reimbursed by CIGNA Dental Health through fixed monthly payments and supplemental payments for certain procedures. No bonuses or financial incentives are used as an inducement to limit services. Network Dentists are also compensated by the fees which you pay, as set out in your Patient Charge Schedule.

All contracts between CIGNA Dental Health and Network Dentists state that you will not be liable to the Network Dentist for any sums owed to the Network Dentist by CIGNA Dental Health.

6. Emergency Dental Care – Reimbursement

An emergency is a dental condition of recent onset and severity which would lead a prudent layperson possessing an average knowledge of dentistry to believe the condition needs immediate dental procedures necessary to control excessive bleeding, relieve severe pain, or eliminate acute infection. You should contact your Network General Dentist if you have an emergency in your Service Area.

a. Emergency Care Away From Home – If an emergency arises while you are more than 50 miles away from home or unable to contact your Network General Dentist, covered services performed by any general dentist for diagnosis and relief of pain will be reimbursed up to a total of $50, per incident, less applicable Patient Charges. This reimbursement will be made after you submit appropriate reports and x-rays to CIGNA Dental Health.

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

7. Services Not Covered Under Your Dental Plan

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

a. services not listed on the Patient Charge Schedule;

b. services provided by a non-Network General Dentist or a non-Network Specialist without CIGNA Dental Health's prior approval except in emergencies, as described in Section 6;

c. injuries for which benefits exist under worker's compensation, occupational disease, or a similar law or act;

d. conditions for which dental treatment is provided by a federal or state government agency or is provided without cost to the Group or any Covered Person by any political subdivision or governmental authority, or a public program other than Medicaid;

e. any injury arising out of any condition which is intentionally self-inflicted;

f. declared or undeclared war or act thereof;

g. service in the armed forces of any country or international authority;

h. cosmetic dentistry or dental surgery performed without functional or pathological need, (dentistry or dental surgery performed solely to improve appearance);

i. prescription drugs, general anesthesia, sedation and nitrous oxide, unless specifically listed on your Patient Charge Schedule. When listed on your Patient Charge Schedule, general anesthesia and IV Sedation are covered when medically necessary and provided in conjunction with Covered Services performed by an Oral Surgeon or Periodontist;

j. procedures, appliances or restorations if the main purpose is to: (1) change vertical dimension (degree of separation of the jaw when teeth are in contact; (2) diagnose or treat abnormal conditions of the temporomandibular joint (TMJ), unless TMJ therapy is specifically listed on your Patient Charge Schedule; or (3) restore teeth which have

been damaged by attrition, abrasion, erosion and/or abfraction;

k. fixed prosthodontic, removable prosthodontic and root canal treatment in progress which was initiated prior to the effective date of the Covered Person's CIGNA Dental Health coverage;

l. replacement of lost or stolen appliances;

m. replacement of fixed or removable prosthodontic or orthodontic appliances that are rendered nonfunctional due to patient abuse, misuse or neglect;

n. any procedure or service associated with the placement or prosthodontic restoration of a dental implant;

o. any procedure considered to be unnecessary or experimental in nature;

p. hospitalization, including any associated incremental charges for dental services performed in a hospital;

q. services to the extent a Covered Person is compensated for them under any group medical plan, no-fault auto insurance policy, or uninsured motorist policy;

r. crowns and bridges used solely for splinting; nor

s. resin bonded retainers and associated pontics.

Except as set forth above, preexisting conditions are not excluded.

8. Limitations on Covered Services

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

a. Frequency – The frequency of certain covered services such as cleanings, is limited as shown on the applicable Patient Charge Schedule.

b. Specialty Care – Payment authorization is required for coverage of services by a Network Specialist.

c. Pediatric Dentistry – Coverage for a referral to a Pediatric Dentist ends on your child's 7th birthday; however, exceptions for medical reasons may be considered on an individual basis. Your Network General Dentist will provide care after your child's 7th birthday.

d. Oral Surgery – The surgical removal of an impacted wisdom tooth is not covered if the tooth is not symptomatic or if the removal is for other reasons.

9. Charges for Broken Appointments

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

10. Choice of Dentist / Dental Offices

You and your Dependents should have selected a Dental Office when you enrolled in the Dental Plan. The benefits of the Dental Plan are available only at your Dental Office, except in the case of an emergency or when CIGNA Dental Health authorizes a payment for specialty referrals.

These facilities are operated by independent General Dentists for the provision of ordinary and customary dental treatment.

To make an appointment with your Network General Dentist, call the Dental Office that you have selected. When you call, your Dental Office will ask for your identification number (Social Security number or Employee ID number) and will check your eligibility.

If for any reason your selected Dental Office cannot provide your dental care, or if your Network General Dentist terminates from the network, CIGNA Dental Health will let you know and will arrange a transfer to another Dental Office.

Transfers between participating facilities, for any reason, can be arranged through the CIGNA Dental Health administrative office and will be effective on the first of the month following the processing of the request. There will be no charge to the Subscriber for such transfers in excess of the outstanding balance due to the Network General Dentist, if any.

To obtain a list of Dental Offices near you, call the Dental Office Locator at 1-800-CIGNA24. It is available 24 hours a day, 7 days per week. If you would like to have the list faxed to you, enter your fax number, including your area code. You may always obtain a current Dental Office Directory by calling Member Services.

If on a temporary basis there is no Network General Dentist in your Service Area, CIGNA Dental Health will let you know and you may obtain Covered Services from a non-Network Dentist. You will pay the non-Network Dentist the applicable Patient Charge for Covered Services. CIGNA Dental Health will pay the non-Network Dentist the difference, if any, between his or her usual fee and the applicable Patient Charge.

11. Method of Treatment / Confidentiality

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

12. Specialty Care

Your Network General Dentist at your Dental Office has primary responsibility for your professional dental care. Because you may need specialty care, the CIGNA Dental Health Network includes the following types of Specialists:

Pediatric Dentists – Children's dentistry.
Endodontists – Root canal treatment.
Periodontists – Treatment of gums and bone.
Oral Surgeons – Complex extractions and other surgical procedures.
Orthodontists – Tooth movement.

There is no coverage for referrals to prosthodontists or other specialty dentists not listed above.

When specialty care is needed, your Network General Dentist must start the referral process. X-rays taken by your Network General Dentist should be sent to the Network Specialist.

13. Specialist Referral

Upon referral from a Network General Dentist, your Network Specialist will submit a specialty care treatment plan to CIGNA Dental Health for payment authorization, except for Endodontics, for which prior authorization is not required. You should verify with the Network Specialist that your treatment plan has been authorized for payment by CIGNA Dental Health before treatment begins.

When CIGNA Dental Health authorizes payment to the Network Specialist, the fees or no-charge services listed on the Patient Charge Schedule in effect on the date each procedure is started will apply, except as set out in Section 15, *Orthodontics.* Treatment by the Network Specialist must begin within 90 days from the date of CIGNA Dental Health's authorization. If you are unable to obtain treatment within the 90-day period, please call Member Services to request an extension. Your coverage must be in effect when each procedure begins.

For non-Covered Services or if CIGNA Dental Health does not authorize payment to the Network Specialist for Covered Services, including Adverse Determinations, you must pay the Network Specialist's Usual Fee. If you have a question or concern regarding an authorization or a denial, contact Member Services.

After the Network Specialist has completed treatment, you should return to your Network General Dentist for cleanings, regular checkups and other treatment. If you visit a Network Specialist without a referral or if you continue to see a Network Specialist after you have completed specialty care, it will be your responsibility to pay for treatment at the Dentist's Usual Fees.

When your Network General Dentist determines that you need specialty care and a Network Specialist is not available as determined by CIGNA Dental Health, CDH will authorize a referral to a non-Network Specialist. The referral procedures applicable to specialty care will apply. In such cases, you will be responsible for the applicable Patient Charge for Covered Services. CIGNA Dental Health will reimburse the non-Network Dentist the difference, if any, between his or her Usual Fee and the applicable patient Charge. For non-Covered Services or services not authorized for payment, including Adverse Determinations, you must pay the Dentist's Usual Fee.

14. Pediatric Dentistry

If your child up to age 7 needs to be treated by a Pediatric Dentist, contact your Network General Dentist for a specialty referral. Upon appropriate referral, your child may continue under the care of the Network Pediatric Dentist up to age 7 without additional referrals. If you need to change your child's Network Pediatric Dentist, you should return to your Network General Dentist for a new specialty referral up to the child's 7th birthday.

Your Network Pediatric Dentist must submit each specialty treatment plan to CIGNA Dental Health for payment authorization. CIGNA Dental Health's standard payment authorization process as set out above will apply for services rendered by the Network Pediatric Dentist.

For children 7 years and older, your Network General Dentist will provide care. Exceptions for medical reasons may be considered on a case-by-case basis. For children over 7, if you continue to visit the Pediatric Dentist without a referral authorized for payment, you will be fully responsible for the Pediatric Dentist's Usual Fees.

15. Orthodontics

If your Patient Charge Schedule indicates coverage for orthodontic treatments, the following definitions apply:

- **Orthodontic Treatment Plan and Records** - The preparation of orthodontic records and a treatment plan by the Orthodontist.
- **Interceptive Orthodontic Treatment** - Treatment prior to full eruption of the permanent teeth, frequently a first phase preceding comprehensive treatment.
- **Comprehensive Orthodontic Treatment** - Treatment after the eruption of most permanent teeth, generally the final phase of treatment before retention.
- **Retention (Post Treatment Stabilization)** - The period following orthodontic treatment during which you may

wear an appliance to maintain and stabilize the new position of the teeth.

The Patient Charge for your entire orthodontic case, including retention, will be based upon the Patient Charge Schedule in effect on the date of your visit for Treatment Plan and Records. This charge will apply unless: (a) banding/appliance insertion does not occur within 90 days of such visit; (b) your treatment plan changes; or (c) there is an interruption in your coverage or treatment, in which case a later change in the Patient Charge Schedule may apply.

The Patient Charge for Orthodontic Treatment is based upon 24 months of interceptive and/or comprehensive treatment. If you require more than 24 months of treatment in total, you will be charged an additional amount for each additional month of treatment, based upon the Orthodontist's Contract Fee. If you require less than 24 months of treatment, your Patient Charge will be reduced on a pro-rated basis.

Additional Charges - You will be responsible for the Orthodontist's Usual Fees for the following non-Covered Services:

- Incremental costs associated with optional/elective materials, including but not limited to ceramic, clear, lingual brackets, or other cosmetic appliances;
- Orthognathic surgery and associated incremental costs;
- Appliances to guide minor tooth movement;
- Appliances to correct harmful habits; and
- Services which are not typically included in orthodontic treatment. These services will be identified on a case-by-case basis.

Orthodontics in Progress - If orthodontic treatment is in progress for you or your Dependent at the time you enroll, call Member Services at 1-800-CIGNA24 to find out if you are entitled to any benefits under the Dental Plan.

16. Complex Rehabilitation / Multiple Crown Units

Complex rehabilitation is extensive dental restoration involving 6 or more "units" of crown and/or bridge in the same treatment plan. Using full crowns (caps) and/or fixed bridges which are cemented in place, your Network General Dentist will rebuild natural teeth, fill in spaces where teeth are missing and establish conditions which allow each tooth to function in harmony with occlusion (bite). The extensive procedures involved in complex rehabilitation require an extraordinary amount of time, effort, skill and laboratory collaboration for a successful outcome.

Complex rehabilitation will be covered when performed by your Network General Dentist after consultation with you about diagnosis, treatment plan and charges. Each tooth or tooth replacement included in the treatment plan is referred to as a "unit" on your Patient Charge Schedule. The crown and bridge charges on your Patient Charge Schedule are for each unit of crown or bridge. You pay the per unit charge for each unit of crown and/or bridge PLUS an additional charge for each unit when 6 or more units are prescribed in your Network General Dentist's treatment plan.

17. Dual Coverage

You and your Dependents may not be covered twice under this Dental Plan. If you and your spouse have enrolled separately, please contact your Benefit Administrator.

If you or your Dependents have indemnity dental coverage through your spouse's employer or other sources, applicable coordination of benefit rules will determine which coverage is primary or secondary. In most cases, the plan covering you as an employee is primary for you, and the plan covering your spouse as an employee is primary for him or her. Your children are generally covered as primary by the plan of the parent whose birthday occurs earlier in the year. Dual coverage should result in lowering or eliminating your out-of-pocket expenses. It should not result in reimbursement for more than 100% of your expenses.

CIGNA Dental Health's coordination of benefit rules are attached to the Group Contract and may be reviewed by contacting your Benefit Administrator. CIGNA Dental Health coordinates benefits only for specialty care services.

18. What to Do If There is a Problem

For the purposes of this section, any reference to "you" or "your" also refers to a representative or provider designated by you to act on your behalf.

Most problems can be resolved between you and your Dentist. However, we want you to be completely satisfied with the Dental Plan. That is why we have established a process for addressing your concerns and complaints. The complaint procedure is voluntary and will be used only upon your request.

Start with Member Services

We are here to listen and to help. If you have a concern about your Dental Office or the Dental Plan, you may call the toll-free number to explain your concern to one of our Member Services Representatives. We will do our best to respond upon your initial contact or we will get back to you as soon as possible, usually by the end of the next business day.

You may call Member Services from any location at 1-800-CIGNA24. The hearing impaired may contact Member Services at 1-800-962-5169.

19. Appeals Procedure

The Dental Plan has a two-step procedure for complaints and appeals.

a. Level One Appeals "Complaint"

To initiate an appeal, you must submit a request in writing to the Dental Plan within one year from the date of the initial CIGNA Dental decision or occurrence at:

CIGNA Dental Health
Central Region
6600 Campus Circle Drive East
Suite 100
Irving, Texas 75063

You should state the reason why you feel your request should be approved and include any information supporting your request. If you are unable or choose not to write, you may ask Member Services to register your request by calling the toll-free number.

Your level one appeal will be considered and the resolution made by someone not involved in the initial decision or occurrence. Issues involving dental necessity or clinical appropriateness will be considered by a dental professional.

We will respond with a decision within 30 calendar days after we receive your request. If the review cannot be completed within 30 days, we will notify you on or before the 30th day of the reason for the delay. The review will be completed within 15 calendar days after that.

If you are not satisfied with our decision, you may request a second level review. To initiate a level two appeal, you must submit your request in writing to CIGNA Dental Health within 60 days after receipt of CIGNA Dental Health's level one decision.

b. Level Two Appeal

Second level reviews will be conducted by CIGNA Dental Health's Appeals Committee, which consists of a minimum of 3 people. Anyone involved in the prior decision may not vote on the Appeals Committee. For appeals involving dental necessity or clinical appropriateness, the Committee will include at least one Dentist. If specialty care is in dispute, the Committee will consult with a Dentist in the same or similar specialty as the care under consideration, as determined by CIGNA Dental Health.

CIGNA Dental Health will acknowledge your appeal in writing within 5 business days and will schedule a Committee review. The acknowledgment will include the name, address, and telephone number of the Appeals Coordinator. Additional information may be requested at that time. The review will be held within 30 calendar days. If the review cannot be completed within 30 calendar days, you will be notified in writing on or before the 15th calendar day, and the review will be completed no later than 45 days after receipt of your request.

You may present your situation to the Committee in person or by conference call. Please advise CIGNA Dental Health 5 days in advance if you or your representative plans to be present. You will be notified in writing of the Committee's decision within 5 business days after the Committee meeting. The resolution will include the specific contractual or clinical reasons for the resolution, as applicable.

c. Expedited Appeals

You may request that the complaint or appeal resolution be expedited if the time frames under the above process would seriously jeopardize your life or health or would jeopardize your ability to regain the dental functionality that existed prior to the onset of your current condition. A dental professional, in consultation with the treating Dentist, will decide if an expedited review is necessary. When a review is expedited, the Dental Plan will respond orally with a decision within 72 hours, followed up in writing within 2 business days of the decision.

d. Independent Review Procedure

If your appeal concerns a dental necessity issue and the Appeals Committee denies coverage, you may request that your appeal be referred to an Independent Review Organization. In order to request a referral to an Independent Review Organization, the reason for the denial must be based on a dental necessity determination by CIGNA Dental Health. Administrative eligibility or benefit coverage limits are not eligible for additional review under this process.

There is no charge for you to initiate this independent review process; however, you must provide written authorization permitting CIGNA Dental Health to release the information to the Independent Reviewer selected. The Independent Review Organization is composed of persons who are not employed by CIGNA Dental Health or any of its affiliates. CIGNA Dental Health will abide by the decision of the Independent Review Organization.

To request a referral to an Independent Review Organization, you must notify the Appeals Coordinator within 60 days of your receipt of the Appeals Committee's level two appeal review denial. CIGNA Dental Health will then forward the file to the Independent Review Organization within 30 days.

The Independent Review Organization will render an opinion with 30 days. When requested and when a delay would be detrimental to your dental condition, as determined by the Dental Plan's Dental Director, the review shall be completed within 3-5 days.

The Independent Review Program is a voluntary program arranged by the Dental Plan and is not available in all areas.

Appeals to the State

You have the right to contact your state's Department of Insurance or Health for assistance at any time.

CIGNA Dental Health will not cancel or refuse to renew coverage because you or your Dependent has filed a complaint

or appealed a decision made by CIGNA Dental Health. You have the right to file suit in a court of law for any claim involving the professional treatment performed by a Dentist.

20. Disenrollment from the Dental Plan / Termination of Benefits

Except as otherwise provided in the Sections titled "Extension/Continuation of Benefits" or in your Group Contract, disenrollment from the Dental Plan/termination of benefits and coverages will be as follows:

a. The last day of the month in which Premiums are not remitted to CIGNA Dental Health.

b. The last day of the month in which eligibility requirements are no longer met.

c. Upon 30 days notice from CIGNA Dental Health due to permanent breakdown of the dentist-patient relationship as determined by CIGNA Dental Health, after at least two opportunities to transfer to another Dental Office.

d. Upon 30 days notice from CIGNA Dental Health due to fraud or misuse of dental services and/or Dental Offices.

e. Upon 60 days notice by CIGNA Dental Health, due to continued lack of Dental Office in your Service Area.

f. The last day of the month after voluntary disenrollment.

When one of your Dependents is disenrolled, you and your other Dependents may continue to be enrolled. When you are disenrolled, your Dependents will be disenrolled as well.

21. Extension of Benefits

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

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

If the orthodontist has agreed to or is receiving quarterly payments, coverage will be extended to the end of the calendar quarter or 60 days after termination of the Covered Person's coverage under this Contract, whichever is later.

22. Conversions

Any Subscriber who terminates his employment with the Group, or any Dependent who ceases to be eligible for coverage under this Contract because of the termination of a Subscriber's employment, except as described below may obtain coverage under an individual dental plan issued by CIGNA Dental Health, on behalf of Connecticut General, at the prevailing conversion rates of CIGNA Dental Health for the standard conversion benefit plan. Any Dependent who ceases to be eligible for coverage under the Group Contract because of his or her dissolution of marriage with a Subscriber or because of age limitations also may obtain coverage under an individual dental plan issued by CIGNA Dental Health, on behalf of Connecticut General.

Written application for the individual dental plan must be made, and the first premium paid to CIGNA Dental Health, acting on behalf of Connecticut General, not later than the latter of: (a) 31 days after termination of coverage under the Dental Plan (or 60 days in the event that termination of coverage was due to dissolution of marriage); or (b) 15 days after the Subscriber or Dependent has been given written notice of the existence of the conversion privilege, but in no event later than 60 days after such termination.

You and your enrolled Dependents are eligible for conversion coverage unless benefits were discontinued due to:

a. Permanent breakdown of the dentist-patient relationship;

b. Fraud or misuse of dental services and/or Dental Offices;

c. Nonpayment of Premiums/Prepayment Fees by the Subscriber; or

d. Selection of alternate dental coverage by your Group.

Benefits and rates for CIGNA Dental Health's conversion coverage and any succeeding renewals will be based on the Covered Services listed in the then-current standard conversion plan may not be the same as those for your Group's Dental Plan. Please call the CIGNA Dental Conversion Department at 1-800-CIGNA24 to obtain current rates and make arrangements for continuing coverage.

23. Miscellaneous

Certain Network General Dentists may provide discounts on services not listed on the Patient Charge Schedule, including a 10% discount on bleaching services. You should contact your Network General Dentist to determine if he or she offers such discounts.

CDC ILL0406V2

Your Rights Under Federal Law

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

Please call Member Services at 1-800-CIGNA24 if you have any questions. The hearing impaired may call the state TTY toll-free relay service listed in their local telephone directory.

TABLE OF CONTENTS

V. Notice of Requirements of the Omnibus Budget Reconciliation Act of 1993 (OBRA 93)

What is OBRA?

What is a Qualified Medical Child Support Order?

When Your Natural Child is Eligible for Coverage

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

Payment of Benefits

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

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

What is ERISA?

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

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

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

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

ERISA Entitles You to Receive Information About Your Plan and Benefits

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

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

- to continue dental care coverage for yourself, your spouse or your Dependents if there is a loss of coverage under the Plan as a result of a qualifying event. You or your Dependents may have to pay for such coverage.
- reduction or elimination of exclusionary periods of coverage for preexisting conditions under your group dental plan. You should be provided a certificate of creditable coverage, free of charge, from your group dental plan or issuer when you lose coverage under the Plan, when you become entitled to elect federal continuation coverage, when your federal continuation coverage ceases, if you request it before losing coverage, or if you request it up to 24 months after losing coverage. 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.

ERISA Requires Prudent Actions by Plan Fiduciaries

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

ERISA Allows You to Enforce Your Rights

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

In addition, if you disagree with the Plan's decision or lack thereof concerning the qualified status of a domestic relations order or a medical child support order you may file suit in federal court. If it should happen that plan fiduciaries misuse the Plan's money, or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor, or you may file suit in 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.

ERISA Requires Disclosures About Your Plan

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

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

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

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

Effect of Plan Termination

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

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

Claim Determination Procedures Under ERISA:

Procedures Regarding Medical Necessity Determinations

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

Preservice Medical Necessity Determinations

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

If the determination periods above would (a) seriously jeopardize your life or health, you ability to regain maximum function, or (b) in the opinion of a Dentist with knowledge of your health condition, cause you severe pain which cannot be managed without the requested services, we will make the preservice determination on an expedited basis. Our Dental reviewer, in consultation with the treating Dentist, will decide if an expedited appeal is necessary. We will notify you or your representative of an expedited determination within 72 hours after receiving the request. However, if necessary information is missing from the request, we will notify you or your

representative within 24 hours after receiving the request to specify what information is needed.

You or your representative must provide the specified information to us within 48 hours after receiving the notice. We will notify you or your representative of the expedited benefit determination within 48 hours after you or your representative responds to the notice. Expedited determinations may be provided orally, unless you or your representative requests written notification.

Postservice Medical Necessity and Postservice Claims Determinations

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

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

Notice of Adverse Determination

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

- the specific reason or reasons for the adverse determination;
- reference to the specific plan provisions on which the determination is based;
- a description of any additional material or information necessary to perfect the claim and an explanation of why such material or information is necessary;
- a description of the Plan's review procedures and the time limits applicable, including the statement of a claimant's rights to bring a civil action under section 502(a) of ERISA following an adverse determination on appeal;
- upon request and free of charge, a copy of any internal rule, guideline, protocol or other similar criterion that was relied upon in making the adverse determination regarding your claim, and an explanation of the scientific or clinical judgment for a determination that is based on a medical necessity, experimental treatment or other similar exclusion or limit;
- in the case of a claim involving urgent care, a description of the expedited review process applicable to such claim.

Assistance With Your Questions

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

FEDRIDER01 V1 M

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

What is USERRA?

USERRA sets requirements for continuation and reinstatement of your and/or your Dependent's dental coverage and reemployment in regard to military leaves of absence.

Leaves are as follows:

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

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

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

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

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

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

USERRA Allows You to Reinstate Your Benefits

If your coverage ends during the leave because you do not elect USERRA or an available conversion plan at the expiration of USERRA and you are reemployed by your

current Employer, coverage for you and your Dependent(s) may be reinstated if:

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

You and your Dependent(s) will be subject to only the balance of a preexisting condition limitation or waiting period that was not yet satisfied before the leave began. However, if an injury or sickness occurs or is aggravated during the military leave, full plan limitations will apply. Any 63-day break in coverage regarding credit for time accrued toward a preexisting condition limitation waiting period will be waived.

USERRA Sets Timeframes for Requesting Reemployment

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

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

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

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

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

What is FMLA?

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

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

Continuation of Dental Insurance During Leave

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

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

The cost of your dental insurance during such leave of absence must be paid, whether by your Employer or by you and your Employer.

Reinstatement of Canceled Insurance Following Leave

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

You will not be required to satisfy any eligibility or benefit waiting period or the requirement of any Preexisting Condition Limitation to the extent that they have been satisfied prior to start of such leave of absence. Your Employer will give you detailed information about FMLA if you choose to take a leave of absence.

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

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

What is COBRA?

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

Employees and Dependents Continuation Provision

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

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

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

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

Dependent Continuation Provision

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

1. your death;
2. divorce or legal separation; or
3. with respect to a Dependent child, failure to continue to qualify as a Dependent, such insurance may be continued upon payment of the required premium to the Employer. In the case of 2. or 3. above, you or your Dependent must notify your Employer within 60 days from the later of: (a) the date the insurance would otherwise cease; or (b) the date notice of the right to continue insurance is sent.

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

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

Subsequent Events Affecting Dependent Coverage

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

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

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

Disabled Individuals Continuation Provisions

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

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

To be eligible you or your Dependent must:

a. be declared disabled as of a day before or during the first 60 days of continuation, under Title II or XVI by the Social Security Administration; and

b. notify the Plan Administrative of the Social Security Administration's determination within 60 days following the determination and within the initial 18-month continuation period, and provide the Plan Administrator with a copy of the determination.

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

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

Effect of Employer Chapter 11 Proceeding on Retiree Coverage

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

Payment of Premium

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

Applicable premium is determined as follows:

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

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

Providing Notification of Status to Providers During the Grace Period

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

Notification Requirements

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

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

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

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

Conversion Available Following Continuation

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

Interaction With Other Continuation Benefits

A person who is eligible to continue insurance under both federal law and state law may continue the insurance, upon payment of any required premium, for a period of time not to exceed the longer of: (1) the continuation required by federal law; or (2) any other continuation of insurance provided in your plan booklet or certificate.

Newly Acquired Dependents

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

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

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

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

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

What is OBRA?

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

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

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

What is a Qualified Medical Child Support Order?

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

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

The Qualified Medical Child Support Order may not require the policy to provide coverage for any type or form of benefit or option not otherwise provided under the policy, except an order may require a plan to comply with state laws regarding child dental care coverage.

When Your Natural Child is Eligible for Coverage

If a Qualified Medical Child Support Order is issued for your child, that child will be eligible for coverage as required by the order and will not be considered a late entrant for Dependent insurance. You must notify your Employer and elect coverage for that child, and yourself if you are not already, within 31 days of the Qualified Medical Child Support Order being issued.

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

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

Payment of Benefits

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

FEDRIDER02 M