

**FOUNDATION FOR ADVANCED
EDUCATION IN THE
SCIENCES, INC.**

**Dental Benefits
Effective January 1, 2000**

CN001

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

CONNECTICUT GENERAL LIFE INSURANCE COMPANY

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

POLICYHOLDER: FOUNDATION FOR ADVANCED EDUCATION IN
THE SCIENCES, INC.

GROUP POLICY(S) — COVERAGE
3014448-01DC CIGNA DENTAL CARE

EFFECTIVE DATE: January 1, 2000

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.


Susan L. Cooper
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.

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 or temporary Employee; and
- you normally work at least 32 hours a week.

If you were previously insured and your insurance ceased, you must satisfy the New Employee Group 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.

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

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

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: A period of time which ends on the first day of the month following the date of hire

New Employee Group: Date of hire

Classes of Eligible Employees

Each Employee who is a resident of the District of Columbia, Indiana, Michigan, Minnesota, Montana, New York, Oregon, South Carolina, Utah, Virginia and West Virginia

ELIGIBILITY — EFFECTIVE DATE

For Dental Insurance - Employees

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

Effective Date of Your Insurance

You will become insured on the first day of the month after the later of: (a) the date you elect the insurance by signing an approved election form; or (b) the date you become eligible. If you are a Late Entrant, you may elect the insurance only during an Open Enrollment Period. Your insurance will become effective on the first day of the month of the new plan year in which you elect it.

Late Entrant

You are a Late Entrant if:

- you do not elect the insurance within 30 days after you become eligible;
- you again elect it after you cancel your coverage.

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

Open Enrollment Period

Open Enrollment Period means a period in each calendar year as designated by your Employer.

Choice of Participating Dental Facility

When you elect Employee Insurance, you may select a Participating Dental Facility from the list provided by CDH. If your first choice of a Participating Dental Facility is not available, you will be notified by CDH of your designated Participating Dental Facility, based on your alternate selection. You and each of your insured Dependents may select your own designated Participating Dental Facility. No Dental Benefits are covered unless the Dental Service is received from your designated Participating Dental Facility, referred by a Participating Dentist at that Facility to a specialist approved by CDH, or otherwise authorized by CDH, except for Emergency Dental Treatment specified in the section, "DENTAL BENEFITS For You and Your Dependents." A transfer from one Participating Dental Facility to another Participating Dental Facility may be requested by you through CDH. Any such transfer will take effect on the first day of the month after it is authorized by CDH. A transfer will not be authorized if you or your Dependent has an outstanding balance at the Participating Dental Facility.

ELIGIBILITY—EFFECTIVE DATE

For Dental Insurance - Dependents

For your Dependents to be insured, you may be required to pay part of the full cost of Dependent Insurance.

Effective Date of Dependent Insurance

Insurance for your Dependents will become effective on the first day of the month after the later of: (a) the date you elect it by signing an approved election form; or (b) 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, you may elect that insurance only during an Open Enrollment Period. The insurance for each of your Dependents will become effective on the first day of the month after the later of: (a) the first day of the month of the new plan year; or (b) the date CG agrees in writing to insure that Dependent.

Your Dependents will be insured only if you are insured.

Late Entrant

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 coverage.

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

**REQUIREMENTS OF THE OMNIBUS BUDGET
RECONCILIATION ACT OF 1993 (OBRA'93)**

These health coverage requirements do not apply to any benefits for loss of life, dismemberment or loss of income.

Any other provisions in this certificate that provide for: (a) the definition of an adopted child and the effective date of eligibility for coverage of that child; and (b) eligibility requirements for a child for whom a court order for medical support is issued; are superseded by these provisions required by the federal Omnibus Budget Reconciliation Act of 1993, where applicable.

A. Eligibility for Coverage under a Qualified Medical Child Support Order

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 you will not be considered a Late Entrant for Dependent Insurance.

You must notify your Employer and elect coverage for that child within 31 days of the court order being issued.

Qualified Medical Child Support Order

A Qualified Medical Child Support Order is a judgment, decree or order (including approval of a settlement agreement) issued by a court of competent jurisdiction or state agency, and satisfies all of the following:

1. the order specifies your name and last known address, and the child's name and last known address;
2. the order provides a description of the coverage to be provided, or the manner in which the type of coverage is to be determined;
3. the order states the period to which it applies; and
4. the order specifies each plan that it applies to.

The Qualified Medical Child Support Order 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.

**REQUIREMENTS OF THE OMNIBUS BUDGET
RECONCILIATION ACT OF 1993 (OBRA'93) (Continued)**

B. 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.

Any "Pre-existing Condition Limitation" in this certificate will be waived for an adopted child or a child placed for adoption.

DENTAL BENEFITS - CIGNA DENTAL CARE

For You and Your Dependents

CG will pay for Covered Dental Services received by you or any one of your Dependents, excluding any dollar amounts listed in the Patient Charge Schedule.

Further, if you or any one of your Dependents, while insured for these benefits, incurs expenses for charges made by a Dentist, other than a Participating General Dentist, for Emergency Dental Treatment, CG will pay for the expenses so incurred up to \$50, less any amount listed in the Patient Charge Schedule, for each emergency; provided that: (1) the need for treatment occurs at least 50 miles from the person's home; or (2) the person is unable to contact his designated Participating Dental Facility; and the treatment is performed during regular office hours.

For Emergency Dental Treatment received after regular office hours a fee will be charged as listed in the Patient Charge Schedule.

Emergency Dental Treatment means diagnostic and palliative procedures administered in the case of: (a) a dental emergency which involves acute pain; and (b) a dental condition which requires immediate treatment.

No Dental Benefits are covered unless the Dental Service is received from your designated Participating Dental Facility, referred by a Participating General Dentist at that Facility to a Specialist approved by CDH, or otherwise authorized by CDH, except as specified above for Emergency Dental Treatment.

Covered Dental Service

The term Covered Dental Service means a Dental Service listed in the Patient Charge Schedule when that Dental Service:

- is performed by or under the direction of the designated Participating Dental Facility or upon referral by the Participating General Dentist to an approved Specialist and authorized by CDH; and
- is essential for the necessary care of the teeth and supporting structure (gums); and
- starts and is completed while the person is insured.

DENTAL BENEFITS - CIGNA DENTAL CARE

Covered Dental Service (Continued)

A Dental Service is deemed to start when the actual performance of the service starts except that:

- for fixed bridgework and full or partial dentures, it starts when the first impressions are taken and/or abutment teeth fully prepared.
- for a crown, inlay or onlay, it starts on the first date of preparation of the tooth involved.
- for root canal therapy, it starts when the pulp chamber of the tooth is opened.

Specialty Referrals

When specialized dental care services are required, a Participating General Dentist must initiate the referral process. Upon a referral approved for payment by CDH to an endodontist, oral surgeon, orthodontist, pedodontist or periodontist, you and your Dependent will be liable for any applicable fee including fees for any dental service rendered but not listed in the Patient Charge Schedule. All fees correspond to the Patient Charge Schedule in effect on the date the procedure is initiated.

A person must be insured for these benefits when treatment by a Specialist is rendered. Such treatment must occur no later than 90 days from the approval by CDH. The x-rays taken by the Participating General Dentist must be sent to the Specialist with the referral form to avoid unnecessary expense and exposure to radiation.

Complex Rehabilitation

Complex Rehabilitation is extensive dental restoration involving 6 or more "units" of crown and/or bridge in the same treatment plan. The crown and bridge charges listed in the Patient Charge Schedule are for each tooth (or "unit"). An additional amount is charged for each unit when Complex Rehabilitation is performed.

Services Not Covered

Covered Dental Services will not include or, where applicable, no payment will be made for any:

- service performed solely for cosmetic reasons;
- replacement of a lost or stolen appliance;
- procedures, appliances or restorations whose main purpose is to: (a) change vertical dimension; or (b) diagnose or treat conditions or dysfunction of the temporomandibular joint except as specified in the Patient Charge Schedule;
- prescription drugs; and sedation or a general anesthesia;

DENTAL BENEFITS - CIGNA DENTAL CARE

Services Not Covered (Continued)

- procedures or appliances for minor tooth guidance or to control harmful habits;
- treatment rendered by a pedodontist on your Dependent child who has reached seven years of age; however, an exception may be made due to medical reasons;
- service to the extent that it is compensable under any group medical plan;
- replacement of fixed or removable prosthodontic appliances made useless due to patient abuse, misuse or neglect;
- any procedure or service associated with the placement or prosthodontic restoration of a dental implant;
- service excluded according to the "General Limitations" section.

**GENERAL LIMITATIONS
DENTAL BENEFITS**

No payment will be made for expenses incurred or services received:

- 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;
- to the extent that payment is unlawful where the person resides when the expenses are incurred or the services are received;
- which the person would not be legally required to pay;
- when charges would not have been made if the person had no insurance;
- 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 or services 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.

GENERAL LIMITATIONS (Continued)
DENTAL BENEFITS

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

- to the extent that benefits are paid or payable for those expenses or services under the mandatory part of any auto insurance policy written to comply with:
 - a “no-fault” insurance law; or
 - an uninsured motorist insurance law.

CG will take into account any adjustment option chosen under such part by you or any one of your Dependents.

PAYMENT OF BENEFITS

To Whom Payable

The Policyholder and CG agree that, except in the case of Emergency Dental Treatment received from a non-Participating Dentist, all Dental Benefits will be paid directly to the person or institution providing the dental care. Any Dental Benefits for Emergency Dental Treatment received from a non-Participating Dentist will be paid, at the option of CG, either to you or to the person or institution providing the dental care.

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. However, 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.

Payment as described above will release CG from all liability to the extent of any payment made.

TERMINATION OF INSURANCE - EMPLOYEES

Your insurance will cease on the earliest date below:

- the last day of the calendar month you cease to be in a Class of Eligible Employees or cease to qualify for the insurance.
- the last day of the calendar month for which you have made any required contribution for the insurance.
- with respect to your Dental benefits, the date upon permanent breakdown of your relationship with your Dentist as determined by CDH, after at least one opportunity to transfer to another Participating Dental Facility.
- the date the policy is canceled.
- the last day of the calendar month 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 90 days past the date your coverage 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 may be continued until the date on which your Employer stops paying premium for you or otherwise cancels the insurance.

TERMINATION OF INSURANCE - DEPENDENTS

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

- the date your insurance ceases.
- the last day of the calendar month you cease to be eligible for Dependent Insurance.
- the last day of the calendar month for which you have made any required contribution for the insurance.
- with respect to your CIGNA Dental Care benefits, the date upon permanent breakdown of your Dependent's relationship with his Dentist, as determined by CDH, after at least one opportunity to transfer to another Participating Dental Facility.
- 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.

TERMINATION OF INSURANCE

CONTINUATION REQUIRED BY FEDERAL LAW FOR YOU AND YOUR DEPENDENTS

The Continuation Required by Federal Law does not apply to any benefits for loss of life, dismemberment or loss of income.

Federal law enables you or your Dependent to continue health 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 health 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 health plan(s) and is subject to federal law, regulations and interpretations.

A. Employees and Dependents Continuation Provision

If you and 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 health 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: (a) the date of a reduction of your work hours or your termination of employment; or (b) the date notice of the right to continue insurance is sent. Such insurance will not be continued by CG 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;
- following enrollment in Medicare; for you, the date you become entitled to Medicare, and for your Dependent, the date he becomes entitled to Medicare;
- the effective date of coverage under another group health 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.

TERMINATION OF INSURANCE

CONTINUATION REQUIRED BY FEDERAL LAW FOR YOU AND YOUR DEPENDENTS (Continued)

B. Dependent Continuation Provision

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

- (1) your death;
- (2) divorce or legal separation; or
- (3) with respect to a Dependent child, failure to continue to qualify as a Dependent,

such insurance may be continued upon payment of the required premium to the Employer. In the case of (2) or (3) above, you or your Dependent must notify your Employer within 60 days of such event. In addition, a Dependent must elect to continue insurance within 60 days from the later of: (a) the date the insurance would otherwise cease; or (b) the date notice of the right to continue insurance is sent.

CG will not continue the health insurance of a Dependent beyond the earliest of the following dates:

- 36 months from the date of (1), (2) or (3) above, whichever may occur first;
- the date coverage ends due to failure to pay the required subsequent premium within 30 days of the due date;
- the date the Dependent becomes entitled to Medicare, following his/her enrollment in Medicare;
- the date the policy cancels; or
- the date the Dependent becomes covered under another group health 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.

C. 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) of Section B, 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.

TERMINATION OF INSURANCE

CONTINUATION REQUIRED BY FEDERAL LAW FOR YOU AND YOUR DEPENDENTS (Continued)

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 ends 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 follow termination of employment or a reduction in work hours, the disabled person may continue health insurance for up to an additional 11 months beyond the 18-month period.

The disabled person may also continue the coverage for other family members continuously covered for the initial 18-month continuation period as either the Employee covering a Dependent, or as the Employee's Dependents; if they otherwise remain eligible.

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 administrator 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 29-month period 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 in sections A and B which apply to the initial 18 months will also apply to any or all covered persons for any additional months of coverage.

TERMINATION OF INSURANCE

CONTINUATION REQUIRED BY FEDERAL LAW FOR YOU AND YOUR DEPENDENTS (Continued)

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 Medical Conversion benefit then available to Employees and their Dependents.

Interaction With Other Continuation Benefits

A person who is eligible to continue insurance under both (1) and (2) below 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 this 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
- CG is notified of your newly acquired Dependent in accordance with the terms of the policy.

If events (1) or (2) of Section B should subsequently occur 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 events described in Section C should subsequently occur for your child who is born, adopted or placed for adoption as a newly acquired Dependent, coverage will be continued according to that section.

TERMINATION OF INSURANCE

REQUIREMENTS OF FAMILY AND MEDICAL LEAVE ACT OF 1993

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

A. Continuation of Health Insurance During Leave

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

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

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

B. Reinstatement of Canceled Insurance Following Leave

Upon your return to Active Service following a leave of absence that qualifies under the Family and Medical Leave Act of 1993, any canceled insurance (health, life or disability) will be reinstated as of the date of your return.

You will not be required to satisfy any eligibility or benefit waiting period or the requirements of any Pre-existing Condition Limitation to the extent that they had been satisfied prior to the start of such leave of absence.

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

PROVISIONS

Problems and Grievances

Almost all controversies can be solved on a personal level by your Participating General Dentist or Specialist. Further, Member Services is able to solve problems and act as a liaison between you and the Participating Dental Facility which you have chosen.

If you have questions about your treatment plan or the care process, please call or write to CDH. The Member Services Department is staffed with experienced persons who can help to further explain the treatment plan rationale, charges for certain services, or any other question you may have about the Plan.

- (1) If the problem concerns quality of care, a local dental director will be consulted to review your treatment and resolve the issue. The director's decisions shall be final if he rules in your favor; however, if the director decides against you, an appointment can be arranged with a mutually agreed upon Dentist for a second opinion, at CDH's expense. Resolution should be within two weeks, if appointment time is available. The final decision will be made by the CDH Dental Director, based upon independent analysis of the second opinion and CDH's review.
- (2) If the problem concerns plan definitions or limitations, or Dentist/patient relationship, the Director of Member Services will be consulted. A written or verbal response will be provided within fifteen working days.

PROVISIONS

Problems and Grievances (Cont.)

If you are not satisfied with CDH's decision, a Grievance Committee (the Committee) composed of three members will be formed within three months of first notice to CDH. If the grievance is of a strictly professional nature with respect to the qualifications of, or treatment provided by a CDH Dentist, all three members shall be Dentists. If the parties cannot agree on a third member, the local dental community will be asked to participate. In each case, members shall be:

1. a representative chosen by CDH,
2. a representative chosen by you, and
3. a mutually agreed upon representative of the local dental community, who shall preside over the Committee.

You and CDH will each pay one's own expenses related to the Committee process. Both parties shall share, on an equal basis, the expenses of the third member presiding over the Committee.

Nevertheless, all parties reserve the right, after the Committee has reached a final decision, to pursue legal recourse in the appropriate court with respect to any claims arising from professional treatment performed by a Dentist.

PROVISIONS

Dental Conversion Privilege

Any Employee or Dependent whose Dental Insurance ceases for a reason other than failure to pay any required contribution or cancellation of the policy may be eligible for coverage under another Group Dental Insurance Policy underwritten by CG; provided that: (a) he applies in writing and pays the first premium to CG within 31 days after his insurance ceases; and (b) he is not considered to be overinsured.

CDH or CG, as the case may be, or the Policyholder will give the Employee, on request, further details of the Converted Policy.

ACCIDENT AND HEALTH PROVISIONS

Notice of Claim, Claim Forms and Proof of Loss provisions do not apply to services received from, or upon referral by, a Participating Dental Facility or a Participating Dentist.

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 nor 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

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.

DEFINITIONS

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.

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.

Dependent

Dependents are:

- your lawful spouse; and
- any unmarried child of yours who is
 - less than 19 years old.
 - 19 years but less than 24 years old, enrolled in school as a full-time student and primarily supported by you. Proof of the child's age, status as a student and dependence must be submitted to CG as of the later of his 19th birthday or the date he is enrolled for Dependent Insurance. After that, CG may require such proof at least once each year until he attains age 24.
 - 19 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 a legally adopted child. It also includes a stepchild who lives with you.

Benefits for a Dependent child will continue until the last day of the calendar month in which his 19th birthday occurs, or in the case of a student, his 24th birthday.

Anyone who is eligible as an Employee will not be considered as a Dependent.

No one may be considered as a Dependent of more than one Employee.

DEFINITIONS

Employee

The term Employee means a full-time or temporary employee of the Employer. The term does not include employees who normally work less than 32 hours a week for the Employer.

Employer

The term Employer means the Policyholder and all Affiliated Employers.

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.

Medicare

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

Participating Dental Facility

The term Participating Dental Facility means an approved dental care facility for the provision of ordinary and customary dental care; such care to be provided at predetermined fees as negotiated by CG and CDH.

The Participating Dental Facilities and Participating General Dentists may change from time to time. A list of the current Participating Dental Facilities will be provided to the Policyholder periodically by CDH for the purpose of Employee selection of a Participating Dental Facility.

Participating General Dentist

The term Participating General Dentist means a person practicing dentistry within the scope of his license at a Participating Dental Facility, under the terms of his provider contract with CDH.

Patient Charge Schedule

The Patient Charge Schedule is a separate list of covered services and amounts payable by you.

Specialist

The term Specialist means any person or organization licensed as necessary: (a) who delivers or furnishes specialized dental care services; and (b) who provides such services upon approved referral to persons insured for these benefits.

Synopsis for job W33616E [MXB] Requested by:

Composed on 28-MAR-00 at 4:15 with no errors.
Job: W33616E Account name: FOUNDATION FOR ADVAN
Account number: 3014448 Policyholder Category:
Job type: GBC6 Job category: NEW Job style: S
Region: 1 Group office: Type of business: X
Budget code: 8E30 Quantity: 229 Due date:

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30	Medicare	DFS149
30	Participating Dental Facility	DFS593
30	Participating General Dentist	DFS594
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