Premier Plus Dental Care Plan

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Produced by GuideStone Financial Resources of the Southern Baptist Convention

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The Schedule

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

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Introduction

Thank you for choosing this Plan from GuideStone Financial Resources of the Southern Baptist Convention (GuideStone). This document constitutes your Premier Plus Dental Care Plan (Plan). The GuideStone Plan is made available to eligible employers for their employees and retirees.

Some words and phrases in this booklet, such as "Plan", have special meanings. We call these words and phrases "defined terms". Usually, these defined terms are capitalized. "Definitions" at the end of this booklet give the meanings of these defined terms.

Other organizations help the Plan serve you:

Cigna, the Claims Administrator for the Plan, administers payment of claims, but has no liability for the funding of the benefits.

This booklet tells you about Plan benefits effective January 1, 2026. Claims for dental services or supplies you received before your current Plan effective date, will be paid under the terms of the plan in which you were a member when the claims were incurred. Usually, a claim is incurred when a covered service and supply is received by a covered person.

CHURCH PLAN

The Plan is intended to be a church plan as defined in the Employee Retirement Income Security Act of 1974, as amended (ERISA), and the Internal Revenue Code. Because it is a church plan that has not made a 410(d) election under ERISA, it is not subject to the requirements of ERISA

IMPORTANT PHONE NUMBERS

GuideStone Customer Relations:

1-844-INS-GUIDE (1-844-467-4843)

Cigna's toll-free care line:

1-800-CIGNA24 (1-800-244-6224)

IMPORTANT WEBSITES

www.GuideStone.org
www.mycigna.com
www.cigna.com

DENTAL NETWORK

The Claims Administrator works throughout the country to ensure coverage includes **Total Cigna Healthcare**[SM] **Dental PPO (DPPO) Network** in many areas. You can call Cigna customer service at **1-800-CIGNA24** (1-800-244-6224)**,** or go to the Cigna website at *www.cigna.com* to locate a provider.

How To File Your Claim

Claims can be submitted by the provider if the provider is able and willing to file on your behalf. If the provider is not submitting on your behalf, you must send your completed claim form and itemized bills to the claims address listed on the claim form.

You may get the required claim forms from the website listed on your identification card or by calling Member Services using the toll-free number on your identification card.

CLAIM REMINDERS

Be sure to use your member ID and account/group number when you file the Claims Administrator claim forms, or when you call you're the Claims Administrator claim office.

Your member ID is the ID shown on your benefits identification card.

Your account/group number is shown on your benefit identification card.

Be sure to follow the instructions listed on the back of the claim form carefully when submitting a claim to the Claims Administrator.

TIMELY FILING

The Claims Administrator will consider claims for coverage under the Plan when proof of loss (a claim) is submitted within one year (365 days) after services are rendered. If services are rendered on consecutive days the limit will be counted from the last date of service. If claims are not submitted within one year, the claim will not be considered valid and will be denied.

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Eligibility - Effective Date

Employee Coverage

This Plan is offered to you as an Employee.

Eligibility for Employee Coverage

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

- you are in a class of eligible Employees; and
- you are an eligible, full-time Employee as defined by your Employer; and
- you work at least the number of hours that your Employer requires to be considered a full-time Employee, but not less than 20 hours a week.

Eligibility for Dependent Coverage

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

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

Enrollment Waiting Period

As determined by your employer.
If you were previously covered and your coverage ceased, you must satisfy the Enrollment Waiting Period to become covered again. If your coverage ceased because you were no longer employed in a class of eligible Employees, you are not required to satisfy any Enrollment Waiting Period if you again become a member of a class of eligible Employees within one year after your coverage ceased.

Classes of Eligible Employees

Class 1 – An active Employee earning wages from a church or ministry organization that is eligible to utilize products and services made available by or through GuideStone.

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

Class 3 - You are a Mission Service Corps missionary assigned by the North American Mission Board.

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

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

Class 6 - A full-time vocational evangelist who meets GuideStone's criteria.

Class 7 - A retiree from an eligible Employer who meets GuideStone's criteria.

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

Effective Date of Employee Coverage

You will become covered on the date GuideStone receives your enrollment form, but no earlier than the date you become eligible.

For Employee coverage, you must be in Active Service on the date your coverage is to be effective, unless you are not in Active Service due to a health status.

Dependent coverage

Your Dependents will be covered, on the date GuideStone receives your enrollment form, but no earlier than the date you become eligible.

Effective Date of Dependent coverage

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

Your Dependents will be covered only if you are covered.

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Premier Plus Dental Care Plan

The Schedule

For you and your Dependents

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

Deductibles

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

Benefit Payment

Services of a Contracted Dentist are paid based on the Contracted Fee agreed upon by the provider and the Claims Administrator.
Services of a non-Contracted Dentist are based on the Maximum Reimbursable Charge. For this Plan, the Maximum Reimbursable Charge is calculated at the 90th percentile of all provider charges in the geographic area.

BENEFIT MAXIMUMS AND DEDUCTIBLES	PARTICIPATING PROVIDER	NON-PARTICIPATING PROVIDER
Classes I, II, III Calendar Year Maximum	$1,500	$1,500
Class IV Lifetime Maximum	$1,000	$1,000
Calendar Year Deductible	$50 per person Not Applicable to Class I	

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

Benefits Paid for Participating and Non-Participating Provider Services will be applied toward both the Participating and Non-Participating maximum shown in the Schedule.

BENEFIT HIGHLIGHTS	PARTICIPATING PROVIDER	NON-PARTICIPATING PROVIDER
Class I	**The Percentage of Covered Expenses the Plan Pays**	**The Percentage of Covered Expenses the Plan Pays**
Preventive Care	100%	100%
Class II	**The Percentage of Covered Expenses the Plan Pays**	**The Percentage of Covered Expenses the Plan Pays**
Basic Restorative	80% after plan deductible	80% after plan deductible
Class III	**The Percentage of Covered Expenses the Plan Pays**	**The Percentage of Covered Expenses the Plan Pays**
Major Restorative (Includes coverage for implants)	50% after plan deductible	50% after plan deductible
Class IV	**The Percentage of Covered Expenses the Plan Pays**	**The Percentage of Covered Expenses the Plan Pays**
Orthodontia	50%	50%

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Covered Dental Expense

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

- the service is ordered or prescribed by a Dentist;
- the service is essential for the Necessary care of teeth;
- the service is within the scope of coverage limitations;
- the Deductible amount in The Schedule has been met;
- the maximum benefit in The Schedule has not been exceeded;
- the charge does not exceed the amount allowed under the Alternate Benefit Provision; and
- for Class I, II or III the service is started and completed while coverage is in effect, except for services described in the "Benefits Extension" section.

Alternate Benefit Provision

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

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

Predetermination of Benefits

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

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

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

Review of proposed treatment is advised whenever extensive dental work is recommended when charges exceed $300.

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

Payment of Benefits

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

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

Plan payment for a covered service delivered by a non-Contracted Provider is the Maximum Reimbursable Charge for that procedure, times the benefit percentage that applies to the class of service, as specified in the Schedule.

The covered person is responsible for the balance of the non-Contracted Provider's actual charge.

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Covered Services

The following section lists covered dental services. The Claims Administrator may agree to cover expenses for a service not listed. To be considered the service should be identified using the American Dental Association Uniform Code of Dental Procedures and Nomenclature, or by description and then submitted to the Claims Administrator.

Class I Services – Diagnostic and Preventive

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

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

Prophylaxis (Cleaning), including Periodontal maintenance procedures (following active therapy) – Only 2 per person per calendar year (combined maximum).

Topical application of fluoride (excluding prophylaxis) – Limited to persons under 14 years old. Only 1 per person per calendar year.

Topical application of sealant, per tooth, on a posterior tooth for a person less than 16 years old - Only 1 treatment per tooth in any 3 calendar years.

Space Maintainers, fixed unilateral – Limited to a person less than 16 years old includes adjustments within 6 months of installation and limited to nonorthodontic treatment.

Class II Services – Basic Restorations

Amalgam Filling (new or replacement)

Composite/Resin Filling (new or replacement)

Routine Extractions

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

Oral Surgery includes Simple Extractions and Surgical Incision and Drainage of Abscess, excludes Complex Oral Surgery.

X-rays – Complete series or Panoramic (Panorex) – Only one per person, including panoramic film, in any 60 consecutive months.

All other x-rays (except Bitewings)

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

Emergency care to relieve pain

Class III Services – Major Restorations

Repair of bridges, crowns and inlays

Adjustments – Complete Denture

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

Periodontal maintenance including prophylaxis (following active therapy) – Maximum of 2 per person per calendar year combined with Cleaning Maximum (Class I Service)

Replacement of any type of prosthesis with a prosthesis supported by an implant or implant abutment is only payable if the existing prosthesis is at least 60 consecutive months old, is not serviceable and cannot be repaired.

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

Removal of Impacted Tooth, Soft Tissue

Removal of Impacted Tooth, Partially Bony

Removal of Impacted Tooth, Completely Bony

Class IV Services - Orthodontics

Each month of active treatment is a separate Dental Service.

Covered Expenses include:

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

Continued active treatment after the first month.

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

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

Payments for comprehensive full-banded orthodontic treatment are made in installments. Benefit payments will be made every 3 months. The first payment is due when the appliance is installed. Later payments are due at the end of each 3-month period. The first installment is 25% of the charge for the entire course of treatment. The remainder of the charge is prorated over the estimated duration of treatment.

Payment are only made for services provided while a person is covered. If coverage ends or treatment ceases, payment for the last 3-month period will be prorated.

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Class V Services – Major Restorations

Denture Adjustments, Rebasing, and Relining

Denture Repairs

Endodontics - Root Canals

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

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

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

Crowns are covered in Classes VI & V. Crowns in Class V are limited to Stainless Steel/Plastic

Crowns. Initial restorative care or replacement after 5 years

from initial installation

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

Porcelain Fused to High Noble Metal

Full Cast, High Noble Metal

Three-Fourths Cast, Metallic

Removable Appliances

Complete (Full) Dentures, Upper or Lower

Partial Dentures

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

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

Class VI Services – Major Restorations

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

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

Crowns are covered in Classes VI & V. Crowns in Class V are Limited to Stainless Steel/Plastic Crowns. Initial restorative care or replacement after 5 years from initial installation. All other Crowns covered under Class VI Dentures are (Includes Partial or Complete Dentures and Diagnostic Casts)

Complex Oral Surgery:

Surgical Extractions;

Oroantral Fistula Closure;

Tooth Reimplantation and/or Stabilization of Accidentally Evulsed or displaced tooth and/or Alveolus;

Tooth Transplantation; Surgical Exposure of Impacted/Unerupted Tooth to Aid Eruption;

Biopsy of Oral Tissue; Transseptal Fiberotomy;

Alveoplasty;

Vestibuloplasty;

Removal of Exostosis;

Removal of Foreign Body, Skin or Subcutaneous Areolar Tissue;

Removal of Reaction-Producing Foreign Bodies Musculoskeletal System;

Maxillary Sinusotomy for Removal of Tooth Fragment/Foreign Body;

Frenulectomy (Frenectom or Frenotomy) Separate Procedure;

Excision of Hyperplastic Tissue - Per arch;

Excision of Pericoronal Gingiva;

Sialolithotomy;

Excision of Salivary Gland;

Sialodochoplasty;

Closure of Salivary Fistula;

All Impacted Wisdom Teeth Procedures.

Minor (Adjunctive Periodontal Service):

Provisional Splinting, Occlusal

Adjustments;

Scaling and Root Planning.

Major periodontics limited to once every 36 months per area

Surgical services: Gingivectomy or Gingivoplasty;

Gingival Flap Procedure;

Mucogingival Surgery;

Osseous Surgery;

Clinical Crown Lengthening;

Guided Tissue Regeneration;

Soft Tissue Graft;

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Subepithelial Connective Tissue Graft;

Distal or Proximal Wedge;

Occlusal Guard - No more than 1 in any 24 months in a row

Class VII Services – Major Restorations

Bridges

Labial Veneers

The following items will also be considered Class VII expenses:

Inlays

Onlays

Expenses Not Covered

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

- services performed solely for cosmetic reasons, except for the treatment of congenital defects in a newborn child;
- replacement of a lost or stolen appliance;
- replacement of a bridge, crown or denture within 5 years after the date it was originally installed unless: the replacement is made necessary by the placement of an original opposing full denture or the necessary extraction of natural teeth; or the bridge, crown or denture, while in the mouth, has been damaged beyond repair as a result of an injury received while a person is covered for these benefits;
- any replacement of a bridge, crown or denture which is or can be made useable according to common dental standards;
- procedures, appliances or restorations (except full dentures) whose main purpose is to: change vertical dimension; diagnose or treat conditions or dysfunction of the temporomandibular joint; stabilize periodontally involved teeth; or restore occlusion;
- porcelain or acrylic veneers of crowns or pontics on, or replacing the upper and lower first, second and third molars;
- bite registrations; precision or semiprecision attachments; or splinting;
- instruction for plaque control, oral hygiene and diet; dental services that do not meet common dental standards; services that are deemed to be medical services;
- services and supplies received from a Hospital;
- services for which benefits are not payable according to the "General Limitations" section.

General Limitations

Dental Benefits

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

- for or in connection with an Injury arising out of, or in the course of, any employment for wage or profit;
- for or in connection with a Sickness which is covered under any workers' compensation or similar law;
- for charges made by a Hospital owned or operated by or which provides care or performs services for, the United States Government, if such charges are directly related to a military-service-connected condition;
- services or supplies received as a result of dental disease, defect or injury due to an act of war, declared or undeclared;
- to the extent that payment is unlawful where the person resides when the expenses are incurred;
- for charges which the person is not legally required to pay;
- for charges which would not have been made if the person had no coverage;
- to the extent that billed charges exceed the rate of reimbursement as described in the Schedule;
- for charges for unnecessary care, treatment or surgery;
- to the extent that you or any of your Dependents is in any way paid or entitled to payment for those expenses by or through a public program, other than Medicaid;
- for or in connection with experimental procedures or treatment methods not approved by the American Dental Association or the appropriate dental specialty society.

Coordination of Benefits

This section applies if you or any one of your Dependents is covered under more than one Plan and determines how benefits payable from all such Plans will be coordinated. You should file all claims with each Plan.

Definitions

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

Plan

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

- Group coverage and/or group-type coverage, whether covered or self-covered which neither can be purchased by the general public, nor is individually underwritten,

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including closed panel coverage.

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

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

Closed Panel Plan

A Plan that provides medical or dental benefits primarily in the form of services through a panel of employed or contracted providers, and that limits or excludes benefits provided by providers outside of the panel, except in the case of emergency or if referred by a provider within the panel.

Primary Plan

The Plan that determines and provides or pays benefits without taking into consideration the existence of any other Plan.

Secondary Plan

A Plan that determines, and may reduce its benefits after taking into consideration, the benefits provided or paid by the Primary Plan. A Secondary Plan may also recover from the Primary Plan the Reasonable Cash Value of any services it provided to you.

Allowable Expense

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

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

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

Claim Determination Period

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

Reasonable Cash Value

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

Order of Benefit Determination Rules

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

If the Plan does have a coordination of benefits rule consistent with this section, the first of the following rules that applies to the situation is the one to use:

- The Plan that covers you as an enrollee or an employee shall be the Primary Plan and the Plan that covers you as a Dependent shall be the Secondary Plan;
- If you are a Dependent child whose parents are not divorced or legally separated, the Primary Plan shall be the Plan which covers the parent whose birthday falls first in the calendar year as an enrollee or employee;
- If you are the Dependent of divorced or separated parents, benefits for the Dependent shall be determined in the following order:
    - first, if a court decree states that one parent is responsible for the child's healthcare expenses or health coverage and the Plan for that parent has actual knowledge of the terms of the order, but only from the time of actual knowledge;
    - then, the Plan of the parent with custody of the child;
    - then, the Plan of the spouse of the parent with custody of the child;
    - then, the Plan of the parent not having custody of the child; and
    - finally, the Plan of the spouse of the parent not having custody of the child.
- The Plan that covers you as an active employee (or as that employee's Dependent) shall be the Primary Plan and the Plan that covers you as laid-off or retired employee (or as that employee's Dependent) shall be the secondary Plan. If the other Plan does not have a similar provision and, as a result, the Plans cannot agree on the order of benefit determination, this paragraph shall not apply.
- The Plan that covers you under a right of continuation which is provided by federal or state law shall be the Secondary Plan and the Plan that covers you as an active employee or retiree (or as that employee's Dependent) shall be the Primary Plan. If the other Plan does not have a similar provision and, as a result, the Plans cannot agree on the order of benefit determination, this paragraph shall not apply.

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- If one of the Plans that covers you is issued out of the state whose laws govern this Policy, and determines the order of benefits based upon the gender of a parent, and as a result, the Plans do not agree on the order of benefit determination, the Plan with the gender rules shall determine the order of benefits.

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

Effect on the Benefits of This Plan

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

The difference between the amount that this Plan would have paid if this Plan had been the Primary Plan, and the benefit payments that this Plan had actually paid as the Secondary Plan, will be recorded as a benefit reserve for you. the Claims Administrator will use this benefit reserve to pay any Allowable Expense not otherwise paid during the Claim Determination Period.
As each claim is submitted, the Claims Administrator will determine the following:

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

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

Recovery of Excess Benefits

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

The Claims Administrator will have sole discretion to seek such recovery from any person to, or for whom, or with respect to whom, such services were provided or such payments made by any coverage company, healthcare plan or other organization. If we request, you must execute and deliver to us such instruments and documents as we determine are necessary to secure the right of recovery.

Right to Receive and Release Information

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

Expenses For Which A Third Party May Be Responsible

This Plan does not cover:

- Expenses incurred by you or your Dependent (hereinafter individually and collectively referred to as a "Participant,") for which another party may be responsible as a result of having caused or contributed to an Injury or Sickness.
- Expenses incurred by a Participant to the extent any payment is received for them either directly or indirectly from a third party tortfeasor or as a result of a settlement, judgment or arbitration award in connection with any automobile medical, automobile no-fault, uncovered or undercovered motorist, homeowners, workers' compensation, government coverage (other than Medicaid), or similar type of insurance or coverage.

Right Of Reimbursement

If a Participant incurs a Covered Expense for which, in the opinion of the Plan or its Claim Administrator, another party may be responsible or for which the Participant may receive payment as described above, the Plan is granted a right of reimbursement, to the extent of the benefits provided by the Plan, from the proceeds of any recovery whether by settlement, judgment, or otherwise.

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Lien Of The Plan

By accepting benefits under this Plan, a Participant:

- grants a lien and assigns to the Plan an amount equal to the benefits paid under the Plan against any recovery made by or on behalf of the Participant which is binding on any attorney or other party who represents the Participant whether or not an agent of the Participant or of any coverage company or other financially responsible party against whom a Participant may have a claim provided said attorney, coverage carrier or other party has been notified by the Plan or its agents;
- agrees that this lien shall constitute a charge against the proceeds of any recovery and the Plan shall be entitled to assert a security interest thereon;
- agrees to hold the proceeds of any recovery in trust for the benefit of the Plan to the extent of any payment made by the Plan.

Additional Terms

- No adult Participant hereunder may assign any rights that it may have to recover medical expenses from any third party or other person or entity to any minor Dependent of said adult Participant without the prior express written consent of the Plan. The Plan's right to recover shall apply to decedents', minors', and incompetent or disabled persons' settlements or recoveries.
- No Participant shall make any settlement, which specifically reduces or excludes, or attempts to reduce or exclude, the benefits provided by the Plan.
- The Plan's right of recovery shall be a prior lien against any proceeds recovered by the Participant. This right of recovery shall not be defeated nor reduced by the application of any so-called "Made-Whole Doctrine", "Rimes Doctrine", or any other such doctrine purporting to defeat the Plan's recovery rights by allocating the proceeds exclusively to non-medical expense damages.
- No Participant hereunder shall incur any expenses on behalf of the Plan in pursuit of the Plan's rights hereunder, specifically; no court costs, attorneys' fees or other representatives' fees may be deducted from the Plan's recovery without the prior express written consent of the Plan. This right shall not be defeated by any so-called "Fund Doctrine", "Common Fund Doctrine", or "Attorney's Fund Doctrine".
- The Plan shall recover the full amount of benefits provided hereunder without regard to any claim of fault on the part of any Participant, whether under comparative negligence or otherwise.
- In the event that a Participant shall fail or refuse to honor its obligations hereunder, then the Plan shall be entitled to recover any costs incurred in enforcing the terms hereof including, but not limited to, attorney's fees, litigation, court costs, and other expenses. The Plan shall also be entitled to offset the reimbursement obligation against any entitlement to future medical benefits hereunder until the Participant has fully complied with his reimbursement obligations hereunder, regardless of how those future medical benefits are incurred.

By acceptance of benefits under the Plan, the Participant agrees that a breach hereof would cause irreparable and substantial harm and that no adequate remedy at law would exist. Further, the Plan shall be entitled to invoke such equitable remedies as may be necessary to enforce the terms of the Plan, including, but not limited to, specific performance, restitution, the imposition of an equitable lien and/or constructive trust, as well as injunctive relief.

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Payment of Benefits

To Whom Payable

Dental benefits are assignable to the provider. When you assign benefits to a provider, you have assigned the entire amount of the benefits due on that claim. If the provider is overpaid because of accepting a patient's payment on the charge, it is the provider's responsibility to reimburse the patient. Because of the Claims Administrator's contracts with providers, all claims from contracted providers should be assigned.

The Claims Administrator may, at its option, make payment to you for the cost of any covered expenses from a non-participating provider even if benefits have been assigned. When benefits are paid to you or your Dependent, you or your Dependents are responsible for reimbursing the provider.

If any person to whom benefits are payable is a minor or, in the opinion of the Claims Administer is not able to give a valid receipt for any payment due him, such payment will be made to his legal guardian. If no request for payment has been made by his legal guardian, the Claims Administrator may, at its option, make payment to the person or institution appearing to have assumed his custody and support.

When one of our participants passes away, the Claims Administrator may receive notice that an executor of the estate has been established. The executor has the same rights as our covered and benefit payments for unassigned claims should be made payable to the executor.

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

Recovery of Overpayment

When an overpayment has been made by the Claims Administrator, the Claims Administrator will have the right at any time to: recover that overpayment from the person to whom or on whose behalf it was made; or offset the amount of that overpayment from a future claim payment.

Miscellaneous

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

If you are a Plan member and you have one or more of the conditions listed below, you may apply for 100% reimbursement of your copayment or coinsurance for certain periodontal or caries-protection procedures (up to the applicable Plan maximum reimbursement levels and annual Plan maximums).

For members with diabetes, cerebrovascular or cardiovascular disease:

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

For members who are pregnant:

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

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

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

Please refer to the Plan enrollment materials for further details.

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Termination of Coverage

Employees

Your coverage will cease on the earliest date below:

- the date you cease to be in a class of eligible Employees or cease to qualify for the coverage.
- the last day for which you have made any required contribution for the coverage.
- the date the policy is canceled.
- the date you supply information for enrollment or claims for benefits that is determined to be fraudulent or an intentional misrepresentation.
- the date your Active Service ends except as described below.

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

Continued Coverage for Covered Dependents after your Death

If you die while covered under the Plan, your covered Dependents may continue their Plan coverage. This continued coverage will end when any one of these things happens:

- Your dependent is no longer an eligible Dependent.
- Your dependent becomes eligible for benefits under any other dental plan.
- The Plan stops offering Dependent coverage.
- GuideStone or your Employer stops offering the Plan.
- Required costs of coverage are not paid when due.

Additional Continuation Coverage for you and your Covered Dependents

Some Employers allow you and your covered Dependents to continue Plan coverage after it would otherwise end. This applies only if your Employer does all of these things:

- Elects to offer this continuation coverage.
- Continues to offer Plan coverage to its employees.
- Determine You were not fired for gross misconduct.

The maximum length of continuation coverage is:

- 18 months for you and your covered Dependents if the loss of Plan coverage is because you either lost your job or you work fewer than the hours required for active, full-time employment.
- 36 months for your Spouse or covered Dependent child if the loss of Plan coverage is due to you and your Spouse's divorce or legal separation, or your covered Dependent child is no longer an eligible Dependent.

Enrollment for Continuation Coverage.

If you want this continuation coverage, you or your covered Dependents must:

- Get an application and other information about this coverage from your Employer.
- Apply for continuation coverage within 60 days after the date Plan coverage would otherwise end.

Adding eligible Dependents to your Continuation Coverage.

You may add a newborn or an adopted child to your continuation coverage within 60 days after birth, adoption or placement in your home. Also, if you get married, you may add your new Spouse and any new eligible Dependents to your continuation coverage within 60 days after your marriage.

You must act promptly. If you do not, you and your dependents will not be eligible for this continuation coverage.

Charges for Continuation Coverage.

The monthly charge for continuation coverage will be up to 102% of the full cost of each covered person's Plan coverage. **You must pay these costs of coverage when due, or your continuation coverage will end.**

Early Termination of Continuation Coverage.

Continuation coverage will end sooner than the 18 or 36 months if:

- Costs of coverage are not paid when due.
- The covered person becomes covered under other dental coverage, either as an employee or dependent.
- GuideStone stops offering the Plan.
- Your Employer stops offering the Plan.

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Injury or Sickness

If your Active Service ends due to an Injury or Sickness, your coverage will be continued while you remain totally and continuously disabled as a result of the Injury or Sickness.
However, your coverage will not continue past the date the costs of the coverage cease to be paid, or your employer cancels your coverage.

Dependents

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

- the date your coverage ceases.
- the date you cease to be eligible for Dependent Coverage.
- the last day for which you have made any required contribution for the coverage.
- the date you supply information for enrollment or claims for benefits that is determined to be fraudulent or an intentional misrepresentation
- the date Dependent Coverage is canceled.

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

Dental Benefits Extension

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

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

There is no extension for any dental service not shown above.

Qualified Medical Child Support Order (QMCSO)

Eligibility for Coverage Under a QMCSO

If a Qualified Medical Child Support Order (QMCSO) is issued for your child, that child will be eligible for coverage as required by the order and you will not be considered a Late Entrant for Dependent coverage.

You must notify your Employer and elect coverage for that child, and yourself if you are not already enrolled, within 60 days of the QMCSO being issued.

Qualified Medical Child Support Order Defined

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

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

The QMCSO may not require the Plan to provide coverage for any type or form of benefit or option not otherwise provided under the Plan.

Payment of Benefits

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

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Definitions

Active Service

You will be considered in Active Service:

- on any of your Employer's scheduled work days if you are performing the regular duties of your work on a full-time basis on that day either at your Employer's place of business or at some location to which you are required to travel for your Employer's business.
- on a day which is not one of your Employer's scheduled work days if you were in Active Service on the preceding scheduled work day.

Charges

The term Charges means actual billed charges; except when the Contracted Dentist has contracted directly or indirectly with the Claims Administrator for a different amount. If the Contracted Dentist has contracted to receive payment on a basis other than fee- for-service amount then "charges" will be calculated based on a the Claims Administrator determined fee schedule or on a Claims Administrator determined percentage of actual billed charges.

Claims Administrator.

For eligibility claims, GuideStone. For dental benefits, Cigna.

Contracted Dentist

The term Contracted Dentist means:

a dentist, or a professional corporation, professional association, partnership, or other entity which has entered into a contract with the Claims Administrator to provide dental services at predetermined fees.

The Dentists qualifying as Contracted Dentists may change from time to time. A list of the current Contracted Dentists is available through www.cigna.com or by calling Cigna's customer service at 1-800-244-6224.

Contracted Fee

The term Contracted Fee refers to:

the total compensation level that a Contracted Dentist has agreed to accept as payment for dental procedures and services performed on an Employee or Dependent, according to the Employee's dental benefit Plan

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 Spouse as defined in this Plan booklet; and
- Any child of yours
  - through the end of the month in which they reach age 26.
  - age 26 or over and primarily supported by you and incapable of self-sustaining employment by reason of mental or physical disability. Proof of the child's condition and dependent must be submitted to the Claims Administrator after the date the child ceases to qualify above. During the next two years the Claims Administrator may, from time to time, require proof of the continuation of such condition and dependence. After that, the Claims Administrator may require proof no more than once a year.

"Child" means:

- Your or your Spouse's natural (biological) child.
- Your or your Spouse's legally adopted child or a child placed in your home for adoption.
- Your or your Spouse's stepchild or foster child.
- Your or your Spouse's grandchild who is dependent on you for support and maintenance.
- A child for whom you or your Spouse must provide healthcare by court order or order of a state agency authorized to issue National Medical Support Notices under federal law.
- A child for whom you or your Spouse are the legal guardian or managing conservator.

If two covered employees want to cover the same dependent child

Your child can't be covered under the Plan as a dependent of two covered persons working for the same Employer. You and your Spouse may both work for the same Employer and both have Employee coverage under the Plan, but you must decide which of you will carry the child as a dependent. You also have to tell your Employer what you decide.

Exceptions - dependent not eligible

There are three exceptions to the rules for dependent eligibility. Your Spouse or child is not an eligible Dependent under this Plan if he or she:

- Is on active duty in the armed forces of any country.
- Already has Employee coverage under this Plan through your Employer (no one can have both Employee coverage and Dependent coverage under the Plan through the same Employer).

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Employee

The term Employee means a full-time employee of the Employer who is currently in Active Service. The term does not include employees who are part-time or temporary or who normally work less than 20 hours a week for the Employer.

Employer

A church or ministry organization that is eligible to utilize products and Services made available by or through GuideStone and offers Plan coverage to its eligible Employees and eligible retirees.

Maximum Reimbursable Charge - Dental

The Maximum Reimbursable Charge is the lesser of:

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

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

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

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

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

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.

Spouse

A person of the opposite sex to whom You are married at the relevant time by a religious or civil ceremony effective under the laws of the state in which the marriage was contracted.

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