

Ensign Services, Inc.

CIGNA DENTAL CARE INSURANCE

EFFECTIVE DATE: January 1, 2025

CN010
2499682

This document printed in October, 2024 takes the place of any documents previously issued to you which described your benefits.

Printed in U.S.A.

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

CIGNA HEALTH AND LIFE INSURANCE COMPANY

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

POLICYHOLDER: Ensign Services, Inc.

GROUP POLICY(S) — COVERAGE

2499682 - DHMO2 CIGNA DENTAL CARE INSURANCE

EFFECTIVE DATE: January 1, 2025

NOTICE! This certificate provides dental benefits only. Review your certificate carefully.

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.



Geneva Cambell Brown, 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.



Important Notices

Discrimination is Against the Law

Cigna complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability or sex. Cigna does not exclude people or treat them differently because of race, color, national origin, age, disability or sex.

Cigna:

- Provides free aids and services to people with disabilities to communicate effectively with us, such as:
 - Qualified sign language interpreters
 - Written information in other formats (large print, audio, accessible electronic formats, other formats)
- Provides free language services to people whose primary language is not English, such as
 - Qualified interpreters
 - Information written in other languages

If you need these services, contact customer service at the toll-free phone number shown on your ID card, and ask a Customer Service Associate for assistance.

If you believe that Cigna has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability or sex, you can file a grievance by sending an email to ACAGrievance@cigna.com or by writing to the following address:

Cigna
Nondiscrimination Complaint Coordinator
P.O. Box 188016
Chattanooga, TN 37422

If you need assistance filing a written grievance, please call the number on the back of your ID card or send an email to ACAGrievance@cigna.com. You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights electronically through the Office for Civil Rights Complaint Portal, available at: <https://ocrportal.hhs.gov/ocr/portal/lobby.jsf>, or by mail or phone at:

U.S. Department of Health and Human Services
200 Independence Avenue, SW
Room 509F, HHH Building
Washington, D.C. 20201
1-800-368-1019, 800-537-7697 (TDD)

Complaint forms are available at
<http://www.hhs.gov/ocr/office/file/index.html>.

HC-NOT96

07-17

Proficiency of Language Assistance Services

English – ATTENTION: Language assistance services, free of charge, are available to you. For current Cigna customers, call the number on the back of your ID card. Otherwise, call 1.800.244.6224 (TTY: Dial 711).

Spanish – ATENCIÓN: Hay servicios de asistencia de idiomas, sin cargo, a su disposición. Si es un cliente actual de Cigna, llame al número que figura en el reverso de su tarjeta de identificación. Si no lo es, llame al 1.800.244.6224 (los usuarios de TTY deben llamar al 711).

Chinese – 注意：我們可為您免費提供語言協助服務。對於 Cigna 的現有客戶，請致電您的 ID 卡背面的號碼。其他客戶請致電 1.800.244.6224（聽障專線：請撥 711）。

Vietnamese – XIN LƯU Ý: Quý vị được cấp dịch vụ trợ giúp về ngôn ngữ miễn phí. Dành cho khách hàng hiện tại của Cigna, vui lòng gọi số ở mặt sau thẻ Hội viên. Các trường hợp khác xin gọi số 1.800.244.6224 (TTY: Quay số 711).

Korean – 주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 현재 Cigna 가입자님들께서는 ID 카드 뒷면에 있는 전화번호로 연락해주시고. 기타 다른 경우에는 1.800.244.6224 (TTY: 다이얼 711)번으로 전화해주십시오.

Tagalog – PAUNAWA: Makakakuha ka ng mga serbisyo sa tulong sa wika nang libre. Para sa mga kasalukuyang customer ng Cigna, tawagan ang numero sa likuran ng iyong ID card. O kaya, tumawag sa 1.800.244.6224 (TTY: I-dial ang 711).

Russian – ВНИМАНИЕ: вам могут предоставить бесплатные услуги перевода. Если вы уже участвуете в плане Cigna, позвоните по номеру, указанному на обратной стороне вашей идентификационной карточки участника плана. Если вы не являетесь участником одного из наших планов, позвоните по номеру 1.800.244.6224 (TTY: 711).

Arabic – برجاء الانتباه خدمات الترجمة المجانية متاحة لكم. لعملاء Cigna الحاليين برجاء الاتصال بالرقم المدون على ظهر بطاقتكم الشخصية. او اتصل ب 1.800.244.6224 (TTY : اتصل ب 711).



French Creole – ATANSYON: Gen sèvis èd nan lang ki disponib gratis pou ou. Pou kliyan Cigna yo, rele nimewo ki dèyè kat ID ou. Sinon, rele nimewo 1.800.244.6224 (TTY: Rele 711).

French – ATTENTION: Des services d'aide linguistique vous sont proposés gratuitement. Si vous êtes un client actuel de Cigna, veuillez appeler le numéro indiqué au verso de votre carte d'identité. Sinon, veuillez appeler le numéro 1.800.244.6224 (ATS : composez le numéro 711).

Portuguese – ATENÇÃO: Tem ao seu dispor serviços de assistência linguística, totalmente gratuitos. Para clientes Cigna atuais, ligue para o número que se encontra no verso do seu cartão de identificação. Caso contrário, ligue para 1.800.244.6224 (Dispositivos TTY: marque 711).

Polish – UWAGA: w celu skorzystania z dostępnej, bezpłatnej pomocy językowej, obecni klienci firmy Cigna mogą dzwonić pod numer podany na odwrocie karty identyfikacyjnej. Wszystkie inne osoby prosimy o skorzystanie z numeru 1 800 244 6224 (TTY: wybierz 711).

Japanese –

注意事項：日本語を話される場合、無料の言語支援サービスをご利用いただけます。現在のCignaのお客様は、IDカード裏面の電話番号まで、お電話にてご連絡ください。その他の方は、1.800.244.6224 (TTY: 711) まで、お電話にてご連絡ください。

Italian – ATTENZIONE: Sono disponibili servizi di assistenza linguistica gratuiti. Per i clienti Cigna attuali, chiamare il numero sul retro della tessera di identificazione. In caso contrario, chiamare il numero 1.800.244.6224 (utenti TTY: chiamare il numero 711).

German – ACHTUNG: Die Leistungen der Sprachunterstützung stehen Ihnen kostenlos zur Verfügung. Wenn Sie gegenwärtiger Cigna-Kunde sind, rufen Sie bitte die Nummer auf der Rückseite Ihrer Krankenversicherungskarte an. Andernfalls rufen Sie 1.800.244.6224 an (TTY: Wählen Sie 711).

Persian (Farsi) – توجه: خدمات کمک زبانی، به صورت رایگان به شما ارائه می‌شود. برای مشتریان فعلی Cigna، لطفاً با شماره‌ای که در پشت کارت شناسایی شماست تماس بگیرید. در غیر اینصورت با شماره 1.800.244.6224 تماس بگیرید (شماره تلفن ویژه ناشنوايان: شماره 711 را شماره‌گیری کنید).

NOTICE OF PROTECTION PROVIDED BY THE UTAH LIFE AND HEALTH INSURANCE GUARANTY ASSOCIATION

This disclaimer provides a brief summary of the Utah Life and Health Insurance Guaranty Association (Association) and the protection it provides for policyholders. The safety net was created under Utah law, which determines who and what is covered and the amounts of coverage.

The Association was established to provide protection in the unlikely event that your life, annuity or health insurance company becomes financially unable to meet its obligations and is taken over by its insurance department. If this should happen, the Association will typically arrange to continue coverage and pay claims, in accordance with Utah law, with the funding from assessments paid by other insurance companies. (For the purposes of this notice, the terms “insurance company” and “insurer” include health maintenance organizations (HMOs) and limited health plans.).

The basic protections provided by the Association are:

- Life Insurance
 - \$500,000 in death benefits
 - \$200,000 in cash surrender or withdrawal values
- Accident and Health Insurance
 - \$500,000 for health benefit plans
 - \$500,000 in disability income insurance benefits
 - \$500,000 in long-term care insurance benefits
 - \$500,000 in other types of health insurance benefits
- Annuities
 - \$250,000 in the present value of annuity benefits in aggregate, including any net cash surrender and net cash withdrawal values

The maximum amount of protection for each individual, regardless of the number of policies or contracts, is \$500,000. Special rules may apply with regard to health benefit plans.

Note: Certain policies and contracts may not be covered or fully covered. For example, coverage does not extend to any portion(s) of a policy or contract that the insurer does not guarantee, such as certain investment additions to the account value of a variable life insurance policy or a variable annuity contract. There are also various residency requirements and other limitations under Utah law.

Benefits provided by a long-term care rider to a life insurance policy or annuity contract shall be considered the same type of benefit as the base life insurance policy or annuity contract to which it relates.



To learn more about the above protections, please visit the Association's website at www.ulhiga.org, or contact:

Utah Life and Health Insurance Guaranty Assoc.	Utah Insurance Department
466 South 500 East, Suite 100	4315 S. 2700 W., Suite 2300
Salt Lake City, UT 84102	Taylorsville, UT 84129
(801) 320-9955	(801) 957-9200

HCDFB-IMP75

02-22

Eligibility - Effective Date

Employee Insurance

This plan is offered to you as an Employee.

Eligibility for Employee Insurance

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

- you are in a Class of Eligible Employees; and
- you are an eligible, full-time Employee; and
- you normally work at least 40 hours a week; and
- you pay any required contribution.

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

Eligibility for Dependent Insurance

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

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

Waiting Period

The first day of the month following 60 days from date of hire.

Classes of Eligible Employees

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

Effective Date of Employee Insurance

You will become insured on the date you elect the insurance by signing an approved payroll deduction or enrollment form, as applicable, but no earlier than 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 after the end of that Open Enrollment Period in which you elect it.

You will become insured on your first day of eligibility, following your election, if you are in Active Service on that date, or if you are not in Active Service on that date due to your health status.

Late Entrant – Employee

You are a Late Entrant if:

- you elect the insurance more than 30 days after you become eligible; or
- you again elect it after you cancel your payroll deduction (if required).

Open Enrollment Period

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

Dependent Insurance

For your Dependents to be insured, you will have to pay the required contribution, if any, toward the cost of Dependent Insurance.

Effective Date of Dependent Insurance

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

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

Your Dependents will be insured only if you are insured.

Late Entrant – Dependent

You are a Late Entrant for Dependent Insurance if:

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

Choice of Dental Office for Cigna Dental Care

When you elect Employee Insurance, you may select a Dental Office from the list provided by CDH. If your first choice of a



Dental Office is not available, you will be notified by CDH of your designated Dental Office, based on your alternate selection. You and each of your insured Dependents may select your own designated Dental Office. No Dental Benefits are covered unless the Dental Service is received from your designated Dental Office, referred by a Network General Dentist at that facility to a specialist approved by CDH, or otherwise authorized by CDH, except for Emergency Dental Treatment. A transfer from one Dental Office to another Dental Office 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 Dental Office.

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Important Information about Your Dental Plan

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

- **Cigna Dental Care; or**
- **Cigna Dental Preferred Provider**

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

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

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

Change in Option Elected

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

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

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

Effective Date of Change

If you change options during open enrollment, you (and your Dependents) will become insured on the effective date of the plan. If you change options other than at open enrollment (as

allowed by your plan), you will become insured on the first day of the month after the transfer is processed.

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HC-IMP74

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Dental Benefits – Cigna Dental Care

Your Cigna Dental Coverage

The information below outlines your coverage and will help you to better understand your Dental Plan. Included is information about which services are covered, which are not, and how much dental services will cost you.

Customer Service

If you have any questions or concerns about the Dental Plan, Customer Service Representatives are just a toll-free phone call away. They can explain your benefits or help with matters regarding your Dental Office or Dental Plan. For assistance with transfers, specialty referrals, eligibility, second opinions, emergencies, Covered Services, plan benefits, ID cards, location of Dental Offices, conversion coverage or other matters, call Customer Service from any location at 1-800-Cigna24. The hearing impaired may contact the state TTY toll-free relay service number listed in their local telephone directory.

Other Charges – Patient Charges

Your Patient Charge Schedule lists the dental procedures covered under your Dental Plan. Some dental procedures are covered at no charge to you. For other Covered Services, the Patient Charge Schedule lists the fees you must pay when you visit your Dental Office. 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 policies. Timely payment is important. It is possible that the Dental Office may add late charges to overdue balances.

Your Patient Charge Schedule is subject to annual change. Cigna Dental will give written notice to your Group of any change in Patient Charges at least 60 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.

Choice of Dentist

You and your Dependents should have selected a Dental Office when you enrolled in the Dental Plan. If you did not, you must advise Cigna Dental of your Dental Office selection



prior to receiving treatment. The benefits of the Dental Plan are available only at your Dental Office, except in the case of an emergency or when Cigna Dental otherwise approves payment for out-of-network benefits.

You may select a network Pediatric Dentist as the Network General Dentist for your dependent child under age 13 by calling Customer Service at 1-800-Cigna24 for a list of network Pediatric Dentists in your Service Area or, if your Network General Dentist sends your child under age 13 to a network Pediatric Dentist, the network Pediatric Dentist's office will have primary responsibility for your child's care. Your Network General Dentist should provide care for children 13 years and older.

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 will let you know and will arrange a transfer to another Dental Office. Refer to the Section titled "Office Transfers" if you wish to change your Dental Office.

To obtain a list of Dental Offices near you, visit our website at myCigna.com, or 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 Customer Service.

Your Payment Responsibility (General Care)

For Covered Services provided by your Dental Office, you will be charged the fees listed on your Patient Charge Schedule. For services listed on your Patient Charge Schedule at any other dental office, you may be charged Usual Fees. For non-Covered Services, you are responsible for paying Usual Fees.

If, on a temporary basis, there is no Network General Dentist in your Service Area, Cigna Dental 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 will pay the non-network Dentist the difference, if any, between his or her Usual Fee and the applicable Patient Charge.

See the *Specialty Referrals* section regarding payment responsibility for specialty care.

All contracts between Cigna Dental 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.

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.

• Emergency Care Away From Home

If you have an emergency while you are out of your Service Area or unable to contact your Network General Dentist, you may receive emergency Covered Services as defined above from any general dentist. Routine restorative procedures or definitive treatment (e.g. root canal) are not considered emergency care. You should return to your Network General Dentist for these procedures. For emergency Covered Services, you will be responsible for the Patient Charges listed on your Patient Charge Schedule. Cigna Dental will reimburse you the difference, if any, between the dentist's Usual Fee for emergency Covered Services and your Patient Charge, up to a total of \$50 per incident. To receive reimbursement, send appropriate reports and x-rays to Cigna Dental at the address listed for your state on the front of this booklet.

• 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.

Limitations on Covered Services

Listed below are limitations on services when covered by your Dental Plan:

- **Frequency** – The frequency of certain Covered Services, like cleanings, is limited. Your Patient Charge Schedule lists any limitations on frequency.
- **Pediatric Dentistry** – Coverage for treatment by a Pediatric Dentist ends on your child's 13th birthday. Effective on your child's 13th birthday, dental services must be obtained from a Network General Dentist; however, exceptions for medical reasons may be considered on an individual basis.
- **Oral Surgery** – The surgical removal of an impacted wisdom tooth may not be covered if the tooth is not diseased or if the removal is only for orthodontic reasons. Your Patient Charge Schedule lists any limitations on oral surgery.
- **Periodontal (gum tissue and supporting bone) Services** - Periodontal regenerative procedures are limited to one regenerative procedure per site (or per tooth, if applicable), when covered on the Patient Charge Schedule.

Localized delivery of antimicrobial agents is limited to eight teeth (or eight sites, if applicable) per 12 consecutive months, when covered on the Patient Charge Schedule.

- **Clinical Oral Evaluations** – When this limitation is noted on the Patient Charge Schedule, periodic oral evaluations, comprehensive oral evaluations, comprehensive periodontal evaluations, and oral evaluations for patients under 3 years of age are limited to a combined total of 4 evaluations during a 12 consecutive month period.
- **Surgical Placement of Implant Services** – When covered on the Patient Charge Schedule, surgical placement of a dental implant; repair, maintenance, or removal of a dental implant; implant abutment(s); or any services related to the surgical placement of a dental implant are limited to one per year with replacement of a surgical implant frequency limitation of one every 10 years.
- **Prosthesis Over Implant** – When covered on the Patient Charge Schedule, a prosthetic device, supported by an implant or implant abutment is considered a separate distinct service(s) from surgical placement of an implant. Replacement of any type of prosthesis with a prosthesis supported by an implant or implant abutment is only covered if the existing prosthesis is at least 5 calendar years old, is not serviceable and cannot be repaired.

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 charges which would not have been made in any facility, other than a Hospital or a Correctional Institution owned or operated by the United States Government or by a state or municipal government if the person had no insurance;
- to the extent that payment is unlawful where the person resides when the expenses are incurred or the services are received;
- for charges which the person is not legally required to pay;
- for charges which would not have been made if the person had no insurance;
- due to injuries which are intentionally self-inflicted.

Services Not Covered Under Your Dental Plan

Listed below are the services or expenses which are NOT covered under your Dental Plan and which are your responsibility at the dentist's Usual Fees. There is no coverage for:

- services not listed on the Patient Charge Schedule.
- services provided by a non-network Dentist without Cigna Dental's prior approval (except in emergencies).
- services related to an injury or illness paid under workers' compensation, occupational disease or similar laws.

- services provided or paid by or through a federal or state governmental agency or authority, political subdivision or a public program, other than Medicaid.
- services required while serving in the armed forces of any country or international authority or relating to a declared or undeclared war or acts of war.
- cosmetic dentistry or cosmetic dental surgery (dentistry or dental surgery performed solely to improve appearance) unless the service is specifically listed on your Patient Charge Schedule. If bleaching (tooth whitening) is listed on your Patient Charge Schedule, only the use of take-home bleaching gel with trays is covered; other types of bleaching methods are not covered.
- 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. There is no coverage for general anesthesia or intravenous sedation when used for the purposes of anxiety control or patient management.
- prescription medications.
- procedures, appliances or restorations if the main purpose is to: change vertical dimension (degree of separation of the jaw when teeth are in contact); restore teeth which have been damaged by attrition, abrasion, erosion and/or abfraction; or restore the occlusion.
- replacement of fixed and/or removable appliances (including fixed and removable orthodontic appliances) that have been lost, stolen, or damaged due to patient abuse, misuse or neglect.
- surgical placement of a dental implant; repair, maintenance or removal of a dental implant; implant abutment(s); or any services related to the surgical placement of a dental implant, unless specifically listed on your Patient Charge Schedule.
- services considered to be unnecessary or experimental in nature or do not meet commonly accepted dental standards.
- procedures or appliances for minor tooth guidance or to control harmful habits.
- hospitalization, including any associated incremental charges for dental services performed in a hospital. (Benefits are available for network Dentist charges for covered services performed at a hospital. Other associated charges are not covered and should be submitted to the medical carrier for benefit determination.)
- the completion of crowns, bridges, dentures or root canal treatment already in progress on the effective date of your Cigna Dental coverage.

- the completion of implant supported prosthesis (including crowns, bridges and dentures) already in progress on the effective date of your Cigna Dental coverage, unless specifically listed on your Patient Charge Schedule.
- consultations and/or evaluations associated with services that are not covered.
- endodontic treatment and/or periodontal (gum tissue and supporting bone) surgery of teeth exhibiting a poor or hopeless periodontal prognosis.
- bone grafting and/or guided tissue regeneration when performed at the site of a tooth extraction, unless specifically listed on your Patient Charge Schedule.
- bone grafting and/or guided tissue regeneration when performed in conjunction with an apicoectomy or periradicular surgery.
- intentional root canal treatment in the absence of injury or disease to solely facilitate a restorative procedure.
- services performed by a prosthodontist.
- localized delivery of antimicrobial agents when performed alone or in the absence of traditional periodontal therapy.
- infection control and/or sterilization. Cigna Dental considers this to be incidental to and part of the charges for services provided and not separately chargeable.
- the recementation of any inlay, onlay, crown, post and core or fixed bridge within 180 days of initial placement. Cigna Dental considers recementation within this timeframe to be incidental to and part of the charges for the initial restoration.
- the recementation of any implant supported prosthesis (including crowns, bridges and dentures) within 180 days of initial placement. Cigna Dental considers recementation within this timeframe to be incidental to and part of the charges for the initial restoration unless specifically listed on your Patient Charge Schedule.
- services to correct congenital malformations, including the replacement of congenitally missing teeth.
- the replacement of an occlusal guard (night guard) beyond one per any 24 consecutive month period when this limitation is noted on your Patient Charge Schedule.
- crowns, bridges and/or implant supported prosthesis used solely for splinting.
- resin bonded retainers and associated pontics.

Pre-existing conditions are not excluded if the procedures involved are otherwise covered in your Patient Charge Schedule.

Should any law require coverage for any particular service(s) noted above, the exclusion or limitation for that service(s) shall not apply.

Appointments

To make an appointment with your network Dentist, call the Dental Office that you have selected. When you call, your Dental Office will ask for your identification number and will check your eligibility.

Broken Appointments

The time your network Dentist schedules for your appointment is valuable to you and the dentist. Broken appointments make it difficult for your Dental Office to schedule time with other patients.

If you or your enrolled Dependent break an appointment with less than 24 hours notice to the Dental Office, you may be charged a broken appointment fee.

Office Transfers

If you decide to change Dental Offices, we can arrange a transfer. You should complete any dental procedure in progress before transferring to another Dental Office. To arrange a transfer, call Customer Service at 1-800-Cigna24. To obtain a list of Dental Offices near you, visit our website at myCigna.com, or call the Dental Office Locator at 1-800-Cigna24.

Your transfer request may take up to 5 days to process. Transfers will be effective the first day of the month after the processing of your request. Unless you have an emergency, you will be unable to schedule an appointment at the new Dental Office until your transfer becomes effective. You can check the status of your request by visiting myCigna.com, or by calling us at 1-800-Cigna24.

There is no charge to you for the transfer; however, all Patient Charges which you owe to your current Dental Office must be paid before the transfer can be processed.

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 network includes the following types of specialty dentists:

- 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.



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 Specialty Dentist.

Specialty Referrals

In General

Preauthorization is not required for coverage of services by a Network Specialty Dentist.

When Cigna Dental approves payment to the Network Specialty Dentist, 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 the Orthodontics section. Treatment by the Network Specialty Dentist must begin within 90 days from the date of Cigna Dental's approval. If you are unable to obtain treatment within the 90-day period, please call Customer Service to request an extension. Your coverage must be in effect when each procedure begins.

For non-Covered Services or if Cigna Dental does not approve payment to the Network Specialty Dentist for Covered Services, including Adverse Determinations, you must pay the Network Specialty Dentist's Usual Fee. If you have a question or concern regarding an approval or a denial, contact Customer Service.

After the Network Specialty Dentist has completed treatment, you should return to your Network General Dentist for cleanings, regular checkups and other treatment. If you visit a Network Specialty Dentist without a referral or if you continue to see a Network Specialty Dentist 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 Specialty Dentist is not available, as determined by Cigna Dental, Cigna Dental will approve a referral to a non-Network Specialty Dentist. 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 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 approved for payment, including Adverse Determinations, you must pay the dentist's Usual Fee.

Orthodontics - (This section is only applicable if Orthodontia is listed on your Patient Charge Schedule.)

Definitions –

- **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.

Patient Charges

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. However, if banding/appliance insertion does not occur within 90 days of such visit; your treatment plan changes; or there is an interruption in your coverage or treatment, 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 prorated 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, the fee listed on the Patient Charge Schedule is not applicable. Please call Customer



Service at 1-800-Cigna24 to find out if you are entitled to any benefit under the Dental Plan.

Complex Rehabilitation/Multiple Crown Units

Complex rehabilitation is extensive dental restoration involving 6 or more "units" of crown, and/or bridge and/or implant supported prosthesis (including crowns and bridges) in the same treatment plan. Using full crowns (caps), and/or fixed bridges and/or implant supported prosthesis (including crowns and 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 the 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 and/or implant supported prosthesis (including crowns and bridges) 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 and/or implant supported prosthesis (including crowns and bridges) PLUS an additional charge for each unit when 6 or more units are prescribed in your Network General Dentist's treatment plan.

Note: Complex rehabilitation only applies for implant supported prosthesis, when implant supported prosthesis are specifically listed on your Patient Charge Schedule.

HC-DEN243

01-19

Coordination of Benefits

Under this dental plan coordination of benefits rules apply to specialty care only.

This section describes what this Plan will pay for covered expenses that are also covered under one or more other Plans. 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:

- An insurance policy or certificate or HMO service agreement issued to an individual or a group or a self-insured group health plan providing benefits in the form of reimbursement or services for dental care or treatment/item.
- Governmental benefits as permitted by law, excepting Medicaid, Medicare and Medicare supplement policies.
- Medical benefits coverage under any form of group or individual automobile insurance.

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

Closed Panel Plan does not include:

- hospital indemnity coverage benefits or other fixed indemnity coverage; accident only coverage; specified disease or specified accident coverage; limited benefit health coverage, as defined in Utah law;
- school accident-type coverages that cover students for accidents only, including athletic injuries, either on a twenty-four-hour basis or on a "to and from school" basis;
- benefits provided in long-term care insurance policies for non-medical services, for example, personal care, adult day care, homemaker services, assistance with activities of daily living, respite care and custodial care or for contracts that pay a fixed daily benefit without regard to expenses incurred or the receipt of services;
- Medicare supplement policies; Medicaid; or a governmental plan, which, by law, provides benefits that are in excess of those of any private insurance plan or other non-governmental plan.

Primary Plan

Primary Plan means a Plan whose benefits for a person's health care coverage must be determined without taking the existence of any other Plan into consideration. A Plan is a Primary Plan if:

- the Plan has no order of benefit determination;
- its rules differ from those permitted by this rule; or
- all Plans which cover the person use the order of benefit determination rules below and under those requirements the Plan determines its benefits first.

Secondary Plan

Secondary Plan means any Plan, which is not a Primary Plan.

Allowable Expense

The portion of a covered expense used in determining the benefits this Plan pays when it is the Secondary Plan. The Allowable Expense is the lesser of:

- the charge used by the Primary Plan in determining the benefits it pays;
- the charge that would be used by this Plan in determining the benefits it would pay if it were the Primary Plan; and
- the amount of the covered expense.

If all Plans covering you are high-deductible health plans and you intend to contribute to a health savings account established in accordance with Section 223 of the Internal Revenue Code of 1986, the primary high-deductible health plan's deductible is not an Allowable Expense, except for any health care expense incurred that may not be subject to the deductible as described in Section 223 of the Internal Revenue Code of 1986.

If the benefits for a covered expense under your Primary Plan are reduced because you did not comply with the Primary Plan's requirements (for example, getting pre-certification of hospital admission or a second surgical opinion), the amount of the Allowable Expense is reduced by the amount of the reduction.

Claim Determination Period

A calendar year, excluding any part of a calendar year during which you are not covered under this Plan or any date before this section or any similar provision takes effect.

Order of Benefit Determination Rules

A Plan that does not have coordination of benefits rules consistent with these rules is the Primary Plan. If the Plan has coordination of benefits rules consistent with these rules, the first of the following rules that applies to the situation is the one that applies:

- 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, the Primary Plan for the Dependent shall be determined in the following order:
 - 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, then it shall be Primary, but only from the time of actual knowledge. If the parent with responsibility has no health care coverage for the child's health care expenses, but the spouse of the responsible parent does have health care coverage for the child's health care expenses the responsible parent's spouse's plan shall be Primary;
 - the Plan of the parent with custody of the child;
 - the Plan of the spouse of the parent with custody of the child;
 - the Plan of the parent not having custody of the child; and
 - 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 a 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 do not reach an agreement 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 do not reach an agreement on the order of benefit determination, this paragraph shall not apply.
- If the preceding rules do not determine the order of benefits, the Plan that has covered you for the longer period of time is the Primary Plan and the Plan that has covered you for the shorter period of time is the Secondary Plan.

If none of the above rules determine the Primary Plan, the Allowable Expenses shall be shared equally between the Plans.

If the Plans cannot agree on the order of benefits within 30 calendar days after the Plans have received all of the information needed to pay the claim, the Plans shall immediately pay the claim in equal shares and determine their relative liabilities following payment, except that no Plan shall be required to pay more than it would have paid had it been the Primary Plan.



Effect on the Benefits Payable

If this Plan is the Primary Plan, the amount this Plan pays for a covered expense will be determined without regard to the benefits payable under any other Plan.

If this Plan is the Secondary Plan, the amount this Plan pays for a covered expense is the Allowable Expense less the amount payable by the Primary Plan during a Claim Determination Period.

The difference between the amount that this Plan pays when it is the Secondary Plan and what it would have paid as the Primary Plan, will be recorded as a benefit reserve for you. This benefit reserve will be used to pay any covered expense not otherwise paid during the Claim Determination Period.

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

- whether the expense for which the claim is made is covered under this Plan;
- whether to record a benefit reserve for you; and
- whether you incurred any covered expenses during the Claims Determination Period that were not paid by this Plan or the Primary Plan.

The benefit reserve recorded for you will be used to pay any covered expenses incurred during the Claim Determination Period that are not otherwise paid by the Primary Plan or this Plan. At the beginning of each Claim Determination Period, your benefit reserve will be zero and a new benefit reserve will be recorded for you as described above. Benefit reserve amounts not used in the prior Claim Determination Period do not carry over to the next Claim Determination Period.

Other Cigna Coverage

If while covered under this Plan, you are also covered by another Cigna individual or group Plan, you will be entitled to the benefits of only one Plan. You may choose which Plan will provide coverage. Cigna will then cancel the other coverage and refund any premium received under the other Cigna Plan for the time period both Plans were in effect. However, any claim payments made by Cigna under the Plan for which your coverage is cancelled will be deducted from any such refund amount.

Recovery of Excess Benefits

If this Plan is the Secondary Plan and Cigna pays for covered expenses that should have been paid by the Primary Plan, or if Cigna pays any amount in excess of what it is obligated to pay under this Plan, Cigna will have the right to recover the amount of the overpayment. Cigna will have sole discretion to seek such recovery. If we request, you must execute and deliver to us such documents as we determine are necessary to secure our 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 your 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 may be processed.

HC-COB130

01-16

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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, uninsured or underinsured motorist, homeowners, workers' compensation, government insurance (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.

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 insurance company or other financially responsible party against whom a Participant may have a claim provided said attorney, insurance 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.

- Any reference to state law in any other provision of this plan shall not be applicable to this provision, if the plan is governed by ERISA. 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.

HC-SUB2

04-10

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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 Cigna's contracts with providers, all claims from contracted providers should be assigned.

Cigna 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 Cigna 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, Cigna 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, Cigna may receive notice that an executor of the estate has been established. The executor has the same rights as our insured and benefit payments for unassigned claims should be made payable to the executor.

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



Recovery of Overpayment

When an overpayment has been made by Cigna, Cigna 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.

HC-POB4

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Miscellaneous

Certain Dental Offices may provide discounts on services not listed on the Patient Charge Schedule, including a 10% discount on bleaching services. You should contact your participating Dental Office to determine if such discounts are offered.

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

HC-POB27

04-10

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Termination of Insurance

Employees

Your insurance will cease on the earliest date below:

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

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

Temporary Layoff or Leave of Absence

If your Active Service ends due to temporary layoff or leave of absence, your insurance will be continued until the date your Employer: stops paying premium for you; or otherwise cancels your insurance. However, your insurance will not be

continued for more than 60 days past the date your Active Service ends.

Injury or Sickness

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

Note:

When a person's Dental Insurance ceases, Cigna does not offer any Converted Policy either on an individual or group basis. However, upon termination of insurance due to termination of employment in an eligible class or ceasing to qualify as a Dependent, you or any of your Dependents may apply to Cigna Dental Health, Inc. for coverage under an individual dental plan.

Upon request, Cigna Dental Health Inc. or your Employer will provide you with further details of the Converted Policy.

Dependents

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

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

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

HC-TRM72

04-10

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Dental Benefits Extension

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

- for fixed bridgework and full or partial dentures, the first impressions are taken and/or abutment teeth fully prepared while he is insured and the device installed or delivered to him within 3 calendar months after his insurance ceases.
- for a crown, inlay or onlay, the tooth is prepared while he is insured and the crown, inlay or onlay installed within 3 calendar months after his insurance ceases.



- for root canal therapy, the pulp chamber of the tooth is opened while he is insured and the treatment is completed within 3 calendar months after his insurance ceases.

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

This extension of benefits does not apply if insurance ceases due to nonpayment of premiums.

HC-BEX38

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Dental Conversion Privilege

Dental Conversion Privilege for Cigna Dental Care, Cigna Dental Preferred Provider and Cigna Traditional Dental

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

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

HC-CNV2

04-10
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Notice of an Appeal or a Grievance

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

HC-SPP4

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The Following Will Apply To Residents of Utah

When You Have A Complaint or an Appeal

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

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

Start With Member Services

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

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

We will do our best to resolve the matter on your initial contact. If we need more time to review or investigate your concern, we will get back to you as soon as possible, but in any case within 30 days.

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

Appeals Procedure

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

Level-One Appeal

Your appeal will be reviewed and the decision made by someone not involved in the initial decision. Appeals involving Medical Necessity or clinical appropriateness will be considered by a health care professional.

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



information is needed to make the determination, we will notify you in writing to request an extension of up to 15 calendar days and to specify any additional information needed to complete the review.

Level Two Appeal

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

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

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

Independent Review Procedure

If you are not fully satisfied with the decision of Cigna's level-two appeal review regarding your Medical Necessity or clinical appropriateness issue, you may request that your appeal be referred to an Independent Review Organization. The Independent Review Organization is composed of persons who are not employed by HealthCare or any of its affiliates. A decision to use the voluntary level of appeal will not affect the claimant's rights to any other benefits under the plan.

There is no charge for you to initiate this independent review process. Cigna will abide by the decision of the Independent Review Organization.

In order to request a referral to an Independent Review Organization, certain conditions apply. The reason for the denial must be based on a Medical Necessity or clinical appropriateness determination by Cigna. Administrative, eligibility or benefit coverage limits or exclusions are not eligible for appeal under this process.

To request a review, you must notify the Appeals Coordinator within 180 days of your receipt of Cigna's level two appeal

review denial. Cigna will then forward the file to the Independent Review Organization.

The Independent Review Organization will render an opinion within 30 days. When requested and when a delay would be detrimental to your condition, as determined by Cigna's Dentist reviewer, the review shall be completed within 3 days.

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

Appeal to the State of Utah

You have the right to contact the Utah State Department of Insurance for assistance at any time. The Utah State Department of Insurance may be contacted at the following address and telephone number:

Utah State Department of Insurance
State Office Building, Room 3110
Salt Lake City, UT 84114-6901
800-439-3805

Notice of Benefit Determination on Appeal

Every notice of a determination on appeal will be provided in writing or electronically and, if an adverse determination, will include: the specific reason or reasons for the adverse determination; reference to the specific plan provisions on which the determination is based; a statement that the claimant is entitled to receive, upon request and free of charge, reasonable access to and copies of all documents, records, and other Relevant Information as defined; a statement describing any voluntary appeal procedures offered by the plan and the claimant's right to bring an action under ERISA section 502(a); upon request and free of charge, a copy of any internal rule, guideline, protocol or other similar criterion that was relied upon in making the adverse determination regarding your appeal, and an explanation of the scientific or clinical judgment for a determination that is based on a Medical Necessity, experimental treatment or other similar exclusion or limit.

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

Relevant Information

Relevant Information is any document, record, or other information which was relied upon in making the benefit determination; was submitted, considered, or generated in the course of making the benefit determination, without regard to



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

Legal Action

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

HC-APL92

04-10
V1

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.

HC-DFS1

04-10
V1

Adverse Determination

An Adverse Determination is a decision made by Cigna Dental that it will not authorize payment for certain limited specialty care procedures. Any such decision will be based on the necessity or appropriateness of the care in question. To be considered clinically necessary, the treatment or service must be reasonable and appropriate and must meet the following requirements. It must:

- be consistent with the symptoms, diagnosis or treatment of the condition present;
- conform to commonly accepted standards of treatment;
- not be used primarily for the convenience of the member or provider of care; and
- not exceed the scope, duration or intensity of that level of care needed to provide safe and appropriate treatment.

Requests for payment authorizations that are declined by Cigna Dental based upon the above criteria will be the responsibility of the member at the dentist's Usual Fees.

HC-DFS350

04-10
V1

Cigna Dental Health (herein referred to as CDH)

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

HC-DFS352

04-10
V1

Contract Fees

Contract Fees are the fees contained in the Network Specialty Dentist agreement with Cigna Dental which represent a discount from the provider's Usual Fees.

HC-DFS353

04-10
V1



Covered Services

Covered Services are the dental procedures listed in your Patient Charge Schedule.

HC-DFS354

04-10
V1

Dental Office

Dental Office means the office of the Network General Dentist(s) that you select as your provider.

HC-DFS355

04-10
V1

Dental Plan

The term Dental Plan means the managed dental care plan offered through the Group Contract between Cigna Dental and your Group.

HC-DFS356

04-10
V2

Dentist

The term Dentist means a person practicing dentistry or oral surgery within the scope of his license. It will also include a provider operating within the scope of his license when he performs any of the Dental Services described in the policy.

HC-DFS125

04-10
V3

Dependent

Dependents are:

- your lawful spouse; or
- your Domestic Partner; and
- any child of yours who is
 - less than 26 years old.
 - 26 or more years old, unmarried, 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 dependence must be submitted to Cigna within 31 days after the date the child ceases to qualify above. From time to time, but not more frequently than

once a year, Cigna may require proof of the continuation of such condition and dependence.

The term child means a child born to you, a child who is entitled to Dependent coverage by a court or administrative order, or a child legally adopted by you, including that child from the date of placement for adoption. Coverage for an adopted child will begin from:

- the moment of birth, if adoption occurs within 30 days of the child's birth; or
- the date of placement, if placement for adoption occurs 30 days or more after the child's birth.

This coverage requirement ends if the child is removed from placement prior to the child being legally adopted.

"Placement For Adoption" means the assumption and retention by a person of a legal obligation for total or partial support of a child in anticipation of the adoption of the child.

It also includes a stepchild or a child for whom you are the legal guardian. If your Domestic Partner has a child, that child will also be included as a Dependent.

Benefits for a Dependent child will continue until the last day of the calendar month in which the limiting age is reached.

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.

HC-DFS820

01-16
V1

Domestic Partner

A Domestic Partner is defined as a person of the same or opposite sex who:

- shares your permanent residence;
- has resided with you for no less than one year;
- is no less than 18 years of age;
- 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; community 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 a durable power of attorney or health care power of attorney; or such other proof as is considered by Cigna to be sufficient to establish



financial interdependency under the circumstances of your particular case;

- is not a blood relative any closer than would prohibit legal marriage; and
- has signed jointly with you, a notarized affidavit attesting to the above which can be made available to Cigna upon request.

In addition, you and your Domestic Partner will be considered to have met the terms of this definition as long as neither you nor your Domestic Partner:

- has signed a Domestic Partner affidavit or declaration with any other person within twelve months prior to designating each other as Domestic Partners hereunder;
- is currently legally married to another person; or
- has any other Domestic Partner, spouse or spouse equivalent of the same or opposite sex.

You and your Domestic Partner must have registered as Domestic Partners, if you reside in a state that provides for such registration.

The section of this certificate entitled "COBRA Continuation Rights Under Federal Law" will not apply to your Domestic Partner and his or her Dependents.

HC-DFS47

04-10
V1

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 40 hours a week for the Employer.

HC-DFS7

04-10
V3

Employer

The term Employer means the Policyholder and all Affiliated Employers.

HC-DFS8

04-10
V1

Group

The term Group means the Employer, labor union or other organization that has entered into a Group Contract with Cigna Dental for managed dental services on your behalf.

HC-DFS357

04-10
V1

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.

HC-DFS16

04-10
V1

Medicare

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

HC-DFS17

04-10
V1

Network General Dentist

A Network General Dentist is a licensed dentist who has signed an agreement with Cigna Dental to provide general dental care services to plan members.

HC-DFS358

04-10
V1

Network Specialty Dentist

A Network Specialty Dentist is a licensed dentist who has signed an agreement with Cigna Dental to provide specialized dental care services to plan members.

HC-DFS359

04-10
V1



Patient Charge Schedule

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

HC-DFS360 04-10
V1

Service Area

The Service Area is the geographical area designated by Cigna Dental within which it shall provide benefits and arrange for dental care services.

HC-DFS361 04-10
V1

Specialist

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

HC-DFS362 04-10
V1

Subscriber

The subscriber is the enrolled employee or member of the Group.

HC-DFS363 04-10
V1

Usual Fee

The customary fee that an individual Dentist most frequently charges for a given dental service.

HC-DFS138 04-10
V1



Cigna Dental Care – Cigna Dental Health Plan

**The certificate and the state specific riders listed in the next section apply if you are a resident of one of the following states:
AZ, CO, DE, KS/NE, MD, OH**

CDO32V1



Cigna Dental Companies

Cigna Dental Health Plan of Arizona, Inc.
Cigna Dental Health of Colorado, Inc.
Cigna Dental Health of Delaware, Inc.
Cigna Dental Health of Florida, Inc. **(a Prepaid Limited Health Services Organization licensed under Chapter 636, Florida Statutes)**
Cigna Dental Health of Kansas, Inc. (Kansas and Nebraska)
Cigna Dental Health of Kentucky, Inc.
Cigna Dental Health of Maryland, Inc.
Cigna Dental Health of Missouri, Inc.
Cigna Dental Health of New Jersey, Inc.
Cigna Dental Health of North Carolina, Inc.
Cigna Dental Health of Ohio, Inc.
P.O. Box 453099
Sunrise, Florida 33345-3099

This Plan Booklet/Combined Evidence of Coverage and Disclosure Form/Certificate of Coverage is intended for your information; it constitutes a summary of the Dental Plan and is included as a part of the agreement between Cigna Dental and your Group (collectively, the “Group Contract”). The Group Contract must be consulted to determine the rates and the exact terms and conditions of coverage. If rates or coverages are changed under your Group Contract, your rates and coverage will also change. A prospective customer has the right to view the Combined Evidence of Coverage and Disclosure Form prior to enrollment. It should be read completely and carefully. Customers with special health care needs should read carefully those sections that apply to them. Please read the following information so you will know from whom or what group of dentists dental care may be obtained.

NOTICE: IF YOU OR YOUR FAMILY MEMBERS ARE COVERED BY MORE THAN ONE HEALTH CARE PLAN, YOU MAY NOT BE ABLE TO COLLECT BENEFITS FROM BOTH PLANS. EACH PLAN MAY REQUIRE YOU TO FOLLOW ITS RULES OR USE SPECIFIC DOCTORS OR HOSPITALS, AND IT MAY BE IMPOSSIBLE TO COMPLY WITH BOTH PLANS AT THE SAME TIME. READ ALL OF THE RULES VERY CAREFULLY, INCLUDING THE DUAL COVERAGE SECTION.

Important Cancellation Information – Please Read the Provision Entitled “Disenrollment from the Dental Plan–Termination of Benefits.”

READ YOUR PLAN BOOKLET CAREFULLY

Please call Customer Service 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.

In some instances, state laws will supersede or augment the provisions contained in this booklet. These requirements are listed at the end of this booklet as a State Rider. In case of a conflict between the provisions of this booklet and your State Rider, the State Rider will prevail.



I. Definitions

Capitalized terms, unless otherwise defined, have the meanings listed below.

Adverse Determination - a decision by Cigna Dental 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 customer or dentist 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 authorizations that are declined by Cigna Dental based upon the above criteria will be the responsibility of the customer at the dentist's Usual Fees. A licensed dentist will make any such denial.

Cigna Dental - 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 Dentist agreement with Cigna Dental.

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

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

Dental Plan - managed dental care plan offered through the Group Contract between Cigna Dental and your Group.

Dependent - your lawful spouse, or your Domestic Partner; your child (including newborns, adopted children, stepchildren, a child for whom you must provide dental coverage under a court order; or, a dependent child who resides in your home as a result of court order or administrative placement) who is:

- (a) less than 26 years old; or
- (b) 26 years or older, unmarried and if he or she is both:
 - i. incapable of self-sustaining employment due to mental or physical disability, and
 - ii. reliant upon you for maintenance and support.

A Newly Acquired Dependent is a dependent child who is adopted, born, or otherwise becomes your dependent after you become covered under the Plan.

Coverage for dependents living outside a Cigna Dental service area is subject to the availability of an approved network where the dependent resides.

Group - employer, labor union or other organization that has entered into a Group Contract with Cigna Dental for managed dental services on your behalf.

Network Dentist - a licensed dentist who has signed an agreement with Cigna Dental 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 - a licensed dentist who has signed an agreement with Cigna Dental under which he or she agrees to provide dental care services to you.

Network Specialty Dentist - a licensed dentist who has signed an agreement with Cigna Dental under which he or she agrees to provide specialized dental care services to you.

Patient Charge - the amount you owe your Network Dentist for any dental procedure listed on your Patient Charge Schedule.

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

Premiums - fees that your Group remits to Cigna Dental, on your behalf, during the term of your Group Contract.

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

Subscriber/You - the enrolled employee or customer of the Group.

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

II. Introduction To Your Cigna Dental Plan

Welcome to the Cigna Dental Plan. We encourage you to use your dental benefits. Please note that enrollment in the Dental Plan allows the release of patient records to Cigna Dental or its designee for health plan operation purposes.

III. Eligibility/When Coverage Begins

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



If you enrolled in the Dental Plan before the effective date of your Group Contract, you will be covered on the first day the Group Contract is effective. If you enrolled in the Dental Plan after the effective date of the Group Contract, you will be covered on the first day of the month following processing of your enrollment (unless effective dates other than the first day of the month are provided for in your Group Contract).

Dependents may be enrolled in the Dental Plan at the time you enroll, during an open enrollment, or within 31 days of becoming eligible due to a life status change such as marriage, birth, adoption, placement, or court or administrative order. You may drop coverage for your Dependents only during the open enrollment periods for your Group, unless there is a change in status such as divorce. Cigna Dental may require evidence of good dental health at your expense if you or your Dependents enroll after the first period of eligibility (except during open enrollment) or after disenrollment because of nonpayment of Premiums.

If you have family coverage, 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 must be enrolled in the Dental Plan and you must begin paying Premiums, if any additional are due, during that period.

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 Premiums, if any, which you would have paid if you had not taken the leave. Additional information is available through your Benefits Representative.

IV. Your Cigna Dental Coverage

The information below outlines your coverage and will help you to better understand your Dental Plan. Included is information about which services are covered, which are not, and how much dental services will cost you. A copy of the Group Contract will be furnished to you upon your request.

A. Customer Service

If you have any questions or concerns about the Dental Plan, Customer Service Representatives are just a toll-free phone call away. They can explain your benefits or help with matters regarding your Dental Office or Dental Plan. For assistance with transfers, specialty referrals, eligibility, second opinions, emergencies, Covered Services, plan benefits, ID cards, location of Dental Offices, conversion coverage or other matters, call Customer Service from any location at 1-800-Cigna24. The hearing impaired may contact the state TTY toll-free

relay service number listed in their local telephone directory.

B. Premiums

Your Group sends a monthly fee to Cigna Dental for customers participating in the Dental Plan. The amount and term of this fee is 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.

C. Other Charges – Patient Charges

Network General Dentists are typically reimbursed by Cigna Dental 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.

Your Patient Charge Schedule lists the dental procedures covered under your Dental Plan. Some dental procedures are covered at no charge to you. For other Covered Services, the Patient Charge Schedule lists the fees you must pay when you visit your Dental Office. 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 policies. Timely payment is important. It is possible that the Dental Office may add late charges to overdue balances.

Your Patient Charge Schedule is subject to annual change in accordance with your Group Contract. Cigna Dental will give written notice to your Group of any change in Patient Charges at least 60 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.

D. Choice of Dentist

You and your Dependents should have selected a Dental Office when you enrolled in the Dental Plan. If you did not, you must advise Cigna Dental of your Dental Office selection prior to receiving treatment. The benefits of the Dental Plan are available only at your Dental Office, except in the case of an emergency or when Cigna Dental otherwise authorizes payment for out-of-network benefits.

You may select a network Pediatric Dentist as the Network General Dentist for your dependent child under age 7 by calling Customer Service at 1-800-Cigna24 to

get a list of network Pediatric Dentists in your Service Area or if your Network General Dentist sends your child under the age of 7 to a network Pediatric Dentist, the network Pediatric Dentist's office will have primary responsibility for your child's care. For children 7 years and older, your Network General Dentist will provide care. If your child continues to visit the Pediatric Dentist upon the age of 7, you will be fully responsible for the Pediatric Dentist's Usual Fees. Exceptions for medical reasons may be considered on a case-by-case basis.

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 will let you know and will arrange a transfer to another Dental Office. Refer to the Section titled "Office Transfers" if you wish to change your Dental Office.

To obtain a list of Dental Offices near you, visit our website at myCigna.com, or 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 Customer Service.

E. Your Payment Responsibility (General Care)

For Covered Services at your Dental Office, you will be charged the fees listed on your Patient Charge Schedule. For services listed on your Patient Charge Schedule at any other dental office, you may be charged Usual Fees. For non-Covered Services, you are responsible for paying Usual Fees.

If, on a temporary basis, there is no Network General Dentist in your Service Area, Cigna Dental 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 will pay the non-Network Dentist the difference, if any, between his or her Usual Fee and the applicable Patient Charge.

See Section IX, *Specialty Referrals*, regarding payment responsibility for specialty care.

All contracts between Cigna Dental 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.

F. 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.

1. Emergency Care Away From Home

If you have an emergency while you are out of your Service Area or you are unable to contact your Network General Dentist, you may receive emergency Covered Services as defined above from any general dentist. Routine restorative procedures or definitive treatment (e.g. root canal) are not considered emergency care. You should return to your Network General Dentist for these procedures. For emergency Covered Services, you will be responsible for the Patient Charges listed on your Patient Charge Schedule. Cigna Dental will reimburse you the difference, if any, between the dentist's Usual Fee for emergency Covered Services and your Patient Charge, up to a total of \$50 per incident. To receive reimbursement, send appropriate reports and x-rays to Cigna Dental at the address listed for your state on the front of this booklet.

2. 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.

G. Limitations on Covered Services

Listed below are limitations on services when covered by your Dental Plan:

- **Frequency** - The frequency of certain Covered Services, like cleanings, is limited. Your Patient Charge Schedule lists any limitations on frequency.
- **Pediatric Dentistry** - Coverage for treatment by a Pediatric Dentist ends on your child's 7th birthday. Effective on your child's 7th birthday, dental services must be obtained from a Network General Dentist however, exceptions for medical reasons may be considered on an individual basis.
- **Oral Surgery** - The surgical removal of an impacted wisdom tooth may not be covered if the tooth is not diseased or if the removal is only for orthodontic reasons. Your Patient Charge Schedule lists any limitations on oral surgery.
- **Periodontal (gum tissue and supporting bone) Services** - Periodontal regenerative procedures are limited to one regenerative procedure per site (or per tooth, if applicable), when covered on the Patient Charge Schedule.

Localized delivery of antimicrobial agents is limited to eight teeth (or eight sites, if applicable) per 12

consecutive months, when covered on the Patient Charge Schedule.

- **Clinical Oral Evaluations** – When this limitation is noted on the Patient Charge Schedule, periodic oral evaluations, comprehensive oral evaluations, comprehensive periodontal evaluations, and oral evaluations for patients under 3 years of age, are limited to a combined total of 4 evaluations during a 12 consecutive month period.
- **Surgical Placement of Implant Services** – When covered on the Patient Charge Schedule, surgical placement of a dental implant; repair, maintenance, or removal of a dental implant; implant abutment(s); or any services related to the surgical placement of a dental implant are limited to one per year with replacement of a surgical implant frequency limitation of one every 10 years.
- **Prosthesis Over Implant** - When covered on the Patient Charge Schedule, a prosthetic device, supported by an implant or implant abutment is considered a separate distinct service(s) from surgical placement of an implant. Replacement of any type of prosthesis with a prosthesis supported by an implant or implant abutment is only covered if the existing prosthesis is at least 5 calendar years old, is not serviceable and cannot be repaired.

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 charges which would not have been made in any facility, other than a Hospital or a Correctional Institution owned or operated by the United States Government or by a state or municipal government if the person had no insurance;
- to the extent that payment is unlawful where the person resides when the expenses are incurred or the services are received;
- for the charges which the person is not legally required to pay;
- for charges which would not have been made if the person had no insurance;
- due to injuries which are intentionally self-inflicted.

H. Services Not Covered Under Your Dental Plan

Listed below are the services or expenses which are NOT covered under your Dental Plan and which are your responsibility at the dentist's Usual Fees. There is no coverage for:

- services not listed on the Patient Charge Schedule.

- services provided by a non-Network Dentist without Cigna Dental's prior approval (except emergencies, as described in Section IV.F).
- services related to an injury or illness paid under workers' compensation, occupational disease or similar laws.
- services provided or paid by or through a federal or state governmental agency or authority, political subdivision or a public program, other than Medicaid.
- services required while serving in the armed forces of any country or international authority or relating to a declared or undeclared war or acts of war.
- cosmetic dentistry or cosmetic dental surgery (dentistry or dental surgery performed solely to improve appearance) unless specifically listed on your Patient Charge Schedule. If bleaching (tooth whitening) is listed on your Patient Charge Schedule, only the use of take-home bleaching gel with trays is covered; all other types of bleaching methods are not covered.
- 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. (Maryland residents: General anesthesia is covered when medically necessary and authorized by your physician.) There is no coverage for general anesthesia or intravenous sedation when used for the purposes of anxiety control or patient management.
- prescription medications.
- procedures, appliances or restorations if the main purpose is to: change vertical dimension (degree of separation of the jaw when teeth are in contact) or restore teeth which have been damaged by attrition, abrasion, erosion and/or abfraction.
- replacement of fixed and/or removable appliances (including fixed and removable orthodontic appliances) that have been lost, stolen, or damaged due to patient abuse, misuse or neglect.
- surgical placement of a dental implant; repair, maintenance, or removal of a dental implant; implant abutment(s); or any services related to the surgical placement of a dental implant, unless specifically listed on your Patient Charge Schedule.
- services considered to be unnecessary or experimental in nature or do not meet commonly accepted dental standards.
- procedures or appliances for minor tooth guidance or to control harmful habits.

- hospitalization, including any associated incremental charges for dental services performed in a hospital. (Benefits are available for Network Dentist charges for Covered Services performed at a hospital. Other associated charges are not covered and should be submitted to the medical carrier for benefit determination.)
- services to the extent you or your enrolled Dependent are compensated under any group medical plan, no-fault auto insurance policy, or uninsured motorist policy. (Arizona residents: Coverage for covered services to the extent compensated under group medical plan, no fault auto insurance policies or uninsured motorist policies is not excluded. Kentucky and North Carolina residents: Services compensated under no-fault auto insurance policies or uninsured motorist policies are not excluded. Maryland residents: Services compensated under group medical plans are not excluded.)
- the completion of crowns, bridges, dentures, or root canal treatment, already in progress on the effective date of your Cigna Dental coverage?
- the completion of implant supported prosthesis (including crowns, bridges and dentures) already in progress on the effective date of your Cigna Dental coverage, unless specifically listed on your Patient Charge Schedule.
- consultations and/or evaluations associated with services that are not covered.
- endodontic treatment and/or periodontal (gum tissue and supporting bone) surgery of teeth exhibiting a poor or hopeless periodontal prognosis.
- bone grafting and/or guided tissue regeneration when performed at the site of a tooth extraction unless specifically listed on your Patient Charge Schedule.
- bone grafting and/or guided tissue regeneration when performed in conjunction with an apicoectomy or periradicular surgery.
- intentional root canal treatment in the absence of injury or disease to solely facilitate a restorative procedure.
- services performed by a prosthodontist.
- localized delivery of antimicrobial agents when performed alone or in the absence of traditional periodontal therapy.
- any localized delivery of antimicrobial agent procedures when more than eight (8) of these procedures are reported on the same date of service.
- infection control and/or sterilization. Cigna Dental considers this to be incidental to and part of the charges for services provided and not separately chargeable.

- the recementation of any inlay, onlay, crown, post and core or fixed bridge within 180 days of initial placement. Cigna Dental considers recementation within this timeframe to be incidental to and part of the charges for the initial restoration.
- the recementation of any implant supported prosthesis (including crowns, bridges and dentures) within 180 days of initial placement. Cigna Dental considers recementation within this timeframe to be incidental to and part of the charges for the initial restoration unless specifically listed on your Patient Charge Schedule.
- services to correct congenital malformations, including the replacement of congenitally missing teeth.
- the replacement of an occlusal guard (night guard) beyond one per any 24 consecutive month period, when this limitation is noted on the Patient Charge Schedule.
- crowns, bridges and/or implant supported prosthesis used solely for splinting.
- resin bonded retainers and associated pontics.

Pre-existing conditions are not excluded if the procedures involved are otherwise covered under your Patient Charge Schedule.

Should any law require coverage for any particular service(s) noted above, the exclusion or limitation for that service(s) shall not apply.

V. Appointments

To make an appointment with your Network Dentist, call the Dental Office that you have selected. When you call, your Dental Office will ask for your identification number and will check your eligibility.

VI. Broken Appointments

The time your Network Dentist schedules for your appointment is valuable to you and the dentist. Broken appointments make it difficult for your Dental Office to schedule time with other patients.

If you or your enrolled Dependent breaks an appointment with less than 24 hours notice to the Dental Office, you may be charged a broken appointment fee.

VII. Office Transfers

If you decide to change Dental Offices, we can arrange a transfer. You should complete any dental procedure in progress before transferring to another Dental Office. To

arrange a transfer, call Customer Service at 1-800-Cigna24. To obtain a list of Dental Offices near you, visit our website at myCigna.com, or call the Dental Office Locator at 1-800-Cigna24.

Your transfer request will take about 5 days to process. Transfers will be effective the first day of the month after the processing of your request. Unless you have an emergency, you will be unable to schedule an appointment at the new Dental Office until your transfer becomes effective.

There is no charge to you for the transfer; however, all Patient Charges which you owe to your current Dental Office must be paid before the transfer can be processed.

VIII. 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 Network includes the following types of specialty dentists:

- 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 Specialty Dentist.

See Section IV.D, *Choice of Dentist*, regarding treatment by a Pediatric Dentist.

IX. Specialty Referrals

A. In General

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

When Cigna Dental authorizes payment to the Network Specialty Dentist, 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 IX.B., Orthodontics. Treatment by the Network Specialty Dentist must begin within 90 days from the date of Cigna Dental’s authorization. If you are unable to obtain treatment within the 90 day period, please call Customer Service to request an extension. Your coverage must be in effect when each procedure begins.

For non-Covered Services or if Cigna Dental does not authorize payment to the Network Specialty Dentist for Covered Services, including Adverse Determinations, you must pay the Network Specialty Dentist’s Usual Fee. If you have a question or concern regarding an authorization or a denial, contact Customer Service.

After the Network Specialty Dentist has completed treatment, you should return to your Network General Dentist for cleanings, regular checkups and other treatment. If you visit a Network Specialty Dentist without a referral or if you continue to see a Network Specialty Dentist 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 Specialty Dentist is not available, as determined by Cigna Dental, Cigna Dental will authorize a referral to a non-Network Specialty Dentist. 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 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.

B. Orthodontics (This section is applicable only when Orthodontics is listed on your Patient Charge Schedule.)

1. **Definitions** – If your Patient Charge Schedule indicates coverage for orthodontic treatment, the following definitions apply:
 - a. **Orthodontic Treatment Plan and Records** – the preparation of orthodontic records and a treatment plan by the Orthodontist.
 - b. **Interceptive Orthodontic Treatment** – treatment prior to full eruption of the permanent teeth, frequently a first phase preceding comprehensive treatment.
 - c. **Comprehensive Orthodontic Treatment** – treatment after the eruption of most permanent

teeth, generally the final phase of treatment before retention.

- d. **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.

2. Patient Charges

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. However, if 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, 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.

3. Additional Charges

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

- a. incremental costs associated with optional/elective materials, including but not limited to ceramic, clear, lingual brackets, or other cosmetic appliances;
- b. orthognathic surgery and associated incremental costs;
- c. appliances to guide minor tooth movement;
- d. appliances to correct harmful habits; and
- e. services which are not typically included in Orthodontic Treatment. These services will be identified on a case-by-case basis.

4. Orthodontics In Progress

If Orthodontic Treatment is in progress for you or your Dependent at the time you enroll, the fee listed on the Patient Charge Schedule is not applicable. Please call Customer Service at 1-800-Cigna24 to find out if you are entitled to any benefit under the Dental Plan.

X. Complex Rehabilitation/Multiple Crown Units

Complex rehabilitation is extensive dental restoration involving 6 or more "units" of crown, bridge and/or implant supported prosthesis (including crowns and bridges) in the same treatment plan. Using full crowns (caps), fixed bridges and/or implant supported prosthesis (including crowns and 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 the 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, bridge and/or implant supported prosthesis (including crowns and bridges) 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, bridge and/or implant supported prosthesis (including crowns and bridges) PLUS an additional charge for each unit when 6 or more units are prescribed in your Network General Dentist's treatment plan.

Note: Complex rehabilitation only applies for implant supported prosthesis, when implant supported prosthesis are specifically listed on your Patient Charge Schedule.

XI. 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 dentist designated by you to act on your behalf. **Time frames or requirements may vary depending on the laws in your State. Consult your State Rider for further details.**

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.

A. Start with Customer Service

We are here to listen and to help. If you have a concern about your Dental Office or the Dental Plan, you can call 1-800-Cigna24 toll-free and explain your concern to one of our Customer Service Representatives. You can also express that concern in writing to Cigna Dental, P.O. Box 188047, Chattanooga, TN 37422-8047. We will do our

best to resolve the matter during your initial contact. If we need more time to review or investigate your concern, we will get back to you as soon as possible, usually by the end of the next business day, but in any case within 30 days.

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

B. Appeals Procedure

Cigna Dental has a two-step appeals procedure for coverage decisions. To initiate an appeal, you must submit a request in writing to Cigna Dental, P.O. Box 188047, Chattanooga, TN 37422-8047, within 1 year from the date of the initial Cigna Dental decision. You should state the reason you feel your appeal should be approved and include any information to support your appeal. If you are unable or choose not to write, you may ask Customer Service to register your appeal by calling 1-800-Cigna24.

1. Level-One Appeals

Your level-one appeal will be reviewed and the decision made by someone not involved in the initial review. Appeals involving dental necessity or clinical appropriateness will be reviewed by a dental professional.

If your appeal concerns a denied pre-authorization, we will respond with a decision within 15 calendar days after we receive your appeal. For appeals concerning all other coverage issues, we will respond with a decision within 30 calendar days after we receive your appeal. If we need more information to make your level-one appeal decision, we will notify you in writing to request an extension of up to 15 calendar days and to specify any additional information needed to complete the review.

You may request that the 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, Cigna Dental will respond orally with a decision within 72 hours, followed up in writing.

If you are not satisfied with our level-one appeal decision, you may request a level-two appeal.

2. Level-Two Appeals

To initiate a level-two appeal, follow the same process required for a level-one appeal. Your level-two appeal will be reviewed and a decision made by someone not involved in the level-one appeal. For appeals involving dental necessity or clinical appropriateness, the decision will be made by a dentist. If specialty care is in dispute, the appeal will be conducted by a dentist in the same or similar specialty as the care under review.

The review will be completed within 30 calendar days. If we need more information to complete the appeal, we will notify you in writing to request an extension of up to 15 calendar days and to specify any additional information needed to complete the review. The decision will include the specific contractual or clinical reasons for the decision, as applicable.

You may request that the 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.

3. Independent Review Procedure

The independent review procedure is a voluntary program arranged by the Dental Plan and is not available in all areas. Consult your State Rider for more details if applicable.

4. Appeals to the State

You have the right to contact your State's Department of Insurance and/or Department of Health for assistance at any time. **See your State Rider for further details.**

Cigna Dental will not cancel or refuse to renew your coverage because you or your Dependent has filed a complaint or an appeal involving a decision made by Cigna Dental. You have the right to file suit in a court of law for any claim involving the professional treatment performed by a dentist.

XII. Dual Coverage

You and your Dependents may not be covered twice under this Dental Plan. If you and your spouse have enrolled each



other or the same Dependents twice, please contact your Benefit Administrator.

If you or your Dependents have dental coverage through your spouse's employer or other sources such as an HMO or similar dental plan, 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.

Coordination of benefit rules are attached to the Group Contract and may be reviewed by contacting your Benefit Administrator. Cigna Dental coordinates benefits only for specialty care services.

XIII. Disenrollment From the Dental Plan – Termination of Benefits

A. Time Frames for Disenrollment/Termination

Except as otherwise provided in the sections titled "Extension/Continuation of Benefits" or in your Group Contract, disenrollment from the Dental Plan and termination of benefits will occur on the last day of the month:

1. in which Premiums are not remitted to Cigna Dental.
2. in which eligibility requirements are no longer met.
3. after 30 days notice from Cigna Dental due to permanent breakdown of the dentist-patient relationship as determined by Cigna Dental, after at least two opportunities to transfer to another Dental Office.
4. after 30 days notice from Cigna Dental due to fraud or misuse of dental services and/or Dental Offices.
5. after 60 days notice by Cigna Dental, due to continued lack of a Dental Office in your Service Area.
6. after voluntary disenrollment.

B. Effect on Dependents

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.

XIV. Extension of Benefits

Coverage for completion of a dental procedure (other than orthodontics) which was started before your disenrollment from the Dental Plan will be extended for 90 days after disenrollment unless disenrollment was due to nonpayment of Premiums.

Coverage for orthodontic treatment which was started before disenrollment from the Dental Plan will be extended to the end of the quarter or for 60 days after disenrollment, whichever is later, unless disenrollment was due to nonpayment of Premiums.

XV. Continuation of Benefits (COBRA)

For Groups with 20 or more employees, federal law requires the employer to offer continuation of benefits coverage for a specified period of time after termination of employment or reduction of work hours, for any reason other than gross misconduct. You will be responsible for sending payment of the required Premiums to the Group. Additional information is available through your Benefits Representative.

XVI. Conversion Coverage

If you are no longer eligible for coverage under your Group's Dental Plan, you and your enrolled Dependents may continue your dental coverage by enrolling in the Cigna Dental conversion plan. You must enroll within three (3) months after becoming ineligible for your Group's Dental Plan. Premium payments and coverage will be retroactive to the date coverage under your Group's Dental Plan ended. You and your enrolled Dependents are eligible for conversion coverage unless benefits were discontinued due to:

- Permanent breakdown of the dentist-patient relationship,
- Fraud or misuse of dental services and/or Dental Offices,
- Nonpayment of Premiums by the Subscriber,
- Selection of alternate dental coverage by your Group, or
- Lack of network/Service Area.

Benefits and rates for Cigna Dental conversion coverage and any succeeding renewals will be based on the Covered Services listed in the then-current standard conversion plan and 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.



XVII. Confidentiality/Privacy

Cigna Dental is committed to maintaining the confidentiality of your personal and sensitive information. Information about Cigna Dental's confidentiality policies and procedures is made available to you during the enrollment process and/or as part of your customer plan materials. You may obtain additional information about Cigna Dental's confidentiality policies and procedures by calling Customer Service at 1-800-Cigna24, or via the Internet at myCigna.com.

XVIII. Miscellaneous

As a Cigna Dental plan customer, you may be eligible for various discounts, benefits, or other consideration for the purpose of promoting your general health and well being. Please visit our website at myCigna.com for details.

As a Cigna Dental plan customer, you may also be eligible for additional dental benefits during certain health conditions. For example, certain frequency limitations for dental services may be relaxed for pregnant women and customers participating in certain disease management programs. Please review your plan enrollment materials for details.

SEE YOUR STATE RIDER FOR ADDITIONAL DETAILS.

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State Rider Cigna Dental Health Plan of Arizona, Inc.

Arizona Residents:

I. Definitions

Dependent

The following provision, included as the next to the last sentence under the definition of "Dependent" in your Plan Booklet, does not apply to Arizona residents:

Coverage for dependents living outside a Cigna Dental service area is subject to the availability of an approved network where the dependent resides.

III. Eligibility/When Coverage Begins

Employees may enroll within 31 days of becoming eligible.

If you have family coverage, a newborn child, newly adopted child, or a child newly placed in your home for adoption by you, is automatically covered during the first 31 days of life, adoption or

placement. If you wish to continue coverage beyond the first 31 days, you should enroll your child in the Dental Plan and you need to begin to pay any additional Premiums during that period.

IV. Your Cigna Dental Coverage

F. Emergency Dental Care - Reimbursement

An emergency is a dental problem that requires immediate treatment (includes control of bleeding, acute infection, or relief of pain including local anesthesia). Reimbursement for emergencies will be made by Cigna Dental in accordance with your plan benefits, regardless of the location of the facility providing the services.

H. Services Not Covered Under Your Dental Plan

The following bullet does not apply to Arizona residents.

- services to the extent you or your enrolled Dependent are compensated under any group medical plan, no-fault auto insurance policy, or uninsured motorist policy. Arizona residents: Coverage for covered services to the extent compensated under group medical plan, no fault auto insurance policies or uninsured motorist policies is not excluded.

XI. What to Do if There is a Problem

Section B, "Appeals Procedure," is hereby deleted and replaced with the following:

B. Problems Concerning Denied Pre-authorizations or Denied Claims for Services Already Provided

If your problem concerns a specialty referral pre-authorization that is not approved for payment or a claim for services already provided that is denied by Cigna Dental, you or your designated representative may request a review as set out below by contacting Customer Service, P.O. Box 188047, Chattanooga, TN 37422, Telephone 1-800-Cigna24.

1. Expedited Review Process (Pre-authorizations Only)

a. Expedited Review

An Expedited Review is available if your Network Dentist certifies in writing that the time to follow the Informal Reconsideration process, as described below, would cause a significant negative change in your medical condition. Cigna Dental will notify you and your dentist of its decision, by telephone and by mail within 1 business day after receipt of all documentation. If Cigna Dental upholds the denial, the written

notice will include the criteria used, the clinical reasons for the decision, references to any supporting documentation, and notice of your right to proceed to an Expedited Appeal.

b. Expedited Appeal

An Expedited Appeal is available if Cigna Dental upholds the denial of a pre-authorization at the Expedited Review level. To request an Expedited Appeal, your Network Dentist must immediately inform Cigna Dental, in writing, that you are requesting an Expedited Appeal. Cigna Dental will notify you and your dentist of its decision, by telephone and by mail, within 72 hours of receiving the request. If Cigna Dental upholds the denial, you may request an Expedited External Independent Review.

c. Expedited External Independent Review

An Expedited External Independent Review is available if Cigna Dental upholds the denial of a pre-authorization at the Expedited Appeal level. You have 5 business days from the date you receive written notice that your denial was upheld at the Expedited Appeal level to request an Expedited External Independent Review. You must send your request in writing to the Appeals Coordinator at the above address. Cigna Dental will notify the Director of Insurance and will acknowledge your request in writing within 1 business day. The Director of Insurance will advise you and your treating dentist of the decision.

2. Informal Reconsideration (Pre-authorizations Only)

An Informal Reconsideration is available if Cigna Dental denies a pre-authorization that does not qualify for Expedited Review. You have up to 2 years from the date your pre-authorization was denied to request Informal Reconsideration. Your coverage must be in effect at the time of the request. Cigna Dental will acknowledge your request for Informal Reconsideration in writing within 5 business days. An Appeals Information Packet will be included. Cigna Dental will notify you and your treating dentist of its decision in writing within 15 days. If Cigna Dental upholds the denial, the notice will include a description of the criteria used, the clinical reasons for the decision, references to any supporting documentation, and notice of your right to proceed to a Formal Appeal.

3. Formal Appeal (Pre-authorizations and Claims for Services Already Provided)

- a. Denied Pre-authorizations: You have 60 days from the date you receive notice that your denial was upheld at the Informal Reconsideration level to request a Formal Appeal. Cigna Dental will notify you and your dentist of its decision in writing within 15 days.
- b. Denied Claims for Services Already Provided: You have 2 years from the date your claim was denied to request a Formal Appeal. Cigna Dental will notify you and your dentist of its decision in writing within 60 days.

You must send your request for a Formal Appeal in writing to the Appeals Coordinator at the above address. You or your Network Dentist must provide Cigna Dental with any material justification or documentation to support your request. Cigna Dental will acknowledge your appeal in writing within 5 business days of your request. If Cigna Dental upholds the denial, the written notice will include the criteria used, the clinical reasons for the decision, references to any supporting documentation, and your right to proceed to External Independent Review.

4. External Independent Review (Pre-authorizations and Claims for Services Already Provided)

If Cigna Dental upholds the denial of a pre-authorization or a claim for services already provided at the Formal Appeal level, you may seek an External Independent Review. You have 30 days from the date you receive notice that your denial was upheld at the Formal Appeal level to request an External Independent Review. You must send your request for an External Independent Review in writing to the Appeals Coordinator at the above address. Cigna Dental will notify the Director of Insurance and will acknowledge your request in writing within 5 business days. The Director of Insurance will notify you and your treating dentist of the Independent Review Organization's decision.

Further information concerning the above Appeal Process is contained in the Appeals information Packet. You may obtain a replacement packet by contacting Customer Service at 1-800-Cigna24.

5. Appeals to the State

You have the right to contact the Arizona Department of Insurance and/or Department of Health for assistance at any time.



XII. Dual Coverage

If you are also an insured or a certificate holder under an indemnity health insurance policy that provides benefits for Covered Services provided by the Dental Plan, the indemnity health insurance policy will pay benefits without regard to the existence of the Cigna Dental Plan. Notwithstanding, the indemnity plan is not obligated to pay any amount for a procedure provided under the Dental Plan at no charge or to pay in excess of the amount of the Patient Charge for any Covered Service. In the event the Patient Charge has been paid to the Network Dentist, then the Indemnity Plan must remit any payments due directly to you.

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State Rider

Cigna Dental Health of Colorado, Inc.

Colorado Residents:

I. Definitions

Dependent – your lawful spouse, partner in a Civil Union or domestic partner;

IV. Your Cigna Dental Coverage

D. Choice of Dentist

If you decide to obtain dental services from a non-network Dentist at your own cost, you may return to your Network Dentist to receive Covered Services without penalty.

IX. Specialty Referrals

If you have a dental emergency which requires Specialty Care, your Network Dentist will contact Cigna Dental for an expedited referral.

Referrals approved by Cigna Dental cannot be retrospectively denied except for fraud or abuse; however, your Cigna Dental coverage must be in effect at the time your Network Specialist begins each procedure.

XI. What to Do if There is a Problem

The following is applicable only to Adverse Determinations and is in addition to the Appeals Procedure listed in Sections XI.B.1 and XI.B.2. of your Plan Booklet:

1. **Level One Appeals:** The reviewer will consult with a dentist in the same or similar specialty as the care under consideration. A resolution to your written complaint will be provided to you and your Network Dentist, in writing, within 20 working days of receipt. The written decision will contain the name, title, and qualifying credentials of the reviewer and of any specialist consulted, a statement of the reviewer's understanding of the reason for your appeal, clinical rationale, a reference to the documentation used to make the determination, clinical criteria used, and instructions for requesting the clinical review criteria, and a description of the process for requesting a second level appeal.
2. **Level Two Appeals:** A majority of the Appeals Committee will consist of licensed Dentists who have appropriate expertise. The licensed Dentist may not have been previously involved in the care or decision under consideration, may not be members of the board of directors or employees of Cigna Dental, and may have no direct financial interest in either the case or its outcome.

The Appeals Committee will schedule and hold a review within 45 working days of receipt of your request. You will be notified in writing at least 15 working days prior to the review date of your right to: be present at the review; present your case to the Grievance Committee, in person or in writing; submit supporting documentation; ask questions of the reviewers prior to or at the review; and be represented by a person of your choice. If you wish to be present, the review will be held during regular business hours at a location reasonably accessible to you. If a face-to-face meeting is not practical for geographic reasons, you will have the opportunity to be present by conference call at Cigna Dental's expense. Please notify Cigna Dental within 5 working days prior to the review if you intend to have an attorney present.

The Appeals Committee's decision will include: the names, titles and qualifying credentials of the reviewers; a statement of the reviewer's understanding of the nature of the appeal and the pertinent facts; the rationale for the decision; reference to any documentation used in making the decision; instructions for requesting the clinical



rationale, including the review criteria used to make the determination; additional appeal rights, if any; and the right to contact the Department of Insurance, including the address and telephone number of the Commissioner's office.

3. Expedited Appeals: Within 1 working day after your request, Cigna Dental will provide reasonable access to the Dentist who will perform the expedited review.

The following process replaces Section XI.B.3. of your Plan Booklet, entitled "Independent Review Procedure":

If the Appeals Committee upholds a denial based on clinical necessity, and you have exhausted Cigna Dental's Appeals Process, you may request that your appeal be referred to an Independent Review Organization (IRO). In order to request a referral to an IRO, the reason for the denial must be based on a dental necessity determination by Cigna Dental.

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 to release the information to the Independent Reviewer selected. The IRO is composed of persons who are not employed by Cigna Dental or any of its affiliates. Cigna Dental will abide by the decision of the IRO.

To request a referral to an IRO, you must notify the Appeals Coordinator within 60 days of your receipt of the Appeals Committee's level two appeal review denial. Cigna Dental will then forward the file to the Colorado Department of Insurance within 2 working days, or within 1 working day for expedited reviews. We will send you descriptive information on the entity that the Department selects to conduct the review.

The IRO may request additional information to support the request for an independent review. Upon receipt of copies of any additional information, Cigna Dental may reconsider its decision. If Cigna Dental provides coverage, the independent review process will end.

The IRO will provide written notice of its decision to you, your provider and Cigna Dental within 30 working days after Cigna Dental receives your request for an independent review. When requested and when a delay would be detrimental to your dental condition as certified by your treating dentist, the IRO will complete the review within 7 working days after Cigna Dental receives your request. The IRO may request another 10 working days, or another 5 working days for expedited requests, to consider additional information.

If the IRO reverses Cigna Dental's adverse decision, we will provide coverage within 1 working day for preauthorizations and within 5 working days for services already rendered.

XVIII. Miscellaneous

In addition to the information contained in this booklet, Cigna Dental Health maintains a written plan concerning accessibility of Network Dentists, quality management programs, procedures for continuity of care in the event of insolvency, and other administrative matters. Under Colorado law, these materials are available at Cigna Dental Health administrative offices and will be provided to interested parties upon request.

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State Rider

Cigna Dental Health of Maryland, Inc.

P.O. Box 453099

Sunrise, FL 33345-3099

Maryland Residents:

This State Rider contains information that either replaces, or is in addition to, information contained in your Plan Booklet.

III. Eligibility/When Coverage Begins

If you are required under an order to provide dental insurance coverage for your child and you are eligible for dependent dental insurance:

- regardless of enrollment period restrictions, Cigna will allow the insured to enroll in dependent coverage and include his child in that coverage specified in the enrollment form;
- if the insured is enrolled in dental insurance but does not include his child in the enrollment, Cigna will allow either the noninsuring parent, the Child Support Enforcement Agency, or the Maryland Department of Health to apply for the enrollment on behalf of such child and include such child in dental insurance under the enrollment regardless of enrollment period restrictions; and

Cigna may not disenroll or eliminate dental insurance for the child, unless written evidence is provided to Cigna that:

- the order is no longer in effect;
- the child has been or will be enrolled under other reasonable dental insurance which will take effect no later than the effective date of the disenrollment;



- the employer has eliminated dependent dental insurance from the plan for all Employees; or
- the employer no longer employs the parent under whose name the child has been enrolled for coverage except to the extent that if the parent elects to exercise the provisions of the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA) then the dental insurance coverage must be provided for the child consistent with the employer's plan relating to post-employment dental insurance coverage for dependents.

IV. Your Cigna Dental Coverage

D. Choice of Dentist

You and your Dependents should have selected a Dental Office when you enrolled in the Dental Plan. If you did not, you must advise Cigna Dental of your Dental Office selection prior to receiving treatment. The benefits of the Dental Plan are available only at your Dental Office, except in the case of an emergency or when Cigna Dental otherwise approves payment for out-of-network benefits.

You may select a network Pediatric Dentist as the Network General Dentist for your dependent child under age 13 by calling Customer Service at 1.800.Cigna24 to get a list of network Pediatric Dentists in your Service Area or if your Network General Dentist sends your child under the age of 13 to a network Pediatric Dentist, the network Pediatric Dentist's office will have primary responsibility for your child's care. For children 13 years and older, your Network General Dentist will provide care. If your child continues to visit the Pediatric Dentist upon the age of 13, you will be fully responsible for the Pediatric Dentist's Usual Fees. Exceptions for medical reasons may be considered on a case-by-case basis.

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 will let you know and will arrange a transfer to another Dental Office. Refer to the Section titled "Office Transfers" if you wish to change your Dental Office.

If, due to circumstances beyond the control of Cigna Dental, such as complete or partial destruction of Dental Offices, war, riot, civil insurrection, labor disputes, or the disability of a significant number of Network Dentists, no Network Dentist can render Covered Services, then you may seek Covered Services from a non-Network Dentist and Cigna Dental will reimburse you as follows: 1. for no-charge services as listed on the applicable Patient Charge Schedule, to the extent that the non-Network Dentist's fees are reasonable and customary for dentists in

the same geographical area; and 2. for other Covered Services, the difference between the applicable Patient Charge Schedule and the non-Network Dentist's reasonable and customary fee. This reimbursement will be made after you submit appropriate reports and X-rays to Cigna Dental.

To obtain a list of Dental Offices near you, visit our website at my.cigna.com, or 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 Customer Service.

Continuity of Care Notice

You have special rights in Maryland when you are a new enrollee and may be moving from Maryland Medical Assistance or another company's dental plan to Cigna Dental coverage and if you currently are receiving treatment.

Right to use non-network providers. If you have been receiving services from a health care provider, and that provider is a non-network provider under your new health plan with us, you may be able to continue to see your provider as though the provider were an in-network provider. You or your parent, guardian, designee, or health care provider may also contact us on your behalf at 1-800-Cigna24 to request the right to continue to see the non-network provider as if the provider were an in-network provider with us.

This right applies only if you are being treated by the non-network provider for covered services for one or more of the following types of conditions:

1. Acute dental conditions;
2. Serious chronic dental conditions;
3. Any other condition upon which we and the out-of-network provider agree.

There is a time limit for how long you can continue to see a non-network provider and only need to pay cost-sharing as though the provider were an in-network provider. For all conditions the time limit is 90 days or until the course of treatment is completed, whichever is sooner. The 90-day limit is measured from the date your coverage starts under the new plan.

You or your representative need to contact Cigna so that Cigna can pay your claim as if you are still receiving care from a network dentist. If the non-network dentist accepts Cigna's rate of payment, the dentist is only permitted to bill you for the in-network cost-sharing amounts that apply to the service, such as copayments, coinsurance and deductible.

If the non-network dentist will not accept Cigna's rate of payment, the dentist may decide not to provide services to you, or may continue to provide services to you and bill you not only for any copayment, coinsurance or deductible that applies, but also bill you for the difference between the dentist's fee and the allowable charge determined by Cigna. If you have any questions please contact us at 1-800-Cigna24.

F. Emergency Dental Care - Reimbursement

1. Emergency Care Away From Home

If you have an emergency while you are out of your Service Area or you are unable to contact your Network General Dentist, you may receive emergency Covered Services as defined above from any general dentist. Routine restorative procedures or definitive treatment (e.g. root canal) are not considered emergency care. You should return to your Network General Dentist for these procedures. For emergency Covered Services, you will be responsible for the Patient Charges listed on your Patient Charge Schedule. Cigna Dental will reimburse you the difference, if any, between the dentist's Usual Fee for emergency Covered Services and your Patient Charge, up to a total of \$50 per incident. To receive reimbursement, send appropriate reports and x-rays to Cigna Dental at the address listed for your state on the front of this booklet.

G. Limitations on Covered Services

Listed below are limitations on services when covered by your Dental Plan:

- **Pediatric Dentistry** - Coverage for treatment by a Pediatric Dentist ends on your child's 13th birthday. Effective on your child's 13th birthday, dental services must be obtained from a Network General Dentist however, exceptions for medical reasons may be considered on an individual basis.

H. Services Not Covered Under Your Dental Plan

The following bullet is amended for Maryland residents

- 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. **Maryland residents: General anesthesia is covered when medically necessary and authorized by your physician.** There is no coverage for general anesthesia or intravenous sedation when used for the purposes of anxiety control or patient management.

The following bullet

- services considered to be unnecessary or experimental in nature or do not meet commonly accepted dental standards.

Is replaced by

- Services considered to be unnecessary in nature or do not meet commonly accepted dental standards.

The following bullet

- services to the extent you or your enrolled Dependent are compensated under any group medical plan, no-fault auto insurance policy, or uninsured motorist policy.

Is replaced by

- services to the extent you or your enrolled Dependent are compensated under any group medical plan.

Maryland residents: Services compensated under group medical plans are not excluded.

VII. Office Transfers

If you decide to change Dental Offices, we can arrange a transfer. You should complete any dental procedure in progress before transferring to another Dental Office. To arrange a transfer, call Customer Service at 1.800.Cigna24. To obtain a list of Dental Offices near you, visit our website at my.cigna.com, or call the Dental Office Locator at 1.800.Cigna24.

Your transfer request may take up to 5 days to process. Transfers will be effective the first day of the month after the processing of your request. Unless you have an emergency, you will be unable to schedule an appointment at the new Dental Office until your transfer becomes effective. You can check the status of your request by visiting myCigna.com, or by calling us at 1.800.Cigna24.

There is no charge to you for the transfer; however, all Patient Charges which you owe to your current Dental Office must be paid before the transfer can be processed.

IX. Specialty Referrals

A. In General

Preauthorization is not required for coverage of services by a Network Specialty Dentist.

When Cigna Dental approves payment to the Network Specialty Dentist, 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 IX.B., Orthodontics. Treatment by the Network



Specialty Dentist must begin within 90 days from the date of Cigna Dental's approval. If you are unable to obtain treatment within the 90 day period, please call Customer Service to request an extension. Your coverage must be in effect when each procedure begins.

For non-Covered Services or if Cigna Dental does not approve payment to the Network Specialty Dentist for Covered Services, including Adverse Determinations, you must pay the Network Specialty Dentist's Usual Fee. If you have a question or concern regarding an approval or a denial, contact Customer Service.

After the Network Specialty Dentist has completed treatment, you should return to your Network General Dentist for cleanings, regular checkups and other treatment. If you visit a Network Specialty Dentist without a referral or if you continue to see a Network Specialty Dentist 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 Specialty Dentist is not available, as determined by Cigna Dental, Cigna Dental will approve a referral to a non-Network Specialty Dentist. 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 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 approved for payment, including Adverse Determinations, you must pay the dentist's Usual Fee.

Your Network General Dentist may not refer you to a dental care entity in which your Network General Dentist and/or his or her immediate family owns a beneficial interest or has a compensation arrangement, unless the services are personally performed by your Network General Dentist or under his or her direct supervision. This provision does not prohibit a referral to another dentist in the same group practice as your Network General Dentist.

If your Network General Dentist refers you to a specialist who is not a Network Specialty Dentist, Cigna Dental will reimburse the non-Network Specialty Dentist the difference, if any, between his or her Usual Fee and the applicable Patient Charge. You must pay the specialist's Usual Fee for non-Covered Services.

Referral for Services by a Non-Participating Specialist or Non-physician Specialist:

You may receive a referral to a non-participating specialist or non-physician specialist if you are diagnosed with a condition or disease that requires specialized health care services or medical care; we do not have a participating specialist or non-physician specialist with the professional training and expertise to treat or provide health care services for the condition or disease; or we cannot provide reasonable access to a specialist or non-physician specialist with the professional training and expertise to treat or provide health care services for the condition or disease without unreasonable delay or travel. Any deductible or coinsurance applicable to the services for which the referral is requested will be calculated as if the services were received from a Participating Provider.

XI. What To Do If There Is A Problem

The following information replaces Section XI of your Plan Booklet in its entirety.

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.

A. Start With Customer Service

We are here to listen and to help. If you have a concern about your Dental Office or the Dental Plan, you can call 1.800.Cigna24 toll-free and explain your concern to one of our Customer Service Representatives. You can also express that concern in writing to the address listed for your state on the cover page of your Plan Booklet. We'll do our best to resolve the matter during your initial contact. If we need more time to review or investigate your concern, we'll get back to you as soon as possible, usually by the end of the next business day, but in any case within 30 days.

The Maryland Insurance Administration is also available to assist you with any complaint you may have against the Dental Plan. If your complaint concerns a Coverage Decision or an Adverse Determination, please refer to the appropriate section below. For all other issues, you may register your complaint with the Maryland Insurance



Administration, Life and Health Inquiry and Investigation
Unit, 200 St. Paul Place, Suite 2700 Baltimore, MD,
21202, telephone 410.468.2244.

B. Complaints Involving Coverage Decisions

1. **Definitions** - the following additional definitions apply to this Section:

- a. **Appeal** - a protest regarding a coverage decision filed under Cigna Dental's internal appeal process.
- b. **Appeal Decision** - a final determination by Cigna Dental on an appeal of a coverage decision filed under Cigna Dental's internal appeal process.
- c. **Coverage Decision** - an initial determination by Cigna Dental that results in non-coverage of a dental procedure; a determination that an individual is not eligible for coverage under the plan; or, a determination that results in the rescission of an individual's coverage under the plan. It also includes non-payment of all or any part of a claim. A coverage decision does not include an Adverse Determination, as defined in subsection C. "Complaints Involving Adverse Determinations" of this rider.
- d. **Urgent Medical Condition** - a condition that satisfies either of the following:
 1. A medical condition, including a physical or dental condition, where the absence of medical attention within 72 hours could reasonably be expected by an individual, acting on behalf of a carrier, applying the judgment of a prudent layperson who possesses an average knowledge of health and medicine, to result in:
 - (a) Placing your life or health in serious jeopardy;
 - (b) The inability to regain maximum function;
 - (c) Serious impairment to bodily function; or
 - (d) Serious dysfunction of any bodily organ or part; or
 2. A medical condition, including a physical or dental condition, where the absence of medical attention within 72 hours, in the opinion of a health care provider with knowledge of your medical condition, would subject you to severe pain that cannot be adequately managed without

the care or treatment that is the subject of the Coverage Decision.

2. Appeals Procedure

If you are not satisfied with the results of a Coverage Decision, you may start the Appeals Procedure. Cigna Dental has a two-step Appeals Procedure for Coverage Decisions. To initiate an Appeal, you must submit a request in writing to Cigna Dental, at the address listed for your state on the cover page of your Plan Booklet, within 1 year from the date of the initial Cigna Dental decision. You should state the reason you feel your Appeal should be approved and include any information to support your Appeal. If you are unable or choose not to write, you may ask Customer Service to register your Appeal by calling 1.800.Cigna24. Following a coverage decision, the HAU is also available to assist in mediating and filing an appeal under the internal process. After an Appeal Decision, the Health Education and Advocacy Unit is available to assist the member in filing a complaint with the Commissioner. You may contact the Health Education and Advocacy Unit at:

Office of the Attorney General
Consumer Protection Division
200 St. Paul Place, 16th floor
Baltimore MD 21202
Email: heau@oag.state.md.us
Phone: 410-528-1840
Fax: 410.576.6571
TTY: 1.800.576.6372

a. Level One Appeals

Your Level One Appeal will be reviewed and the decision made by someone not involved in the initial review. If your Appeal concerns a denied pre-authorization, Cigna Dental will render a final decision in writing, to you and any provider acting on your behalf, within 15 calendar days after we receive your Appeal. For Appeals concerning all other Coverage Decisions, Cigna Dental will render a final decision in writing, to you and any provider acting on your behalf, within 30 calendar days after we receive your Appeal. If we need more time or information to make the decision, we will notify you in writing to request an extension of up to 15 calendar days and to specify any additional information needed to complete the review.

You may request that the 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, Cigna Dental will respond orally with a decision within 72 hours, followed up in writing.

If you are not satisfied with our Level One Appeal decision, you may either (1) proceed to a Level Two Appeal or (2) register a complaint with the Maryland Insurance Administration (see "Appeals to the State" below).

b. Level Two Appeals

To initiate a Level Two Appeal, follow the same process required for a Level One Appeal. Level Two Appeals will be conducted by an Appeals Committee consisting of at least 3 people. Anyone involved in the prior decision may not vote on the Appeals Committee. If specialty care is in dispute, the Appeals Committee will consult with a dentist in the same or similar specialty as the care under review.

Cigna Dental will acknowledge your Appeal in writing within 5 business days and schedule an Appeals Committee review. The acknowledgment letter will include the name, address, and telephone number of the Appeals Coordinator. We may request additional information at that time. If your Appeal concerns a denied pre-authorization, the Appeals Committee review will be completed within 15 calendar days. For Appeals concerning all other coverage issues, the Appeals Committee review will be completed within 30 calendar days. If we need more time or information to complete the review, we will notify you in writing to request an extension of up to 15 calendar days and to specify any additional information needed by the Appeals Committee to complete the review.

You may present your Appeal to the Appeals Committee in person or by conference call. You must advise Cigna Dental 5 days in advance if you or your representative plan to attend in person. Cigna Dental will notify you, and any provider acting on your behalf, of the Appeals Committee's final decision, in writing, within 5 business days after the meeting. The decision will include the specific contractual or clinical reasons for the decision, as applicable.

You may request that the Appeal resolution be expedited if the timeframes 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.

If you are not satisfied with our Level Two Appeal Decision, you may register a complaint with the Maryland Insurance Administration by following the instructions below.

3. Appeals to the State

Before seeking the assistance of the Maryland Insurance Administration regarding the Appeal of a Coverage Decision, you must first exhaust Cigna Dental's Level One Appeals Procedure. However, if your complaint involves an Urgent Medical Condition for which care has not yet been rendered, you may file a complaint with the Maryland Insurance Administration without first exhausting Cigna Dental's Level One Appeals Procedure.

If you are not satisfied with Cigna Dental's final resolution regarding your Coverage Decision, you may, within 4 months of receipt of Cigna Dental's Level One or Level Two Appeal Decision, file a written complaint with the Maryland Insurance Administration. Your complaint should be addressed to the Maryland Insurance Administration, 500 St. Paul Place, Suite 2700 Baltimore, MD 21202, telephone (410) 468-2000 or (800) 492-6116, fax (410) 468-2270, TTY (800) 735-2258.

C. Complaints Involving Adverse Determinations

The following applies to decisions made by Cigna Dental that a proposed or delivered Covered Service is or was not necessary, appropriate or efficient and which resulted in non-coverage of the service. For such Adverse Determinations, the complaint/appeal process is designated as a grievance process under Maryland law. Adverse determination means a utilization review determination that a proposed or delivered health care service covered under the member's contract is or was not medically necessary, appropriate, or efficient; and may result in non coverage of the health care service.

1. In General

The Cigna Dental Appeals Coordinator is responsible for the internal grievance process and may be contacted at Cigna Dental, P.O. Box 188047, Chattanooga, TN 37422-8047; Phone 1.800.Cigna24.

A grievance may be filed by you or your designated representative, which may include your Network Dentist.

"Filing Date," as used below, refers to the earlier of 5 days after the date of mailing or the date of receipt.

2. Grievances Involving Pre-authorization Requests and Covered Services Already Provided

For grievances involving preauthorization requests, you or your Network Dentist may request a review in writing within 60 days of receipt of an Adverse Determination. Cigna Dental will render a final decision in writing within 30 working days after the date a grievance is filed unless:

- a. the grievance involves an emergency. An emergency is a service necessary to treat a condition or illness that, without immediate dental attention, would:
 - (1) seriously jeopardize the life or health of the member or the member's ability to regain maximum function, or
 - (2) cause the member to be a danger to self or others.
 - (3) cause the member to continue using intoxicating substances in an imminently dangerous manner.

If your grievance involves an emergency, Cigna Dental will respond orally with a decision within 24 hours after the grievance is filed.

- b. you or your designated representative agrees in writing to an extension for a period not to exceed 30 working days;
- c. the grievance involves Covered Services already provided.

For grievances involving Covered Services already provided, you or your Network Dentist may request a review in writing within 180 days of receipt of an Adverse Determination. Cigna Dental shall render a final decision in writing within 45 working days after the date a grievance is filed; unless you or your designated representative agrees in writing to an extension for a period not to exceed 30 working days.

If, within 5 days of the Filing Date, Cigna Dental does not have sufficient information to complete the grievance process, Cigna Dental will request additional information for review and will assist you or your Network Dentist in gathering information as required.

2. Grievances Involving Preauthorized Requests and Covered Services Already Provided (Continued)

Cigna Dental will notify you or your designated representative orally of its grievance decision, followed

up in writing to you and your designated representative, within 5 working days, and within 1 day if your grievance involves an emergency, after the decision is made. The notice shall include:

- a. the specific factual basis for the decision;
- b. the specific criteria and standards, including interpretive guidelines, on which the grievance decision was based;
- c. the name, business address and telephone number of the Cigna Dental Appeals Coordinator; and
- d. the instructions and timeframe for filing a complaint with the Maryland Insurance Commissioner, including the Commissioner's address, telephone number and facsimile number.

3. Appeals to the State

The Maryland Health Education and Advocacy Unit is available to assist you in filing a grievance under Cigna Dental's internal grievance process or in mediating a resolution to an Adverse Determination. However, it is not available to represent or accompany you during grievance proceedings. The Health Education and Advocacy Unit can be reached at: Consumer Protection Division, Office of the Attorney General, 200 St. Paul Place, 16th Floor, Baltimore, MD 21202; Phone (410) 528-1840 or 1-877-261-8807; Fax (410) 576-6571; Email: heau@oag.state.md.us

If you have exhausted Cigna Dental's internal grievance process and are not satisfied with Cigna Dental's decision, you may also file a written complaint with the Maryland Insurance Commissioner, within four months of receipt of Cigna Dental's grievance decision, at Maryland Insurance Administration, Chief of Complaints, 200 St. Paul Place, Suite 2700 Baltimore, MD 21202; Phone (410) 468-2000 or (800) 492-6116; Fax (410) 468-2270, TTY (800) 735-2258.

You may also file a complaint with the Insurance Commissioner if you do not receive a grievance decision on a timely basis as set out in Section 2.

You or your Network Dentist may file a complaint with the Maryland Insurance Commissioner without first exhausting Cigna Dental's internal grievance process, if you can demonstrate to the Commissioner a compelling reason why you should not proceed under Cigna Dental's internal grievance process. A "compelling reason" demonstrates that the potential delay in receipt of a health care service until after the member or health care provider exhausts the internal grievance process and obtains a final decision under the grievance process could result in loss of life, serious impairment to a



bodily function, serious dysfunction of a bodily organ, or the member remaining seriously mentally ill or using intoxicating substances with symptoms that cause the member to be a danger to self or others, or the member continuing to experience severe withdrawal symptoms.

XIII. Disenrollment From the Dental Plan – Termination of Benefits

The following supercedes the provisions of Section XIII, Subsection A.4. of your Plan Booklet.

4. After 30 days notice from Cigna Dental due to fraud or misuse of dental services and/or Dental Offices. Cigna Dental may not terminate coverage for an entire family because a Dependent fraudulently uses the membership card; only the Dependent's coverage may be terminated.

XVIII. MISCELLANEOUS

The following provision is in addition to information contained in your Plan Booklet.

Maryland Advance Directive Information

An advance directive is a useful, legal way for an individual (or declarant) to direct their medical care, particularly treatment preferences in an emergency or near end of life. An advance directive can also include the name of a health care agent (or proxy) that can make decisions for a declarant if they are unable to do so themselves. For more information and to access the Maryland Advance Directive Information Sheet ("Form") visit the Maryland Health Information Technology webpage:

https://mhcc.maryland.gov/mhcc/pages/hit/hit_advancedirectives/hit_advancedirectives.aspx

CIGNA DENTAL HEALTH
OF MARYLAND, INC.

BY: *Bryan Holgerson, President*

TITLE: President

State Rider

Cigna Dental Health of Kansas, Inc.

Nebraska Residents:

This State Rider contains information that either replaces, or is in addition to, the information contained in your Plan Booklet.

XI. What To Do If There Is A Problem

B.1 Level-One Appeals

Complaints involving an adverse determination will be reviewed by a Dentist in the same or similar specialty as the care under consideration, when reasonably necessary as determined by Cigna Dental, or if requested by your Network Dentist. We will notify you and your Network Dentist in writing of the decision within 15 working days of the request for review.

If your complaint involves any matter other than an adverse determination, you will be provided with the name, address, and telephone number of the person designated to coordinate the review, within 3 days after receipt. You will be provided with a written resolution within 15 working days of receipt of a written complaint. If the review cannot be completed within 15 working days, we will notify you in writing on or before the 15th day of the reason for the delay. The review will be completed within 15 days after that.

The resolution to any written complaint will contain the following: the name, title, and qualifying credentials of the reviewer, a statement of the reviewer's understanding of your complaint, the decision in clear terms and the contract basis or clinical rationale in sufficient detail for you to respond further to Cigna Dental's position, a reference to the evidence or documentation used as the basis for the decision, and, in cases involving an adverse determination, the instructions for requesting a written statement of clinical rationale, including the clinical review criteria used to make the determination. You will also be provided with instructions on how you may proceed to a Level-Two Appeal and how you may contact the Nebraska Department of Insurance.

2. Level-Two Appeals

To initiate a level-two appeal, follow the same process required for a level-one appeal. Level-two appeals will be conducted by an Appeals Committee consisting of at least 3 people. Anyone involved in the prior decision may not vote on the Appeals Committee. For appeals involving dental necessity or clinical appropriateness, the Appeals Committee will include at least one dentist. If specialty care is in dispute, the Appeals Committee will



consult with a dentist in the same or similar specialty as the care under review.

Cigna Dental will acknowledge your appeal in writing within 5 business days and schedule an Appeals Committee review. The acknowledgment letter will include the name, address, and telephone number of the Appeals Coordinator. We may request additional information at that time. If your appeal concerns a denied pre-authorization, the Appeals Committee review will be completed within 15 calendar days. For appeals concerning all other coverage issues, the Appeals Committee review will be completed within 30 calendar days. If we need more time or information to complete the review, we will notify you in writing to request an extension of up to 15 calendar days and to specify any additional information needed by the Appeals Committee to complete the review.

You may present your appeal to the Appeals Committee in person or by conference call. You must advise Cigna Dental 5 days in advance if you or your representative plan to attend in person. You will be notified in writing of the Appeals Committee's decision within 5 business days after the meeting. The decision will include the specific contractual or clinical reasons for the decision, as applicable.

You may request that the 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.

FROM BOTH PLANS. EACH PLAN MAY REQUIRE YOU TO FOLLOW ITS RULES OR USE SPECIFIC DOCTORS AND HOSPITALS, AND IT MAY BE IMPOSSIBLE TO COMPLY WITH BOTH PLANS AT THE SAME TIME. READ ALL OF THE RULES VERY CAREFULLY, INCLUDING THE COORDINATION OF BENEFITS SECTION, AND COMPARE THEM WITH THE RULES OF ANY OTHER PLAN THAT COVERS YOU OR YOUR FAMILY.

The following definition is revised under Section I. Definitions:

Dependent - your lawful spouse, or your Domestic Partner; your unmarried child (including newborns, adopted children, step-children, a child for whom you must provide dental coverage under a court order; or, a dependent child who resides in your home as a result of court order or administrative placement) who is:

- (a) less than 26 years old; or
- (b) less than 23 years old if he or she is both:
 - i. a full-time student enrolled at an accredited educational institution, and
 - ii. reliant upon you for maintenance and support; or
- (c) any age if he or she is both:
 - i. incapable of self-sustaining employment due to mental or physical disability, and
 - ii. reliant upon you for maintenance and support.

For a dependent child 19 years of age or older who is a full-time student at an educational institution, coverage will be provided for an entire academic term during which the child begins as a full-time student and remains enrolled, regardless of whether the number of hours of instruction for which the child is enrolled is reduced to a level that changes the child's academic status to less than that of a full-time student.

A Newly Acquired Dependent is a dependent child who is adopted, born, or otherwise becomes your dependent after you become covered under the Plan.

Coverage for dependents living outside a Cigna Dental service area is subject to the availability of an approved network where the dependent resides.

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State Rider Cigna Dental Health of Ohio, Inc.

Ohio Residents:

The following is in addition to the information on the first page of your Plan Booklet:

NOTICE: IF YOU OR YOUR FAMILY MEMBERS ARE COVERED BY MORE THAN ONE HEALTH CARE PLAN, YOU MAY NOT BE ABLE TO COLLECT BENEFITS



The following definition is added to Section I. Definitions:

I. Definitions

Telehealth services - health care services provided through the use of information and communication technology by a health care professional, within the professional's scope of practice, who is located at a site other than the site where either of the following is located:

- (a) The patient receiving the services;
- (b) Another health care professional with whom the provider of the services is consulting regarding the patient.

Tele-dentistry - the delivery of dental services through the use of synchronous, real-time communication and the delivery of services of a dental hygienist or expanded function dental auxiliary pursuant to a dentist's authorization.

Synchronous, real time communication - a live, two-way interaction between a patient and a dentist conducted through audiovisual technology.

The following is in addition to the process described in Section III. Eligibility/When Coverage Begins:

III. Eligibility/When Coverage Begins

You and your Dependents must live or work in the service area to be eligible for coverage.

Under Ohio law, if you divorce, you cannot terminate coverage for enrolled Dependents until the court determines that you are no longer responsible for providing coverage.

Cigna Dental does not require, make inquiries into, or rely upon genetic screening or testing in processing applications for enrollment or in determining insurability under the Dental Plan.

Section IV is renamed:

IV. Your Cigna Dental Plan

The Choice of Dentist provision under Section IV. D. is deleted and is replaced with the following:

D. Choice Of Dentist

You and your Dependents should have selected a Dental Office when you enrolled in the Dental Plan. If you did not, you must advise Cigna Dental of your Dental Office selection prior to receiving treatment. The benefits of the Dental Plan are available only at your Dental Office, except in the case of an emergency or when Cigna Dental otherwise approves payment for out-of-network benefits.

You may select a network Pediatric Dentist as the Network General Dentist for your dependent child under age 13 by calling Customer Service at 1.800.Cigna24 to get a list of network Pediatric Dentists in your Service

Area or if your Network General Dentist sends your child under the age of 13 to a network Pediatric Dentist, the network Pediatric Dentist's office will have primary responsibility for your child's care. For children 13 years and older, your Network General Dentist will provide care. If your child continues to visit the Pediatric Dentist upon the age of 13, you will be fully responsible for the Pediatric Dentist's Usual Fees. Exceptions for medical reasons may be considered on a case-by-case basis.

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 will let you know and will arrange a transfer to another Dental Office. Refer to the Section titled "Office Transfers" if you wish to change your Dental Office.

To obtain a list of Dental Offices near you, visit our website at myCigna.com, or 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 Customer Service.

The following is in addition to the process described in Section IV. E. of your Plan Booklet:

E. Your Payment Responsibility (General Care)

If, on a temporary basis, there is no Network General Dentist in your Service Area, Cigna Dental 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 will pay the non-Network Dentist the difference, if any, between his or her Usual Fee and the applicable Patient Charge. There is no additional cost to you.

Cigna Dental is not a member of any Guaranty Fund. In the event of Cigna Dental's insolvency, you will not be liable to the Network Dentist for any sums owed to the Network Dentist by Cigna Dental. However, you may be financially responsible for services rendered by a non-network dentist whether or not Cigna Dental authorizes payment for a referral.

If you are undergoing treatment and the Dental Plan becomes insolvent, Cigna Dental will arrange for the continuation of services until the expiration of your Group Contract.



Provision 1 of Emergency Dental Care – Reimbursement under Section IV. F. is deleted and is replaced with the following:

F. Emergency Dental Care – Reimbursement

1. Emergency Care Away From Home

If you have an emergency while you are out of your Service Area or you are unable to contact your Network General Dentist, you may receive emergency Covered Services as defined above from any general dentist. Routine restorative procedures or definitive treatment (e.g. root canal) are not considered emergency care. You should return to your Network General Dentist for these procedures. For emergency Covered Services, you will be responsible for the Patient Charges listed on your Patient Charge Schedule. Cigna Dental will reimburse you the difference, if any, between the dentist's Usual Fee for emergency Covered Services and your Patient Charge, up to a total of \$50 per incident. To receive reimbursement, send appropriate reports and x-rays to Cigna Dental at the address listed for your state on the front of this booklet.

The Pediatric Dentistry provision under Section IV. G. is deleted and replaced with the following:

G. Limitations on Covered Services

Listed below are limitations on services when covered by your Dental Plan:

- **Pediatric Dentistry** - Coverage for treatment by a Pediatric Dentist ends on your child's 13th birthday. Effective on your child's 13th birthday, dental services must be obtained from a Network General Dentist however, exceptions for medical reasons may be considered on an individual basis.

The Office Transfers provision under Section VII. is deleted and replaced with the following:

VII. Office Transfers

If you decide to change Dental Offices, we can arrange a transfer. You should complete any dental procedure in progress before transferring to another Dental Office. To arrange a transfer, call Customer Service at 1.800.Cigna24. To obtain a list of Dental Offices near you, visit our website at myCigna.com, or call the Dental Office Locator at 1.800.Cigna24.

Your transfer request may take up to 5 days to process. Transfers will be effective the first day of the month after the processing of your request. Unless you have an emergency,

you will be unable to schedule an appointment at the new Dental Office until your transfer becomes effective. You can check the status of your request by visiting myCigna.com, or by calling us at 1.800.Cigna24.

There is no charge to you for the transfer; however, all Patient Charges which you owe to your current Dental Office must be paid before the transfer can be processed.

The Specialty Referrals provision under Section IX. A is deleted and replaced with the following:

IX. Specialty Referrals

A. In General

Preauthorization is not required for coverage of services by a Network Specialty Dentist.

When Cigna Dental approves payment to the Network Specialty Dentist, 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 IX.B., Orthodontics. Treatment by the Network Specialty Dentist must begin within 90 days from the date of Cigna Dental's approval. If you are unable to obtain treatment within the 90 day period, please call Customer Service to request an extension. Your coverage must be in effect when each procedure begins.

For non-Covered Services or if Cigna Dental does not approve payment to the Network Specialty Dentist for Covered Services, including Adverse Determinations, you must pay the Network Specialty Dentist's Usual Fee. If you have a question or concern regarding an approval or a denial, contact Customer Service.

After the Network Specialty Dentist has completed treatment, you should return to your Network General Dentist for cleanings, regular checkups and other treatment. If you visit a Network Specialty Dentist without a referral or if you continue to see a Network Specialty Dentist 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 Specialty Dentist is not available, as determined by Cigna Dental, Cigna Dental will approve a referral to a non-Network Specialty Dentist. 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 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 approved for payment, including Adverse Determinations, you must pay the dentist's Usual Fee.

The following is in addition to the process described in Section XI of your Plan Booklet:

XI. What To Do If There Is A Problem

A. Start With Customer Service

You can reach Customer Service by calling 1.800.Cigna24 or by writing to Cigna Dental Health of Ohio, Inc., P.O. Box 453099, Sunrise, Florida 33345-3099, Attention: Customer Service. You may also submit a complaint in person at any Cigna Dental Office.

B. Appeals Procedure

1. Level One Appeals

Cigna Dental will provide a written response to your written complaint.

Within 30 days of receiving a response from Cigna Dental, you may appeal a complaint resolution regarding cancellation, termination or non-renewal of coverage by Cigna Dental to the Ohio Superintendent of Insurance.

The Ohio Department of Insurance is located at 50 W. Town Street, Suite 300, Columbus, Ohio 43215, Attention Consumer Services Division. The Department's toll-free number is 1-800-686-1526 or (614) 644-2673.

XII. Dual Coverage

(This section is not applicable when Cigna Dental does not make payments toward specialty care as indicated by your Patient Charge Schedule. For those plans, Cigna Dental is always the primary plan.)

The following supersedes Section XII of your Plan Booklet:

A. Coordination Of Benefits

The Coordination of Benefits ("COB") provision applies when a person has health care coverage under more than one Plan. Plan is defined below.

The order of benefit determination rules govern the order in which each Plan will pay a claim for benefits. The Plan that pays first is called the Primary Plan. The Primary Plan must pay benefits in accordance with its Policy terms without regard to the possibility that another Plan may cover some expenses. The Plan that pays after the Primary Plan is the Secondary Plan. The Secondary Plan may reduce the benefits it pays so that payments from all Plans does not exceed 100% of the total Allowable expense.

Definitions

A. Plan is any of the following that provides benefits or services for medical or dental care or treatment. If separate contracts are used to provide coordinated coverage for members of a group, the separate contracts are considered parts of the same Plan and there is no COB among those separate contracts.

(1) Plan includes: group and nongroup insurance contracts, health insuring corporation ("HIC") contracts, closed panel Plans or other forms of group or group-type coverage (whether insured or uninsured); medical care components of long-term care contracts, such as skilled nursing care; medical benefits under group or individual automobile contracts; and Medicare or any other federal governmental Plan, as permitted by law.

(2) Plan does not include: hospital indemnity coverage or other fixed indemnity coverage; accident only coverage; specified disease or specified accident coverage; supplemental coverage as described in Revised Code sections 3923.37 and 1751.56; school accident type coverage; benefits for non-medical components of long-term care policies; Medicare supplement policies; Medicaid policies; or coverage under other federal governmental Plans, unless permitted by law.

Each contract for coverage under (1) or (2) is a separate Plan. If a Plan has two parts and COB rules apply only to one of the two, each of the parts is treated as a separate Plan.

B. This Plan means, in a COB provision, the part of the contract providing the health care benefits to which the COB provision applies and which may be reduced because of the benefits of other Plans. Any other part of the contract providing health care benefits is separate from This Plan. A contract may apply one COB provision to certain benefits, such as dental benefits, coordinating only with similar benefits, and may apply another COB provision to coordinate other benefits.

C. The order of benefit determination rules determine whether This Plan is a Primary Plan or Secondary Plan when the person has health care coverage under more than one Plan.

When This Plan is primary, it determines payment for its benefits first before those of any other Plan without considering any other Plan's benefits. When This Plan is secondary, it determines its benefits after those of another Plan and may reduce the benefits it pays so that all Plan benefits do not exceed 100% of the total Allowable expense.

- D. Allowable expense is a health care expense, including deductibles, coinsurance and copayments, that is covered at least in part by any Plan covering the person. When a Plan provides benefits in the form of services, the reasonable cash value of each service will be considered an Allowable expense and a benefit paid. An expense that is not covered by any Plan covering the person is not an Allowable expense. In addition, any expense that a provider by law or in accordance with a contractual agreement is prohibited from charging a covered person is not an Allowable expense.

The following are examples of expenses that are not Allowable expenses:

- (1) The difference between the cost of a semi-private hospital room and a private hospital room is not an Allowable expense, unless one of the Plans provides coverage for private hospital room expenses.
- (2) If a person is covered by 2 or more Plans that compute their benefit payments on the basis of usual and customary fees or relative value schedule reimbursement methodology or other similar reimbursement methodology, any amount in excess of the highest reimbursement amount for a specific benefit is not an Allowable expense.
- (3) If a person is covered by 2 or more Plans that provide benefits or services on the basis of negotiated fees, an amount in excess of the highest of the negotiated fees is not an Allowable expense.
- (4) If a person is covered by one Plan that calculates its benefits or services on the basis of usual and customary fees or relative value schedule reimbursement methodology or other similar reimbursement methodology and another Plan that provides its benefits or services on the basis of negotiated fees, the Primary Plan's payment arrangement shall be the Allowable expense for all Plans. However, if the provider has contracted with the Secondary Plan to provide the benefit or service for a specific negotiated fee or payment amount that is different than the Primary Plan's payment arrangement and if the provider's contract permits, the negotiated fee or payment shall be the Allowable expense used by the Secondary Plan to determine its benefits.
- (5) The amount of any benefit reduction by the Primary Plan because a covered person has failed to comply with the Plan provisions is not an Allowable expense. Examples of these types of Plan provisions include second surgical opinions,

precertification of admissions, and preferred provider arrangements.

- E. Closed panel Plan is a Plan that provides health care benefits to covered persons primarily in the form of services through a panel of providers that have contracted with or are employed by the Plan, and that excludes coverage for services provided by other providers, except in cases of emergency or referral by a panel member.
- F. Custodial parent is the parent awarded custody by a court decree or, in the absence of a court decree, is the parent with whom the child resides more than one half of the calendar year excluding any temporary visitation.

Order of Benefit Determination Rules

When a person is covered by two or more Plans, the rules for determining the order of benefit payments are as follows:

- A. The Primary Plan pays or provides its benefits according to its terms of coverage and without regard to the benefits of under any other Plan.
- B. (1) Except as provided in Paragraph (2), a Plan that does not contain a coordination of benefits provision that is consistent with this regulation is always primary unless the provisions of both Plans state that the complying Plan is primary.
(2) Coverage that is obtained by virtue of membership in a group that is designed to supplement a part of a basic package of benefits and provides that this supplementary coverage shall be excess to any other parts of the Plan provided by the contract holder. Examples of these types of situations are major medical coverages that are superimposed over base Plan hospital and surgical benefits, and insurance type coverages that are written in connection with a Closed panel Plan to provide out-of-network benefits.
- C. A Plan may consider the benefits paid or provided by another Plan in calculating payment of its benefits only when it is secondary to that other Plan.
- D. Each Plan determines its order of benefits using the first of the following rules that apply:
 - (1) Non-Dependent or Dependent. The Plan that covers the person other than as a dependent, for example as an employee, member, policyholder, subscriber or retiree is the Primary Plan and the Plan that covers the person as a dependent is the Secondary Plan. However, if the person is a Medicare beneficiary and, as a result of federal law, Medicare is secondary to the Plan covering the person as a dependent, and primary to the Plan covering the person as other than a dependent (e.g. a retired employee), then the order

of benefits between the two Plans is reversed so that the Plan covering the person as an employee, member, policyholder, subscriber or retiree is the Secondary Plan and the other Plan is the Primary Plan.

- (2) Dependent child covered under more than one Plan. Unless there is a court decree stating otherwise, when a dependent child is covered by more than one Plan the order of benefits is determined as follows:

- (a) For a dependent child whose parents are married or are living together, whether or not they have ever been married:

The Plan of the parent whose birthday falls earlier in the calendar year is the Primary Plan; or

If both parents have the same birthday, the Plan that has covered the parent the longest is the Primary Plan.

However, if one spouse's Plan has some other coordination rule (for example, a "gender rule" which says the father's Plan is always primary), we will follow the rules of that Plan.

- (b) For a dependent child whose parents are divorced or separated or not living together, whether or not they have ever been married:
- (i) If a court decree states that one of the parents is responsible for the dependent child's health care expenses or health care coverage and the Plan of that parent has actual knowledge of those terms, that Plan is primary. This rule applies to Plan years commencing after the Plan is given notice of the court decree;
 - (ii) If a court decree states that both parents are responsible for the dependent child's health care expenses or health care coverage, the provisions of Subparagraph (a) above shall determine the order of benefits;
 - (iii) If a court decree states that the parents have joint custody without specifying that one parent has responsibility for the health care expenses or health care coverage of the dependent child, the provisions of Subparagraph (a) above shall determine the order of benefits; or
 - (iv) If there is no court decree allocating responsibility for the dependent child's health

care expenses or health care coverage, the order of benefits for the child are as follows:

The Plan covering the Custodial parent;

The Plan covering the spouse of the Custodial parent;

The Plan covering the non-custodial parent; and then

The Plan covering the spouse of the non-custodial parent.

- (c) For a dependent child covered under more than one Plan of individuals who are not the parents of the child, the provisions of Subparagraph (a) or (b) above shall determine the order of benefits as if those individuals were the parents of the child.
- (3) Active employee or retired or laid-off employee. The Plan that covers a person as an active employee, that is, an employee who is neither laid off nor retired, is the Primary Plan. The Plan covering that same person as a retired or laid-off employee is the Secondary Plan. The same would hold true if a person is a dependent of an active employee and that same person is a dependent of a retired or laid-off employee. If the other Plan does not have this rule, and as a result, the Plans do not agree on the order of benefits, this rule is ignored. This rule does not apply if the rule labeled D(1) can determine the order of benefits.
- (4) COBRA or state continuation coverage. If a person whose coverage is provided pursuant to COBRA or under a right of continuation provided by state or other federal law is covered under another Plan, the Plan covering the person as an employee, member, subscriber or retiree or covering the person as a dependent of an employee, member, subscriber or retiree is the Primary Plan and the COBRA or state or other federal continuation coverage is the Secondary Plan. If the other Plan does not have this rule, and as a result, the Plans do not agree on the order of benefits, this rule is ignored. This rule does not apply if the rule labeled D(1) can determine the order of benefits.
- (5) Longer or shorter length of coverage. The Plan that covered the person as an employee, member, policyholder, subscriber or retiree longer is the Primary Plan and the Plan that covered the person the shorter period of time is the Secondary Plan.
- (6) If the preceding rules do not determine the order of benefits, the Allowable expenses shall be shared



equally between the Plans meeting the definition of Plan. In addition, This Plan will not pay more than it would have paid had it been the Primary Plan.

Effect on the Benefits of this Plan

- A. When This Plan is secondary, it may reduce its benefits so that the total benefits paid or provided by all Plans during a Plan year are not more than the total Allowable expenses. In determining the amount to be paid for any claim, the Secondary Plan will calculate the benefits it would have paid in the absence of other health care coverage and apply that calculated amount to any Allowable expense under its Plan that is unpaid by the Primary Plan. The Secondary Plan may then reduce its payment by the amount so that, when combined with the amount paid by the Primary Plan, the total benefits paid or provided by all Plans for the claim do not exceed the total Allowable expense for that claim. In addition, the Secondary Plan shall credit to its Plan deductible any amounts it would have credited to its deductible in the absence of other health care coverage.
- B. If a covered person is enrolled in two or more Closed panel Plans and if, for any reason, including the provision of service by a non-panel provider, benefits are not payable by one Closed panel Plan, COB shall not apply between that Plan and other Closed panel Plans.

Right to Receive and Release Needed Information

Certain facts about health care coverage and services are needed to apply these COB rules and to determine benefits payable under This Plan and other Plans. We may get the facts it needs from or give them to other organizations or persons for the purpose of applying these rules and determining benefits payable under This Plan and other Plans covering the person claiming benefits. We need not tell, or get the consent of, any person to do this. Each person claiming benefits under This Plan must give Us any facts it needs to apply those rules and determine benefits payable.

Facility of Payment

A payment made under another Plan may include an amount that should have been paid under This Plan. If it does, We may pay that amount to the organization that made that payment. That amount will then be treated as though it were a benefit paid under This Plan. We will not have to pay that amount again. The term “payment made” includes providing benefits in the form of services, in which case “payment made” means the reasonable cash value of the benefits provided in the form of services.

Right of Recovery

If the amount of the payments made by Us is more than it should have paid under this COB provision, it may recover the

excess from one or more of the persons it has paid or for whom it has paid, or any other person or organization that may be responsible for the benefits or services provided for the covered person. The “amount of the payments made” includes the reasonable cash value of any benefits provided in the form of services.

Coordination Disputes

If You believe that We have not paid a claim properly, You should first attempt to resolve the problem by contacting Us at the toll-free number or address that appears on your Benefit Identification card, explanation of benefits, or claim form. If You are still not satisfied, You may call the Ohio Department of Insurance for instructions on filing a consumer complaint. Call 1-800-686-1526, or visit the Department’s website at <http://insurance.ohio.gov>.

The following is in addition to the process described in Section XIII. of your Plan Booklet:

XIII. Disenrollment From The Dental Plan/Termination Of Benefits

A. Causes For Disenrollment/Termination

3. Under Ohio law, you will not be terminated from the dental plan due to a permanent breakdown of the dentist-patient relationship. However, your Network Dentist has the right to decline services to a patient because of rude or abusive behavior.

You or your Dependent may appeal any termination action by Cigna Dental by submitting a written complaint as set out in Section XI.

XVI. Conversion Coverage

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

- A. Nonpayment of Premiums/Prepayment Fees by the Subscriber;
- B. Fraud or misuse of dental services and/or Dental Offices;
- C. Selection of alternate dental coverage by your Group.

XVIII. Miscellaneous

A. Governing Law

The Group Contract shall be construed for all purposes as a legal document and shall be interpreted and enforced in accordance with pertinent laws and regulations of the State of Ohio. Any person who, with intent to defraud or knowing that he is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement is guilty of insurance fraud.



B. Availability of Financial Statement

Cigna Dental Health of Ohio, Inc. will make available to you, upon request, its most recent financial statement.

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Cigna Dental Care – Cigna Dental Health Plan

The certificate(s) listed in the next section apply if you are a resident of one of the following states: CA, CT, FL, IL, KY, MO, NJ, NC, PA, TX

CDO33



Cigna Dental Companies

PLAN BOOKLET

COMBINED EVIDENCE OF COVERAGE AND DISCLOSURE FORM/CERTIFICATE OF COVERAGE

Cigna Dental Health Plan of Arizona, Inc.

Cigna Dental Health of Colorado, Inc.

Cigna Dental Health of Delaware, Inc.

Cigna Dental Health of Florida, Inc. (a Prepaid Limited Health Services Organization licensed under Chapter 636, Florida Statutes)

Cigna Dental Health of Kansas, Inc. (Kansas and Nebraska)

Cigna Dental Health of Kentucky, Inc.

Cigna Dental Health of Maryland, Inc.

Cigna Dental Health of Missouri, Inc.

Cigna Dental Health of New Jersey, Inc.

Cigna Dental Health of North Carolina, Inc.

Cigna Dental Health of Ohio, Inc.

Cigna Dental Health of Pennsylvania, Inc.

Cigna Dental Health of Virginia, Inc.

P.O. Box 453099

Sunrise, Florida 33345-3099

This Plan Booklet/Combined Evidence of Coverage and Disclosure Form/Certificate of Coverage is intended for your information; it constitutes a summary of the Dental Plan and is included as a part of the agreement between Cigna Dental and your Group (collectively, the "Group Contract"). The Group Contract must be consulted to determine the rates and the exact terms and conditions of coverage. If rates or coverages are changed under your Group Contract, your rates and coverage will also change. A prospective customer has the right to view the Combined Evidence of Coverage and Disclosure Form prior to enrollment. It should be read completely and carefully. Customers with special health care needs should read carefully those sections that apply to them. Please read the following information so you will know from whom or what group of dentists dental care may be obtained.

NOTICE: IF YOU OR YOUR FAMILY MEMBERS ARE COVERED BY MORE THAN ONE HEALTH CARE PLAN, YOU MAY NOT BE ABLE TO COLLECT BENEFITS FROM BOTH PLANS. EACH PLAN MAY REQUIRE YOU TO FOLLOW ITS RULES OR USE SPECIFIC DOCTORS OR HOSPITALS, AND IT MAY BE IMPOSSIBLE TO COMPLY WITH BOTH PLANS AT THE SAME TIME. READ ALL OF THE RULES VERY CAREFULLY, INCLUDING THE DUAL COVERAGE SECTION.

Important Cancellation Information – Please Read the Provision Entitled “Disenrollment from the Dental Plan—Termination of Benefits.”

READ YOUR PLAN BOOKLET CAREFULLY

Please call Customer Service 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.





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In some instances, state laws will supersede or augment the provisions contained in this booklet. These requirements are listed at the end of this booklet as a State Rider. In case of a conflict between the provisions of this booklet and your State Rider, the State Rider will prevail.



I. Definitions

Capitalized terms, unless otherwise defined, have the meanings listed below.

Adverse Determination - a decision by Cigna Dental 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 customer 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 authorizations that are declined by Cigna Dental based upon the above criteria will be the responsibility of the customer at the dentist's Usual Fees. A licensed dentist will make any such denial.

Cigna Dental - 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 Dentist agreement with Cigna Dental.

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

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

Dental Plan - Managed dental care plan offered through the Group Contract between Cigna Dental and your Group.

Dependent - Your lawful spouse, or your Domestic Partner; your unmarried child (including newborns, adopted children, stepchildren, a child for whom you must provide dental coverage under a court order; or, a dependent child who resides in your home as a result of court order or administrative placement) who is:

- A. Less than 26 years old; or
- B. Less than 26 years old if he or she is both:
 1. A Full-time student enrolled at an accredited educational institution, and
 2. reliant upon you for maintenance and support; or

C. Any age if he or she is both:

1. Incapable of self-sustaining employment due to mental or physical disability, and
2. Reliant upon you for maintenance and support.

For a dependent child 26 years of age or older who is a full-time student at an educational institution, coverage will be provided for an entire academic term during which the child begins as a full-time student and remains enrolled, regardless of whether the number of hours of instruction for which the child is enrolled is reduced to a level that changes the child's academic status to less than that of a full-time student.

For a child who falls into category (B) or (C) above, you will need to furnish Cigna Dental evidence of the child's reliance upon you, in the form requested, within 31 days after the Dependent reaches the age of 19 and once a year thereafter for as long as the child is claimed as a Dependent under the Plan.

A Newly Acquired Dependent is a dependent child who is adopted, born, or otherwise becomes your dependent after you become covered under the Plan.

Coverage for dependents living outside a Cigna Dental service area is subject to the availability of an approved network where the dependent resides.

The following definition of Domestic partner applies:

- A. A person of the same or opposite sex who:
 1. Shares your permanent residence;
 2. Has resided with you for no less than one year;
 3. Is no less than eighteen years of age;
 4. 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;
 5. Is not your blood relative any closer than would be prohibited for a legal marriage; and
 6. 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



- B. 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 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 disapproved by regulatory authorities.

Group - Employer, labor union or other organization that has entered into a Group Contract with Cigna Dental for managed dental services on your behalf.

Network Dentist - A licensed dentist who has signed an agreement with Cigna Dental 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 - A licensed dentist who has signed an agreement with Cigna Dental under which he or she agrees to provide dental care services to you.

Network Specialty Dentist - A licensed dentist who has signed an agreement with Cigna Dental under which he or she agrees to provide specialized dental care services to You.

Patient Charge - The amount you owe your Network Dentist for any dental procedure listed on your Patient Charge Schedule.

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

Premiums - Fees that your Group remits to Cigna Dental, on your behalf, during the term of your Group Contract.

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

Subscriber/You - The enrolled employee or customer of the Group.

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

II. Introduction to Your Cigna Dental Plan

Welcome to the Cigna Dental Plan. We encourage you to use your dental benefits. Please note that enrollment in the Dental Plan allows the release of patient records to Cigna Dental or its designee for health plan operation purposes.

III. Eligibility/When Coverage Begins

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

If you enrolled in the Dental Plan before the effective date of your Group Contract, you will be covered on the first day the Group Contract is effective. If you enrolled in the Dental Plan after the effective date of the Group Contract, you will be covered on the first day of the month following processing of your enrollment (unless effective dates other than the first day of the month are provided for in your Group Contract).

Dependents may be enrolled in the Dental Plan at the time you enroll, during an open enrollment, or within 31 days of becoming eligible due to a life status change such as marriage, birth, adoption, placement, or court or administrative order. You may drop coverage for your Dependents only during the open enrollment periods for your Group, unless there is a change in status such as divorce. Cigna Dental may require evidence of good dental health at your expense if you or your Dependents enroll after the first period of eligibility (except during open enrollment) or after disenrollment because of nonpayment of Premiums.

If you have family coverage, 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 must be enrolled in the Dental Plan and you must begin paying Premiums, if any additional are due, during that period.

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 Premiums, if any, which you would have paid if you had not taken the leave. Additional information is available through your Benefits Representative.

IV. Your Cigna Dental Coverage

The information below outlines your coverage and will help you to better understand your Dental Plan. Included is information about which services are covered, which are not,



and how much dental services will cost you. A copy of the Group Contract will be furnished to you upon your request.

A. Customer Service

If you have any questions or concerns about the Dental Plan, Customer Service Representatives are just a toll-free phone call away. They can explain your benefits or help with matters regarding your Dental Office or Dental Plan. For assistance with transfers, specialty referrals, eligibility, second opinions, emergencies, Covered Services, plan benefits, ID cards, location of Dental Offices, conversion coverage or other matters, call Customer Service from any location at **1.800.Cigna24**. The hearing impaired may contact the state TTY toll-free relay service number listed in their local telephone directory.

B. Premiums

Your Group sends a monthly fee to Cigna Dental for customers participating in the Dental Plan. The amount and term of this fee is 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.

C. Other Charges – Patient Charges

Network General Dentists are typically reimbursed by Cigna Dental 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.

Your Patient Charge Schedule lists the dental procedures covered under your Dental Plan. Some dental procedures are covered at no charge to you. For other Covered Services, the Patient Charge Schedule lists the fees you must pay when you visit your Dental Office. 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 policies. Timely payment is important. It is possible that the Dental Office may add late charges to overdue balances.

Your Patient Charge Schedule is subject to annual change in accordance with your Group Contract. Cigna Dental will give written notice to your Group of any change in Patient Charges at least 60 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.

D. Choice of Dentist

You and your Dependents should have selected a Dental Office when you enrolled in the Dental Plan. If you did not, you must advise Cigna Dental of your Dental Office selection prior to receiving treatment. The benefits of the Dental Plan are available only at your Dental Office, except in the case of an emergency or when Cigna Dental otherwise authorizes payment for out-of-network benefits.

You may select a network Pediatric Dentist as the Network General Dentist for your dependent child under age 7 by calling Customer Service at **1.800.Cigna24** to get a list of network Pediatric Dentists in your Service Area or if your Network General Dentist sends your child under the age of 7 to a network Pediatric Dentist, the network Pediatric Dentist's office will have primary responsibility for your child's care. For children 7 years and older, your Network General Dentist will provide care. If your child continues to visit the Pediatric Dentist upon the age of 7, you will be fully responsible for the Pediatric Dentist's Usual Fees. Exceptions for medical reasons may be considered on a case-by-case basis.

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 will let you know and will arrange a transfer to another Dental Office. Refer to the Section titled "Office Transfers" if you wish to change your Dental Office.

To obtain a list of Dental Offices near you, visit our website at myCigna.com, or 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 Customer Service.

E. Your Payment Responsibility (General Care)

For Covered Services at your Dental Office, you will be charged the fees listed on your Patient Charge Schedule. For services listed on your Patient Charge Schedule at any other dental office, you may be charged Usual Fees. For non-covered services, you are responsible for paying Usual Fees.

If, on a temporary basis, there is no Network General Dentist in your Service Area, Cigna Dental 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 will pay the non-network dentist the difference, if

any, between his or her Usual Fee and the applicable Patient Charge.

See Section IX., *Specialty Referrals*, regarding payment responsibility for specialty care.

All contracts between Cigna Dental 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.

F. 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.

1. Emergency Care Away from Home

If you have an emergency while you are out of your Service Area or you are unable to contact your Network General Dentist, you may receive emergency Covered Services as defined above from any general dentist. Routine restorative procedures or definitive treatment (e.g. root canal) are not considered emergency care. You should return to your Network General Dentist for these procedures. For emergency Covered Services, you will be responsible for the Patient Charges listed on your Patient Charge Schedule. Cigna Dental will reimburse you the difference, if any, between the dentist's Usual Fee for emergency Covered Services and your Patient Charge, up to a total of \$50 per incident. To receive reimbursement, send appropriate reports and x-rays to Cigna Dental at the address listed for your state on the front of this booklet.

2. 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.

G. Limitations on Covered Services

Listed below are limitations on services when covered by your Dental Plan:

- **Frequency** - The frequency of certain Covered Services, like cleanings, is limited. Your Patient Charge Schedule lists any limitations on frequency.
- **Pediatric Dentistry** - Coverage for treatment by a Pediatric Dentist ends on your child's 7th birthday. Effective on your child's 7th birthday, dental services must be obtained from a

Network General Dentist however; exceptions for medical reasons may be considered on an individual basis.

- **Oral Surgery** - The surgical removal of an impacted wisdom tooth may not be covered if the tooth is not diseased or if the removal is only for orthodontic reasons. Your Patient Charge Schedule lists any limitations on oral surgery.
- **Periodontal (gum tissue and supporting bone) Services** – Periodontal regenerative procedures are limited to one regenerative procedure per site (or per tooth, if applicable), when covered on the Patient Charge Schedule.
Localized delivery of antimicrobial agents is limited to eight teeth (or eight sites, if applicable) per 12 consecutive months, when covered on the Patient Charge Schedule.
- **Clinical Oral Evaluations** – When this limitation is noted on the Patient Charge Schedule, periodic oral evaluations, comprehensive oral evaluations, comprehensive periodontal evaluations, and oral evaluations for patients under 3 years of age, are limited to a combined total of four evaluations during a 12 consecutive month period.
- **Surgical Placement of Implant Services** – When covered on the Patient Charge Schedule, surgical placement of a dental implant; repair, maintenance, or removal of a dental implant; implant abutment(s); or any services related to the surgical placement of a dental implant are limited to one per year with replacement of a surgical implant frequency limitation of one every 10 years.
- **Prosthesis Over Implant** - When covered on the Patient Charge Schedule, a prosthetic device, supported by an implant or implant abutment is considered a separate distinct service(s) from surgical placement of an implant. Replacement of any type of prosthesis with a prosthesis supported by an implant or implant abutment is only covered if the existing prosthesis is at least 5 calendar years old, is not serviceable and cannot be repaired.

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 charges which would not have been made in any facility, other than a Hospital or a Correctional Institution owned or operated by the United States Government or by a state or municipal government if the person had no insurance.

- To the extent that payment is unlawful where the person resides when the expenses are incurred or the services are received.
- For the charges which the person is not legally required to pay.
- For charges which would not have been made if the person had no insurance.
- Due to injuries which are intentionally self-inflicted.

H. Services Not Covered Under Your Dental Plan

Listed below are the services or expenses which are NOT covered under your Dental Plan and which are your responsibility at the dentist's Usual Fees. There is no coverage for:

- Services not listed on the Patient Charge Schedule.
- Services provided by a non-network dentist without Cigna Dental's prior approval (except emergencies, as described in Section IV.F).
- Services related to an injury or illness paid under workers' compensation, occupational disease or similar laws.
- Services provided or paid by or through a federal or state governmental agency or authority, political subdivision or a public program, other than Medicaid.
- Services required while serving in the armed forces of any country or international authority or relating to a declared or undeclared war or acts of war.
- Cosmetic dentistry or cosmetic dental surgery (dentistry or dental surgery performed solely to improve appearance) unless specifically listed on your Patient Charge Schedule. If bleaching (tooth whitening) is listed on your Patient Charge Schedule, only the use of take-home bleaching gel with trays is covered; all other types of bleaching methods are not covered.
- 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. (Maryland residents: General anesthesia is covered when medically necessary and authorized by your physician.) There is no coverage for general anesthesia or intravenous sedation when used for the purposes of anxiety control or patient management.
- Prescription medications.
- Procedures, appliances or restorations if the main purpose is to:
 - a. Change vertical dimension (degree of separation of the jaw when teeth are in contact).
 - b. Restore teeth which have been damaged by attrition, abrasion, erosion and/or abfraction.
- Replacement of fixed and/or removable appliances (including fixed and removable orthodontic appliances) that have been lost, stolen, or damaged due to patient abuse, misuse or neglect.
- Surgical placement of a dental implant; repair, maintenance, or removal of a dental implant; implant abutment(s); or any services related to the surgical placement of a dental implant, unless specifically listed on your Patient Charge Schedule.
- Services considered to be unnecessary or experimental in nature or do not meet commonly accepted dental standards.
- Procedures or appliances for minor tooth guidance or to control harmful habits.
- Hospitalization, including any associated incremental charges for dental services performed in a hospital. (Benefits are available for Network Dentist charges for Covered Services performed at a hospital. Other associated charges are not covered and should be submitted to the medical carrier for benefit determination.)
- Services to the extent you or your enrolled Dependent are compensated under any group medical plan, no-fault auto insurance policy, or uninsured motorist policy. (Arizona and Pennsylvania residents: Coverage for covered services to the extent compensated under group medical plan, no fault auto insurance policies or uninsured motorist policies is not excluded. Kentucky and North Carolina residents: Services compensated under no-fault auto insurance policies or uninsured motorist policies are not excluded. Maryland residents: Services compensated under group medical plans are not excluded.)
- The completion of crowns, bridges, dentures, or root canal treatment, already in progress on the effective date of your Cigna Dental coverage.
- The completion of implant supported prosthesis (including crowns, bridges and dentures) already in progress on the effective date of your Cigna Dental coverage, unless specifically listed on your Patient Charge Schedule.
- Consultations and/or evaluations associated with services that are not covered.
- Endodontic treatment and/or periodontal (gum tissue and supporting bone) surgery of teeth exhibiting a poor or hopeless periodontal prognosis.
- Bone grafting and/or guided tissue regeneration when performed at the site of a tooth extraction unless specifically listed on your Patient Charge Schedule.

- Bone grafting and/or guided tissue regeneration when performed in conjunction with an apicoectomy or periradicular surgery.
- Intentional root canal treatment in the absence of injury or disease to solely facilitate a restorative procedure.
- Services performed by a prosthodontist.
- Localized delivery of antimicrobial agents when performed alone or in the absence of traditional periodontal therapy.
- Any localized delivery of antimicrobial agent procedures when more than eight (8) of these procedures are reported on the same date of service.
- Infection control and/or sterilization. Cigna Dental considers this to be incidental to and part of the charges for services provided and not separately chargeable.
- The recementation of any inlay, onlay, crown, post and core or fixed bridge within 180 days of initial placement. Cigna Dental considers recementation within this timeframe to be incidental to and part of the charges for the initial restoration.
- The recementation of any implant supported prosthesis (including crowns, bridges and dentures) within 180 days of initial placement. Cigna Dental considers recementation within this timeframe to be incidental to and part of the charges for the initial restoration unless specifically listed on your Patient Charge Schedule.
- Services to correct congenital malformations, including the replacement of congenitally missing teeth.
- The replacement of an occlusal guard (night guard) beyond one per any 24-consecutive month period, when this limitation is noted on the Patient Charge Schedule.
- Crowns, bridges and/or implant supported prosthesis used solely for splinting.
- Resin bonded retainers and associated pontics.

Preexisting conditions are not excluded if the procedures involved are otherwise covered under your Patient Charge Schedule.

Should any law require coverage for any particular service(s) noted above, the exclusion or limitation for that service(s) shall not apply.

V. Appointments

To make an appointment with your Network Dentist, call the Dental Office that you have selected. When you call, your Dental Office will ask for your identification number and will check your eligibility.

VI. Broken Appointments

The time your Network Dentist schedules for your appointment is valuable to you and the dentist. Broken appointments make it difficult for your Dental Office to schedule time with other patients.

If you or your enrolled Dependent breaks an appointment with less than 24 hours notice to the Dental Office, you may be charged a broken appointment fee.

VII. Office Transfers

If you decide to change Dental Offices, we can arrange a transfer. You should complete any dental procedure in progress before transferring to another Dental Office. To arrange a transfer, call Customer Service at **1.800.Cigna24**. To obtain a list of Dental Offices near you, visit our website at **myCigna.com**, or call the Dental Office Locator at **1.800.Cigna24**.

Your transfer request will take about five days to process. Transfers will be effective the first day of the month after the processing of your request. Unless you have an emergency, you will be unable to schedule an appointment at the new Dental Office until your transfer becomes effective.

There is no charge to you for the transfer; however, all Patient Charges which you owe to your current Dental Office must be paid before the transfer can be processed.

VIII. 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 Network includes the following types of specialty dentists:

- 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 Specialty Dentist.

See Section IV.D., *Choice of Dentist*, regarding treatment by a Pediatric Dentist.

IX. Specialty Referrals

A. In General

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

When Cigna Dental authorizes payment to the Network Specialty Dentist, 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 IX.B., Orthodontics. Treatment by the Network Specialty Dentist must begin within 90 days from the date of Cigna Dental's authorization. If you are unable to obtain treatment within the 90 day period, please call Customer Service to request an extension. Your coverage must be in effect when each procedure begins.

For non-covered services or if Cigna Dental does not authorize payment to the Network Specialty Dentist for Covered Services, including Adverse Determinations, you must pay the Network Specialty Dentist's Usual Fee. If you have a question or concern regarding an authorization or a denial, contact Customer Service.

After the Network Specialty Dentist has completed treatment, you should return to your Network General Dentist for cleanings, regular checkups and other treatment. If you visit a Network Specialty Dentist without a referral or if you continue to see a Network Specialty Dentist 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 Specialty Dentist is not available, as determined by Cigna Dental, Cigna Dental will authorize a referral to a non-network specialty dentist. 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 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.

B. Orthodontics (This section is applicable only when orthodontics is listed on your Patient Charge Schedule.)

1. **Definitions** - If your Patient Charge Schedule indicates coverage for orthodontic treatment, the following definitions apply:
 - a. **Orthodontic Treatment Plan and Records** - the preparation of orthodontic records and a treatment plan by the orthodontist.
 - b. **Interceptive Orthodontic Treatment** - treatment prior to full eruption of the permanent teeth, frequently a first phase preceding comprehensive treatment.
 - c. **Comprehensive Orthodontic Treatment** - treatment after the eruption of most permanent teeth, generally the final phase of treatment before retention.
 - d. **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.

2. Patient Charges

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. However, if 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, 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 prorated basis.

3. Additional Charges

You will be responsible for the Orthodontist's Usual Fees for the following non-covered services:

- a. Incremental costs associated with optional/elective materials, including but not limited to ceramic, clear, lingual brackets, or other cosmetic appliances;
- b. Orthognathic surgery and associated incremental costs;

- c. Appliances to guide minor tooth movement;
- d. Appliances to correct harmful habits; and
- e. Services which are not typically included in Orthodontic Treatment. These services will be identified on a case-by-case basis.

4. Orthodontics in Progress

If Orthodontic Treatment is in progress for you or your Dependent at the time you enroll, the fee listed on the Patient Charge Schedule is not applicable. Please call Customer Service at **1.800.Cigna24** to find out if you are entitled to any benefit under the Dental Plan.

X. Complex Rehabilitation/Multiple Crown Units

Complex rehabilitation is extensive dental restoration involving six or more “units” of crown, bridge and/or implant supported prosthesis (including crowns and bridges) in the same treatment plan. Using full crowns (caps), fixed bridges and/or implant supported prosthesis (including crowns and 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 the 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, bridge and/or implant supported prosthesis (including crowns and bridges) 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, bridge and/or implant supported prosthesis (including crowns and bridges) PLUS an additional charge for each unit when six or more units are prescribed in your Network General Dentist’s treatment plan.

Note: Complex rehabilitation only applies for implant supported prosthesis, when implant supported prosthesis are specifically listed on your Patient Charge Schedule.

XI. 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 dentist designated by you to act on your behalf. **Time frames or requirements may**

vary depending on the laws in your State. Consult your State Rider for further details.

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.

A. Start with Customer Service

We are here to listen and to help. If you have a concern about your Dental Office or the Dental Plan, you can call **1.800.Cigna24** toll-free and explain your concern to one of our Customer Service Representatives. You can also express that concern in writing to Cigna Dental, P.O. Box 188047, Chattanooga, TN 37422-8047. We will do our best to resolve the matter during your initial contact. If we need more time to review or investigate your concern, we will get back to you as soon as possible, usually by the end of the next business day, but in any case within 30 days.

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

B. Appeals Procedure

Cigna Dental has a two-step appeals procedure for coverage decisions. To initiate an appeal, you must submit a request in writing to Cigna Dental, P.O. Box 188047, Chattanooga, TN 37422-8047, within one year from the date of the initial Cigna Dental decision. You should state the reason you feel your appeal should be approved and include any information to support your appeal. If you are unable or choose not to write, you may ask Customer Service to register your appeal by calling **1.800.Cigna24**.

1. Level-One Appeals

Your level-one appeal will be reviewed and the decision made by someone not involved in the initial review. Appeals involving dental necessity or clinical appropriateness will be reviewed by a dental professional.

If your appeal concerns a denied preauthorization, we will respond with a decision within 15 calendar days after we receive your appeal. For appeals concerning all other coverage issues, we will respond with a decision within 30 calendar days after we receive your appeal. If we need more information to make your level-one appeal decision, we will notify you in writing to request an extension of up to 15 calendar days and to specify any additional information needed to complete the review.

You may request that the 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, Cigna Dental will respond orally with a decision within 72 hours, followed up in writing.

If you are not satisfied with our level-one appeal decision, you may request a level-two appeal.

2. Level-Two Appeals

To initiate a level-two appeal, follow the same process required for a level-one appeal. Your level-two appeal will be reviewed and a decision made by someone not involved in the level-one appeal. For appeals involving dental necessity or clinical appropriateness, the decision will be made by a dentist. If specialty care is in dispute, the appeal will be conducted by a dentist in the same or similar specialty as the care under review.

The review will be completed within 30 calendar days. If we need more information to complete the appeal, we will notify you in writing to request an extension of up to 15 calendar days and to specify any additional information needed to complete the review. The decision will include the specific contractual or clinical reasons for the decision, as applicable.

You may request that the 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.

3. Independent Review Procedure

The independent review procedure is a voluntary program arranged by the Dental Plan and is not available in all areas. Consult your State Rider for more details if applicable.

4. Appeals to the State

You have the right to contact your State's Department of Insurance and/or Department of

Health for assistance at any time. **See your State Rider for further details.**

Cigna Dental will not cancel or refuse to renew your coverage because you or your Dependent has filed a complaint or an appeal involving a decision made by Cigna Dental. You have the right to file suit in a court of law for any claim involving the professional treatment performed by a dentist.

XII. Dual Coverage

You and your Dependents may not be covered twice under this Dental Plan. If you and your spouse have enrolled each other or the same Dependents twice, please contact your Benefits Administrator.

If you or your Dependents have dental coverage through your spouse's employer or other sources such as an HMO or similar dental plan, applicable coordination of benefits 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.

Coordination of benefits rules are attached to the Group Contract and may be reviewed by contacting your Benefits Administrator. Cigna Dental coordinates benefits only for specialty care services.

XIII. Disenrollment from the Dental Plan - Termination of Benefits

A. Time Frames for Disenrollment/Termination

Except as otherwise provided in the sections titled "Extension/Continuation of Benefits" or in your Group Contract, disenrollment from the Dental Plan and termination of benefits will occur on the last day of the month:

1. In which Premiums are not remitted to Cigna Dental.
2. In which eligibility requirements are no longer met.
3. After 30 days' notice from Cigna Dental due to permanent breakdown of the dentist-patient relationship as determined by Cigna Dental, after at least two opportunities to transfer to another Dental Office.



4. After 30 days' notice from Cigna Dental due to fraud or misuse of dental services and/or Dental Offices.
5. After 60 days' notice by Cigna Dental, due to continued lack of a Dental Office in your Service Area.
6. After voluntary disenrollment.

B. Effect on Dependents

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.

XIV. Extension of Benefits

Coverage for completion of a dental procedure (other than orthodontics) which was started before your disenrollment from the Dental Plan will be extended for 90 days after disenrollment unless disenrollment was due to nonpayment of Premiums.

Coverage for orthodontic treatment which was started before disenrollment from the Dental Plan will be extended to the end of the quarter or for 60 days after disenrollment, whichever is later, unless disenrollment was due to nonpayment of Premiums.

XV. Continuation of Benefits (COBRA)

For Groups with 20 or more employees, federal law requires the employer to offer continuation of benefits coverage for a specified period of time after termination of employment or reduction of work hours, for any reason other than gross misconduct. You will be responsible for sending payment of the required Premiums to the Group. Additional information is available through your Benefits Representative.

XVI. Conversion Coverage

If you are no longer eligible for coverage under your Group's Dental Plan, you and your enrolled Dependents may continue your dental coverage by enrolling in the Cigna Dental conversion plan. You must enroll within three (3) months after becoming ineligible for your Group's Dental Plan. Premium payments and coverage will be retroactive to the date coverage under your Group's Dental Plan ended. You and your enrolled Dependents are eligible for conversion coverage unless benefits were discontinued due to:

- Permanent breakdown of the dentist-patient relationship.
- Fraud or misuse of dental services and/or Dental Offices.

- Nonpayment of Premiums by the Subscriber.
- Selection of alternate dental coverage by your Group.
- Lack of network/Service Area.

Benefits and rates for Cigna Dental conversion coverage and any succeeding renewals will be based on the Covered Services listed in the then-current standard conversion plan and 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.

XVII. Confidentiality/Privacy

Cigna Dental is committed to maintaining the confidentiality of your personal and sensitive information. Information about Cigna Dental's confidentiality policies and procedures is made available to you during the enrollment process and/or as part of your customer plan materials. You may obtain additional information about Cigna Dental's confidentiality policies and procedures by calling Customer Service at **1.800.Cigna24**, or via the Internet at myCigna.com.

XVIII. Miscellaneous

As a Cigna Dental plan customer, you may be eligible for various discounts, benefits, or other consideration for the purpose of promoting your general health and well being. Please visit our website at myCigna.com for details.

As a Cigna Dental plan customer, you may also be eligible for additional dental benefits during certain health conditions. For example, certain frequency limitations for dental services may be relaxed for pregnant women and customers participating in certain disease management programs. Please review your plan enrollment materials for details.

See Your State Rider for Additional Details.

Cigna Dental Health of Florida, Inc. STATE RIDER

Florida residents: This State Rider is attached to and made part of your Plan Booklet and contains information that either replaces, or is in addition to, information contained in your Plan Booklet.

I. Definitions

Dependent - A child born to or adopted by your covered family member may also be considered a Dependent if the child is pre-enrolled at the time of birth or adoption.



Domestic Partner definition is replaced as follows:

The following definition of Domestic Partner applies:

- A. A person of the same or opposite sex who:
1. Shares your permanent residence;
 2. Is no less than eighteen years of age;
 3. 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;
 4. Is not your blood relative any closer than would be prohibited for a legal marriage; and
 5. 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

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 disapproved by regulatory authorities.

III. Eligibility/when coverage begins

There will be at least one open enrollment period of not less than 30 days every 18 months unless Cigna Dental Health and your Group mutually agree to a shorter period of time than 18 months.

If you have family coverage, your newly-born child, or a newly-born child of a covered family member, is automatically covered during the first 31 days of life if the

child is pre-enrolled in the Dental Plan at the time of birth. If you wish to continue coverage beyond the first 31 days, you need to begin to pay Premiums, if any additional are due, during that period.

IV. Your Cigna Dental coverage

B. Premiums/prepayment fees

Your Group Contract has a 31-day grace period. This provision means that if any required premium is not paid on or before the date is due, it may be paid subsequently during the grace period. During the grace period, the Group Contract will remain in force.

D. CHOICE OF DENTIST

You may receive a description of the process used to analyze the qualifications and credentials of Network Dentists upon request.

XI. What to do if there is a problem

The following is in addition to the Section XI of your Plan Booklet:

B. Appeals procedure

The Appeals Coordinator can be reached at **1.800.Cigna24 (244.6224)** or by writing to P.O. Box 188047, Chattanooga, TN 37422.

1. Level-one appeals

Your written complaint will be processed within 60 days of receipt unless the complaint involves the collection of information outside the service area, in which case Cigna Dental Health will have an additional 30 days to process the complaint. You may file a complaint up to one year from the date of occurrence.

If a meeting with you is necessary, the location of the meeting shall be at Cigna Dental Health's administrative office at a location within the service area that is convenient for you.

4. Appeals to the State

You always have the right to file a complaint with or seek assistance from the Department of Insurance, 200 East Gaines Street, Tallahassee, Florida 32399, 1.800.342.2672.



XIII. Disenrollment from the dental plan/termination

A. Causes for disenrollment/termination

3. Permanent breakdown of the dentist-patient relationship, as determined by Cigna Dental Health, is defined as disruptive, unruly, abusive, unlawful, or uncooperative behavior which seriously impairs Cigna Dental Health's ability to provide services to members, after reasonable efforts to resolve the problem and consideration of extenuating circumstances.

Forty-five days notice will be provided to you if Cigna Dental Health terminates enrollment in the dental plan.

XIV. Extension of benefits

Coverage for all dental procedures in progress, including Orthodontics, is extended for 90 days after disenrollment.

XVI. Converting from your group coverage

You and your enrolled Dependent(s) are eligible for conversion coverage unless benefits are discontinued because you or your Dependent no longer resides in a Cigna Dental Health Service Area, or because of fraud or material misrepresentation in applying for benefits.

Unless benefits were terminated as previously listed, conversion coverage is available to your Dependents, only, as follows:

- A. A surviving spouse and children at Subscriber's death;
- B. A former spouse whose coverage would otherwise end because of annulment or dissolution of marriage; or
- C. A spouse or child whose group coverage ended by reason of ceasing to be an eligible family member under the Subscriber's coverage.

Coverage and Benefits for conversion coverage will be similar to those of your Group's Dental Plan. Rates will be at prevailing conversion levels.

In addition the following provisions apply to your plan:

Expenses for which a third party may be responsible

This plan does not cover:

1. 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.

2. 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, uninsured or underinsured motorist, homeowners, workers' compensation, government insurance (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.

Cigna Dental Health of Florida, Inc.

BY: Matthew G. Menden

TITLE: President

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Benefit Rider

Cigna Dental Companies

Cigna Dental Health of Florida, Inc. (a Prepaid Limited Health Services Organization licensed under Chapter 636, Florida Statutes)

P.O. Box 453099

Sunrise, Florida 33345-3099

This State Rider is attached to and made part of your Plan Booklet/Evidence of Coverage and replaces the following provisions:

D. Choice of Dentist

You and your Dependents should have selected a Dental Office when you enrolled in the Dental Plan. If you did not, you must advise Cigna Dental of your Dental Office selection prior to receiving treatment. The benefits of the Dental Plan are available only at your Dental Office, except in the case of an emergency or when Cigna Dental otherwise approves payment for out-of-network benefits.

You may select a network Pediatric Dentist as the Network General Dentist for your dependent child under age 13 by calling Customer Service at 1.800.Cigna24 to get a list of network Pediatric Dentists in your Service Area or, if your Network General Dentist sends your child under age 13 to a network Pediatric Dentist, the network Pediatric Dentist's office will have primary responsibility for your child's care. For children 13 years and older, your Network General Dentist will provide care. If your child continues to visit the Pediatric Dentist upon the age of 13, you will be fully responsible for the Pediatric Dentist's Usual Fees. Exceptions for medical reasons may be considered on a case-by-case basis.

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 will let you know and will arrange a transfer to another Dental Office. Refer to the Section titled "Office Transfers" if you wish to change your Dental Office.

To obtain a list of Dental Offices near you, visit our website at my.Cigna.com, or 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 Customer Service.

F. 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.

1. Emergency Care Away from Home

If you have an emergency while you are out of your Service Area or you are unable to contact your Network General Dentist, you may receive emergency Covered Services as defined above from any general dentist. Routine restorative procedures or definitive treatment (e.g. root canal) are not considered emergency care. You should return to your Network General Dentist for these procedures.

For emergency Covered Services, you will be responsible for the Patient Charges listed on your Patient Charge Schedule. Cigna Dental will reimburse you the difference, if any, between the dentist's Usual

Fee for emergency Covered Services and your Patient Charge, up to a total of \$50 per incident. To receive reimbursement, send appropriate reports and x-rays to Cigna Dental at the address listed for your state on the front of this booklet.

2. 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.

G. Limitations on Covered Services

Listed below are limitations on services when covered by your Dental Plan:

- **Frequency** - The frequency of certain Covered Services, like cleanings, is limited. Your Patient Charge Schedule lists any limitations on frequency.
- **Pediatric Dentistry** - Coverage for treatment by a Pediatric Dentist ends on your child's 13th birthday. Effective on your child's 13th birthday, dental services must be obtained from a Network General Dentist however, exceptions for medical reasons may be considered on an individual basis.
- **Oral Surgery** - The surgical removal of an impacted wisdom tooth may not be covered if the tooth is not diseased or if the removal is only for orthodontic reasons. Your Patient Charge Schedule lists any limitations on oral surgery.
- **Periodontal (gum tissue and supporting bone) Services** – Periodontal regenerative procedures are limited to one regenerative procedure per site (or per tooth, if applicable), when covered on the Patient Charge Schedule.
- Localized delivery of antimicrobial agents is limited to eight teeth (or eight sites, if applicable) per 12 consecutive months, when covered on the Patient Charge Schedule.
- **Clinical Oral Evaluations** – When this limitation is noted on the Patient Charge Schedule, periodic oral evaluations, comprehensive oral evaluations, comprehensive periodontal evaluations, and oral evaluations for patients under 3 years of age, are limited to a combined total of four evaluations during a 12 consecutive month period.
- **Surgical Placement of Implant Services** – When covered on the Patient Charge Schedule, surgical placement of a dental implant; repair, maintenance, or removal of a dental implant; implant abutment(s); or any services related to the surgical placement of a

dental implant are limited to one per year with replacement of a surgical implant frequency limitation of one every 10 years.

- **Prosthesis Over Implant** – When covered on the Patient Charge Schedule, a prosthetic device, supported by an implant or implant abutment is considered a separate distinct service(s) from surgical placement of an implant. Replacement of any type of prosthesis with a prosthesis supported by an implant or implant abutment is only covered if the existing prosthesis is at least 5 calendar years old, is not serviceable and cannot be repaired.

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 charges which would not have been made in any facility, other than a Hospital or a Correctional Institution owned or operated by the United States Government or by a state or municipal government if the person had no insurance.
- To the extent that payment is unlawful where the person resides when the expenses are incurred or the services are received.
- For the charges which the person is not legally required to pay.
- For charges which would not have been made if the person had no insurance.
- Due to injuries which are intentionally self-inflicted.

VII. Office Transfers

If you decide to change Dental Offices, we can arrange a transfer. You should complete any dental procedure in progress before transferring to another Dental Office. To arrange a transfer, call Customer Service at 1.800.Cigna24. To obtain a list of Dental Offices near you, visit our website at my.Cigna.com, or call the Dental Office Locator at 1.800.Cigna24.

Your transfer request may take up to 5 days to process. Transfers will be effective the first day of the month after the processing of your request. Unless you have an emergency, you will be unable to schedule an appointment at the new Dental Office until your transfer becomes effective. You can check the status of your request by visiting myCigna.com, or by calling us at 1.800.Cigna24.

There is no charge to you for the transfer; however, all Patient Charges which you owe to your current Dental Office must be paid before the transfer can be processed.

IX Specialty Referrals

A. In General

Preauthorization is not required for coverage of services by a Network Specialty Dentist.

When Cigna Dental approves payment to the Network Specialty Dentist, 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 IX.B., Orthodontics. Treatment by the Network Specialty Dentist must begin within 90 days from the date of Cigna Dental's approval. If you are unable to obtain treatment within the 90 day period, please call Customer Service to request an extension. Your coverage must be in effect when each procedure begins.

For non-covered services or if Cigna Dental does not approve payment to the Network Specialty Dentist for Covered Services, including Adverse Determinations, you must pay the Network Specialty Dentist's Usual Fee. If you have a question or concern regarding an approval or a denial, contact Customer Service.

After the Network Specialty Dentist has completed treatment, you should return to your Network General Dentist for cleanings, regular checkups and other treatment. If you visit a Network Specialty Dentist without a referral or if you continue to see a Network Specialty Dentist 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 Specialty Dentist is not available, as determined by Cigna Dental, Cigna Dental will approve a referral to a non-network specialty dentist. 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 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 approved for payment, including Adverse Determinations, you must pay the dentist's Usual Fee.

Cigna Dental Health of Florida, Inc.



Frederick E. Sandall

BY:

TITLE: President

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Cigna Dental Care – Cigna Dental Health Plan

If you are an Illinois and/or Kentucky resident the following Plan Booklet applies to you. Additionally, if you are an Illinois resident the Illinois rider that follows the Plan Booklet also applies to you.

CDO23



Cigna Dental Health of Kentucky, Inc.

P.O. Box 453099
Sunrise, Florida 33345-3099

This Plan Booklet is intended for your information; it constitutes a summary of the Dental Plan and is included as a part of the agreement between Cigna Dental and your Group (collectively, the “Group Contract”). The Group Contract must be consulted to determine the rates and the exact terms and conditions of coverage. If rates or coverages are changed under your Group Contract, your rates and coverage will also change. A prospective customer has the right to view the Combined Evidence of Coverage and Disclosure Form prior to enrollment. It should be read completely and carefully. Customers with special health care needs should read carefully those sections that apply to them. Please read the following information so you will know from whom or what group of dentists dental care may be obtained.

NOTICE: IF YOU OR YOUR FAMILY MEMBERS ARE COVERED BY MORE THAN ONE HEALTH CARE PLAN, YOU MAY NOT BE ABLE TO COLLECT BENEFITS FROM BOTH PLANS. EACH PLAN MAY REQUIRE YOU TO FOLLOW ITS RULES OR USE SPECIFIC DOCTORS OR HOSPITALS, AND IT MAY BE IMPOSSIBLE TO COMPLY WITH BOTH PLANS AT THE SAME TIME. READ ALL OF THE RULES VERY CAREFULLY, INCLUDING THE DUAL COVERAGE SECTION.

Important Cancellation Information – Please Read the Provision Entitled “Disenrollment from the Dental Plan–Termination of Benefits.”

READ YOUR PLAN BOOKLET CAREFULLY

Please call Customer Service 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.

In some instances, state laws will supersede or augment the provisions contained in this booklet. These requirements are listed at the end of this booklet as a State Rider. In case of a conflict between the provisions of this booklet and your State Rider, the State Rider will prevail.

I. Definitions

Capitalized terms, unless otherwise defined, have the meanings listed below.

Adverse Determination - a decision by Cigna Dental 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 customer or dentist 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 authorizations that are declined by Cigna Dental based upon the above criteria will be the responsibility of the customer at the dentist's Usual Fees. A licensed dentist will make any such denial.

Cigna Dental - 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 Dentist agreement with Cigna Dental.

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

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

Dental Plan - managed dental care plan offered through the Group Contract between Cigna Dental and your Group.

Dependent - your lawful spouse, or your Domestic Partner; your unmarried child (including newborns, adopted children, stepchildren, a child for whom you must provide dental coverage under a court order; or, a dependent child who resides in your home as a result of court order or administrative placement) who is:

- (a) less than 26 years old; or
- (b) less than 26 years old if he or she is both:
 - i. a full-time student enrolled at an accredited educational institution, and
 - ii. reliant upon you for maintenance and support; or

(c) any age if he or she is both:

- i. incapable of self-sustaining employment due to mental or physical disability, and
- ii. reliant upon you for maintenance and support.

For a dependent child 26 years of age or older who is a full-time student at an educational institution, coverage will be provided for an entire academic term during which the child begins as a full-time student and remains enrolled, regardless of whether the number of hours of instruction for which the child is enrolled is reduced to a level that changes the child's academic status to less than that of a full-time student.

A Newly Acquired Dependent is a dependent child who is adopted, born, or otherwise becomes your dependent after you become covered under the Plan.

Coverage for dependents living outside a Cigna Dental service area is subject to the availability of an approved network where the dependent resides.

Group - employer, labor union or other organization that has entered into a Group Contract with Cigna Dental for managed dental services on your behalf.

Network Dentist - a licensed dentist who has signed an agreement with Cigna Dental 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 - a licensed dentist who has signed an agreement with Cigna Dental under which he or she agrees to provide dental care services to you.

Network Specialty Dentist - a licensed dentist who has signed an agreement with Cigna Dental under which he or she agrees to provide specialized dental care services to you.

Patient Charge - the amount you owe your Network Dentist for any dental procedure listed on your Patient Charge Schedule.

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

Premiums - fees that your Group remits to Cigna Dental, on your behalf, during the term of your Group Contract.

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

Subscriber/You - the enrolled employee or customer of the Group.

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



II. Introduction To Your Cigna Dental Plan

Welcome to the Cigna Dental Plan. We encourage you to use your dental benefits. Please note that enrollment in the Dental Plan allows the release of patient records to Cigna Dental or its designee for health plan operation purposes for up to 24 months.

III. Eligibility/When Coverage Begins

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

If you enrolled in the Dental Plan before the effective date of your Group Contract, you will be covered on the first day the Group Contract is effective. If you enrolled in the Dental Plan after the effective date of the Group Contract, you will be covered on the first day of the month following processing of your enrollment (unless effective dates other than the first day of the month are provided for in your Group Contract).

Dependents may be enrolled in the Dental Plan at the time you enroll, during an open enrollment, or within 31 days of becoming eligible due to a life status change such as marriage, birth, adoption, placement, or court or administrative order. You may drop coverage for your Dependents only during the open enrollment periods for your Group, unless there is a change in status such as divorce. Cigna Dental may require evidence of good dental health at your expense if you or your Dependents enroll after the first period of eligibility (except during open enrollment) or after disenrollment because of nonpayment of Premiums.

If you have family coverage, 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 must be enrolled in the Dental Plan and you must begin paying Premiums, if any additional are due, during that period.

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 Premiums, if any, which you would have paid if you had not taken the leave. Additional information is available through your Benefits Representative.

IV. Your Cigna Dental Coverage

The information below outlines your coverage and will help you to better understand your Dental Plan. Included is

information about which services are covered, which are not, and how much dental services will cost you. A copy of the Group Contract will be furnished to you upon your request.

A. Customer Service

If you have any questions or concerns about the Dental Plan, Customer Service Representatives are just a toll-free phone call away. They can explain your benefits or help with matters regarding your Dental Office or Dental Plan. For assistance with transfers, specialty referrals, eligibility, second opinions, emergencies, Covered Services, plan benefits, ID cards, location of Dental Offices, conversion coverage or other matters, call Customer Service from any location at 1-800-Cigna24. The hearing impaired may contact the state TTY toll-free relay service number listed in their local telephone directory.

B. Premiums

Your Group sends a monthly fee to Cigna Dental for customers participating in the Dental Plan. The amount and term of this fee is 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.

C. Other Charges – Patient Charges

Network General Dentists are typically reimbursed by Cigna Dental 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.

Your Patient Charge Schedule lists the dental procedures covered under your Dental Plan. Some dental procedures are covered at no charge to you. For other Covered Services, the Patient Charge Schedule lists the fees you must pay when you visit your Dental Office. 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 policies. Timely payment is important. It is possible that the Dental Office may add late charges to overdue balances.

Your Patient Charge Schedule is subject to annual change in accordance with your Group Contract. Cigna Dental will give written notice to your Group of any change in Patient Charges at least 60 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.

D. Choice of Dentist

You and your Dependents should have selected a Dental Office when you enrolled in the Dental Plan. If you did not, you must advise Cigna Dental of your Dental Office selection prior to receiving treatment. The benefits of the Dental Plan are available only at your Dental Office, except in the case of an emergency or when Cigna Dental otherwise authorizes payment for out-of-network benefits.

You may select a network Pediatric Dentist as the Network General Dentist for your dependent child under age 7 by calling Customer Service at 1-800-Cigna24 to get a list of network Pediatric Dentists in your Service Area or if your Network General Dentist sends your child under the age of 7 to a network Pediatric Dentist, the network Pediatric Dentist's office will have primary responsibility for your child's care. For children 7 years and older, your Network General Dentist will provide care. If your child continues to visit the Pediatric Dentist upon the age of 7, you will be fully responsible for the Pediatric Dentist's Usual Fees. Exceptions for medical reasons may be considered on a case-by-case basis.

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 will let you know and will arrange a transfer to another Dental Office. Refer to the Section titled "Office Transfers" if you wish to change your Dental Office.

To obtain a list of Dental Offices near you, visit our website at myCigna.com, or 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 Customer Service.

E. Your Payment Responsibility (General Care)

For Covered Services at your Dental Office, you will be charged the fees listed on your Patient Charge Schedule. For services listed on your Patient Charge Schedule at any other dental office, you may be charged Usual Fees. For non-Covered Services, you are responsible for paying Usual Fees.

If, on a temporary basis, there is no Network General Dentist in your Service Area, Cigna Dental 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 will pay the non-Network Dentist the difference, if

any, between his or her Usual Fee and the applicable Patient Charge.

See Section IX, *Specialty Referrals*, regarding payment responsibility for specialty care.

All contracts between Cigna Dental 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.

F. 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.

1. Emergency Care Away From Home

If you have an emergency while you are out of your Service Area or you are unable to contact your Network General Dentist, you may receive emergency Covered Services as defined above from any general dentist. Routine restorative procedures or definitive treatment (e.g. root canal) are not considered emergency care. You should return to your Network General Dentist for these procedures. For emergency Covered Services, you will be responsible for the Patient Charges listed on your Patient Charge Schedule. Cigna Dental will reimburse you the difference, if any, between the dentist's Usual Fee for emergency Covered Services and your Patient Charge, up to a total of \$50 per incident. To receive reimbursement, send appropriate reports and x-rays to Cigna Dental at the address listed for your state on the front of this booklet.

2. 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.

G. Limitations on Covered Services

Listed below are limitations on services when covered by your Dental Plan:

- **Frequency** - The frequency of certain Covered Services, like cleanings, is limited. Your Patient Charge Schedule lists any limitations on frequency.
- **Pediatric Dentistry** - Coverage for treatment by a Pediatric Dentist ends on your child's 7th birthday. Effective on your child's 7th birthday, dental services

must be obtained from a Network General Dentist; however, exceptions for medical reasons may be considered on an individual basis.

- **Oral Surgery** - The surgical removal of an impacted wisdom tooth may not be covered if the tooth is not diseased or if the removal is only for orthodontic reasons. Your Patient Charge Schedule lists any limitations on oral surgery.
- **Periodontal (gum tissue and supporting bone) Services** – Periodontal regenerative procedures are limited to one regenerative procedure per site (or per tooth, if applicable), when covered on the Patient Charge Schedule.
Localized delivery of antimicrobial agents is limited to eight teeth (or eight sites, if applicable) per 12 consecutive months, when covered on the Patient Charge Schedule.
- **Clinical Oral Evaluations** – When this limitation is noted on the Patient Charge Schedule, periodic oral evaluations, comprehensive oral evaluations, comprehensive periodontal evaluations, and oral evaluations for patients under 3 years of age are limited to a combined total of 4 evaluations during a 12 consecutive month period.
- **Surgical Placement of Implant Services** – When covered on the Patient Charge Schedule, surgical placement of a dental implant; repair, maintenance, or removal of a dental implant; implant abutment(s); or any services related to the surgical placement of a dental implant are limited to one per year with replacement of a surgical implant frequency limitation of one every 10 years.
- **Prosthesis Over Implant** – When covered on the Patient Charge Schedule, a prosthetic device, supported by an implant or implant abutment is considered a separate distinct service(s) from surgical placement of an implant. Replacement of any type of prosthesis with a prosthesis supported by an implant or implant abutment is only covered if the existing prosthesis is at least 5 calendar years old, is not serviceable and cannot be repaired.

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; if eligible for benefits under any workers' compensation act or similar law;
- for charges which would not have been made in any facility, other than a Hospital or a Correctional Institution owned or operated by the United States Government or by a state or municipal government if the person had no insurance;
- to the extent that payment is unlawful where the person resides when the expenses are incurred or the services are received;
- for the charges which the person is not legally required to pay;
- for charges which would not have been made if the person had no insurance;
- due to injuries which are intentionally self-inflicted.

H. Services Not Covered Under Your Dental Plan

Listed below are the services or expenses which are NOT covered under your Dental Plan and which are your responsibility at the dentist's Usual Fees. There is no coverage for:

- services not listed on the Patient Charge Schedule.
- services provided by a non-Network Dentist without Cigna Dental's prior approval (except emergencies, as described in Section IV.F).
- services related to an injury or illness paid under workers' compensation, occupational disease or similar laws.
- services provided or paid by or through a federal or state governmental agency or authority, political subdivision or a public program, other than Medicaid.
- services required while serving in the armed forces of any country or international authority or relating to a declared or undeclared war or acts of war.
- cosmetic dentistry or cosmetic dental surgery (dentistry or dental surgery performed solely to improve appearance) unless specifically listed on your Patient Charge Schedule. If bleaching (tooth whitening) is listed on your Patient Charge Schedule, only the use of take-home bleaching gel with trays is covered; all other types of bleaching methods are not covered.
- 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. There is no coverage for general anesthesia or intravenous sedation when used for the purposes of anxiety control or patient management.

- prescription medications.
- procedures, appliances or restorations if the main purpose is to: change vertical dimension (degree of separation of the jaw when teeth are in contact) or restore teeth which have been damaged by attrition, abrasion, erosion and/or abfraction.
- replacement of fixed and/or removable appliances (including fixed and removable orthodontic appliances) that have been lost, stolen, or damaged due to patient abuse, misuse or neglect.
- surgical placement of a dental implant; repair, maintenance, or removal of a dental implant; implant abutment(s); or any services related to the surgical placement of a dental implant, unless specifically listed on your Patient Charge Schedule.
- services considered to be unnecessary or experimental in nature or do not meet commonly accepted dental standards.
- procedures or appliances for minor tooth guidance or to control harmful habits.
- hospitalization, including any associated incremental charges for dental services performed in a hospital. (Benefits are available for Network Dentist charges for Covered Services performed at a hospital. Other associated charges are not covered and should be submitted to the medical carrier for benefit determination.)
- services to the extent you or your enrolled Dependent are compensated under any group medical plan, no-fault auto insurance policy, or uninsured motorist policy. Kentucky residents: Services compensated under no-fault auto insurance policies or uninsured motorist policies are not excluded.
- the completion of crowns, bridges, dentures, or root canal treatment already in progress on the effective date of your Cigna Dental coverage.
- the completion of implant supported prosthesis (including crowns, bridges and dentures) already in progress on the effective date of your Cigna Dental coverage, unless specifically listed on your Patient Charge Schedule.
- consultations and/or evaluations associated with services that are not covered.
- endodontic treatment and/or periodontal (gum tissue and supporting bone) surgery of teeth exhibiting a poor or hopeless periodontal prognosis.
- bone grafting and/or guided tissue regeneration when performed at the site of a tooth extraction unless specifically listed on your Patient Charge Schedule.
- bone grafting and/or guided tissue regeneration when performed in conjunction with an apicoectomy or periradicular surgery.
- intentional root canal treatment in the absence of injury or disease to solely facilitate a restorative procedure.
- services performed by a prosthodontist.
- localized delivery of antimicrobial agents when performed alone or in the absence of traditional periodontal therapy.
- any localized delivery of antimicrobial agent procedures when more than eight (8) of these procedures are reported on the same date of service.
- infection control and/or sterilization. Cigna Dental considers this to be incidental to and part of the charges for services provided and not separately chargeable.
- the recementation of any inlay, onlay, crown, post and core, or fixed bridge within 180 days of initial placement. Cigna Dental considers recementation within this timeframe to be incidental to and part of the charges for the initial restoration.
- the recementation of any implant supported prosthesis (including crowns, bridges and dentures) within 180 days of initial placement. Cigna Dental considers recementation within this timeframe to be incidental to and part of the charges for the initial restoration unless specifically listed on your Patient Charge Schedule.
- services to correct congenital malformations, including the replacement of congenitally missing teeth.
- the replacement of an occlusal guard (night guard) beyond one per any 24 consecutive month period, when this limitation is noted on the Patient Charge Schedule.
- crowns and bridges used solely for splinting.
- resin bonded retainers and associated pontics.

Pre-existing conditions are not excluded if the procedures involved are otherwise covered under your Patient Charge Schedule.

Should any law require coverage for any particular service(s) noted above, the exclusion or limitation for that service(s) shall not apply.

V. Appointments

To make an appointment with your Network Dentist, call the Dental Office that you have selected. When you call, your



Dental Office will ask for your identification number and will check your eligibility.

VI. Broken Appointments

The time your Network Dentist schedules for your appointment is valuable to you and the dentist. Broken appointments make it difficult for your Dental Office to schedule time with other patients.

If you or your enrolled Dependent breaks an appointment with less than 24 hours notice to the Dental Office, you may be charged a broken appointment fee.

VII. Office Transfers

If you decide to change Dental Offices, we can arrange a transfer. You should complete any dental procedure in progress before transferring to another Dental Office. To arrange a transfer, call Customer Service at 1-800-Cigna24. To obtain a list of Dental Offices near you, visit our website at myCigna.com, or call the Dental Office Locator at 1-800-Cigna24.

Your transfer request will take about 5 days to process. Transfers will be effective the first day of the month after the processing of your request. Unless you have an emergency, you will be unable to schedule an appointment at the new Dental Office until your transfer becomes effective.

There is no charge to you for the transfer; however, all Patient Charges which you owe to your current Dental Office must be paid before the transfer can be processed.

VIII. 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 Network includes the following types of specialty dentists:

- 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 Specialty Dentist.

See Section IV.D, *Choice of Dentist*, regarding treatment by a Pediatric Dentist.

IX. Specialty Referrals

A. In General

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

When Cigna Dental authorizes payment to the Network Specialty Dentist, 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 IX.B., *Orthodontics*. Treatment by the Network Specialty Dentist must begin within 90 days from the date of Cigna Dental’s authorization. If you are unable to obtain treatment within the 90 day period, please call Customer Service to request an extension. Your coverage must be in effect when each procedure begins.

For non-Covered Services or if Cigna Dental does not authorize payment to the Network Specialty Dentist for Covered Services, including Adverse Determinations, you must pay the Network Specialty Dentist’s Usual Fee. If you have a question or concern regarding an authorization or a denial, contact Customer Service.

After the Network Specialty Dentist has completed treatment, you should return to your Network General Dentist for cleanings, regular checkups and other treatment. If you visit a Network Specialty Dentist without a referral or if you continue to see a Network Specialty Dentist 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 Specialty Dentist is not available, as determined by Cigna Dental, Cigna Dental will authorize a referral to a non-Network Specialty Dentist. 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 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.

B. Orthodontics (This section is applicable only when Orthodontics is listed on your Patient Charge Schedule.)

1. Definitions – If your Patient Charge Schedule indicates coverage for orthodontic treatment, the following definitions apply:

- a. **Orthodontic Treatment Plan and Records** – the preparation of orthodontic records and a treatment plan by the Orthodontist.
- b. **Interceptive Orthodontic Treatment** – treatment prior to full eruption of the permanent teeth, frequently a first phase preceding comprehensive treatment.
- c. **Comprehensive Orthodontic Treatment** – treatment after the eruption of most permanent teeth, generally the final phase of treatment before retention.
- d. **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.

2. Patient Charges

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. However, if 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, 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.

3. Additional Charges

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

- a. incremental costs associated with optional/elective materials, including but not

limited to ceramic, clear, lingual brackets, or other cosmetic appliances;

- b. orthognathic surgery and associated incremental costs;
- c. appliances to guide minor tooth movement;
- d. appliances to correct harmful habits; and
- e. services which are not typically included in Orthodontic Treatment. These services will be identified on a case-by-case basis.

4. Orthodontics In Progress

If Orthodontic Treatment is in progress for you or your Dependent at the time you enroll, the fee listed on the Patient Charge Schedule is not applicable. Please call Customer Service at 1-800-Cigna24 to find out if you are entitled to any benefit under the Dental Plan.

X. Complex Rehabilitation/Multiple Crown Units

Complex rehabilitation is extensive dental restoration involving 6 or more "units" of crown, bridge and/or implant supported prosthesis (including crowns and bridges) in the same treatment plan. Using full crowns (caps), fixed bridges and/or implant supported prosthesis (including crowns and 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 the 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, bridge and/or implant supported prosthesis (including crowns and bridges) 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, bridge and/or implant supported prosthesis (including crowns and bridges) PLUS an additional charge for each unit when 6 or more units are prescribed in your Network General Dentist's treatment plan.

Note: Complex rehabilitation only applies for implant supported prosthesis, when implant supported prosthesis are specifically listed on your Patient Charge Schedule.

XI. 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 dentist designated by you to act on your behalf. **Time frames or requirements may vary depending on the laws in your State.**

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.

A. Start with Customer Service

We are here to listen and to help. If you have a concern about your Dental Office or the Dental Plan, you can call 1-800-Cigna24 toll-free and explain your concern to one of our Customer Service Representatives. You can also express that concern in writing to Cigna Dental, P.O. Box 188047, Chattanooga, TN 37422-8047. We will do our best to resolve the matter during your initial contact. If we need more time to review or investigate your concern, we will get back to you as soon as possible, usually by the end of the next business day, but in any case within 30 days.

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

B. Appeals Procedure

Cigna Dental has a one-step appeals procedure for coverage decisions. To initiate an appeal, you must submit a request in writing to Cigna Dental, P.O. Box 188047, Chattanooga, TN 37422-8047, within 1 year from the date of the initial Cigna Dental decision. You should state the reason you feel your appeal should be approved and include any information to support your appeal. If you are unable or choose not to write, you may ask Customer Service to register your appeal by calling 1-800-Cigna24.

A customer is entitled to an internal appeal and can be attained with respect to the denial, reduction, or termination of a plan or the denial of a claim for a health care service in accordance with KRS 304.17C-030(2)(g)(2). A customer, authorized person, or dentist acting on behalf of the customer may request an internal appeal within at least 1 year of receipt of a notice of the initial decision made by Cigna Dental. Cigna Dental will provide a written internal appeal determination within thirty (30) days following receipt of a request for an internal appeal.

1. Level-One Appeals

Your level-one appeal will be reviewed and the decision made by someone not involved in the initial review. Appeals involving dental necessity or clinical appropriateness will be reviewed by a dental professional.

If your appeal concerns a denied pre-authorization, we will respond with a decision within 15 calendar days after we receive your appeal. For appeals concerning all other coverage issues, we will respond with a decision within 30 calendar days after we receive your appeal. If we need more information to make your level-one appeal decision, we will notify you in writing to request an extension of up to 15 calendar days and to specify any additional information needed to complete the review.

You may request that the 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, Cigna Dental will respond orally with a decision within 72 hours, followed up in writing.

If you are not satisfied with our level-one appeal decision, you may request a level-two appeal.

2. Independent Review Procedure

The independent review procedure is a voluntary program arranged by the Dental Plan and is not available in all areas.

3. Appeals to the State

You have a right to contact the Kentucky Department of Insurance by sending to P.O. Box 517, Frankfort, KY 40602-0517 or toll free 1.800.648.6056.

Cigna Dental will not cancel or refuse to renew your coverage because you or your Dependent has filed a complaint or an appeal involving a decision made by Cigna Dental. You have the right to file suit in a court of law for any claim involving the professional treatment performed by a dentist.

XII. Dual Coverage

You and your Dependents may not be covered twice under this Dental Plan. If you and your spouse have enrolled each



other or the same Dependents twice, please contact your Benefit Administrator.

If you or your Dependents have dental coverage through your spouse's employer or other sources such as an HMO or similar dental plan, 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.

Coordination of benefit rules are attached to the Group Contract and may be reviewed by contacting your Benefit Administrator. Cigna Dental coordinates benefits only for specialty care services.

XIII. Disenrollment From the Dental Plan – Termination of Benefits

A. Time Frames for Disenrollment/Termination

Except as otherwise provided in the sections titled "Extension/Continuation of Benefits" or in your Group Contract, disenrollment from the Dental Plan and termination of benefits will occur on the last day of the month:

1. in which Premiums are not remitted to Cigna Dental.
2. in which eligibility requirements are no longer met.
3. after 30 days notice from Cigna Dental due to permanent breakdown of the dentist-patient relationship as determined by Cigna Dental, after at least two opportunities to transfer to another Dental Office.
4. after 30 days notice from Cigna Dental due to fraud or misuse of dental services and/or Dental Offices.
5. after 60 days notice by Cigna Dental, due to continued lack of a Dental Office in your Service Area.
6. after voluntary disenrollment.

B. Effect on Dependents

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.

XIV. Extension of Benefits

Coverage for completion of a dental procedure (other than orthodontics) which was started before your disenrollment from the Dental Plan will be extended for 90 days after disenrollment unless disenrollment was due to nonpayment of Premiums.

Coverage for orthodontic treatment which was started before disenrollment from the Dental Plan will be extended to the end of the quarter or for 60 days after disenrollment, whichever is later, unless disenrollment was due to nonpayment of Premiums.

XV. Continuation of Benefits (COBRA)

For Groups with 20 or more employees, federal law requires the employer to offer continuation of benefits coverage for a specified period of time after termination of employment or reduction of work hours, for any reason other than gross misconduct. You will be responsible for sending payment of the required Premiums to the Group. Additional information is available through your Benefits Representative.

XVI. Conversion Coverage

If you are no longer eligible for coverage under your Group's Dental Plan, you and your enrolled Dependents may continue your dental coverage by enrolling in the Cigna Dental conversion plan. You must enroll within three (3) months after becoming ineligible for your Group's Dental Plan. Premium payments and coverage will be retroactive to the date coverage under your Group's Dental Plan ended. You and your enrolled Dependents are eligible for conversion coverage unless benefits were discontinued due to:

- Permanent breakdown of the dentist-patient relationship,
- Fraud or misuse of dental services and/or Dental Offices,
- Nonpayment of Premiums by the Subscriber,
- Selection of alternate dental coverage by your Group, or
- Lack of network/Service Area.

Benefits and rates for Cigna Dental conversion coverage and any succeeding renewals will be based on the Covered Services listed in the then-current standard conversion plan and 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.



XVII. Confidentiality/Privacy

Cigna Dental is committed to maintaining the confidentiality of your personal and sensitive information. Information about Cigna Dental's confidentiality policies and procedures is made available to you during the enrollment process and/or as part of your customer plan materials. You may obtain additional information about Cigna Dental's confidentiality policies and procedures by calling Customer Service at 1-800-Cigna24, or via the Internet at myCigna.com.

XVIII. Miscellaneous

As a Cigna Dental plan customer, you may be eligible for various discounts, benefits, or other consideration for the purpose of promoting your general health and well being. Please visit our website at myCigna.com for details.

If you are a Cigna Dental Care customer, you may also be eligible for additional dental benefits during certain health conditions. For example, certain frequency limitations for dental services may be relaxed for pregnant women and customers participating in certain disease management programs. Please review your plan enrollment materials for details.

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State Amendment Cigna Dental Health of Kentucky, Inc. (Illinois)

P.O. Box 453099
Sunrise, Florida 33345-3099

Illinois Residents:

This State Amendment contains information that either replaces, or is in addition to, information contained in your Plan Booklet.

The following information is added (by means of this insert) to your Plan Booklet:

I. Definitions:

- The Religious Freedom Protection and Civil Union Act, 750 ILCS 75, allows both same-sex and different-sex couples to enter into a civil union with all the obligations, protections, and legal rights, that Illinois provides to married heterosexual couples. The definition of "Dependent" is amended to include civil union partners and a child acquired through a civil union who meets the eligibility requirements outlined in your Plan Booklet.

Dependent - your lawful spouse, or your Domestic Partner;

Your unmarried child (including newborns, adopted children, stepchildren, a child for whom you must provide dental coverage under a court order; or, a dependent child who resides in your home as a result of court order or administrative placement) who is:

- (a) less than 19 years old; or
- (b) less than 23 years old if he or she is both:
 - i. a full-time student enrolled at an accredited educational institution, and
 - ii. reliant upon you for maintenance and support; or
- (c) any age if he or she is both:
 - i. incapable of self-sustaining employment due to mental or physical disability, and
 - ii. reliant upon you for maintenance and support.

For a dependent child 23 years of age or older who is a full-time student at an educational institution, coverage will be provided for an entire academic term during which the child begins as a full-time student and remains enrolled, regardless of whether the number of hours of instruction for which the child is enrolled is reduced to a level that changes the child's academic status to less than that of a full-time student.

IV. Your Cigna Dental Coverage

H. Services Not Covered Under Your Dental Plan

Illinois Residents: This exclusion does not apply to your Plan.

- services to the extent you or your enrolled Dependent are compensated under any group medical plan, no-fault auto insurance policy, or uninsured motorist policy.

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Benefit Rider

Cigna Dental Companies

Cigna Dental Health of Kentucky, Inc. (Kentucky and Illinois)

P.O. Box 453099
Sunrise, Florida 33345-3099



This State Rider is attached to and made part of your Plan Booklet/Evidence of Coverage and replaces the following provisions:

D. Choice of Dentist

You and your Dependents should have selected a Dental Office when you enrolled in the Dental Plan. If you did not, you must advise Cigna Dental of your Dental Office selection prior to receiving treatment. The benefits of the Dental Plan are available only at your Dental Office, except in the case of an emergency or when Cigna Dental otherwise approves payment for out-of-network benefits.

You may select a network Pediatric Dentist as the Network General Dentist for your dependent child under age 13 by calling Customer Service at 1.800.Cigna24 to get a list of network Pediatric Dentists in your Service Area or if your Network General Dentist sends your child under age 13 to a network Pediatric Dentist, the network Pediatric Dentist's office will have primary responsibility for your child's care. For children 13 years and older, your Network General Dentist will provide care. If your child continues to visit the Pediatric Dentist upon the age of 13, you will be fully responsible for the Pediatric Dentist's Usual Fees. Exceptions for medical reasons may be considered on a case-by-case basis.

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 will let you know and will arrange a transfer to another Dental Office. Refer to the Section titled "Office Transfers" if you wish to change your Dental Office.

To obtain a list of Dental Offices near you, visit our website at my.cigna.com, or 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 Customer Service.

F. Emergency Dental Care - Reimbursement

1. Emergency Care Away From Home

If you have an emergency while you are out of your Service Area or you are unable to contact your Network General Dentist, you may receive emergency Covered Services as defined above from any general dentist. Routine restorative procedures or definitive treatment (e.g. root canal) are not considered emergency care. You should return to your Network General Dentist for these procedures. For emergency Covered Services, you will be responsible for the

Patient Charges listed on your Patient Charge Schedule. Cigna Dental will reimburse you the difference, if any, between the dentist's Usual Fee for emergency Covered Services and your Patient Charge. To receive reimbursement, send appropriate reports and x-rays to Cigna Dental at the address listed for your state on the front of this booklet.

G. Limitations On Covered Services

Listed below are limitations on services when covered by your Dental Plan:

- **Pediatric Dentistry** - Coverage for treatment by a Pediatric Dentist ends on your child's 13th birthday. Effective on your child's 13th birthday, dental services must be obtained from a Network General Dentist however, exceptions for medical reasons may be considered on an individual basis.

VII. Office Transfers

If you decide to change Dental Offices, we can arrange a transfer. You should complete any dental procedure in progress before transferring to another Dental Office. To arrange a transfer, call Customer Service at 1.800.Cigna24. To obtain a list of Dental Offices near you, visit our website at my.cigna.com, or call the Dental Office Locator at 1.800.Cigna24.

Your transfer request may take up to 5 days to process. Transfers will be effective the first day of the month after the processing of your request. Unless you have an emergency, you will be unable to schedule an appointment at the new Dental Office until your transfer becomes effective. You can check the status of your request by visiting myCigna.com, or by calling us at 1.800.Cigna24.

There is no charge to you for the transfer; however, all Patient Charges which you owe to your current Dental Office must be paid before the transfer can be processed.

IX. SPECIALTY REFERRALS

A. IN GENERAL

Preauthorization is not required for coverage of services by a Network Specialty Dentist.

When Cigna Dental approves payment to the Network Specialty Dentist, 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 IX.B., Orthodontics. Treatment by the Network Specialty Dentist must begin within 90 days from the date of Cigna Dental's approval. If you are unable to obtain treatment



within the 90 day period, please call Customer Service to request an extension. Your coverage must be in effect when each procedure begins.

For non-Covered Services or if Cigna Dental does not approve payment to the Network Specialty Dentist for Covered Services, including Adverse Determinations, you must pay the Network Specialty Dentist's Usual Fee. If you have a question or concern regarding an approval or a denial, contact Customer Service.

After the Network Specialty Dentist has completed treatment, you should return to your Network General Dentist for cleanings, regular checkups and other treatment. If you visit a Network Specialty Dentist without a referral or if you continue to see a Network Specialty Dentist 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 Specialty Dentist is not available, as determined by Cigna Dental, Cigna Dental will approve a referral to a non-Network Specialty Dentist. 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 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 approved for payment, including Adverse Determinations, you must pay the dentist's Usual Fee.



Cigna Dental Health of Missouri, Inc.

**P.O. Box 453099
Sunrise, Florida 33345-3099**

This Plan Booklet/Combined Evidence of Coverage and Disclosure Form/Certificate of Coverage is intended for your information; it constitutes a summary of the Dental Plan and is included as a part of the agreement between Cigna Dental and your Group (collectively, the "Group Contract"). The Group Contract must be consulted to determine the rates and the exact terms and conditions of coverage. If rates or coverages are changed under your Group Contract, your rates and coverage will also change. A prospective customer has the right to view the Combined Evidence of Coverage and Disclosure Form prior to enrollment. It should be read completely and carefully. Customers with special health care needs should read carefully those sections that apply to them. Please read the following information so you will know from whom or what group of dentists dental care may be obtained.

NOTICE: IF YOU OR YOUR FAMILY MEMBERS ARE COVERED BY MORE THAN ONE HEALTH CARE PLAN, YOU MAY NOT BE ABLE TO COLLECT BENEFITS FROM BOTH PLANS. EACH PLAN MAY REQUIRE YOU TO FOLLOW ITS RULES OR USE SPECIFIC DOCTORS OR HOSPITALS, AND IT MAY BE IMPOSSIBLE TO COMPLY WITH BOTH PLANS AT THE SAME TIME. READ ALL OF THE RULES VERY CAREFULLY, INCLUDING THE DUAL COVERAGE SECTION.

Important Cancellation Information – Please Read the Provision Entitled "Disenrollment from the Dental Plan–Termination of Benefits."

READ YOUR PLAN BOOKLET CAREFULLY

Please call Customer Service 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.



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I. Definitions

Capitalized terms, unless otherwise defined, have the meanings listed below.

Adverse Determination - a decision by Cigna Dental 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 customer or dentist 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 authorizations that are declined by Cigna Dental based upon the above criteria will be the responsibility of the customer at the dentist's Usual Fees. A licensed dentist will make any such denial.

Cigna Dental - 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 Dentist agreement with Cigna Dental.

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

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

Dental Plan - managed dental care plan offered through the Group Contract between Cigna Dental and your Group.

Dependent - your lawful spouse, or your Domestic Partner; your unmarried child (including newborns, adopted children, stepchildren, a child for whom you must provide dental coverage under a court order; or, a dependent child who resides in your home as a result of court order or administrative placement) who is:

- (a) less than 19 years old; or
- (b) no more than 25 years old if he or she is both:
 - i. a resident of Missouri, and
 - ii. not provided coverage as a named subscriber, insured, enrollee, or covered person under any group or individual health benefit plan, or entitled to

benefits under Title XVIII of the Social Security Act; or

- (c) any age if he or she is both:
 - i. incapable of self-sustaining employment due to mental or physical disability, and
 - ii. reliant upon you for maintenance and support.

For a dependent child 19 years of age or older who is a full-time student at an educational institution, coverage will be provided for an entire academic term during which the child begins as a full-time student and remains enrolled, regardless of whether the number of hours of instruction for which the child is enrolled is reduced to a level that changes the child's academic status to less than that of a full-time student.

A Newly Acquired Dependent is a dependent child who is adopted, born, or otherwise becomes your dependent after you become covered under the Plan.

Coverage for dependents living outside a Cigna Dental service area is subject to the availability of an approved network where the dependent resides.

Group - employer, labor union or other organization that has entered into a Group Contract with Cigna Dental for managed dental services on your behalf.

Network Dentist - a licensed dentist who has signed an agreement with Cigna Dental 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 - a licensed dentist who has signed an agreement with Cigna Dental under which he or she agrees to provide dental care services to you.

Network Specialty Dentist - a licensed dentist who has signed an agreement with Cigna Dental under which he or she agrees to provide specialized dental care services to you.

Patient Charge - the amount you owe your Network Dentist for any dental procedure listed on your Patient Charge Schedule.

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

Premiums - fees that your Group remits to Cigna Dental, on your behalf, during the term of your Group Contract.

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

Subscriber/You - the enrolled employee or customer of the Group.



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

II. Introduction To Your Cigna Dental Plan

Welcome to the Cigna Dental Plan. We encourage you to use your dental benefits. Please note that enrollment in the Dental Plan allows the release of patient records to Cigna Dental or its designee for health plan operation purposes.

III. Eligibility/When Coverage Begins

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

If you enrolled in the Dental Plan before the effective date of your Group Contract, you will be covered on the first day the Group Contract is effective. If you enrolled in the Dental Plan after the effective date of the Group Contract, you will be covered on the first day of the month following processing of your enrollment (unless effective dates other than the first day of the month are provided for in your Group Contract).

Dependents may be enrolled in the Dental Plan at the time you enroll, during an open enrollment, or within 31 days of becoming eligible due to a life status change such as marriage, birth, adoption, placement, or court or administrative order. You may drop coverage for your Dependents only during the open enrollment periods for your Group, unless there is a change in status such as divorce. Cigna Dental may require evidence of good dental health at your expense if you or your Dependents enroll after the first period of eligibility (except during open enrollment) or after disenrollment because of nonpayment of Premiums.

If you have family coverage, 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 must be enrolled in the Dental Plan and you must begin paying Premiums, if any additional are due, during that period.

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 Premiums, if any, which you would have paid if you had not taken the leave. Additional information is available through your Benefits Representative.

IV. Your Cigna Dental Coverage

The information below outlines your coverage and will help you to better understand your Dental Plan. Included is information about which services are covered, which are not, and how much dental services will cost you. A copy of the Group Contract will be furnished to you upon your request.

A. Customer Service

If you have any questions or concerns about the Dental Plan, Customer Service Representatives are just a toll-free phone call away. They can explain your benefits or help with matters regarding your Dental Office or Dental Plan. For assistance with transfers, specialty referrals, eligibility, second opinions, emergencies, Covered Services, plan benefits, ID cards, location of Dental Offices, conversion coverage or other matters, call Customer Service from any location at 1-800-Cigna24. The hearing impaired may contact the state TTY toll-free relay service number listed in their local telephone directory.

B. Premiums

Your Group sends a monthly fee to Cigna Dental for customers participating in the Dental Plan. The amount and term of this fee is 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.

C. Other Charges – Patient Charges

Network General Dentists are typically reimbursed by Cigna Dental 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.

Your Patient Charge Schedule lists the dental procedures covered under your Dental Plan. Some dental procedures are covered at no charge to you. For other Covered Services, the Patient Charge Schedule lists the fees you must pay when you visit your Dental Office. 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 policies. Timely payment is important. It is possible that the Dental Office may add late charges to overdue balances.



Your Patient Charge Schedule is subject to annual change in accordance with your Group Contract. Cigna Dental will give written notice to your Group of any change in Patient Charges at least 60 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.

D. Choice Of Dentist

You and your Dependents should have selected a Dental Office when you enrolled in the Dental Plan. If you did not, you must advise Cigna Dental of your Dental Office selection prior to receiving treatment. The benefits of the Dental Plan are available only at your Dental Office, except in the case of an emergency or when Cigna Dental otherwise approves payment for out-of-network benefits.

You may select a network Pediatric Dentist as the Network General Dentist for your dependent child under age 13 by calling Customer Service at 1-800-Cigna24 to get a list of network Pediatric Dentists in your Service Area or if your Network General Dentist sends your child under the age of 13 to a network Pediatric Dentist, the network Pediatric Dentist's office will have primary responsibility for your child's care. For children 13 years and older, your Network General Dentist will provide care. If your child continues to visit the Pediatric Dentist upon the age of 13, you will be fully responsible for the Pediatric Dentist's Usual Fees. Exceptions for medical reasons may be considered on a case-by-case basis.

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 will let you know and will arrange a transfer to another Dental Office. Refer to the Section titled "Office Transfers" if you wish to change your Dental Office.

To obtain a list of Dental Offices near you, visit our website at myCigna.com, or 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 Customer Service.

E. Your Payment Responsibility (General Care)

For Covered Services at your Dental Office, you will be charged the fees listed on your Patient Charge Schedule. For services listed on your Patient Charge Schedule at any other dental office, you may be charged Usual Fees. For non-Covered Services, you are responsible for paying Usual Fees.

If, on a temporary basis, there is no Network General Dentist in your Service Area, Cigna Dental 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 will pay the non-Network Dentist the difference, if any, between his or her Usual Fee and the applicable Patient Charge.

See Section IX, *Specialty Referrals*, regarding payment responsibility for specialty care.

All contracts between Cigna Dental 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.

F. 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.

• Emergency Care Away From Home

If you have an emergency while you are out of your Service Area or you are unable to contact your Network General Dentist, you may receive emergency Covered Services as defined above from any general dentist. Routine restorative procedures or definitive treatment (e.g. root canal) are not considered emergency care. You should return to your Network General Dentist for these procedures. For emergency Covered Services, you will be responsible for the Patient Charges listed on your Patient Charge Schedule. Cigna Dental will reimburse you the difference, if any, between the dentist's Usual Fee for emergency Covered Services and your Patient Charge, up to a total of \$50 per incident. To receive reimbursement, send appropriate reports and x-rays to Cigna Dental at the address listed for your state on the front of this booklet.

• 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.

G. Limitations On Covered Services

Listed below are limitations on services when covered by your Dental Plan:

- **Frequency** - The frequency of certain Covered Services, like cleanings, is limited. Your Patient Charge Schedule lists any limitations on frequency.
- **Pediatric Dentistry** - Coverage for treatment by a Pediatric Dentist ends on your child's 13th birthday. Effective on your child's 13th birthday, dental services must be obtained from a Network General Dentist however, exceptions for medical reasons may be considered on an individual basis.
- **Oral Surgery** - The surgical removal of an impacted wisdom tooth may not be covered if the tooth is not diseased or if the removal is only for orthodontic reasons. Your Patient Charge Schedule lists any limitations on oral surgery.
- **Periodontal (gum tissue and supporting bone) Services** – Periodontal regenerative procedures are limited to one regenerative procedure per site (or per tooth, if applicable), when covered on the Patient Charge Schedule.

Localized delivery of antimicrobial agents is limited to eight teeth (or eight sites, if applicable) per 12 consecutive months, when covered on the Patient Charge Schedule.
- **Clinical Oral Evaluations** – When this limitation is noted on the Patient Charge Schedule, periodic oral evaluations, comprehensive oral evaluations, comprehensive periodontal evaluations, and oral evaluations for patients under 3 years of age are limited to a combined total of 4 evaluations during a 12 consecutive month period.
- **Surgical Placement of Implant Services** – When covered on the Patient Charge Schedule, surgical placement of a dental implant; repair, maintenance, or removal of a dental implant; implant abutment(s); or any services related to the surgical placement of a dental implant are limited to one per year with replacement of a surgical implant frequency limitation of one every 10 years.
- **Prosthesis Over Implant** – When covered on the Patient Charge Schedule, a prosthetic device, supported by an implant or implant abutment is considered a separate distinct service(s) from surgical placement of an implant. Replacement of any type of prosthesis with a prosthesis supported by an implant or implant abutment is only covered if the existing prosthesis is at least 5 calendar years old, is not serviceable and cannot be repaired.

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 charges which would not have been made in any facility, other than a Hospital or a Correctional Institution owned or operated by the United States Government or by a state or municipal government if the person had no insurance;
- to the extent that payment is unlawful where the person resides when the expenses are incurred or the services are received;
- for the charges which the person is not legally required to pay;
- for charges which would not have been made if the person had no insurance;
- due to injuries which are intentionally self-inflicted.

H. Services Not Covered Under Your Dental Plan

Listed below are the services or expenses which are NOT covered under your Dental Plan and which are your responsibility at the dentist's Usual Fees. There is no coverage for:

- services not listed on the Patient Charge Schedule.
- services provided by a non-Network Dentist without Cigna Dental's prior approval (except emergencies, as described in Section IV.F).
- services related to an injury or illness paid under workers' compensation, occupational disease or similar laws.
- services provided or paid by or through a federal or state governmental agency or authority, political subdivision or a public program, other than Medicaid.
- services required while serving in the armed forces of any country or international authority or relating to a declared or undeclared war or acts of war.
- cosmetic dentistry or cosmetic dental surgery (dentistry or dental surgery performed solely to improve appearance) unless specifically listed on your Patient Charge Schedule. If bleaching (tooth whitening) is listed on your Patient Charge Schedule, only the use of take-home bleaching gel with trays is covered; all other types of bleaching methods are not covered.
- 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. There is no coverage for general anesthesia or intravenous sedation when used for the purposes of anxiety control or patient management.

- prescription medications.
- procedures, appliances or restorations if the main purpose is to: change vertical dimension (degree of separation of the jaw when teeth are in contact) or restore teeth which have been damaged by attrition, abrasion, erosion and/or abfraction.
- replacement of fixed and/or removable appliances (including fixed and removable orthodontic appliances) that have been lost, stolen, or damaged due to patient abuse, misuse or neglect.
- surgical placement of a dental implant; repair, maintenance, or removal of a dental implant; implant abutment(s); or any services related to the surgical placement of a dental implant, unless specifically listed on your Patient Charge Schedule.
- services considered to be unnecessary or experimental in nature or do not meet commonly accepted dental standards.
- procedures or appliances for minor tooth guidance or to control harmful habits.
- hospitalization, including any associated incremental charges for dental services performed in a hospital. (Benefits are available for Network Dentist charges for Covered Services performed at a hospital. Other associated charges are not covered and should be submitted to the medical carrier for benefit determination.)
- the completion of crowns, bridges, dentures or root canal treatment already in progress on the effective date of your Cigna Dental coverage.
- the completion of implant supported prosthesis (including crowns, bridges and dentures) already in progress on the effective date of your Cigna Dental coverage, unless specifically listed on your Patient Charge Schedule.
- endodontic treatment and/or periodontal (gum tissue and supporting bone) surgery of teeth exhibiting a poor or hopeless periodontal prognosis.
- bone grafting and/or guided tissue regeneration when performed at the site of a tooth extraction, unless specifically listed on your Patient Charge Schedule.
- bone grafting and/or guided tissue regeneration when performed in conjunction with an apicoectomy or periradicular surgery.
- intentional root canal treatment in the absence of injury or disease to solely facilitate a restorative procedure.
- services performed by a prosthodontist.
- localized delivery of antimicrobial agents when performed alone or in the absence of traditional periodontal therapy.
- any localized delivery of antimicrobial agent procedures when more than eight (8) of these procedures are reported on the same date of service.
- infection control and/or sterilization. Cigna Dental considers this to be incidental to and part of the charges for services provided and not separately chargeable.
- the recementation of any inlay, onlay, crown, post and core or fixed bridge within 180 days of initial placement. Cigna Dental considers recementation within this timeframe to be incidental to and part of the charges for the initial restoration.
- the recementation of any implant supported prosthesis (including crowns, bridges and dentures) within 180 days of initial placement. Cigna Dental considers recementation within this timeframe to be incidental to and part of the charges for the initial restoration unless specifically listed on your Patient Charge Schedule.
- services to correct congenital malformations, including the replacement of congenitally missing teeth.
- the replacement of an occlusal guard (night guard) beyond one per any 24 consecutive month period, when this limitation is noted on the Patient Charge Schedule.
- crowns, bridges and/or implant supported prosthesis used solely for splinting.
- resin bonded retainers and associated pontics.

Pre-existing conditions are not excluded if the procedures involved are otherwise covered under your Patient Charge Schedule.

Should any law require coverage for any particular service(s) noted above, the exclusion or limitation for that service(s) shall not apply.

V. Appointments

To make an appointment with your Network Dentist, call the Dental Office that you have selected. When you call, your Dental Office will ask for your identification number and will check your eligibility.

VI. Broken Appointments

The time your Network Dentist schedules for your appointment is valuable to you and the dentist. Broken appointments make it difficult for your Dental Office to schedule time with other patients.

If you or your enrolled Dependent breaks an appointment with less than 24 hours notice to the Dental Office, you may be charged a broken appointment fee.

VII. Office Transfers

If you decide to change Dental Offices, we can arrange a transfer. You should complete any dental procedure in progress before transferring to another Dental Office. To arrange a transfer, call Customer Service at 1-800-Cigna24. To obtain a list of Dental Offices near you, visit our website at myCigna.com, or call the Dental Office Locator at 1-800-Cigna24.

Your transfer request may take up to 5 days to process. Transfers will be effective the first day of the month after the processing of your request. Unless you have an emergency, you will be unable to schedule an appointment at the new Dental Office until your transfer becomes effective. You can check the status of your request by visiting myCigna.com, or by calling us at 1-800-Cigna24.

There is no charge to you for the transfer; however, all Patient Charges which you owe to your current Dental Office must be paid before the transfer can be processed.

VIII. 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 Network includes the following types of specialty dentists:

- 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 Specialty Dentist.

See Section IV.D, *Choice of Dentist*, regarding treatment by a Pediatric Dentist.

IX. Specialty Referrals

A. In General

Preauthorization is not required for coverage of services by a Network Specialty Dentist.

When Cigna Dental approves payment to the Network Specialty Dentist, 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 IX.B., Orthodontics. Treatment by the Network Specialty Dentist must begin within 90 days from the date of Cigna Dental's approval. If you are unable to obtain treatment within the 90 day period, please call Customer Service to request an extension. Your coverage must be in effect when each procedure begins.

For non-Covered Services or if Cigna Dental does not approve payment to the Network Specialty Dentist for Covered Services, including Adverse Determinations, you must pay the Network Specialty Dentist's Usual Fee. If you have a question or concern regarding an approval or a denial, contact Customer Service.

After the Network Specialty Dentist has completed treatment, you should return to your Network General Dentist for cleanings, regular checkups and other treatment. If you visit a Network Specialty Dentist without a referral or if you continue to see a Network Specialty Dentist 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 Specialty Dentist is not available, as determined by Cigna Dental, Cigna Dental will approve a referral to a non-Network Specialty Dentist. 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 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 approved for payment, including Adverse Determinations, you must pay the dentist's Usual Fee.

B. Orthodontics (This section is applicable only when Orthodontics is listed on your Patient Charge Schedule.)

Definitions – If your Patient Charge Schedule indicates coverage for orthodontic treatment, 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.

Patient Charges

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. However, if 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, 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, the fee listed on the Patient Charge Schedule is not applicable. Please call Customer Service at 1-800-Cigna24 to find out if you are entitled to any benefit under the Dental Plan.

X. Complex Rehabilitation/Multiple Crown Units

Complex rehabilitation is extensive dental restoration involving 6 or more "units" of crown, bridge and/or implant supported prosthesis (including crowns and bridges) in the same treatment plan. Using full crowns (caps), fixed bridges and/or implant supported prosthesis (including crowns and 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 the 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, bridge and/or implant supported prosthesis (including crowns and bridges) 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, bridge and/or implant supported prosthesis (including crowns and bridges) PLUS an additional charge for each unit when 6 or more units are prescribed in your Network General Dentist's treatment plan.

Note: Complex rehabilitation only applies for implant supported prosthesis, when implant supported prosthesis are specifically listed on your Patient Charge Schedule.

XI. 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 dentist designated by you to act on your behalf. **Time frames or requirements may vary depending on the laws in your State. Consult your State Rider for further details.**

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.



A. Start with Customer Service

We are here to listen and to help. If you have a concern about your Dental Office or the Dental Plan, you can call 1-800-Cigna24 toll-free and explain your concern to one of our Customer Service Representatives. You can also express that concern in writing to Cigna Dental, P.O. Box 188047, Chattanooga, TN 37422-8047. We will do our best to resolve the matter during your initial contact. If we need more time to review or investigate your concern, we will get back to you as soon as possible, usually by the end of the next business day, but in any case within 30 days.

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

B. Appeals Procedure

Cigna Dental has a two-step appeals procedure for coverage decisions. To initiate an appeal, you must submit a request in writing to Cigna Dental, P.O. Box 188047, Chattanooga, TN 37422-8047, within 1 year from the date of the initial Cigna Dental decision. You should state the reason you feel your appeal should be approved and include any information to support your appeal. If you are unable or choose not to write, you may ask Customer Service to register your appeal by calling 1-800-Cigna24.

Level-One Appeals

Your level-one appeal will be reviewed and the decision made by someone not involved in the initial review. Appeals involving dental necessity or clinical appropriateness will be reviewed by a dental professional.

If your appeal concerns a denied pre-authorization, we will respond with a decision within 15 calendar days after we receive your appeal. For appeals concerning all other coverage issues, we will respond with a decision within 30 calendar days after we receive your appeal. If we need more information to make your level-one appeal decision, we will notify you in writing to request an extension of up to 15 calendar days and to specify any additional information needed to complete the review.

You may request that the 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, Cigna Dental will respond orally with a decision within 72 hours, followed up in writing.

If you are not satisfied with our level-one appeal decision, you may request a level-two appeal.

Level-Two Appeals

To initiate a level-two appeal, follow the same process required for a level-one appeal. Your level-two appeal will be reviewed and a decision made by someone not involved in the level-one appeal. For appeals involving dental necessity or clinical appropriateness, the decision will be made by a dentist. If specialty care is in dispute, the appeal will be conducted by a dentist in the same or similar specialty as the care under review.

The review will be completed within 30 calendar days. If we need more information to complete the appeal, we will notify you in writing to request an extension of up to 15 calendar days and to specify any additional information needed to complete the review. The decision will include the specific contractual or clinical reasons for the decision, as applicable.

You may request that the 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.

Independent Review Procedure

The independent review procedure is a voluntary program arranged by the Dental Plan and is not available in all areas.

Appeals to the State

Missouri Department of Insurance,
Financial Institutions and
Professional Registration
301 West High Street, Room 530
Jefferson City, MO 65101

Mailing Address:
PO Box 690
Jefferson City, MO 65102-0690

Phone number:
800-726-7390

Cigna Dental will not cancel or refuse to renew your coverage because you or your Dependent has filed a complaint or an appeal involving a decision made by Cigna Dental. You have the right to file suit in a court of law for any claim involving the professional treatment performed by a dentist.

XII. Dual Coverage

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

If you or your Dependents have dental coverage through your spouse's employer or other sources such as an HMO or similar dental plan, 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.

Coordination of benefit rules are attached to the Group Contract and may be reviewed by contacting your Benefit Administrator. Cigna Dental coordinates benefits only for specialty care services.

XIII. Disenrollment From The Dental Plan – Termination Of Benefits

A. Time Frames For Disenrollment/Termination

Except as otherwise provided in the sections titled "Extension/Continuation of Benefits" or in your Group Contract, disenrollment from the Dental Plan and termination of benefits will occur on the last day of the month:

- in which Premiums are not remitted to Cigna Dental.
- in which eligibility requirements are no longer met.
- after 30 days notice from Cigna Dental due to permanent breakdown of the dentist-patient relationship as determined by Cigna Dental, after at least two opportunities to transfer to another Dental Office.
- after 30 days notice from Cigna Dental due to fraud or misuse of dental services and/or Dental Offices.
- after 60 days notice by Cigna Dental, due to continued lack of a Dental Office in your Service Area.
- after voluntary disenrollment.

B. Effect On Dependents

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.

XIV. Extension Of Benefits

Coverage for completion of a dental procedure (other than orthodontics) which was started before your disenrollment from the Dental Plan will be extended for 90 days after disenrollment unless disenrollment was due to nonpayment of Premiums.

Coverage for orthodontic treatment which was started before disenrollment from the Dental Plan will be extended to the end of the quarter or for 60 days after disenrollment, whichever is later, unless disenrollment was due to nonpayment of Premiums.

XV. Continuation Of Benefits (COBRA) (COBRA)

For Groups with 20 or more employees, federal law requires the employer to offer continuation of benefits coverage for a specified period of time after termination of employment or reduction of work hours, for any reason other than gross misconduct. You will be responsible for sending payment of the required Premiums to the Group. Additional information is available through your Benefits Representative.

XVI. Conversion Coverage

If you are no longer eligible for coverage under your Group's Dental Plan, you and your enrolled Dependents may continue your dental coverage by enrolling in the Cigna Dental conversion plan. You must enroll within three (3) months after becoming ineligible for your Group's Dental Plan. Premium payments and coverage will be retroactive to the date coverage under your Group's Dental Plan ended. You and your enrolled Dependents are eligible for conversion coverage unless benefits were discontinued due to:

- Permanent breakdown of the dentist-patient relationship,
- Fraud or misuse of dental services and/or Dental Offices,
- Nonpayment of Premiums by the Subscriber,
- Selection of alternate dental coverage by your Group, or
- Lack of network/Service Area.

Benefits and rates for Cigna Dental conversion coverage and any succeeding renewals will be based on the Covered Services listed in the then-current standard conversion plan and 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.



XVII. Confidentiality/Privacy

Cigna Dental is committed to maintaining the confidentiality of your personal and sensitive information. Information about Cigna Dental's confidentiality policies and procedures is made available to you during the enrollment process and/or as part of your customer plan materials. You may obtain additional information about Cigna Dental's confidentiality policies and procedures by calling Customer Service at 1-800-Cigna24, or via the Internet at myCigna.com.

XVIII. Miscellaneous

As a Cigna Dental plan customer, you may be eligible for various discounts, benefits, or other consideration for the purpose of promoting your general health and well being. Please visit our website at myCigna.com for details.

As a Cigna Dental plan customer, you may also be eligible for additional dental benefits during certain health conditions. For example, certain frequency limitations for dental services may be relaxed for pregnant women and customers participating in certain disease management programs. Please review your plan enrollment materials for details.



Cigna Dental Companies

Cigna Dental Health of North Carolina, Inc.

P.O. Box 453099
Sunrise, Florida 33345-3099

This Plan Booklet/Combined Evidence of Coverage and Disclosure Form/Certificate of Coverage is intended for your information; it constitutes a summary of the Dental Plan and is included as a part of the agreement between Cigna Dental and your Group (collectively, the “Group Contract”). The Group Contract must be consulted to determine the rates and the exact terms and conditions of coverage. If rates or coverages are changed under your Group Contract, your rates and coverage will also change. A prospective customer has the right to view the Combined Evidence of Coverage and Disclosure Form prior to enrollment. It should be read completely and carefully. Customers with special health care needs should read carefully those sections that apply to them. Please read the following information so you will know from whom or what group of providers dental care may be obtained.

NOTICE: IF YOU OR YOUR FAMILY MEMBERS ARE COVERED BY MORE THAN ONE HEALTH CARE PLAN, YOU MAY NOT BE ABLE TO COLLECT BENEFITS FROM BOTH PLANS. EACH PLAN MAY REQUIRE YOU TO FOLLOW ITS RULES OR USE SPECIFIC DOCTORS OR HOSPITALS, AND IT MAY BE IMPOSSIBLE TO COMPLY WITH BOTH PLANS AT THE SAME TIME. READ ALL OF THE RULES VERY CAREFULLY, INCLUDING THE DUAL COVERAGE SECTION.

Important Cancellation Information – Please Read the Provision Entitled “Disenrollment from the Dental Plan–Termination of Benefits.”

READ YOUR PLAN BOOKLET CAREFULLY

Please call Customer Service 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.

In some instances, state laws will supersede or augment the provisions contained in this booklet. These requirements are listed at the end of this booklet as a State Rider. In case of a conflict between the provisions of this booklet and your State Rider, the State Rider will prevail.

I. DEFINITIONS

Capitalized terms, unless otherwise defined, have the meanings listed below.

Adverse Determination - a decision by Cigna Dental 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 customer 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 authorizations that are declined by Cigna Dental based upon the above criteria will be the responsibility of the customer at the dentist's Usual Fees. A licensed dentist will make any such denial.

Cigna Dental - 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 Dentist agreement with Cigna Dental.

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

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

Dental Plan - managed dental care plan offered through the Group Contract between Cigna Dental and your Group.

Dependent - your lawful spouse, or your domestic partner;

Your unmarried child (including newborns, adopted children, foster children, stepchildren, a child for whom you must provide dental coverage under a court order; or, a dependent child who resides in your home as a result of court order or administrative placement) who is:

- (a) less than 26 years old; or
- (b) less than 26 years old if he or she is both:
 - i. a full-time student enrolled at an accredited educational institution, and
 - ii. reliant upon you for maintenance and support; or
- (c) any age if he or she is both:
 - i. incapable of self-sustaining employment due to mental or physical disability, and
 - ii. reliant upon you for maintenance and support.

For a dependent child 26 years of age or older who is a full-time student at an educational institution, coverage will be provided for an entire academic term during which the child begins as a full-time student and remains enrolled, regardless of whether the number of hours of instruction for which the child is enrolled is reduced to a level that changes the child's academic status to less than that of a full-time student.

For a child who falls into category (b) or (c) above, you will need to furnish Cigna Dental evidence of the child's reliance upon you, in the form requested, within 31 days after the Dependent reaches the age of 19 and once a year thereafter for as long as the child is claimed as a Dependent under the Plan.

A Newly Acquired Dependent is a dependent child who is adopted, born, or otherwise becomes your dependent after you become covered under the Plan.

Coverage for dependents living outside a Cigna Dental service area is subject to the availability of an approved network where the dependent resides.



Group - employer, labor union or other organization that has entered into a Group Contract with Cigna Dental for managed dental services on your behalf.

Network Dentist – a licensed dentist who has signed an agreement with Cigna Dental 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 - a licensed dentist who has signed an agreement with Cigna Dental under which he or she agrees to provide dental care services to you.

Network Specialty Dentist - a licensed dentist who has signed an agreement with Cigna Dental under which he or she agrees to provide specialized dental care services to you.

Patient Charge - the amount you owe your Network Dentist for any dental procedure listed on your Patient Charge Schedule.

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

Premiums - fees that your Group remits to Cigna Dental, on your behalf, during the term of your Group Contract.

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

Subscriber/You - the enrolled employee or customer of the Group.

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

II. INTRODUCTION TO YOUR CIGNA DENTAL PLAN

Welcome to the Cigna Dental Plan. We encourage you to use your dental benefits. Please note that enrollment in the

Dental Plan allows the release of patient records to Cigna Dental or its designee for health plan operation purposes.

III. ELIGIBILITY/WHEN COVERAGE BEGINS

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

If you enrolled in the Dental Plan before the effective date of your Group Contract, you will be covered on the first day the Group Contract is effective. If you enrolled in the Dental Plan after the effective date of the Group Contract, you will be covered on the first day of the month following processing of your enrollment (unless effective dates other than the first day of the month are provided for in your Group Contract).

Dependents may be enrolled in the Dental Plan at the time you enroll, during an open enrollment, or within 30 days of becoming eligible due to a life status change such as marriage, birth, adoption, placement. Dependent children for whom you are required by a court or administrative order to provide dental coverage may be enrolled at any time. You may drop coverage for your Dependents only during the open enrollment periods for your Group, unless there is a change in status such as divorce. If your child is enrolled in the Dental Plan because of a court or administrative order, the child may not be disenrolled unless the order is no longer valid or the child is enrolled in another dental plan with comparable coverage.

If you have family coverage and have a new baby or if you are appointed as guardian or custodian of a foster child who is placed in your home, or an adopted child, the newborn, foster or adopted child will be automatically covered for the first 30 days following birth or placement. Waiting periods do not apply to these categories of Dependents. If you wish to continue coverage beyond the first 30 days, you should enroll the child in the Dental Plan and you need to begin to pay Premiums/Prepayment Fees during the period, if any additional are due, during that period. If additional premium is required you must submit an enrollment form within 30 days of acquiring the new Dependent



child. If no additional premium is required, the child will be covered even if not formally enrolled in the plan. However, for ease of administration, you are encouraged to enroll the new Dependent child when coverage begins.

When a child, covered from the moment of birth or placement in the adoptive or foster home, requires dental care associated with congenital defects and anomalies, the dental only plan shall cover such defects to the same extent an otherwise covered dental service is provided by the plan.

A life status change may also include placement for adoption.

Evidence of good dental health is not required for late enrollees.

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 Premiums, if any, which you would have paid if you had not taken the leave. Additional information is available through your Benefits Representative.

IV. YOUR CIGNA DENTAL COVERAGE

The information below outlines your coverage and will help you to better understand your Dental Plan. Included is information about which services are covered, which are not, and how much dental services will cost you. A copy of the Group Contract will be furnished to you upon your request.

A. CUSTOMER SERVICE

If you have any questions or concerns about the Dental Plan, Customer Service Representatives are just a toll-free phone call away. They can explain your benefits or help with matters regarding your Dental Office or Dental Plan. For assistance with transfers, specialty referrals, eligibility, second opinions, emergencies, Covered Services, plan benefits, ID cards, location of Dental Offices, conversion coverage or other matters, call Customer Service from any location at 1-800-Cigna24.

The hearing impaired may contact the state TTY toll-free relay service number listed in their local telephone directory.

B. PREMIUMS

Your Group sends a monthly fee to Cigna Dental for customers participating in the Dental Plan. The amount and term of this fee is 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.

No schedule of premiums, or any amendment to the schedule, shall be used until it has been filed with and approved by the Commissioner. Premiums are guaranteed for the group for a period of twelve (12) months. However, Premiums may be adjusted by Cigna Dental upon approval by the North Carolina Department of Insurance but no more often than once every 6 months based on at least 12 months of experience and 45 days' notice to the Group if, in Cigna Dental's sole opinion, its liability is altered by any state or federal law.

UNDER NORTH CAROLINA GENERAL STATUTE SECTION 58-50-40, NO PERSON, EMPLOYER, PRINCIPAL, AGENT, TRUSTEE, OR THIRD PARTY ADMINISTRATOR, WHO IS RESPONSIBLE FOR THE PAYMENT OF GROUP HEALTH OR LIFE INSURANCE OR GROUP HEALTH PLAN PREMIUMS, SHALL: (1) CAUSE THE CANCELLATION OR NONRENEWAL OF GROUP HEALTH OR LIFE INSURANCE, HOSPITAL, MEDICAL, OR DENTAL SERVICE CORPORATION PLAN, MULTIPLE EMPLOYER WELFARE ARRANGEMENT, OR GROUP HEALTH PLAN COVERAGES AND THE CONSEQUENTIAL LOSS OF THE COVERAGES OF THE PERSONS INSURED, BY WILLFULLY FAILING TO PAY THOSE PREMIUMS IN ACCORDANCE WITH THE TERMS OF THE INSURANCE OR PLAN CONTRACT, AND (2) WILLFULLY FAIL TO DELIVER, AT LEAST 45 DAYS BEFORE THE TERMINATION OF THOSE COVERAGES, TO ALL PERSONS COVERED BY THE GROUP POLICY A WRITTEN NOTICE OF THE PERSON'S INTENTION TO STOP PAYMENT OF PREMIUMS. THIS WRITTEN NOTICE MUST ALSO CONTAIN A NOTICE TO ALL PERSONS COVERED BY THE GROUP POLICY OF THEIR RIGHTS TO HEALTH INSURANCE CONVERSION POLICIES



UNDER ARTICLE 53 OF CHAPTER 58 OF THE GENERAL STATUTES AND THEIR RIGHTS TO PURCHASE INDIVIDUAL POLICIES UNDER THE FEDERAL HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT AND UNDER ARTICLE 68 OF CHAPTER 58 OF THE GENERAL STATUTES. VIOLATION OF THIS LAW IS A FELONY. ANY PERSON VIOLATING THIS LAW IS ALSO SUBJECT TO A COURT ORDER REQUIRING THE PERSON TO COMPENSATE PERSONS INSURED FOR EXPENSES OR LOSSES INCURRED AS A RESULT OF THE TERMINATION OF THE INSURANCE.

C. OTHER CHARGES – PATIENT CHARGES

Network General Dentists are typically reimbursed by Cigna Dental 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.

Your Patient Charge Schedule lists the dental procedures covered under your Dental Plan. Some dental procedures are covered at no charge to you. For other Covered Services, the Patient Charge Schedule lists the fees you must pay when you visit your Dental Office. 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 policies. Timely payment is important. It is possible that the Dental Office may add late charges to overdue balances.

Your Patient Charge Schedule is subject to annual change in accordance with your Group Contract. Cigna Dental will give written notice to your Group of any change in Patient Charges at least 60 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.

D. CHOICE OF DENTIST

You and your Dependents should have selected a Dental Office when you enrolled in the Dental Plan. If you did not, you must advise Cigna Dental of your Dental Office selection prior to receiving treatment. The benefits of the Dental Plan are available only at your Dental Office, except in the case of an emergency or when Cigna Dental otherwise approves payment for out-of-network benefits.

You may select a network Pediatric Dentist as the Network General Dentist for your dependent child under age 13 by calling Customer Service at 1-800-Cigna24 to get a list of network Pediatric Dentists in your Service Area or if your Network General Dentist sends your child under the age of 13 to a network Pediatric Dentist, the network Pediatric Dentist's office will have primary responsibility for your child's care. For children 13 years and older, your Network General Dentist will provide care. If your child continues to visit the Pediatric Dentist upon the age of 13, you will be fully responsible for the Pediatric Dentist's Usual Fees. Exceptions for medical reasons may be considered on a case-by-case basis.

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 will let you know and will arrange a transfer to another Dental Office. Refer to the Section titled "Office Transfers" if you wish to change your Dental Office.

To obtain a list of Dental Offices near you, visit our website at myCigna.com, or 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 Customer Service.

E. YOUR PAYMENT RESPONSIBILITY (General Care)

For Covered Services at your Dental Office, you will be charged the fees listed on your Patient Charge Schedule. For services listed on your Patient Charge Schedule at any other dental office, you may be charged Usual Fees. For non-Covered Services, you are responsible for paying Usual Fees.



If, on a temporary basis, there is no Network General Dentist in your Service Area, Cigna Dental 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 will pay the non-Network Dentist the difference, if any, between his or her Usual Fee and the applicable Patient Charge.

If you are unable to locate, or you do not have timely access to, an In-Network General Dentist in your area who can provide you with a service or supply that is covered under this plan, you should call customer service at 1-800-Cigna24 to obtain authorization for Out-of-Network Provider coverage. If authorization is obtained for services provided by an Out-of-Network Provider, benefits for those services will be covered at the In-Network benefit level.

See Section IX, *Specialty Referrals*, regarding payment responsibility for specialty care.

All contracts between Cigna Dental 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.

F. 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.

1. Emergency Care Away From Home

If you have an emergency while you are out of your Service Area or you are unable to contact your Network General Dentist, you may receive emergency Covered Services as defined above from any general dentist. Routine restorative procedures or definitive treatment (e.g. root canal) are not considered emergency care. You should return to your Network General Dentist for these procedures. For emergency Covered Services, you will be responsible for the Patient Charges listed on your

Patient Charge Schedule. Cigna Dental will reimburse you the difference, if any, between the dentist's Usual Fee for emergency Covered Services and your Patient Charge, up to a total of \$50 per incident. To receive reimbursement, send appropriate reports and x-rays to Cigna Dental at the address listed for your state on the front of this booklet.

2. 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.

G. LIMITATIONS ON COVERED SERVICES

Listed below are limitations on services when covered by your Dental Plan:

- **Frequency** - The frequency of certain Covered Services, like cleanings, is limited. Your Patient Charge Schedule lists any limitations on frequency.
- **Pediatric Dentistry** - Coverage for treatment by a Pediatric Dentist ends on your child's 13th birthday. Effective on your child's 13th birthday, dental services must be obtained from a Network General Dentist; however, exceptions for medical reasons may be considered on an individual basis.
- **Oral Surgery** - The surgical removal of an impacted wisdom tooth may not be covered if the tooth is not diseased or if the removal is only for orthodontic reasons. Your Patient Charge Schedule lists any limitations on oral surgery.
- **Periodontal (gum tissue and supporting bone) Services** – Periodontal regenerative procedures are limited to one regenerative procedure per site (or per tooth, if applicable), when covered on the Patient Charge Schedule.

Localized delivery of antimicrobial agents is limited to eight teeth (or eight sites, if applicable) per 12 consecutive months, when covered on the Patient Charge Schedule.

- **Clinical Oral Evaluations** – When this limitation is noted on the Patient Charge Schedule, periodic oral evaluations, comprehensive oral evaluations, comprehensive periodontal evaluations, and oral evaluations for patients under 3 years of age, are limited to a combined total of 4 evaluations during a 12 consecutive month period.
- **Surgical Placement of Implant Services** – When covered on the Patient Charge Schedule, surgical placement of a dental implant; repair, maintenance, or removal of a dental implant; implant abutment(s); or any services related to the surgical placement of a dental implant are limited to one per year with replacement of a surgical implant frequency limitation of one every 10 years.
- **Prosthesis Over Implant** – When covered on the Patient Charge Schedule, a prosthetic device, supported by an implant or implant abutment is considered a separate distinct service(s) from surgical placement of an implant. Replacement of any type of prosthesis with a prosthesis supported by an implant or implant abutment is only covered if the existing prosthesis is at least 5 calendar years old, is not serviceable and cannot be repaired.

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 charges which would not have been made in any facility, other than a Hospital or a Correctional Institution owned or operated by the United States Government or by a state or municipal government if the person had no insurance;
- to the extent that payment is unlawful where the person resides when the expenses are incurred or the services are received;
- for the charges which the person is not legally required to pay;
- for charges which would not have been made if the person had no insurance;
- due to injuries which are intentionally self-inflicted.

Exclusions and limitations do not apply to services performed to correct congenital defects, including cosmetic surgery.

H. SERVICES NOT COVERED UNDER YOUR DENTAL PLAN

Listed below are the services or expenses which are NOT covered under your Dental Plan and which are your responsibility at the dentist's Usual Fees. There is no coverage for:

- services not listed on the Patient Charge Schedule.
- services provided by a non-Network Dentist without Cigna Dental's prior approval (except emergencies, as described in Section IV.F).
- services or supplies for the treatment of an occupational injury or sickness which are paid under the North Carolina Workers' Compensation Act only to the extent such services or supplies are the liability of the employee, employer or workers' compensation insurance carrier according to a final adjudication under the North Carolina Workers' Compensation Act or an order of the North Carolina Industrial Commission approving a settlement agreement under the North Carolina Workers' Compensation Act.
- services provided or paid by or through a federal or state governmental agency or authority, political subdivision or a public program, other than Medicaid.
- services required while serving in the armed forces of any country or international authority or relating to a declared or undeclared war or acts of war.
- cosmetic dentistry or cosmetic dental surgery (dentistry or dental surgery performed solely to improve appearance) unless specifically listed on your Patient Charge Schedule. If bleaching (tooth whitening) is listed on your Patient Charge Schedule, only the use of take-home bleaching gel with trays is covered; all other types of bleaching methods are not covered.



- 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. There is no coverage for general anesthesia or intravenous sedation when used for the purposes of anxiety control or patient management.
- prescription medications.
- procedures, appliances or restorations if the main purpose is to: change vertical dimension (degree of separation of the jaw when teeth are in contact) or restore teeth which have been damaged by attrition, abrasion, erosion and/or abfraction.
- replacement of fixed and/or removable appliances (including fixed and removable orthodontic appliances) that have been lost, stolen, or damaged due to patient abuse, misuse or neglect.
- surgical placement of a dental implant; repair, maintenance, or removal of a dental implant; implant abutment(s); or any services related to the surgical placement of a dental implant, unless specifically listed on your Patient Charge Schedule.
- services considered to be unnecessary or experimental in nature or do not meet commonly accepted dental standards.
- procedures or appliances for minor tooth guidance or to control harmful habits.
- hospitalization, including any associated incremental charges for dental services performed in a hospital. (Benefits are available for Network Dentist charges for Covered Services performed at a hospital. Other associated charges are not covered and should be submitted to the medical carrier for benefit determination.)
- services to the extent you or your enrolled Dependent are compensated under any group medical plan when Coordination of Benefits rules are applied.
- the completion of crowns, bridges, dentures, or root canal treatment, already in progress on the effective date of your Cigna Dental coverage.
- the completion of implant supported prosthesis (including crowns, bridges and dentures) already in progress on the effective date of your Cigna Dental coverage, unless specifically listed on your Patient Charge Schedule.
- consultations and/or evaluations associated with services that are not covered.
- endodontic treatment and/or periodontal (gum tissue and supporting bone) surgery of teeth exhibiting a poor or hopeless periodontal prognosis.
- bone grafting and/or guided tissue regeneration when performed at the site of a tooth extraction unless specifically listed on your Patient Charge Schedule.
- bone grafting and/or guided tissue regeneration when performed in conjunction with an apicoectomy or periradicular surgery.
- intentional root canal treatment in the absence of injury or disease to solely facilitate a restorative procedure.
- services performed by a prosthodontist.
- localized delivery of antimicrobial agents when performed alone or in the absence of traditional periodontal therapy.
- any localized delivery of antimicrobial agent procedures when more than eight (8) of these procedures are reported on the same date of service.



- infection control and/or sterilization. Cigna Dental considers this to be incidental to and part of the charges for services provided and not separately chargeable.

- the recementation of any inlay, onlay, crown, post and core, or fixed bridge within 180 days of initial placement. Cigna Dental considers recementation within this timeframe to be incidental to and part of the charges for the initial restoration.

- the recementation of any implant supported prosthesis (including crowns, bridges and dentures) within 180 days of initial placement. Cigna Dental considers recementation within this timeframe to be incidental to and part of the charges for the initial restoration unless specifically listed on your Patient Charge Schedule.

- the replacement of an occlusal guard (night guard) beyond one per any 24 consecutive month period, when this limitation is noted on the Patient Charge Schedule.

- crowns, bridges and/or implant supported prosthesis used solely for splinting.

- resin bonded retainers and associated pontics.

Exclusions and limitations do not apply to services performed to correct congenital defects, including cosmetic surgery.

Pre-existing conditions are not excluded if the procedures involved are otherwise covered under your Patient Charge Schedule.

Should any law require coverage for any particular service(s) noted above, the exclusion or limitation for that service(s) shall not apply.

V. APPOINTMENTS

To make an appointment with your Network Dentist, call the Dental Office that you have selected. When you call, your Dental Office will ask for your identification number and will check your eligibility.

VI. BROKEN APPOINTMENTS

The time your Network Dentist schedules for your appointment is valuable to you and the dentist. Broken appointments make it difficult for your Dental Office to schedule time with other patients.

If you or your enrolled Dependent breaks an appointment with less than 24 hours notice to the Dental Office, you may be charged a broken appointment fee.

VII. OFFICE TRANSFERS

If you decide to change Dental Offices, we can arrange a transfer. You should complete any dental procedure in progress before transferring to another Dental Office. To arrange a transfer, call Customer Service at 1-800-Cigna24. To obtain a list of Dental Offices near you, visit our website at myCigna.com, or call the Dental Office Locator at 1-800-Cigna24.

Your transfer request may take up to 5 days to process. Transfers will be effective the first day of the month after the processing of your request. Unless you have an emergency, you will be unable to schedule an appointment at the new Dental Office until your transfer becomes effective. You can check the status of your request by visiting myCigna.com, or by calling us at 1-800-Cigna24.

There is no charge to you for the transfer; however, all Patient Charges which you owe to your current Dental Office must be paid before the transfer can be processed.

VIII. 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 Network includes the following types of specialty dentists:

- 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 Specialty Dentist.

See Section IV.D, *Choice of Dentist*, regarding treatment by a Pediatric Dentist.

IX. SPECIALTY REFERRALS

A. IN GENERAL

Preauthorization is not required for coverage of services by a Network Specialty Dentist.

When Cigna Dental approves payment to the Network Specialty Dentist, 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 IX.B., *Orthodontics*. Treatment by the Network Specialty Dentist must begin within 90 days from the date of Cigna Dental's authorization. If you are unable to obtain treatment within the 90 day period, please call Customer Service to request an extension. Your coverage must be in effect when each procedure begins.

For non-Covered Services or if Cigna Dental does not approve payment to the Network Specialty Dentist for Covered Services, including Adverse Determinations, you must pay the Network Specialty Dentist's Usual Fee. If you have a question or concern regarding an approval or a denial, contact Customer Service.

After the Network Specialty Dentist has completed treatment, you should return to your Network General Dentist for cleanings, regular checkups and other treatment. If you visit a Network Specialty Dentist

without a referral or if you continue to see a Network Specialty Dentist 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 Specialty Dentist is not available, as determined by Cigna Dental, Cigna Dental will approve a referral to a non-Network Specialty Dentist. 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 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 approved for payment, including Adverse Determinations, you must pay the dentist's Usual Fee.

B. ORTHODONTICS (This section is applicable only when Orthodontics is listed on your Patient Charge Schedule.)

1. Definitions – If your Patient Charge Schedule indicates coverage for orthodontic treatment, 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.

2. Patient Charges

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. However, if 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, 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.

3. Additional Charges

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

- a. incremental costs associated with optional/elective materials, including but not limited to ceramic, clear, lingual brackets, or other cosmetic appliances;
- b. orthognathic surgery and associated incremental costs;
- c. appliances to guide minor tooth movement;
- d. appliances to correct harmful habits; and
- e. services which are not typically included in Orthodontic Treatment. These services will be identified on a case-by-case basis.

4. Orthodontics In Progress

If Orthodontic Treatment is in progress for you or your Dependent at the time you enroll, the fee listed on the Patient Charge Schedule is not applicable. Please call Customer Service at 1-800-Cigna24 to find out if you are entitled to any benefit under the Dental Plan.

X. COMPLEX REHABILITATION/MULTIPLE CROWN UNITS

Complex rehabilitation is extensive dental restoration involving 6 or more "units" of crown, bridge and/or implant supported prosthesis (including crowns and bridges) in the same treatment plan. Using full crowns

(caps), fixed bridges and/or implant supported prosthesis (including crowns and 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 the 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, bridge and/or implant supported prosthesis (including crowns and bridges) 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, bridge and/or implant supported prosthesis (including crowns and bridges) PLUS an additional charge for each unit when 6 or more units are prescribed in your Network General Dentist's treatment plan.

Note: Complex Rehabilitation only applies for implant supported prosthesis, when implant supported prosthesis are specifically listed on your Patient Charge Schedule.

XI. 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. **Time frames or requirements may vary depending on the laws in your State. Consult your State Rider for further details.**

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.

A. START WITH CUSTOMER SERVICE

We are here to listen and to help. If you have a concern about your Dental Office or the Dental Plan, you can call



1-800-Cigna24 toll-free and explain your concern to one of our Customer Service Representatives. You can also express that concern in writing to Cigna Dental, P.O. Box 188047, Chattanooga, TN 37422-8047. We will do our best to resolve the matter during your initial contact. If we need more time to review or investigate your concern, we will get back to you as soon as possible, usually by the end of the next business day, but in any case within 30 days.

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

B. APPEALS PROCEDURE

Cigna Dental has a two-step appeals procedure for coverage decisions. To initiate an appeal, you must submit a request in writing to Cigna Dental, P.O. Box 188047, Chattanooga, TN 37422-8047, within 1 year from the date of the initial Cigna Dental decision. You should state the reason you feel your appeal should be approved and include any information to support your appeal. If you are unable or choose not to write, you may ask Customer Service to register your appeal by calling 1-800-Cigna24.

1. Level-One Appeals

Your level-one appeal will be reviewed and the decision made by someone not involved in the initial review. Appeals involving dental necessity or clinical appropriateness will be reviewed by a dental professional.

If your appeal concerns a denied pre-authorization, we will respond with a decision within 15 calendar days after we receive your appeal. For appeals concerning all other coverage issues, we will respond with a decision within 30 calendar days after we receive your appeal. If we need more information to make your level-one appeal decision, we will notify you in writing to request an extension of up to 15 calendar days and to specify any additional information needed to complete the review.

You may request that the 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, Cigna Dental will respond orally with a decision within 72 hours, followed up in writing.

If you are not satisfied with our level-one appeal decision, you may request a level-two appeal.

2. Level-Two Appeals

To initiate a level-two appeal, follow the same process required for a level-one appeal. Your level-two appeal will be reviewed and a decision made by someone not involved in the level-one appeal. For appeals involving dental necessity or clinical appropriateness, the decision will be made by a dentist. If specialty care is in dispute, the appeal will be conducted by a dentist in the same or similar specialty as the care under review.

The review will be completed within 30 calendar days. If we need more information to complete the appeal, we will notify you in writing to request an extension of up to 15 calendar days and to specify any additional information needed to complete the review. You will be notified in writing of the decision no later than 30 days after the date the appeal is made. The decision will include the specific contractual or clinical reasons for the decision, as applicable.

You may request that the 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.

3. Appeals to the State

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



Cigna Dental will not cancel or refuse to renew your coverage because you or your Dependent has filed a complaint or an appeal involving a decision made by Cigna Dental. You have the right to file suit in a court of law for any claim involving the professional treatment performed by a dentist.

XII. DUAL COVERAGE

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

If you or your Dependents have dental coverage through your spouse's employer or other sources such as an HMO or similar dental plan, 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.

Coordination of benefit rules are attached to the Group Contract and may be reviewed by contacting your Benefit Administrator. Cigna Dental coordinates benefits only for specialty care services.

XIII. DISENROLLMENT FROM THE DENTAL PLAN – TERMINATION OF BENEFITS

A. TIME FRAMES FOR DISENROLLMENT/TERMINATION

Except as otherwise provided in the sections titled "Extension/Continuation of Benefits" or in your Group Contract, disenrollment from the Dental Plan and termination of benefits will occur on the last day of the month:

1. in which Premiums are not remitted to Cigna Dental.
2. in which eligibility requirements are no longer met.
3. after 30 days notice from Cigna Dental due to permanent breakdown of the dentist-patient relationship as determined by Cigna Dental, after at least two opportunities to transfer to another Dental Office.
4. after 30 days notice from Cigna Dental due to fraud or misuse of dental services and/or Dental Offices.
5. after voluntary disenrollment.

B. EFFECT ON DEPENDENTS

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.

XIV. EXTENSION OF BENEFITS

Coverage for completion of a dental procedure (other than orthodontics) which was started before your disenrollment from the Dental Plan will be extended for



90 days after disenrollment unless disenrollment was due to nonpayment of Premiums.

Coverage for orthodontic treatment which was started before disenrollment from the Dental Plan will be extended to the end of the quarter or for 60 days after disenrollment, whichever is later, unless disenrollment was due to nonpayment of Premiums.

XV. CONTINUATION OF BENEFITS (COBRA)

For Groups with 20 or more employees, federal law requires the employer to offer continuation of benefits coverage for a specified period of time after termination of employment or reduction of work hours, for any reason other than gross misconduct. You will be responsible for sending payment of the required Premiums to the Group. Additional information is available through your Benefits Representative.

XVI. CONVERSION COVERAGE

If you are no longer eligible for coverage under your Group's Dental Plan, you and your enrolled Dependents may continue your dental coverage by enrolling in the Cigna Dental conversion plan. You must enroll within three (3) months after becoming ineligible for your Group's Dental Plan. Premium payments and coverage will be retroactive to the date coverage under your Group's Dental Plan ended. You and your enrolled Dependents are eligible for conversion coverage unless benefits were discontinued due to:

- Permanent breakdown of the dentist-patient relationship,
- Fraud or misuse of dental services and/or Dental Offices,
- Nonpayment of Premiums by the Subscriber,
- Selection of alternate dental coverage by your Group, or
- Lack of network/Service Area.

Benefits and rates for Cigna Dental conversion coverage and any succeeding renewals will be based on

the Covered Services listed in the then-current standard conversion plan and 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.

XVII. CONFIDENTIALITY/PRIVACY

Cigna Dental is committed to maintaining the confidentiality of your personal and sensitive information. Information about Cigna Dental's confidentiality policies and procedures is made available to you during the enrollment process and/or as part of your customer plan materials. You may obtain additional information about Cigna Dental's confidentiality policies and procedures by calling Customer Service at 1-800-Cigna24, or via the Internet at myCigna.com.

XVIII. MISCELLANEOUS

A. HEALTHY REWARDS

From time to time, Cigna Dental Health may offer or provide certain persons who enroll in the Cigna Dental plan access to certain discounts, benefits or other consideration for the purpose of promoting general health and well being. Discounts arranged by our Cigna HealthCare affiliates may be offered in areas such as acupuncture, cosmetic dentistry, fitness club memberships, hearing care and hearing instruments, laser vision correction, vitamins and herbal supplements, and non-prescription health and wellness products. In addition, our Cigna HealthCare affiliates may arrange for third party service providers, such as chiropractors, massage therapists and optometrists, to provide discounted goods and services to those persons who enroll in the Cigna Dental plan. While Cigna HealthCare has arranged these goods, services and/or third party provider discounts, the third party service providers are liable to enrollees for the provision of such goods and/or services. Cigna HealthCare and Cigna Dental Health are not responsible for the provision of such goods and/or services, nor are we liable for the failure of the provision of the same. Further,



Cigna HealthCare and Cigna Dental Health are not liable to enrollees for the negligent provision of such goods and/or services by third party service providers.

As a Cigna Dental plan customer, you may also be eligible for additional dental benefits during certain health conditions. For example, certain frequency limitations for dental services may be relaxed for pregnant women and customers participating in certain disease management programs. Please review your plan enrollment materials for details.

B. INCONTESTABILITY

Under North Carolina law, no misstatements made by a Subscriber in the application for benefits can be used to void coverage after a period of two years from the date of issue.

C. WILLFUL FAILURE TO PAY GROUP INSURANCE PREMIUMS

UNDER NORTH CAROLINA GENERAL STATUTE SECTION 58-50-40, NO PERSON, EMPLOYER, PRINCIPAL, AGENT, TRUSTEE, OR THIRD PARTY ADMINISTRATOR, WHO IS RESPONSIBLE FOR THE PAYMENT OF GROUP HEALTH OR LIFE INSURANCE OR GROUP HEALTH PLAN PREMIUMS, SHALL: (1) CAUSE THE CANCELLATION OR NONRENEWAL OF GROUP HEALTH OR LIFE INSURANCE, HOSPITAL, MEDICAL, OR DENTAL SERVICE CORPORATION PLAN, MULTIPLE EMPLOYER WELFARE ARRANGEMENT, OR GROUP HEALTH PLAN COVERAGES AND THE CONSEQUENTIAL LOSS OF THE COVERAGES OF THE PERSONS INSURED, BY WILLFULLY FAILING TO PAY THOSE PREMIUMS IN ACCORDANCE WITH THE TERMS OF THE INSURANCE OR PLAN CONTRACT, AND (2) WILLFULLY FAIL TO DELIVER, AT LEAST 45 DAYS BEFORE THE TERMINATION OF THOSE COVERAGES, TO ALL PERSONS COVERED

BY THE GROUP POLICY A WRITTEN NOTICE OF THE PERSON'S INTENTION TO STOP PAYMENT OF PREMIUMS. THIS WRITTEN NOTICE MUST ALSO CONTAIN A NOTICE TO ALL PERSONS COVERED BY THE GROUP POLICY OF THEIR RIGHTS TO HEALTH INSURANCE CONVERSION POLICIES UNDER ARTICLE 53 OF CHAPTER 58 OF THE GENERAL STATUTES AND THEIR RIGHTS TO PURCHASE INDIVIDUAL POLICIES UNDER THE FEDERAL HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT AND UNDER ARTICLE 68 OF CHAPTER 58 OF THE GENERAL STATUTES. VIOLATION OF THIS LAW IS A FELONY. ANY PERSON VIOLATING THIS LAW IS ALSO SUBJECT TO A COURT ORDER REQUIRING THE PERSON TO COMPENSATE PERSONS INSURED FOR EXPENSES OR LOSSES INCURRED AS A RESULT OF THE TERMINATION OF THE INSURANCE.

D. NC LIFE & HEALTH GUARANTY ASSOCIATION NOTICE

NOTICE CONCERNING COVERAGE LIMITATIONS AND EXCLUSIONS UNDER THE NORTH CAROLINA LIFE AND HEALTH INSURANCE GUARANTY ASSOCIATION ACT

Residents of this state who purchase life insurance, annuities or health insurance should know that the insurance companies licensed in this state to write these types of insurance are members of the North Carolina Life and Health Insurance Guaranty Association. The purpose of this association is to assure that policyholders will be protected, within limits, in the unlikely event that a member insurer becomes financially unable to meet its obligations. If this should happen, the guaranty association will assess its other member insurance companies for the money to pay the claims of the insured persons who live in this state and, in some cases, to keep coverage in force. The valuable extra protection provided by these insurers through the guaranty association is not unlimited, however. And, as noted below, this protection is not a substitute for consumers' care in selecting companies that are well-managed and financially stable.



The North Carolina Life and Health Insurance Guaranty association may not provide coverage for this policy. If coverage is provided, it may be subject to substantial limitations or exclusions, and require continued residency in North Carolina. You should not rely on coverage by the North Carolina Life and Health Insurance Guaranty Association in selecting an insurance company or in selecting an insurance policy.

Coverage is NOT provided for your policy or any portion of it that is not guaranteed by the insurer or for which you have assumed the risk, such as a variable contract sold by prospectus.

Insurance companies or their agents are required by law to give or send you this notice. However, insurance companies and their agents are prohibited by law from using the existence of the guaranty association to induce you to purchase any kind of insurance policy.

The North Carolina Life and Health Insurance Guaranty Association
4441 Six Forks Rd., STE 160-153
Raleigh, North Carolina, 27605

North Carolina Department of Insurance, Consumer Services Division
1201 Mail Service Center
Raleigh, NC 27699-1201

The state law that provides for this safety-net coverage is called the North Carolina Life and Health Insurance Guaranty Association Act. *On the back of this page* is a brief summary of this law's coverages, exclusions and limits. This summary does not cover all provisions of the law; nor does it in any way change anyone's rights or obligations under the act or the rights or obligations of the guaranty association.

NC LIFE & HEALTH GUARANTY ASSOCIATION NOTICE

COVERAGE

Generally, individuals will be protected by the life and health insurance guaranty association if they live in this state and hold a life or health insurance contract, or an annuity, or if they are insured under a group insurance

contract, issued by a member insurer. The beneficiaries, payees or assignees of insured persons are protected as well, even if they live in another state.

EXCLUSIONS FROM COVERAGE

However, persons holding such policies are not protected by this association if:

- they are eligible for protection under the laws of another state (this may occur when the insolvent insurer was incorporated in another state whose guaranty association protects insureds who live outside that state);
- the insurer was not authorized to do business in this state;
- their policy was issued by an HMO, a fraternal benefit society, a mandatory state pooling plan, a mutual assessment company or similar plan in which the policyholder is subject to future assessments, or by an insurance exchange.

The association also does not provide coverage for:

- any policy or portion of a policy which is not guaranteed by the insurer or for which the individual has assumed the risk, such as a variable contract sold by prospectus;
- any policy of reinsurance (unless an assumption certificate was issued);
- interest rate yields that exceed the average rate specified in the law;
- dividends;
- experience or other credits given in connection with the administration of a policy by a group contractholder;
- employers' plans to the extent they are self-funded (that is, not insured by an insurance company, even if an insurance company administers them);
- unallocated annuity contracts (which give rights to group contractholders, not individuals), unless they fund a government lottery or a benefit plan of an employer, association or union, except that unallocated annuities issued to employee benefit plans protected by the Federal Pension Benefit Guaranty Corporation are not covered.

LIMITS ON AMOUNT OF COVERAGE

The benefits for which the Association is liable do not, in any event, exceed the lesser of:

(1) The contractual obligations for which the insurer is liable or would have been liable if it were not a delinquent insurer; or

(2) With respect to any one individual, regardless of the number of policies, three hundred thousand dollars (\$300,000) for all benefits, including cash values; or

(2a) With respect to health insurance benefits for any one individual, regardless of the number of policies:

a. Three hundred thousand dollars (\$300,000) for coverages not defined as basic hospital, medical, and surgical insurance or major medical insurance as defined in this Chapter and regulations adopted pursuant to this Chapter, including disability insurance and long-term care insurance; or

b. Five hundred thousand dollars (\$500,000) for basic hospital, medical, and surgical insurance or major medical insurance as defined in this Chapter and regulations adopted pursuant to this Chapter;

(3) With respect to each individual participating in a governmental retirement plan established under section 401, 403(b), or 457 of the Internal Revenue Code covered by an unallocated annuity contract, or the beneficiaries of each individual if deceased, in the aggregate, three hundred thousand dollars (\$300,000) in present value annuity benefits, including net cash surrender and net cash withdrawal values; or

(4) With respect to any one contract holder covered by any unallocated annuity contract not included in subdivision (3) of this subsection, five million dollars (\$5,000,000) in benefits, regardless of the number of such contracts held by that contract holder; or

(5) With respect to any one payee (or beneficiaries of one payee if the payee is deceased) of a structured settlement annuity, one million dollars (\$1,000,000) for all benefits, including cash values.

(6) However, in no event shall the Association be obligated to cover more than an aggregate of three hundred thousand dollars (\$300,000) in benefits with respect to any one individual under subdivisions (2) and (3) and sub subdivision (2a)a. except with respect to benefits for basic hospital, medical, and surgical and major medical insurance under sub subdivision (2a)b. of this subsection, in which case the aggregate liability of the Association shall not exceed five hundred thousand dollars (\$500,000) with respect to any one individual.



Cigna Dental Health of New Jersey, Inc.

**P.O. Box 453099
Sunrise, Florida 33345-3099**

This Plan Booklet/Combined Evidence of Coverage and Disclosure Form/Certificate of Coverage is intended for your information; it constitutes a summary of the Dental Plan and is included as a part of the agreement between Cigna Dental and your Group (collectively, the “Group Contract”). The Group Contract must be consulted to determine the rates and the exact terms and conditions of coverage. If rates or coverages are changed under your Group Contract, your rates and coverage will also change. Please read the following information so you will know from whom or what group of dentists dental care may be obtained. This certificate is subject to the laws of the state of New Jersey.

NOTICE: IF YOU OR YOUR FAMILY MEMBERS ARE COVERED BY MORE THAN ONE HEALTH CARE PLAN, YOU MAY NOT BE ABLE TO COLLECT BENEFITS FROM BOTH PLANS. EACH PLAN MAY REQUIRE YOU TO FOLLOW ITS RULES OR USE SPECIFIC DOCTORS OR HOSPITALS, AND IT MAY BE IMPOSSIBLE TO COMPLY WITH BOTH PLANS AT THE SAME TIME. READ ALL OF THE RULES VERY CAREFULLY, INCLUDING THE DUAL COVERAGE SECTION.

Important Cancellation Information - Please Read the Provision Entitled “Disenrollment from the Dental Plan - Termination of Benefits.”

READ YOUR PLAN BOOKLET CAREFULLY

Please call Customer Service 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.



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I. Definitions

Capitalized terms, unless otherwise defined, have the meanings listed below.

Adverse Determination - a decision by Cigna Dental 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 customer or dentist 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 authorizations that are declined by Cigna Dental based upon the above criteria will be the responsibility of the customer at the dentist's Usual Fees. A licensed dentist will make any such denial.

Cigna Dental - 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 Dentist agreement with Cigna Dental.

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

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

Dental Plan - managed dental care plan offered through the Group Contract between Cigna Dental and your Group.

Dependent - your lawful spouse, civil union or your domestic partner (if established in New Jersey prior to February 19, 2007 or if established outside the state of New Jersey prior to or after February 19, 2007); your unmarried or unpartnered child (including newborns, adopted children, stepchildren, a child for whom you must provide dental coverage under a court order; or, a Dependent child who resides in your home as a result of court order or administrative placement; or a Dependent child acquired through a civil union) who is:

- A. less than 19 years old; or
- B. less than 23 years old if he or she is both:
 1. a full-time student enrolled at an accredited educational institution, and

2. reliant upon you for maintenance and support; or
- C. any age if he or she is both:
 1. incapable of self-sustaining employment due to mental or physical disability, and
 2. reliant upon you for maintenance and support.

For a Dependent child 19 years of age or older who is a full-time student at an educational institution, coverage will be provided for an entire academic term during which the child begins as a full-time student and remains enrolled, regardless of whether the number of hours of instruction for which the child is enrolled is reduced to a level that changes the child's academic status to less than that of a full-time student.

A Newly Acquired Dependent is a dependent child who is adopted, born, or otherwise becomes your dependent after you become covered under the Plan.

Coverage for Dependents living outside a Cigna Dental Service Area is subject to the availability of an approved network where the Dependent resides.

This definition of "Dependent" applies unless modified by your Group Contract.

Group - employer, labor union or other organization that has entered into a Group Contract with Cigna Dental for managed dental services on your behalf.

Network Dentist - a licensed dentist who has signed an agreement with Cigna Dental 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 - a licensed dentist who has signed an agreement with Cigna Dental under which he or she agrees to provide dental care services to you.

Network Specialty Dentist - a licensed dentist who has signed an agreement with Cigna Dental under which he or she agrees to provide specialized dental care services to you.

Patient Charge - the amount you owe your Network Dentist for any dental procedure listed on your Patient Charge Schedule.

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

Premiums - fees that your Group remits to Cigna Dental, on your behalf, during the term of your Group Contract.

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



Subscriber/You - the enrolled employee or customer of the Group.

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

II. Introduction To Your Cigna Dental Plan

Welcome to the Cigna Dental Plan. We encourage you to use your dental benefits. Please note that enrollment in the Dental Plan allows the release of patient records to Cigna Dental or its designee for health plan operation purposes.

III. Eligibility When Coverage Begins

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

If you enrolled in the Dental Plan before the effective date of your Group Contract, you will be covered on the first day the Group Contract is effective. If you enrolled in the Dental Plan after the effective date of the Group Contract, you will be covered on the first day of the month following processing of your enrollment (unless effective dates other than the first day of the month are provided for in your Group Contract).

Dependents may be enrolled in the Dental Plan at the time you enroll, during an open enrollment, or within 31 days of becoming eligible due to a life status change such as marriage, birth, adoption, placement, or court or administrative order. You may drop coverage for your Dependents only during the open enrollment periods for your Group, unless there is a change in status such as divorce. Cigna Dental may require evidence of good dental health at your expense if you or your Dependents enroll after the first period of eligibility (except during open enrollment) or after disenrollment because of nonpayment of Premiums.

If you have family coverage, 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 must be enrolled in the Dental Plan and you must begin paying Premiums, if any additional are due, during that period.

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 Premiums, if any, which you would have paid if you had not taken the leave. Additional information is available through your Benefits Representative.

IV. Your Cigna Dental Coverage

The information below outlines your coverage and will help you to better understand your Dental Plan. Included is information about which services are covered, which are not, and how much dental services will cost you. A copy of the Group Contract will be furnished to you upon your request.

A. Customer Service

If you have any questions or concerns about the Dental Plan, Customer Service Representatives are just a toll-free phone call away. They can explain your benefits or help with matters regarding your Dental Office or Dental Plan. For assistance with transfers, specialty referrals, eligibility, second opinions, emergencies, Covered Services, plan benefits, ID cards, location of Dental Offices, conversion coverage or other matters, call Customer Service from any location at 1-800-Cigna24. The hearing impaired may contact the state TTY toll-free relay service number listed in their local telephone directory.

B. Premiums

Your Group sends a monthly fee to Cigna Dental for customers participating in the Dental Plan. The amount and term of this fee is 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.

C. Other Charges – Patient Charges

Network General Dentists are reimbursed by Cigna Dental 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.

Your Patient Charge Schedule lists the dental procedures covered under your Dental Plan. Some dental procedures are covered at no charge to you. For other Covered Services, the Patient Charge Schedule lists the fees you must pay when you visit your Dental Office. 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 policies. Timely payment is important. It is possible that the Dental Office may add late charges to overdue balances.

Your Patient Charge Schedule is subject to annual change in accordance with your Group Contract. Cigna Dental



will give written notice to your Group of any change in Patient Charges at least 60 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.

D. Choice of Dentist

You and your Dependents should have selected a Dental Office when you enrolled in the Dental Plan. If you did not, you must advise Cigna Dental of your Dental Office selection prior to receiving treatment. The benefits of the Dental Plan are available only at your Dental Office, except in the case of an emergency or when Cigna Dental otherwise authorizes payment for out-of-network benefits.

You may select a network Pediatric Dentist as the Network General Dentist for your dependent child under age 7 by calling Customer Service at 1-800-Cigna24 to get a list of network Pediatric Dentists in your Service Area or if your Network General Dentist sends your child under the age of 7 to a network Pediatric Dentist, the network Pediatric Dentist's office will have primary responsibility for your child's care. For children 7 years and older, your Network General Dentist will provide care. If your child continues to visit the Pediatric Dentist upon the age of 7, you will be fully responsible for the Pediatric Dentist's Usual Fees. Exceptions for medical reasons may be considered on a case-by-case basis.

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 will let you know and will arrange a transfer to another Dental Office. Refer to the Section titled "Office Transfers" if you wish to change your Dental Office.

To obtain a list of Dental Offices near you, visit our website at myCigna.com, or 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 Customer Service.

E. Your Payment Responsibility (General Care)

For Covered Services at your Dental Office, you will be charged the fees listed on your Patient Charge Schedule. For services listed on your Patient Charge Schedule at any other dental office, you may be charged Usual Fees. For non-Covered Services, you are responsible for paying Usual Fees.

See Section IX, *Specialty Referrals*, regarding payment responsibility for specialty care.

All contracts between Cigna Dental 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.

F. 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.

Emergency Care Away From Home - If you have an emergency while you are out of your Service Area or you are unable to contact your Network General Dentist, you may receive emergency Covered Services as defined above from any general dentist. Routine restorative procedures or definitive treatment (e.g. root canal) are not considered emergency care. You should return to your Network General Dentist for these procedures. For emergency Covered Services, you will be responsible for the Patient Charges listed on your Patient Charge Schedule. Cigna Dental will reimburse you the difference, if any, between the dentist's Usual Fee for emergency Covered Services and your Patient Charge, up to a total of \$50 per incident. To receive reimbursement, send appropriate reports and x-rays to Cigna Dental at the address listed on the front of this booklet.

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.

G. Limitations on Covered Services

Listed below are limitations on services when covered by your Dental Plan:

- **Frequency** - The frequency of certain Covered Services, like cleanings, is limited. Your Patient Charge Schedule lists any limitations on frequency.
- **Pediatric Dentistry** - Coverage for treatment by a Pediatric Dentist ends on your child's 7th birthday; however, exceptions for medical reasons may be considered on an individual basis. Effective on your child's 7th birthday, dental services must be obtained from a Network General Dentist.
- **Oral Surgery** - The surgical removal of an impacted wisdom tooth may not be covered if the tooth is not diseased or if the removal is only for orthodontic

reasons. Your Patient Charge Schedule lists any limitations on oral surgery.

- **Periodontal (gum tissue and supporting bone)**

Services – Periodontal regenerative procedures are limited to one regenerative procedure per site (or per tooth, if applicable), when covered on the Patient Charge Schedule. Localized delivery of antimicrobial agents is limited to eight teeth (or eight sites, if applicable) per 12 consecutive months, when covered on the Patient Charge Schedule.

- **Clinical Oral Evaluations** – When this limitation is noted on the Patient Charge Schedule, periodic oral evaluations, comprehensive oral evaluations, comprehensive periodontal evaluations, and oral evaluations for patients under 3 years of age are limited to a combined total of 4 evaluations during a 12 consecutive month period.

- **Surgical Placement of Implant Services** – When covered on the Patient Charge Schedule, surgical placement of a dental implant; repair, maintenance, or removal of a dental implant; implant abutment(s); or any services related to the surgical placement of a dental implant are limited to one per year with replacement of a surgical implant frequency limitation of one every 10 years.

- **Prosthesis Over Implant** – When covered on the Patient Charge Schedule, a prosthetic device, supported by an implant or implant abutment is considered a separate distinct service(s) from surgical placement of an implant. Replacement of any type of prosthesis with a prosthesis supported by an implant or implant abutment is only covered if the existing prosthesis is at least 5 calendar years old, is not serviceable and cannot be repaired.

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 charges which would not have been made in any facility, other than a Hospital or a Correctional Institution owned or operated by the United States Government or by a state or municipal government if the person had no insurance;
- to the extent that payment is unlawful where the person resides when the expenses are incurred or the services are received;

- for the charges which the person is not legally required to pay;
- for charges which would not have been made if the person had no insurance;
- due to injuries which are intentionally self-inflicted.

H. Services Not Covered Under Your Dental Plan

Listed below are the services or expenses which are NOT covered under your Dental Plan and which are your responsibility at the dentist's Usual Fees. There is no coverage for:

- services not listed on the Patient Charge Schedule.
- services provided by a non-Network Dentist without Cigna Dental's prior approval (except emergencies, as described in Section IV. F.).
- services related to an injury or illness paid under workers' compensation, occupational disease or similar laws.
- services provided or paid by or through a federal or state governmental agency or authority, political subdivision or a public program, other than Medicaid.
- services required while serving in the armed forces of any country or international authority or relating to a declared or undeclared war or acts of war.
- cosmetic dentistry or cosmetic dental surgery (dentistry or dental surgery performed solely to improve appearance) unless specifically listed on your Patient Charge Schedule. If bleaching (tooth whitening) is listed on your Patient Charge Schedule, only the use of take-home bleaching gel with trays is covered; all other types of bleaching methods are not covered.
- 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. There is no coverage for general anesthesia or intravenous sedation when used for the purposes of anxiety control or patient management.
- prescription medications.
- procedures, appliances or restorations if the main purpose is to: change vertical dimension (degree of separation of the jaw when teeth are in contact) or restore teeth which have been damaged by attrition, abrasion, erosion and/or abfraction.
- replacement of fixed and/or removable appliances (including fixed and removable orthodontic appliances)

that have been lost, stolen, or damaged due to patient abuse, misuse or neglect.

- surgical placement of a dental implant; repair, maintenance, or removal of a dental implant; implant abutment(s); or any services related to the surgical placement of a dental implant, unless specifically listed on your Patient Charge Schedule.
- services considered to be unnecessary or experimental in nature or do not meet commonly accepted dental standards.
- procedures or appliances for minor tooth guidance or to control harmful habits.
- hospitalization, including any associated incremental charges for dental services performed in a hospital. (Benefits are available for Network Dentist charges for Covered Services performed at a hospital. Other associated charges are not covered and should be submitted to the medical carrier for benefit determination.)
- the completion of crowns, bridges, dentures or root canal treatment already in progress on the effective date of your Cigna Dental coverage.
- the completion of implant supported prosthesis (including crowns, bridges and dentures) already in progress on the effective date of your Cigna Dental coverage, unless specifically listed on your Patient Charge Schedule.
- consultations and/or evaluations associated with services that are not covered.
- endodontic treatment and/or periodontal (gum tissue and supporting bone) surgery of teeth exhibiting a poor or hopeless periodontal prognosis.
- bone grafting and/or guided tissue regeneration when performed at the site of a tooth extraction, unless specifically listed on your Patient Charge Schedule.
- bone grafting and/or guided tissue regeneration when performed in conjunction with an apicoectomy or periradicular surgery.
- intentional root canal treatment in the absence of injury or disease to solely facilitate a restorative procedure.
- services performed by a prosthodontist.
- localized delivery of antimicrobial agents when performed alone or in the absence of traditional periodontal therapy.
- any localized delivery of antimicrobial agent procedures when more than eight (8) of these procedures are reported on the same date of service.

- infection control and/or sterilization. Cigna Dental considers this to be incidental to and part of the charges for services provided and not separately chargeable.
- the recementation of any inlay, onlay, crown, post and core or fixed bridge within 180 days of initial placement. Cigna Dental considers recementation within this timeframe to be incidental to and part of the charges for the initial restoration.
- the recementation of any implant supported prosthesis (including crowns, bridges and dentures) within 180 days of initial placement. Cigna Dental considers recementation within this timeframe to be incidental to and part of the charges for the initial restoration unless specifically listed on your Patient Charge Schedule.
- services to correct congenital malformations, including the replacement of congenitally missing teeth.
- the replacement of an occlusal guard (night guard) beyond one per any 24 consecutive month period, when this limitation is noted on the Patient Charge Schedule.
- crowns, bridges and/or implant supported prosthesis used solely for splinting.
- resin bonded retainers and associated pontics.

Pre-existing conditions are not excluded if the procedures involved are otherwise covered under your Patient Charge Schedule.

Should any law require coverage for any particular service(s) noted above, the exclusion or limitation for that service(s) shall not apply.

V. Appointments

To make an appointment with your Network Dentist, call the Dental Office that you have selected. When you call, your Dental Office will ask for your identification number and will check your eligibility.

VI. Broken Appointments

The time your Network Dentist schedules for your appointment is valuable to you and the dentist. Broken appointments make it difficult for your Dental Office to schedule time with other patients.

If you or your enrolled Dependent breaks an appointment with less than 24 hours notice to the Dental Office, you may be charged a broken appointment fee.

VII. Office Transfers

If you decide to change Dental Offices, we can arrange a transfer. You should complete any dental procedure in progress before transferring to another Dental Office. To arrange a transfer, call Customer Service at 1-800-Cigna24. To obtain a list of Dental Offices near you, visit our website at myCigna.com, or call the Dental Office Locator at 1-800-Cigna24.

Your transfer request will take about 5 days to process. Transfers will be effective the first day of the month after the processing of your request. Unless you have an emergency, you will be unable to schedule an appointment at the new Dental Office until your transfer becomes effective.

There is no charge to you for the transfer, however, all Patient Charges which you owe to your current Dental Office must be paid before the transfer can be processed.

VIII. 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 Network includes the following types of specialty dentists:

- 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 Specialty Dentist.

See Section IV.D., *Choice of Dentist*, regarding treatment by a Pediatric Dentist.

IX. Specialty Referrals

A. In General

Upon referral from a Network General Dentist, your Network Specialty Dentist will submit a specialty care treatment plan to Cigna Dental for payment authorization, except for Pediatrics, Orthodontics and 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 before treatment begins.

When Cigna Dental authorizes payment to the Network Specialty Dentist, the fees for 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 IX. B. *Orthodontics*. Treatment by the Network Specialist must begin within 90 days from the date of Cigna Dental's authorization. If you are unable to obtain treatment within the 90-day period, please call Customer Service to request an extension. Your coverage must be in effect when each procedure begins.

For non-Covered Services or if Cigna Dental does not authorize payment to the Network Specialty Dentist for Covered Services, including Adverse Determinations, you must pay the Network Specialty Dentist's Usual Fee.

If you have a question or concern regarding an authorization or a denial, contact Customer Service.

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

B. Orthodontics (This section is applicable only when Orthodontics is listed on your Patient Charge Schedule.)

Definitions - If your Patient Charge Schedule indicates coverage for orthodontic treatment, 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.

Patient Charges

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. However, if 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, 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, the fee listed on the Patient Charge Schedule is not applicable. Please call Customer Service at 1-800-Cigna24 to find out if you are entitled to any benefit under the Dental Plan.

X. Complex Rehabilitation/Multiple Crown Units

Complex rehabilitation is extensive dental restoration involving 6 or more "units" of crown, bridge and/or implant supported prosthesis (including crowns and bridges) in the same treatment plan. Using full crowns (caps), fixed bridges and/or implant supported prosthesis (including crowns and 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 the 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, bridge and/or implant supported prosthesis (including crowns and bridges) 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, bridge and/or implant supported prosthesis (including crowns and bridges) PLUS an additional charge for each unit when 6 or more units are prescribed in your Network General Dentist's treatment plan.

Note: Complex rehabilitation only applies for implant supported prosthesis, when implant supported prosthesis are specifically listed on your Patient Charge Schedule.

XI. 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 dentist 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.

A. Start With Customer Service

We are here to listen and to help. If you have a concern about your Dental Office or the Dental Plan, you can call 1-800-Cigna24 toll-free and explain your concern to one of our Customer Service Representatives. You can also express that concern in writing to Cigna Dental, P.O. Box 188047, Chattanooga, TN 37422-8047. We will do our best to resolve the matter during your initial contact. If we need more time to review or investigate your concern, we will get back to you as soon as possible, usually by the end of the next business day, but in any case within 15 working days.

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

B. Appeals Procedure

Cigna Dental has a two-step appeals procedure for coverage decisions. To initiate an appeal, you must submit a request in writing to Cigna Dental, P.O. Box 188047, Chattanooga, TN 37422-8047, within 1 year from the date of the initial Cigna Dental decision. You should state the reason you feel your appeal should be approved and include any information to support your

appeal. If you are unable or choose not to write, you may ask Customer Service to register your appeal by calling 1-800-Cigna24.

Level-One Appeals

Your level-one appeal will be reviewed and the decision made by someone not involved in the initial review. Appeals involving dental necessity or clinical appropriateness will be reviewed by a dental professional.

We will respond with a decision within 15 working days after we receive your appeal. If we need more time or information to make the decision, we will notify you in writing to request an extension of up to 15 calendar days and to specify any additional information needed to complete the review.

You may request that the 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, Cigna Dental will respond orally with a decision within 72 hours, followed up in writing.

If you are not satisfied with our level-one appeal decision, you may request a level-two appeal.

Level-Two Appeals

To initiate a level-two appeal, follow the same process required for a level-one appeal. Your level-two appeal will be reviewed and a decision made by someone not involved in the level-one appeal. For appeals involving dental necessity or clinical appropriateness, the decision will be made by a dentist. If specialty care is in dispute, the appeal will be conducted by a dentist in the same or similar specialty as the care under review.

The review will be completed within 15 working days. If we need more time or information to complete the review, we will notify you in writing to request an extension of up to 15 calendar days and to specify any additional information needed to complete the review. The decision will include the specific contractual or clinical reasons for the decision, as applicable.

You may request that the 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.

Appeals to the State

You have the right to contact the New Jersey Department of Insurance and/or Department of Health for assistance at any time.

Cigna Dental will not cancel or refuse to renew your coverage because you or your Dependent has filed a complaint or an appeal involving a decision made by Cigna Dental. You have the right to file suit in a court of law for any claim involving the professional treatment performed by a dentist.

XII. Dual Coverage

A. In General

“Coordination of benefits” is the procedure used to pay health care expenses when a person is covered by more than one plan. Cigna Dental follows rules established by New Jersey law to decide which plan pays first and how much the other plan must pay. The objective is to make sure the combined payments of all plans are no more than your actual bills.

When you or your family members are covered by another group plan in addition to this one, we will follow New Jersey coordination of benefit rules to determine which plan is primary and which is secondary. You must submit all bills first to the primary plan. The primary plan must pay its full benefits as if you had no other coverage. If the primary plan denies the claim or does not pay the full bill, you may then submit the balance to the secondary plan.

Cigna Dental pays for dental care when you follow our rules and procedures. If our rules conflict with those of another plan, it may be impossible to receive benefits from both plans, and you will be forced to choose which plan to use.

B. How Cigna Dental Pays As Primary Plan

When you receive care from a Network Specialty Dentist, Cigna Dental pays the Network Specialty Dentist a contracted fee amount less your copayment for the Covered Service. When we are primary, we will pay the full benefit allowed as if you had no other coverage.

C. How Cigna Dental Pays As Secondary Plan

- If your primary plan pays on the basis of UCR, Cigna Dental will pay the difference between the provider’s billed charges and the benefits paid by the primary plan

up to the amount Cigna Dental would have paid if primary. Cigna Dental's payment will first be applied toward satisfaction of your copayment of your primary plan. You will not be liable for any billed charges in excess of the sum of the benefits paid by your primary plan, Cigna Dental as your secondary plan and the copayment you paid under either the primary or secondary plan. When Cigna Dental pays as secondary, you will never be responsible for paying more than your copayment for the Covered Service.

- When both your primary plan and Cigna Dental pay network providers on the basis of a contractual fee schedule and the provider is a network provider of both plans, the allowable expense will be considered to be the contractual fee of your primary plan. Your primary plan will pay the benefit it would have paid regardless of any other coverage you may have. Cigna Dental will pay the copayment for the Covered Service for which you are liable up to the amount Cigna Dental would have paid if primary and provided that the total amount received by the provider from the primary plan, Cigna Dental and you does not exceed the contractual fee of the primary plan. You will not be responsible for an amount more than your copayment.
- When your primary plan pays network providers on a basis of capitation or a contractual fee schedule or pays a benefit on the basis of UCR, and Cigna Dental pays network providers on the basis of capitation and a service or supply is provided by a network provider of Cigna Dental, we will not be obligated to pay to the network provider any amount other than the capitation payment required under the contract between Cigna Dental and the network provider and we shall not be liable for any deductible, coinsurance or copayment imposed by your primary plan. You will not be responsible for the payment of any amount for eligible services.
- We will pay only for health care expenses that are covered by Cigna Dental.
- We will pay only if you have followed all of our procedural requirements, including: care is obtained from or arranged by your primary care dentist; coverage in effect when procedures begin; procedures begin within 90 days of referral.

XIII. Disenrollment From the Dental Plan – Termination of Benefits

A. Time Frames For Disenrollment/Termination

Except as otherwise provided in the sections titled “Extension/Continuation of Benefits” or in your Group Contract, disenrollment from the Dental Plan and termination of benefits will occur on the last day of the month:

- in which Premiums are not remitted to Cigna Dental;
- in which eligibility requirements are no longer met;
- after 30 days notice from Cigna Dental due to permanent breakdown of the dentist-patient relationship as determined by Cigna Dental, after at least two opportunities to transfer to another Dental Office;
- after 30 days notice from Cigna Dental due to fraud or misuse of dental services and/or Dental Offices;
- after 60 days notice by Cigna Dental, due to continued lack of a Dental Office in your Service Area;
- after voluntary disenrollment.

B. Effect on Dependents

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.

XIV. Extension of Benefits

Coverage for completion of a dental procedure which was started before your disenrollment from the Dental Plan will be extended for 90 days after disenrollment unless disenrollment was due to nonpayment of Premiums.

XV. Continuation of Benefits (COBRA)

For Groups with 20 or more employees, federal law requires the employer to offer continuation of benefits coverage for a specified period of time after termination of employment or reduction of work hours, for any reason other than gross misconduct. You will be responsible for sending payment of the required Premiums to the Group. Additional information is available through your Benefits Representative.

XVI. Conversion Coverage

If you are no longer eligible for coverage under your Group's Dental Plan, you and your enrolled Dependents may continue your dental coverage by enrolling in the Cigna Dental



conversion plan. You must enroll within three months after becoming ineligible for your Group's Dental Plan. Premium payments and coverage will be retroactive to the date coverage under your Group's Dental Plan ended. You and your enrolled Dependents are eligible for conversion coverage unless benefits were discontinued due to:

- permanent breakdown of the dentist-patient relationship;
- fraud or misuse of dental services and/or Dental Offices;
- nonpayment of Premiums by the Subscriber;
- selection of alternate dental coverage by your Group; or
- lack of network/Service Area.

Benefits and rates for Cigna Dental conversion coverage and any succeeding renewals will be based on the Covered Services listed in the then-current standard conversion plan and 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.

XVII. Confidentiality/Privacy

Cigna Dental is committed to maintaining the confidentiality of your personal and sensitive information. Information about Cigna Dental's confidentiality policies and procedures is made available to you during the enrollment process and/or as part of your customer plan materials. You may obtain additional information about Cigna Dental's confidentiality policies and procedures by calling Customer Service at 1-800-Cigna24, or via the Internet at myCigna.com.

XVIII. Miscellaneous

As a Cigna Dental plan customer, you may be eligible for various discounts, benefits, or other consideration for the purpose of promoting your general health and well being. Please visit our website at myCigna.com for details.

If you are a Cigna Dental Care customer you may also be eligible for additional dental benefits during certain health conditions. For example, certain frequency limitations for dental services may be relaxed for pregnant women and customers participating in certain disease management programs. Please review your plan enrollment materials for details.



Cigna Dental Health of Pennsylvania, Inc.

**P.O. Box 453099
Sunrise, Florida 33345-3099**

This Plan Booklet/Combined Evidence of Coverage and Disclosure Form/Certificate of Coverage is intended for your information; it constitutes a summary of the Dental Plan and is included as a part of the agreement between Cigna Dental and your Group (collectively, the “Group Contract”). The Group Contract must be consulted to determine the rates and the exact terms and conditions of coverage. If rates or coverages are changed under your Group Contract, your rates and coverage will also change. A prospective customer has the right to view the Combined Evidence of Coverage and Disclosure Form prior to enrollment. It should be read completely and carefully. Customers with special health care needs should read carefully those sections that apply to them. Please read the following information so you will know from whom or what group of providers dental care may be obtained.

NOTICE: IF YOU OR YOUR FAMILY MEMBERS ARE COVERED BY MORE THAN ONE HEALTH CARE PLAN, YOU MAY NOT BE ABLE TO COLLECT BENEFITS FROM BOTH PLANS. EACH PLAN MAY REQUIRE YOU TO FOLLOW ITS RULES OR USE SPECIFIC DOCTORS OR HOSPITALS, AND IT MAY BE IMPOSSIBLE TO COMPLY WITH BOTH PLANS AT THE SAME TIME. READ ALL OF THE RULES VERY CAREFULLY, INCLUDING THE DUAL COVERAGE SECTION.

Important Cancellation Information – Please Read the Provision Entitled “Disenrollment from the Dental Plan—Termination of Benefits.”

READ YOUR PLAN BOOKLET CAREFULLY

Please call Customer Service 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.

I. Definitions

Capitalized terms, unless otherwise defined, have the meanings listed below.

Adverse Determination - a decision by Cigna Dental not to approve 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 customer 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 approvals that are declined by Cigna Dental based upon the above criteria will be the responsibility of the customer at the dentist's Usual Fees. A licensed dentist will make any such denial.

Cigna Dental - 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 Dentist agreement with Cigna Dental.

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

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

Dental Plan - managed dental care plan offered through the Group Contract between Cigna Dental and your Group.

Dependent - your lawful spouse, or your Domestic Partner;

Your unmarried child (including newborns, adopted children, stepchildren, a child for whom you must provide dental coverage under a court order; or, a Dependent child who resides in your home as a result of court order or administrative placement) who is:

- (a) less than 26 years old; or
- (b) less than 26 years old if he or she is both:
 - i. a full-time student enrolled at an accredited educational institution, and
 - ii. reliant upon you for maintenance and support; or

(c) any age if he or she is both:

- i. incapable of self-sustaining employment due to mental or physical disability, and
- ii. reliant upon you for maintenance and support; or

(d) any unmarried child of yours who is:

- i. 19 years but less than 23 years old, enrolled in school as a full-time student and primarily supported by you. If while a full-time registered student, the child was called or ordered to active duty (other than active duty for training) for 30 or more consecutive days in the Pennsylvania National Guard or any reserve component of the armed forces of the United States, the child is eligible to enroll as a Dependent while a full-time student for a period equal to the duration of the military service. Eligibility in this situation will end when the child is no longer a full-time student. The child must submit the form provided by the Department of Military and Veterans Affairs to Cigna when initially called to duty, when returning from duty, and when reenrolling as a full-time student.

For a Dependent child 26 years of age or older who is a full-time student at an educational institution, coverage will be provided for an entire academic term during which the child begins as a full-time student and remains enrolled, regardless of whether the number of hours of instruction for which the child is enrolled is reduced to a level that changes the child's academic status to less than that of a full-time student.

For a child who falls into category (b) or (c) above, you will need to furnish Cigna Dental evidence of the child's reliance upon you, in the form requested, within 31 days after the Dependent reaches the age of 19 and once a year thereafter for as long as the child is claimed as a Dependent under the Plan.

A newly acquired dependent is a Dependent child who is adopted, born or otherwise becomes your Dependent after you become covered under the Plan. A child born of a Dependent child of a Subscriber shall also be considered a Subscriber's Dependent so long as such Dependent child remains eligible for benefits. Coverage for Dependents living outside a Cigna Dental Service Area is subject to the availability of an approved network where the Dependent resides.

Domestic Partner -

A. A person of the same or opposite sex who:

- 1. shares your permanent residence;
- 2. has resided with you for no less than one year;
- 3. is no less than eighteen years of age;
- 4. 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;

5. is not your blood relative any closer than would be prohibited for a legal marriage; and
 6. 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
- B. 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 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 disapproved by regulatory authorities.

Group - employer, labor union or other organization that has entered into a Group Contract with Cigna Dental for managed dental services on your behalf.

Network Dentist – a licensed dentist who has signed an agreement with Cigna Dental 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 - a licensed dentist who has signed an agreement with Cigna Dental under which he or she agrees to provide dental care services to you.

Network Specialty Dentist - a licensed dentist who has signed an agreement with Cigna Dental under which he or she agrees to provide specialized dental care services to you.

Patient Charge - the amount you owe your Network Dentist for any dental procedure listed on your Patient Charge Schedule.

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

Premiums - fees that your Group remits to Cigna Dental, on your behalf, during the term of your Group Contract.

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

Subscriber/You - the enrolled employee or customer of the Group.

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

II. Introduction To Your Cigna Dental Plan

Welcome to the Cigna Dental Plan. We encourage you to use your dental benefits. Please note that enrollment in the Dental Plan allows the release of patient records to Cigna Dental or its designee for health plan operation purposes.

III. Eligibility/When Coverage Begins

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

If you enrolled in the Dental Plan before the effective date of your Group Contract, you will be covered on the first day the Group Contract is effective. If you enrolled in the Dental Plan after the effective date of the Group Contract, you will be covered on the first day of the month following processing of your enrollment (unless effective dates other than the first day of the month are provided for in your Group Contract).

Dependents may be enrolled in the Dental Plan at the time you enroll, during an open enrollment, or within 31 days of becoming eligible due to a life status change such as marriage, birth, adoption, placement, or court or administrative order. You may drop coverage for your Dependents only during the open enrollment periods for your Group, unless there is a change in status such as divorce. Cigna Dental may require evidence of good dental health at your expense if you or your Dependents enroll after the first period of eligibility (except during open enrollment) or after disenrollment because of nonpayment of Premiums.

A Dependent child may be enrolled within 60 days of a court order.



If you have family coverage, a newly born child of a Dependent child is automatically covered during the first 31 days of life. If you wish to continue coverage beyond the first 31 days, the newborn needs to be enrolled in the Dental Plan and you need to begin to pay Premiums/Prepayment Fees during that period.

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 Premiums, if any, which you would have paid if you had not taken the leave. Additional information is available through your Benefits Representative.

IV. Your Cigna Dental Coverage

The information below outlines your coverage and will help you to better understand your Dental Plan. Included is information about which services are covered, which are not, and how much dental services will cost you. A copy of the Group Contract will be furnished to you upon your request.

A. Customer Service

If you have any questions or concerns about the Dental Plan, Customer Service Representatives are just a toll-free phone call away. They can explain your benefits or help with matters regarding your Dental Office or Dental Plan. For assistance with transfers, specialty referrals, eligibility, second opinions, emergencies, Covered Services, plan benefits, ID cards, location of Dental Offices, conversion coverage or other matters, call Customer Service from any location at 1.800.Cigna24. The hearing impaired may contact the state TTY toll-free relay service number listed in their local telephone directory.

B. Premiums

Your Group sends a monthly fee to Cigna Dental for customers participating in the Dental Plan. The amount and term of this fee is 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.

C. Other Charges – Patient Charges

Network General Dentists are typically reimbursed by Cigna Dental 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.

Your Patient Charge Schedule lists the dental procedures covered under your Dental Plan. Some dental procedures are covered at no charge to you. For other Covered Services, the Patient Charge Schedule lists the fees you must pay when you visit your Dental Office. 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 policies. Timely payment is important. It is possible that the Dental Office may add late charges to overdue balances.

Your Patient Charge Schedule is subject to annual change in accordance with your Group Contract. Cigna Dental will give written notice to your Group of any change in Patient Charges at least 60 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.

D. Choice of Dentist

You and your Dependents should have selected a Dental Office when you enrolled in the Dental Plan. If you did not, you must advise Cigna Dental of your Dental Office selection prior to receiving treatment. The benefits of the Dental Plan are available only at your Dental Office, except in the case of an emergency or when Cigna Dental otherwise approves payment for out-of-network benefits.

You may select a network Pediatric Dentist as the Network General Dentist for your Dependent child under age 13 by calling Customer Service at 1.800.Cigna24 to get a list of network Pediatric Dentists in your Service Area or if your Network General Dentist sends your child under the age of 13 to a network Pediatric Dentist, the network Pediatric Dentist's office will have primary responsibility for your child's care. For children 13 years and older, your Network General Dentist will provide care. If your child continues to visit the Pediatric Dentist upon the age of 13, you will be fully responsible for the Pediatric Dentist's Usual Fees. Exceptions for medical reasons may be considered on a case-by-case basis.

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 will let you know and will arrange a transfer to another Dental Office. Refer to the Section titled "Office Transfers" if you wish to change your Dental Office.

To obtain a list of Dental Offices near you, visit our website at myCigna.com, or 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 Customer Service.

E. Your Payment Responsibility (General Care)

For Covered Services at your Dental Office, you will be charged the fees listed on your Patient Charge Schedule. For services listed on your Patient Charge Schedule at any other dental office, you may be charged Usual Fees. For non-Covered Services, you are responsible for paying Usual Fees.

If, on a temporary basis, there is no Network General Dentist in your Service Area, Cigna Dental 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 will pay the non-Network Dentist the difference, if any, between his or her Usual Fee and the applicable Patient Charge.

See Section IX, *Specialty Referrals*, regarding payment responsibility for specialty care.

All contracts between Cigna Dental 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.

F. 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.

1. Emergency Care Away From Home

If you have an emergency while you are out of your Service Area or you are unable to contact your Network General Dentist, you may receive emergency Covered Services as defined above from any general dentist. Routine restorative procedures or definitive treatment (e.g. root canal) are not considered emergency care. You should return to your Network General Dentist for these procedures. For emergency Covered Services, you will be responsible for the Patient Charges listed on your Patient Charge Schedule. Cigna Dental will reimburse you the difference, if any, between the dentist's Usual Fee for emergency Covered Services and your Patient Charge, up to a total of \$50 per

incident. To receive reimbursement, send appropriate reports and x-rays to Cigna Dental at the address listed for your state on the front of this booklet.

2. 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.

G. Limitations on Covered Services

Listed below are limitations on services when covered by your Dental Plan:

- **Frequency** - The frequency of certain Covered Services, like cleanings, is limited. Your Patient Charge Schedule lists any limitations on frequency.
- **Pediatric Dentistry** - Coverage for treatment by a Pediatric Dentist ends on your child's 13th birthday. Effective on your child's 13th birthday, dental services must be obtained from a Network General Dentist however, exceptions for medical reasons may be considered on an individual basis.
- **Oral Surgery** - The surgical removal of an impacted wisdom tooth may not be covered if the tooth is not diseased or if the removal is only for orthodontic reasons. Your Patient Charge Schedule lists any limitations on oral surgery.
- **Periodontal (gum tissue and supporting bone) Services** – Periodontal regenerative procedures are limited to one regenerative procedure per site (or per tooth, if applicable), when covered on the Patient Charge Schedule.

Localized delivery of antimicrobial agents is limited to eight teeth (or eight sites, if applicable) per 12 consecutive months, when covered on the Patient Charge Schedule.
- **Clinical Oral Evaluations** – When this limitation is noted on the Patient Charge Schedule, periodic oral evaluations, comprehensive oral evaluations, comprehensive periodontal evaluations, and oral evaluations for patients under 3 years of age, are limited to a combined total of 4 evaluations during a 12 consecutive month period.
- **Surgical Placement of Implant Services** – When covered on the Patient Charge Schedule, surgical placement of a dental implant; repair, maintenance, or removal of a dental implant; implant abutment(s); or any services related to the surgical placement of a dental implant are limited to one per year with replacement of a surgical implant frequency limitation of one every 10 years.
- **Prosthesis Over Implant** - When covered on the Patient Charge Schedule, a prosthetic device, supported by an implant or implant abutment is considered a separate

distinct service(s) from surgical placement of an implant. Replacement of any type of prosthesis with a prosthesis supported by an implant or implant abutment is only covered if the existing prosthesis is at least 5 calendar years old, is not serviceable and cannot be repaired.

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 charges which would not have been made in any facility, other than a Hospital or a Correctional Institution owned or operated by the United States Government or by a state or municipal government if the person had no insurance;
- to the extent that payment is unlawful where the person resides when the expenses are incurred or the services are received;
- for the charges which the person is not legally required to pay;
- for charges which would not have been made if the person had no insurance;
- due to injuries which are intentionally self-inflicted.

H. Services Not Covered Under Your Dental Plan

Listed below are the services or expenses which are NOT covered under your Dental Plan and which are your responsibility at the dentist's Usual Fees. There is no coverage for:

- services not listed on the Patient Charge Schedule.
- services provided by a non-Network Dentist without Cigna Dental's prior approval (except emergencies, as described in Section IV.F).
- services related to an injury or illness paid under workers' compensation, occupational disease or similar laws.
- services provided or paid by or through a federal or state governmental agency or authority, political subdivision or a public program, other than Medicaid.
- services required while serving in the armed forces of any country or international authority or relating to a declared or undeclared war or acts of war.
- cosmetic dentistry or cosmetic dental surgery (dentistry or dental surgery performed solely to improve appearance) unless specifically listed on your Patient Charge Schedule. If bleaching (tooth whitening) is listed on your Patient Charge Schedule, only the use of take-home bleaching gel with trays is covered; all other types of bleaching methods are not covered.

- 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. There is no coverage for general anesthesia or intravenous sedation when used for the purposes of anxiety control or patient management.
- prescription medications.
- procedures, appliances or restorations if the main purpose is to: change vertical dimension (degree of separation of the jaw when teeth are in contact) or restore teeth which have been damaged by attrition, abrasion, erosion and/or abfraction.
- replacement of fixed and/or removable appliances (including fixed and removable orthodontic appliances) that have been lost, stolen, or damaged due to patient abuse, misuse or neglect.
- surgical placement of a dental implant; repair, maintenance, or removal of a dental implant; implant abutment(s); or any services related to the surgical placement of a dental implant, unless specifically listed on your Patient Charge Schedule.
- services considered to be unnecessary or experimental in nature or do not meet commonly accepted dental standards.
- procedures or appliances for minor tooth guidance or to control harmful habits.
- hospitalization, including any associated incremental charges for dental services performed in a hospital. (Benefits are available for Network Dentist charges for Covered Services performed at a hospital. Other associated charges are not covered and should be submitted to the medical carrier for benefit determination.)
- services to the extent you or your enrolled Dependent are compensated under any group medical plan, no-fault auto insurance policy, or uninsured motorist policy. Coverage for Covered Services to the extent compensated under group medical plan, no fault auto insurance policies or uninsured motorist policies is not excluded.
- the completion of crowns, bridges, dentures, or root canal treatment, already in progress on the effective date of your Cigna Dental coverage.
- the completion of implant supported prosthesis (including crowns, bridges and dentures) already in progress on the effective date of your Cigna Dental coverage, unless specifically listed on your Patient Charge Schedule.
- consultations and/or evaluations associated with services that are not covered.

- endodontic treatment and/or periodontal (gum tissue and supporting bone) surgery of teeth exhibiting a poor or hopeless periodontal prognosis.
- bone grafting and/or guided tissue regeneration when performed at the site of a tooth extraction unless specifically listed on your Patient Charge Schedule.
- bone grafting and/or guided tissue regeneration when performed in conjunction with an apicoectomy or periradicular surgery.
- intentional root canal treatment in the absence of injury or disease to solely facilitate a restorative procedure.
- services performed by a prosthodontist.
- localized delivery of antimicrobial agents when performed alone or in the absence of traditional periodontal therapy.
- any localized delivery of antimicrobial agent procedures when more than eight (8) of these procedures are reported on the same date of service.
- infection control and/or sterilization. Cigna Dental considers this to be incidental to and part of the charges for services provided and not separately chargeable.
- the recementation of any inlay, onlay, crown, post and core or fixed bridge within 180 days of initial placement. Cigna Dental considers recementation within this timeframe to be incidental to and part of the charges for the initial restoration.
- the recementation of any implant supported prosthesis (including crowns, bridges and dentures) within 180 days of initial placement. Cigna Dental considers recementation within this timeframe to be incidental to and part of the charges for the initial restoration unless specifically listed on your Patient Charge Schedule.
- services to correct congenital malformations, including the replacement of congenitally missing teeth.
- the replacement of an occlusal guard (night guard) beyond one per any 24 consecutive month period, when this limitation is noted on the Patient Charge Schedule.
- crowns, bridges and/or implant supported prosthesis used solely for splinting.
- resin bonded retainers and associated pontics.

Pre-existing conditions are not excluded if the procedures involved are otherwise covered under your Patient Charge Schedule.

Should any law require coverage for any particular service(s) noted above, the exclusion or limitation for that service(s) shall not apply.

V. Appointments

To make an appointment with your Network Dentist, call the Dental Office that you have selected. When you call, your Dental Office will ask for your identification number and will check your eligibility.

VI. Broken Appointments

The time your Network Dentist schedules for your appointment is valuable to you and the dentist. Broken appointments make it difficult for your Dental Office to schedule time with other patients.

If you or your enrolled Dependent breaks an appointment with less than 24 hours notice to the Dental Office, you may be charged a broken appointment fee.

VII. Office Transfers

If you decide to change Dental Offices, we can arrange a transfer. You should complete any dental procedure in progress before transferring to another Dental Office. To arrange a transfer, call Customer Service at 1.800.Cigna24. To obtain a list of Dental Offices near you, visit our website at myCigna.com, or call the Dental Office Locator at 1.800.Cigna24.

Your transfer request may take up to 5 days to process. Transfers will be effective the first day of the month after the processing of your request. Unless you have an emergency, you will be unable to schedule an appointment at the new Dental Office until your transfer becomes effective. You can check the status of your request by visiting myCigna.com or by calling us at 1.800.Cigna24.

There is no charge to you for the transfer; however, all Patient Charges which you owe to your current Dental Office must be paid before the transfer can be processed.

VIII. 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 Network includes the following types of specialty dentists:

- 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 Specialty Dentist.

See Section IV.D, *Choice of Dentist*, regarding treatment by a Pediatric Dentist.

IX. Specialty Referrals

A. In General

Preauthorization is not required for coverage of services by a Network Specialty Dentist.

When Cigna Dental approves payment to the Network Specialty Dentist, 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 IX.B., Orthodontics. Treatment by the Network Specialty Dentist must begin within 90 days from the date of Cigna Dental's approval. If you are unable to obtain treatment within the 90 day period, please call Customer Service to request an extension. Your coverage must be in effect when each procedure begins.

For non-Covered Services or if Cigna Dental does not approve payment to the Network Specialty Dentist for Covered Services, including Adverse Determinations, you must pay the Network Specialty Dentist's Usual Fee. If you have a question or concern regarding an approval or a denial, contact Customer Service.

After the Network Specialty Dentist has completed treatment, you should return to your Network General Dentist for cleanings, regular checkups and other treatment. If you visit a Network Specialty Dentist without a referral or if you continue to see a Network Specialty Dentist 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 Specialty Dentist is not available, as determined by Cigna Dental, Cigna Dental will approve a referral to a non-Network Specialty Dentist. 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 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 approved for payment, including Adverse Determinations, you must pay the dentist's Usual Fee.

B. Orthodontics (This section is applicable only when Orthodontics is listed on your Patient Charge Schedule.)

1. **Definitions** – If your Patient Charge Schedule indicates coverage for orthodontic treatment, the following definitions apply:
 - a. **Orthodontic Treatment Plan and Records** – the preparation of orthodontic records and a treatment plan by the Orthodontist.
 - b. **Interceptive Orthodontic Treatment** – treatment prior to full eruption of the permanent teeth, frequently a first phase preceding comprehensive treatment.
 - c. **Comprehensive Orthodontic Treatment** – treatment after the eruption of most permanent teeth, generally the final phase of treatment before retention.
 - d. **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.

2. Patient Charges

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. However, if 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, 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.

3. Additional Charges

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

- a. incremental costs associated with optional/elective materials, including but not limited to ceramic, clear, lingual brackets, or other cosmetic appliances;

- b. orthognathic surgery and associated incremental costs;
- c. appliances to guide minor tooth movement;
- d. appliances to correct harmful habits; and
- e. services which are not typically included in Orthodontic Treatment. These services will be identified on a case-by-case basis.

4. Orthodontics In Progress

If Orthodontic Treatment is in progress for you or your Dependent at the time you enroll, the fee listed on the Patient Charge Schedule is not applicable. Please call Customer Service at 1.800.Cigna24 to find out if you are entitled to any benefit under the Dental Plan.

X. Complex Rehabilitation/Multiple Crown Units

Complex rehabilitation is extensive dental restoration involving 6 or more “units” of crown, bridge and/or implant supported prosthesis (including crowns and bridges) in the same treatment plan. Using full crowns (caps), fixed bridges and/or implant supported prosthesis (including crowns and 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 the 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, bridge and/or implant supported prosthesis (including crowns and bridges) 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, bridge and/or implant supported prosthesis (including crowns and bridges) PLUS an additional charge for each unit when 6 or more units are prescribed in your Network General Dentist’s treatment plan.

Note: Complex rehabilitation only applies for implant supported prosthesis, when implant supported prosthesis are specifically listed on your Patient Charge Schedule.

XI. 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.

A. Start with Customer Service

We are here to listen and to help. If you have a concern about your Dental Office or the Dental Plan, you can call 1.800.Cigna24 toll-free and explain your concern to one of our Customer Service Representatives. You can also express that concern in writing to Cigna Dental, P.O. Box 188047, Chattanooga, TN 37422-8047. We will do our best to resolve the matter during your initial contact. If we need more time to review or investigate your concern, we will get back to you as soon as possible, usually by the end of the next business day, but in any case within 30 days.

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

B. Appeals Procedure

Cigna Dental has a two-step appeals procedure for coverage decisions. To initiate an appeal, you must submit a request in writing to Cigna Dental, P.O. Box 188047, Chattanooga, TN 37422-8047, within 1 year from the date of the initial Cigna Dental decision. You should state the reason you feel your appeal should be approved and include any information to support your appeal. If you are unable or choose not to write, you may ask Customer Service to register your appeal by calling 1.800.Cigna24.

1. Level-One Appeals

Your level-one appeal will be reviewed and the decision made by someone not involved in the initial review. Appeals involving dental necessity or clinical appropriateness will be reviewed by a dental professional.

If your appeal concerns a denied pre-authorization, we will respond with a decision within 15 calendar days after we receive your appeal. For appeals concerning all other coverage issues, we will respond with a decision within 30 calendar days after we receive your appeal. If we need more information to make your level-one appeal decision, we will notify you in writing to request an extension of up to 15

calendar days and to specify any additional information needed to complete the review.

You may request that the 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, Cigna Dental will respond orally with a decision within 72 hours, followed up in writing.

If you are not satisfied with our level-one appeal decision, you may request a level-two appeal.

2. Level-Two Appeals

To initiate a level-two appeal, follow the same process required for a level-one appeal. Your level-two appeal will be reviewed and a decision made by someone not involved in the level-one appeal. For appeals involving dental necessity or clinical appropriateness, the decision will be made by a dentist. If specialty care is in dispute, the appeal will be conducted by a dentist in the same or similar specialty as the care under review.

The review will be completed within 30 calendar days. If we need more information to complete the appeal, we will notify you in writing to request an extension of up to 15 calendar days and to specify any additional information needed to complete the review. The decision will include the specific contractual or clinical reasons for the decision, as applicable.

You may request that the 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.

3. Independent Review Procedure

The independent review procedure is a voluntary program arranged by the Dental Plan and is not available in all areas.

4. Appeals to the State

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

You always have the right to file a complaint with or seek assistance from the Pennsylvania Insurance Department, 1326 Strawberry Square, Harrisburg, Pennsylvania, 17120-0701, (717) 787-2317.

Cigna Dental will not cancel or refuse to renew your coverage because you or your Dependent has filed a complaint or an appeal involving a decision made by Cigna Dental. You have the right to file suit in a court of law for any claim involving the professional treatment performed by a dentist.

XII. Dual Coverage

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

If you or your Dependents have dental coverage through your spouse's employer or other sources such as an HMO or similar dental plan, 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.

Coordination of benefit rules are attached to the Group Contract and may be reviewed by contacting your Benefit Administrator. Cigna Dental coordinates benefits only for specialty care services.

All benefits provided under the Dental Plan shall be in excess of and not in duplication of first party medical benefits payable under the Pennsylvania Motor Vehicle Financial Responsibility Law, 75 Pa. C.S.A. § 1711, et. seq.

XIII. Disenrollment From the Dental Plan – Termination of Benefits

A. Time Frames for Disenrollment/Termination

Except as otherwise provided in the sections titled "Extension/Continuation of Benefits" or in your Group Contract, disenrollment from the Dental Plan and



termination of benefits will occur on the last day of the month:

1. in which Premiums are not remitted to Cigna Dental.
2. in which eligibility requirements are no longer met.
3. after 30 days notice from Cigna Dental due to permanent breakdown of the dentist-patient relationship as determined by Cigna Dental, after at least two opportunities to transfer to another Dental Office.
4. after 30 days notice from Cigna Dental due to fraud or misuse of dental services and/or Dental Offices.
5. after 60 days notice by Cigna Dental, due to continued lack of a Dental Office in your Service Area.
6. after voluntary disenrollment.

B. Effect on Dependents

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.

XIV. Extension of Benefits

Coverage for completion of a dental procedure (other than orthodontics) which was started before your disenrollment from the Dental Plan will be extended for 90 days after disenrollment unless disenrollment was due to nonpayment of Premiums.

Coverage for orthodontic treatment which was started before disenrollment from the Dental Plan will be extended to the end of the quarter or for 60 days after disenrollment, whichever is later, unless disenrollment was due to nonpayment of Premiums.

XV. Continuation of Benefits (COBRA)

For Groups with 20 or more employees, federal law requires the employer to offer continuation of benefits coverage for a specified period of time after termination of employment or reduction of work hours, for any reason other than gross misconduct. You will be responsible for sending payment of the required Premiums to the Group. Additional information is available through your Benefits Representative.

XVI. Conversion Coverage

If you are no longer eligible for coverage under your Group's Dental Plan, you and your enrolled Dependents may continue

your dental coverage by enrolling in the Cigna Dental conversion plan. You must enroll within three (3) months after becoming ineligible for your Group's Dental Plan. Premium payments and coverage will be retroactive to the date coverage under your Group's Dental Plan ended. You and your enrolled Dependents are eligible for conversion coverage unless benefits were discontinued due to:

- Permanent breakdown of the dentist-patient relationship,
- Fraud or misuse of dental services and/or Dental Offices,
- Nonpayment of Premiums by the Subscriber,
- Selection of alternate dental coverage by your Group, or
- Lack of network/Service Area.

Benefits and rates for Cigna Dental conversion coverage and any succeeding renewals will be based on the Covered Services listed in the then-current standard conversion plan and 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.

XVII. Confidentiality/Privacy

Cigna Dental is committed to maintaining the confidentiality of your personal and sensitive information. Information about Cigna Dental's confidentiality policies and procedures is made available to you during the enrollment process and/or as part of your customer plan materials. You may obtain additional information about Cigna Dental's confidentiality policies and procedures by calling Customer Service at 1.800.Cigna24, or via the Internet at myCigna.com.

XVIII. Miscellaneous

As a Cigna Dental plan customer, you may be eligible for various discounts, benefits, or other consideration for the purpose of promoting your general health and well being. Please visit our website at myCigna.com for details.

As a Cigna Dental plan customer, you may also be eligible for additional dental benefits during certain health conditions. For example, certain frequency limitations for dental services may be relaxed for pregnant women and customers participating in certain disease management programs. Please review your plan enrollment materials for details.

The Group Contract, including the Patient Charge Schedule, Pre-Contract Application, and Coordination of Benefits provisions, and any amendments or additions thereto, represents the entire agreement between the parties with respect to the subject matter. The invalidity or unenforceability of any section or sub-section of the contract



will not affect the validity or enforceability of the remaining sections or sub-sections.

The Group Contract is construed for all purposes as a legal document and will be interpreted and enforced in accordance with the pertinent laws and regulations of the Commonwealth of Pennsylvania and with pertinent federal laws and regulations.

PB09.PA

09.01.2020



Cigna Dental Health of Texas, Inc.

**1640 Dallas Parkway
Plano, TX 75093
my.cigna.com**

This Certificate of Coverage is intended for your information; and is included as a part of the agreement between Cigna Dental and your Group (collectively, the “Group Contract”). The Group Contract must be consulted to determine the rates and the exact terms and conditions of coverage. If rates or coverages are changed under your Group Contract, your rates and coverage will also be changed. Please read the following information so you will know from whom or what group of dentists dental care may be obtained.

Important Cancellation Information - Please Read the Provision Entitled “Disenrollment from the Dental Plan - Termination of Benefits.”

READ YOUR PLAN BOOKLET CAREFULLY

Please call Customer Service at 1-800-Cigna24 if you have any questions.

If you have a hearing or speech disability, please use your state Telecommunications Relay Service to call us. This service makes it easier for people who have hearing or speech disabilities to communicate with people who do not. Check your local telephone directory for your Relay Service’s phone number.

If you have a visual disability, you may call Customer Service and request this booklet in a larger print type or Braille.



Have a complaint or need help?

If you have a problem with a claim or your premium, call your insurance company or HMO first. If you can't work out the issue, the Texas Department of Insurance may be able to help.

Even if you file a complaint with the Texas Department of Insurance, you should also file a complaint or appeal through your insurance company or HMO. If you don't, you may lose your right to appeal.

Cigna Dental Health of Texas, Inc.

To get information or file a complaint with your insurance company or HMO:

Call: National Appeal Unit at 1-855-363-5836

Toll-free: 1-800-244-6224

Email: DenisonAppealTeam@cigna.com

Mail: P.O. Box 188047, Chattanooga, TN 37422

The Texas Department of Insurance

To get help with an insurance question or file a complaint with the state:

Call with a question: 1-800-252-3439

File a complaint: www.tdi.texas.gov

Email: ConsumerProtection@tdi.texas.gov

Mail: Consumer Protection, MC: CO-CP, Texas
Department of Insurance, P.O. Box 12030, Austin, TX
78711-2030



¿Tiene una queja o necesita ayuda?

Si tiene un problema con una reclamación o con su prima de seguro, llame primero a su compañía de seguros o HMO. Si no puede resolver el problema, es posible que el Departamento de Seguros de Texas (Texas Department of Insurance, por su nombre en inglés) pueda ayudar.

Aun si usted presenta una queja ante el Departamento de Seguros de Texas, también debe presentar una queja a través del proceso de quejas o de apelaciones de su compañía de seguros o HMO. Si no lo hace, podría perder su derecho para apelar.

Cigna Dental Health of Texas, Inc.

Para obtener información o para presentar una queja ante su compañía de seguros o HMO:

Llame a: National Appeal Unit al 1-855-363-5836

Teléfono gratuito: 1-800-244-6224

Correo electrónico: DenisonAppealTeam@cigna.com

Dirección postal: P.O. Box 188047, Chattanooga, TN 37422

El Departamento de Seguros de Texas

Para obtener ayuda con una pregunta relacionada con los seguros o para presentar una queja ante el estado:

Llame con sus preguntas al: 1-800-252-3439

Presente una queja en: www.tdi.texas.gov

Correo electrónico: ConsumerProtection@tdi.texas.gov

Dirección postal: Consumer Protection, MC: CO-CP, Texas Department of Insurance, P.O. Box 12030, Austin, TX 78711-2030

ction, MC: CO-CP, Texas Department of Insurance, P.O. Box 12030, Austin, TX 78711-2030

- If you believe that the network is inadequate, you may file a complaint with the Texas Department of Insurance at: www.tdi.texas.gov/consumer/complfrm.html.
- If your HMO approves a referral for out-of-network services because no network physician or provider is available, or if you have received out-of-network emergency care, the HMO must, in most cases, resolve the out-of-network physician's or provider's bill so that you only have to pay any applicable in-network copayment, coinsurance, and deductible amounts.
- You may obtain a current directory of network physicians and providers at the following website: myCigna.com or by calling 1.800.Cigna24 for assistance in finding available network physicians and providers. If you relied on materially inaccurate directory information, you may be entitled to have a claim by an out-of-network physician or provider paid as if it were from a network physician or provider, if you present a copy of the inaccurate directory information to the HMO, dated not more than 30 days before you received the service.

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NOTICE OF RIGHTS

- A health maintenance organization (HMO) plan provides no benefits for services you receive from out-of-network physicians or providers, with specific exceptions as described in your evidence of coverage and below.
- You have the right to an adequate network of in-network physicians and providers (known as network physicians and providers).



XVIII. Miscellaneous

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I. Definitions

Capitalized terms, unless otherwise defined, have the meanings listed below.

Adverse Determination - a determination by a utilization review agent that the dental care services provided or proposed to be furnished to you or your Dependents are not medically necessary or are experimental or investigational. To be considered medically necessary, the specialty referral procedure 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 customer or dentist 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 approvals that are declined by Cigna Dental based upon the above criteria will be the responsibility of the customer at the dentist's Usual Fees. A licensed dentist will make any such denial.

Cigna Dental - 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 Dentist agreement with Cigna Dental.

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

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

Dental Plan - managed dental care plan offered through the Group Contract between Cigna Dental and your Group.

Dependent - your lawful spouse; your unmarried child (including newborns, adopted children (includes a child who has become the subject of a suit for adoption), stepchildren, a child for whom you must provide dental coverage under a court order; or, a dependent child who resides in your home as a result of court order or administrative placement) who is:

- less than 25 years old; or
- any age if he or she is both:
 - incapable of self sustaining employment due to mental or physical disability; and
 - reliant upon you for maintenance and support.

A Dependent includes your grandchild if the child is your dependent for federal income tax purposes at the time of application, or a child for whom you must provide medical or dental support under a court order.

Coverage for dependents living outside a Cigna Dental Service Area is subject to the availability of an approved network where the dependent resides.

This definition of "Dependent" applies unless modified by your Group Contract.

Group - employer, labor union or other organization that has entered into a Group Contract with Cigna Dental for managed dental services on your behalf.

Network Dentist - a licensed dentist who has signed an agreement with Cigna Dental 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 - a licensed dentist who has signed an agreement with Cigna Dental under which he or she agrees to provide dental care services to you.

Network Specialty Dentist - a licensed dentist who has signed an agreement with Cigna Dental under which he or she agrees to provide specialized dental care services to you.

Patient Charge - the amount you owe your Network Dentist for any dental procedure listed on your Patient Charge Schedule.

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

Premiums - fees that your Group remits to Cigna Dental, on your behalf, during the term of your Group Contract.

Service Area - the geographical area designated by Cigna Dental within which it shall provide benefits and arrange for dental care services, as set out in the attached list of service areas.

Subscriber/You - the enrolled employee or customer of the Group.

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

II. Introduction To Your Cigna Dental Plan

Welcome to the Cigna Dental Plan. We encourage you to use your dental benefits. Please note that enrollment in the Dental Plan allows the release of patient records to Cigna Dental or its designee for health plan operation purposes.

III. Eligibility/When Coverage Begins

To enroll in the Dental Plan, you and your Dependents must live, work or reside within the Cigna Dental Service Area. Other eligibility requirements are determined by your Group.

If the legal residence of an enrolled Dependent is different from that of the Subscriber, the Dependent must:

- A. reside in the Service Area with a person who has temporary or permanent guardianship, including adoptees or children subject to adoption, and the Subscriber must have legal responsibility for that Dependent's health care; or
- B. reside in the Service Area, and the Subscriber must have legal responsibility for that Dependent's health care; or
- C. reside in the Service Area with the Subscriber's spouse; or
- D. reside anywhere in the United States when the Dependent's coverage is required by a medical or dental support order.

If you or your Dependent becomes eligible for Medicare, you may continue coverage so long as you or your Medicare-eligible Dependent meet all other group eligibility requirements.

If you enrolled in the Dental Plan before the effective date of your Group Contract, you will be covered on the first day the Group Contract is effective. If you enrolled in the Dental Plan after the effective date of the Group Contract, you will be covered on the first day of the month following processing of your enrollment (unless effective dates other than the first day of the month are provided for in your Group Contract).

Dependents may be enrolled in the Dental Plan at the time you enroll, during an open enrollment, or within 31 days of becoming eligible due to a life status change such as marriage, birth, adoption, placement, or court or administrative order. You may drop coverage for your Dependents only during the open enrollment periods for your Group, unless there is a change in status such as divorce. Cigna Dental may require evidence of good dental health at your expense if you or your Dependents enroll after the first period of eligibility (except during open enrollment) or after disenrollment because of nonpayment of Premiums.

If you have family coverage, 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 must be enrolled in the Dental Plan and you must begin paying Premiums, if any additional are due, during that period.

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 Premiums, if any, which you would have paid if you had not taken the leave. Additional information is available through your Benefits Representative.

IV. Your Cigna Dental Coverage

The information below outlines your coverage and will help you to better understand your Dental Plan. Included is information about which services are covered, which are not, and how much dental services will cost you. A copy of the Group Contract will be furnished to you upon your request.

A. Customer Service

If you have any questions or concerns about the Dental Plan, Customer Service Representatives are just a toll-free phone call away. They can explain your benefits or help with matters regarding your Dental Office or Dental Plan. For assistance with transfers, specialty referrals, eligibility, second opinions, emergencies, Covered Services, plan benefits, ID cards, location of Dental Offices, conversion coverage or other matters, call Customer Service from any location at 1-800-Cigna24. The hearing impaired may contact Customer Service through the State Relay Service located in your local telephone directory.

B. Premiums

Your Group sends a monthly fee to Cigna Dental for customers participating in the Dental Plan. The amount and term of this fee is 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. Your Premium is subject to annual change in accordance with your Group Contract. Cigna Dental will give written notice to your Group of any change in Premiums at least 60 days before any change.

In addition to any other premiums for which the Group is liable, the Group shall also be liable for a customer's premiums from the time the customer is no longer eligible for coverage under the contract until the end of the month in which the Group notifies Cigna Dental that the customer is no longer part of the group eligible for coverage.

C. Other Charges – Patient Charges

Cigna Dental typically pays Network General Dentists fixed monthly payments for each covered customer 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 that you pay, as set out in your Patient Charge Schedule.

Your Patient Charge Schedule lists the dental procedures covered under your Dental Plan. Some dental procedures are covered at no charge to you. For other Covered Services, the Patient Charge Schedule lists the fees you must pay when you visit your Dental Office. 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 policies. Timely payment is important. The Dental Office may add late charges to overdue balances.

Your Patient Charge Schedule is subject to annual change in accordance with your Group Contract. Cigna Dental will give written notice to your Group of any change in Patient Charges at least 60 days prior to such change. You must pay the Patient Charge listed on the Patient Charge Schedule that is in effect on the date a procedure is started.

D. Choice of Dentist

You and your Dependents should have selected a Dental Office when you enrolled in the Dental Plan. If you did not, you must advise Cigna Dental of your Dental Office selection prior to receiving treatment. The benefits of the Dental Plan are available only at your Dental Office, except in the case of an emergency or when Cigna Dental otherwise approves payment for out-of-network benefits.

You may select a network Pediatric Dentist as the Network General Dentist for your dependent children under age 13 by calling Customer Service at 1-800-Cigna24 to get a list of network Pediatric Dentists in your Service Area or if your Network General Dentist sends your child under the age of 13 to a network Pediatric Dentist, the network Pediatric Dentist's office will have primary responsibility for your child's care. For children 13 years and older, your Network General Dentist will provide care. If your child continues to visit the Pediatric Dentist upon the age of 13, you will be fully responsible for the Pediatric Dentist's Usual Fees. Exceptions for medical reasons may be considered on a case-by-case basis.

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 will let you know and will arrange a transfer to another Dental Office. Refer to the Section titled "Office Transfers" if you wish to change your Dental Office.

To obtain a list of Dental Offices near you, visit our website at myCigna.com, or 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 Customer Service.

E. Your Payment Responsibility (General Care)

For Covered Services at your Dental Office, you will be charged the fees listed on your Patient Charge Schedule. For services listed on your Patient Charge Schedule at any other dental office, you may be charged Usual Fees. For non-Covered Services, you are responsible for paying Usual Fees.

If on a temporary basis there is no Network General Dentist in your Service Area, Cigna Dental will let you know and you may obtain Covered Services from a non-Network Dentist. Cigna Dental will approve a referral to a non-Network Dentist within 5 business days. You will pay the non-Network Dentist the applicable Patient Charge for Covered Services. Cigna Dental will pay the non-Network Dentist the difference, if any, between his or her Usual Fee and the applicable Patient Charge.

See Section IX, *Specialty Referrals*, regarding payment responsibility for specialty care.

All contracts between Cigna Dental 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.

F. General Care - Reimbursement

Cigna Dental Health will acknowledge your claim for covered services within 15 days and accept, deny, or request additional information within 15 business days of receipt. If Cigna Dental Health accepts your claim, reimbursement for all appropriate covered services will be made within 5 days of acceptance.

G. Emergency Dental Care - Reimbursement

Emergency dental services are limited to procedures administered in a dental office, dental clinic or other comparable facility to evaluate and stabilize emergency dental conditions of recent onset and severity accompanied by excessive bleeding, severe pain, or acute infection that would lead a prudent layperson with average knowledge of dentistry to believe that immediate care is needed.

- 1. Emergency Care Away From Home** - If you have an emergency while you are out of your Service Area or unable to contact your Network General Dentist, you may receive emergency Covered Services as defined above without restrictions as to where the services are rendered. Routine restorative procedures or definitive treatment (e.g. root canal) are not considered emergency care. You should return to your Network General Dentist for these procedures.

For emergency Covered Services, you will be responsible for the Patient Charges listed on your Patient Charge Schedule. Cigna Dental will reimburse you the difference, if any, between the dentist's Usual Fee for emergency Covered Services and your Patient Charge.

To receive reimbursement, send appropriate reports and x-rays to Cigna Dental at the address listed on the front of this booklet. Cigna Dental Health will acknowledge your claim for emergency services within 15 days and accept, deny, or request additional information within 15 business days of receipt. If Cigna Dental Health accepts your claim, reimbursement for all appropriate emergency services will be made within 5 days of acceptance. Claims for non-emergency services will be processed within the same timeframes as claims for emergency services.

H. Limitations on Covered Services

Listed below are limitations on services when covered by your Dental Plan:

- **Frequency** - The frequency of certain Covered Services, like cleanings, is limited. Your Patient Charge Schedule lists any limitations on frequency. If your Network General Dentist certifies to Cigna Dental that, due to medical necessity, you require certain Covered Services more frequently than the limitation allows, Cigna Dental may waive the applicable limitation.
- **Pediatric Dentistry** - Coverage for treatment by a Pediatric Dentist ends on your child's 13th birthday. Effective on your child's 13th birthday, dental services must be obtained from a Network General Dentist; however, exceptions for medical reasons may be considered on an individual basis.
- **Oral Surgery** - The surgical removal of an impacted wisdom tooth may not be covered if the tooth is not diseased or if the removal is only for orthodontic reasons. Your Patient Charge Schedule lists any limitations on oral surgery.
- **Periodontal (gum tissue and supporting bone) Services** – Periodontal regenerative procedures are limited to one regenerative procedure per site (or per tooth, if applicable), when covered on the Patient Charge Schedule.

Localized delivery of antimicrobial agents is limited to eight teeth (or eight sites, if applicable) per 12 consecutive months, when covered on the Patient Charge Schedule.
- **Clinical Oral Evaluations** – When this limitation is noted on the Patient Charge Schedule, periodic oral evaluations, comprehensive oral evaluations,

comprehensive periodontal evaluations, and oral evaluations for patients under 3 years of age are limited to a combined total of 4 evaluations during a 12 consecutive month period.

- **Surgical Placement of Implant Services** – When covered on the Patient Charge Schedule, surgical placement of a dental implant; repair, maintenance, or removal of a dental implant; implant abutment(s); or any services related to the surgical placement of a dental implant are limited to one per year with replacement of a surgical implant frequency limitation of one every 10 years.
- **Prosthesis Over Implant** – When covered on the Patient Charge Schedule, a prosthetic device, supported by an implant or implant abutment is considered a separate distinct service(s) from surgical placement of an implant. Replacement of any type of prosthesis with a prosthesis supported by an implant or implant abutment is only covered if the existing prosthesis is at least 5 calendar years old, is not serviceable and cannot be repaired.

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 charges which would not have been made in any facility, other than a Hospital or a Correctional Institution owned or operated by the United States Government or by a state or municipal government if the person had no insurance;
- to the extent that payment is unlawful where the person resides when the expenses are incurred or the services are received;
- for the charges which the person is not legally required to pay;
- for charges which would not have been made if the person had no insurance;
- due to injuries which are intentionally self-inflicted.

I. Services Not Covered Under Your Dental Plan

Listed below are the services or expenses which are NOT covered under your Dental Plan and which are your responsibility at the dentist's Usual Fees. There is no coverage for:

- services not listed on the Patient Charge Schedule.
- services provided by a non-Network Dentist without Cigna Dental's prior approval (except emergencies, as described in Section IV. F.).

- services related to an injury or illness paid under workers' compensation, occupational disease or similar laws.
- services provided or paid by or through a federal or state governmental agency or authority, political subdivision or a public program, other than Medicaid.
- services required while serving in the armed forces of any country or international authority or relating to a declared or undeclared war or acts of war.
- cosmetic dentistry or cosmetic dental surgery (dentistry or dental surgery performed solely to improve appearance) unless specifically listed on your Patient Charge Schedule. If bleaching (tooth whitening) is listed on your Patient Charge Schedule, only the use of take-home bleaching gel with trays is covered; all other types of bleaching methods are not covered.
- 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. There is no coverage for general anesthesia or intravenous sedation when used for the purposes of anxiety control or patient management.
- prescription medications.
- procedures, appliances or restorations if the main purpose is to: change vertical dimension (degree of separation of the jaw when the teeth are in contact); restore teeth which have been damaged by attrition, abrasion, erosion and/or abfraction; or restore the occlusion.
- replacement of fixed and/or removable appliances (including fixed and removable orthodontic appliances) that have been lost, stolen, or damaged due to patient abuse, misuse or neglect.
- surgical placement of a dental implant, repair, maintenance, or removal of a dental implant; implant abutment(s); or any services related to the surgical placement of a dental implant, unless specifically listed on your Patient Charge Schedule.
- services considered to be unnecessary or experimental in nature or do not meet commonly accepted dental standards.
- procedures or appliances for minor tooth guidance or to control harmful habits.
- hospitalization, including any associated incremental charges for dental services performed in a hospital. (Benefits are available for Network Dentist charges for Covered Services performed at a hospital. Other associated charges are not covered and should be submitted to the medical carrier for benefit determination.)
- services to the extent you or your enrolled Dependent are compensated under any group medical plan, no-fault auto insurance policy, or uninsured motorist policy.
- crowns, bridges and/or implant supported prosthesis used solely for splinting.
- resin bonded retainers and associated pontics.
- consultations and/or evaluations associated with services that are not covered.
- endodontic treatment and/or periodontal (gum tissue and supporting bone) surgery of teeth exhibiting a poor or hopeless prognosis.
- bone grafting and/or guided tissue regeneration when performed at the site of a tooth extraction unless specifically listed on your Patient Charge Schedule.
- bone grafting and/or guided tissue regeneration when performed in conjunction with an apicoectomy or periradicular surgery.
- intentional root canal treatment in the absence of injury or disease to solely facilitate a restorative procedure.
- services performed by a prosthodontist.
- localized delivery of antimicrobial agents when performed alone or in the absence of traditional periodontal therapy.
- any localized delivery of antimicrobial agent procedures when more than eight (8) of these procedures are reported on the same date of service.
- infection control and/or sterilization. Cigna Dental considers this to be incidental to and part of the charges for services provided and not separately chargeable.
- the recementation of any inlay, onlay, crown, post and core, or fixed bridge within 180 days of initial placement. Cigna Dental considers recementation within the timeframe to be incidental to and part of the charges for the initial restoration.
- the recementation of any implant supported prosthesis (including crowns, bridges and dentures) within 180 days of initial placement. Cigna Dental considers recementation within the timeframe to be incidental to and part of the charges for the initial restoration unless specifically listed on your Patient Charge Schedule.
- services to correct congenital malformations, including the replacement of congenitally missing teeth.
- the replacement of an occlusal guard (night guard) beyond one per any 24 consecutive month period, when

this limitation is noted on your Patient Charge Schedule.

Pre-existing conditions are not excluded if the procedures involved are otherwise covered under your Patient Charge Schedule.

Should any law require coverage for any particular service(s) noted above, the exclusion or limitation for that service(s) shall not apply.

V. Appointments

To make an appointment with your Network Dentist, call the Dental Office that you have selected. When you call, your Dental Office will ask for your identification number and will check your eligibility.

VI. Broken Appointments

The time your Network Dentist schedules for your appointment is valuable to you and the dentist. Broken appointments make it difficult for your Dental Office to schedule time with other patients. If you must change your appointment, please contact your dentist at least 24 hours before the scheduled time.

VII. Office Transfers

If you decide to change Dental Offices, we can arrange a transfer at no charge. You should complete any dental procedure in progress before transferring to another Dental Office. To arrange a transfer, call Customer Service at 1-800-Cigna24. To obtain a list of Dental Offices near you, visit our website at myCigna.com, or call the Dental Office Locator at 1-800-Cigna24.

Your transfer may take up to 5 days to process. Transfers will be effective the first day of the month after the processing of your request. Unless you have an emergency, you will be unable to schedule an appointment at the new Dental Office until your transfer becomes effective. You can check the status of your request by visiting myCigna.com, or by calling us 1-800-Cigna24.

Network Dentists are Independent Contractors. Cigna Dental cannot require that you pay your Patient Charges before processing of your transfer request; however, it is suggested that all Patient Charges owed to your current Dental Office be paid prior to transfer.

VIII. 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 Network includes the following types of specialty dentists:

- 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 Specialty Dentist.

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

Contact your Benefit Administrator for more information.

See Section IV.D, *Choice of Dentist*, regarding treatment by a Pediatric Dentist

IX. Specialty Referrals

A. In General

Preauthorization is not required for coverage of services by a Network Specialty Dentist.

When Cigna Dental approves payment to the Network Specialty Dentist, 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 IX. B, **Orthodontics**. Treatment by the Network Specialty Dentist must begin within 90 days from the date of Cigna Dental's approval. If you are unable to obtain treatment within the 90-day period, please call Customer Service to request an extension. Your coverage must be in effect when each procedure begins.

For non-Covered Services or if Cigna Dental does not approve payment to the Network Specialty Dentist for Covered Services, including Adverse Determinations, you must pay the Network Specialty Dentist's Usual Fee. If you have a question or concern regarding an approval or a denial, contact Customer Service.

After the Network Specialty Dentist has completed treatment, you should return to your Network General Dentist for cleanings, regular checkups and other treatment. If you visit a Network Specialty Dentist without a referral or if you continue to see a Network

Specialty Dentist after you have completed specialty care, you must pay for treatment at the dentist's Usual Fees.

When your Network General Dentist determines that you need specialty care and a Network Specialty Dentist is not available, as determined by Cigna Dental, Cigna Dental will approve a referral to a non-Network Specialty Dentist within 5 business days. 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 will pay 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 approved for payment, including Adverse Determinations, you must pay the dentist's Usual Fee.

B. Orthodontics (This section is applicable only when Orthodontics is listed on your Patient Charge Schedule.)

1. **Definitions** - If your Patient Charge Schedule indicates coverage for orthodontic treatment, the following definitions apply:
 - a. **Orthodontic Treatment Plan and Records** - the preparation of orthodontic records and a treatment plan by the Orthodontist.
 - b. **Interceptive Orthodontic Treatment** - treatment prior to full eruption of the permanent teeth, frequently a first phase preceding comprehensive treatment.
 - c. **Comprehensive Orthodontic Treatment** - treatment after the eruption of most permanent teeth, generally the final phase of treatment before retention.
 - d. **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.

2. Patient Charges

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. However, if 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 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.

3. **Additional Charges** - You will be responsible for the Orthodontist's Usual Fees for the following non-Covered Services:
 - a. incremental costs associated with optional/elective materials, including but not limited to ceramic, clear, lingual brackets, or other cosmetic appliances;
 - b. orthognathic surgery and associated incremental costs;
 - c. appliances to guide minor tooth movement;
 - d. appliances to correct harmful habits; and
 - e. services which are not typically included in orthodontic treatment. These services will be identified on a case-by-case basis.
4. **Orthodontics in Progress** - If orthodontic treatment is in progress for you or your Dependent at the time you enroll, the fee listed on the Patient Charge Schedule is not applicable. Please call Customer Service at 1-800-Cigna24 to find out if you are entitled to any benefit under the Dental Plan.

X. Complex Rehabilitation/Multiple Crown Units

Complex rehabilitation is extensive dental restoration involving 6 or more "units" of crown, bridge and/or implant supported prosthesis (including crowns and bridges) in the same treatment plan. Using full crowns (caps), fixed bridges and/or implant supported prosthesis (including crowns and 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 the 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, bridge and/or implant supported prosthesis (including crowns and bridges) 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, bridge and/or implant supported prosthesis (including crowns and bridges) PLUS an additional charge for

each unit when 6 or more units are prescribed in your Network General Dentist's treatment plan.

Note: Complex rehabilitation only applies for implant supported prosthesis, when implant supported prosthesis are specifically listed on your Patient Charge Schedule.

XI. 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 dentist 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.

A. Start With Customer Service

We are here to listen and to help. If you have a question about your Dental Office or the Dental Plan, you can call the toll-free number to reach one of our Customer Service Representatives. We will do our best to respond upon your initial contact or get back to you as soon as possible, usually by the end of the next business day. You can call Customer Service at 1-800-Cigna24 or you may write P.O. Box 188047, Chattanooga, TN 37422-8047.

If you are unable to undergo dental treatment in an office setting or under local anesthesia due to a documented physical, mental, or medical reason as determined by the dentist providing you dental care, please contact Cigna at 1-800-Cigna24 and we will assist you in getting the care you need.

B. Appeals Procedure

1. Problems Concerning Plan Benefits, Quality of Care, or Plan Administration

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

a. Level One Review ("Complaint")

For the purposes of this section, a complaint means a written or oral expression of dissatisfaction with any aspect of the Dental Plan's operation. A complaint is not (1) a misunderstanding or misinformation that is resolved promptly by supplying the appropriate information or clearing up a misunderstanding to your satisfaction; nor (2) you or your dentist's dissatisfaction or disagreement with an Adverse Determination.

To initiate a complaint, submit a request in writing to the Dental Plan stating 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 Customer Service to register your request by calling the toll-free number.

Within 5 business days of receiving your complaint, we will send you a letter acknowledging the date the complaint was received, a description of the complaint procedure and timeframes for resolving your complaint. For oral complaints, you will be asked to complete a one-page complaint form to confirm the nature of your problem or to provide additional information.

Upon receipt of your written complaint or one-page complaint form, Customer Service will review and/or investigate your problem. Your complaint will be considered and the resolution made by someone not involved in the initial decision or occurrence. Issues involving clinical appropriateness will be considered by a dental professional. A written resolution will be provided to you within 30 calendar days. If applicable, the written resolution will include a statement of the specific dental or contractual reasons for the resolution, the specialization of any dentist consulted, and a description of the appeals process, including the time frames for the appeals process and final decision of the appeal. If you are not satisfied with our decision, you may request an appeal.

b. Level Two Review ("Appeal")

Cigna Dental will acknowledge your appeal in writing within 5 business days. The acknowledgment will include the name, address, and telephone number of the Appeals Coordinator. The review will be held at Cigna Dental Health's administrative offices or at another location within the Service Area, including the location where you normally receive services, unless you agree to another site.

Additional information may be requested at that time. Second level reviews will be conducted by an Appeals Committee, which will include:

- (1) An employee of Cigna Dental Health;
- (2) A dentist who will preside over the Appeals Panel; and

- (3) An enrollee who is not an employee of Cigna Dental Health.

Anyone involved in the prior decision may not vote on the Appeals Committee. If specialty care is in dispute, the Committee will include a dentist in the same or similar specialty as the care under consideration, as determined by Cigna Dental. The review will be held and you will be notified in writing of the Committee's decision within 30 calendar days.

Cigna Dental will identify the committee members to you and provide copies of any documentation to be used during the review no later than 5 business days before the review, unless you agree otherwise. You, or your designated representative if you are a minor or disabled, may appear in person or by conference call before the Appeals Committee; present expert testimony; and, request the presence of and question any person responsible for making the prior determination that resulted in your appeal.

Please advise Cigna Dental 5 days in advance if you or your representative plans to be present. Cigna Dental will pay the expenses of the Appeals Committee; however, you must pay your own expenses, if any, relating to the Appeals process including any expenses of your designated representative.

The appeal will be heard and you will be notified in writing of the committee's decision within 30 calendar days from the date of your request. Notice of the Appeals Committee's decision will include a statement of the specific clinical determination, the clinical basis and contractual criteria used, and the toll-free telephone number and address of the Texas Department of Insurance.

2. Problems Concerning Adverse Determinations

a. Appeals

For the purpose of this section, a complaint concerning an Adverse Determination constitutes an appeal of that determination. You, your designated representative, or your dentist may appeal an Adverse Determination orally or in writing. We will acknowledge the appeal in writing within 5 working days of receipt, confirming the date we received the appeal, outlining the appeals procedure, and requesting any documents you should send us. For oral appeals, we will include a one-page appeal form.

Appeal decisions will be made by a licensed dentist; provided that, if the appeal is denied and your dentist sends us a letter showing good cause, the denial will be reviewed by a specialty dentist in the same or similar specialty as the care under review. The specialty review will be completed within 15 working days of receipt.

We will send you and your dentist a letter explaining the resolution of your appeal as soon as practical but in no case later than 30 calendar days after we receive the request. If the appeal is denied, the letter will include:

- (1) the clinical basis and principal reasons for the denial;
- (2) the specialty of the dentist making the denial;
- (3) a description of the source of the screening criteria used as guidelines in making the adverse determination; and
- (4) notice of the rights to seek review of the denial by an independent review organization and the procedure for obtaining that review.

b. Independent Review Organization

If the appeal of an Adverse Determination is denied, you, your representative, or your dentist have the right to request a review of that decision by an Independent Review Organization ("IRO".) The written denial outlined above will include information on how to appeal the denial to an IRO, and the forms that must be completed and returned to us to begin the independent review process.

In life-threatening situations, you are entitled to an immediate review by an IRO without having to comply with our procedures for internal appeals of Adverse Determinations. Call Customer Service to request the review by the IRO if you have a life-threatening condition and we will provide the required information.

In order to request a referral to an IRO, the reason for the denial must be based on a medical necessity determination by Cigna Dental. Administrative, eligibility or benefit coverage limits are not eligible for additional review under this process.

c. Expedited Appeals

You may request that the above complaint and appeal process be expedited if the timeframes 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.

Investigation and resolution of expedited complaints and appeals will be concluded in accordance with the clinical immediacy of the case but will not exceed 1 business day from receipt of the complaint. If an expedited appeal involves an ongoing emergency, you may request that the appeal be reviewed by a dental professional in the same or similar specialty as the care under consideration.

d. Filing Complaints with the Texas Department of Insurance

Any person, including persons who have attempted to resolve complaints through our complaint system process and who are dissatisfied with the resolution, may file a complaint in writing with the Texas Department of Insurance at P.O. Box 149091, Austin, Texas 78714-9091, or you may call their toll-free number, 1-800-252-3439.

The Department will investigate a complaint against Cigna Dental to determine compliance with insurance laws within 30 days after the Department receives your complaint and all information necessary for the Department to determine compliance. The Department may extend the time necessary to complete an investigation in the event any of the following circumstances occur:

- (1) additional information is needed;
- (2) an on-site review is necessary;
- (3) we, the physician or dentist, or you do not provide all documentation necessary to complete the investigation; or
- (4) other circumstances occur that are beyond the control of the Department.

Cigna Dental cannot retaliate against a Network General Dentist or Network Specialty Dentist for filing a complaint or appealing a decision on your behalf. Cigna Dental 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. You have the right to file suit in a court of law for any claim

involving the professional treatment performed by a Dentist.

XII. Treatment In Progress

A. Treatment In Progress For Procedures Other Than Orthodontics

If your dental treatment is in progress when you enroll in the Cigna Dental Plan, you should check to make sure your dentist is in the Cigna Dental Plan Network by contacting Customer Service at 1-800-Cigna24 as treatment in progress will only be covered on an in-network basis. You can elect a new dentist at this time. If you do not, your treatment expenses will not be covered by the Cigna Dental Plan.

B. Treatment in Progress For Orthodontics

If orthodontic treatment is in progress for you or your Dependent at the time you enroll in this Dental plan, the copays listed on your Patient Charge Schedule do not apply to treatment that is already in progress. This is because your enrollment in this Dental plan does not override any obligation you or your Dependent may have under any agreement with an Orthodontist prior to your enrollment. Cigna may make a quarterly contribution toward the completion of your treatment, even if your Orthodontist does not participate in the Cigna Dental Health network. Cigna's contribution is based on the Patient Charge Schedule selected by your Employer and the number of months remaining to complete your interceptive or comprehensive treatment, excluding retention. Please call Customer Service at 1-800-Cigna24 to obtain an Orthodontics in Progress Information Form. You and your Orthodontist should complete this form and return it to Cigna to receive confirmation of Cigna's contribution.

XIII. 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. Termination of Your Group

1. due to nonpayment of Premiums, coverage shall remain in effect for 30 days after the due date of the Premium. If the late payment is received within the 30-day grace period, a 20% penalty will be added to the Premium. If payment is not received within the 30 days, coverage will be canceled on the 31st day

and the terminated customers will be liable for the cost of services received during the grace period.

2. either the Group or Cigna Dental Health may terminate the Group Contract, effective as of any renewal date of the Group Contract, by providing at least 60 days prior written notice to the other party.

B. Termination of Benefits For You and/or Your Dependents

1. the last day of the month in which Premiums are not paid to Cigna Dental.
2. the last day of the month in which eligibility requirements are no longer met.
3. the last day of the month in which your Group notifies Cigna Dental of your termination from the Dental Plan.
4. the last day of the month after voluntary disenrollment.
5. upon 15 days written notice from Cigna Dental due to fraud or intentional material misrepresentation or fraud in the use of services or dental offices.
6. immediately for misconduct detrimental to safe plan operations and delivery of services.
7. for failure to establish a satisfactory patient-dentist relationship, Cigna Dental will give 30 days written notification that it considers the relationship unsatisfactory and will specify necessary changes. If you fail to make such changes, coverage may be cancelled at the end of the 30-day period.
8. upon 30 days notice, due to neither residing, living nor working in the Service Area. Coverage for a dependent child who is the subject of a medical or dental support order cannot be cancelled solely because the child does not reside, live or work in the Service Area.

When coverage for one of your Dependents ends, you and your other Dependents may continue to be enrolled. When your coverage ends, your Dependents coverage will also end.

XIV. Extension of Benefits

Coverage for completion of a dental procedure (other than orthodontics) which was started before your disenrollment from the Dental Plan will be extended for 90 days after disenrollment unless disenrollment was due to nonpayment of Premiums.

Coverage for orthodontic treatment which was started before disenrollment from the Dental Plan will be extended to the end of the quarter or for 60 days after disenrollment, whichever is

later, unless disenrollment was due to nonpayment of Premiums.

XV. Continuation of Benefits (COBRA)

For Groups with 20 or more employees, federal law requires the employer to offer continuation of benefits coverage for a specified period of time after termination of employment or reduction of work hours, for any reason other than gross misconduct. You will be responsible for sending payment of the required Premiums to the Group. Additional information is available through your Benefits Representative.

Under Texas law you may also choose continuation coverage for you and your Dependents if coverage is terminated for any reason except your involuntary termination for cause and if you or your Dependent has been continuously covered for 3 consecutive months prior to the termination. You must request continuation coverage from your Group in writing and pay the monthly Premiums, in advance, within 60 days of the date your termination ends or the date your Group notifies you of your rights to continuation. If you elect continuation coverage, it will not end until the earliest of:

- A. 9 months after the date you choose continuation coverage if you or your dependents are not eligible for COBRA.
- B. 6 months after the date you choose continuation coverage if you or your dependents are eligible for COBRA;
- C. the date you and/or your Dependent becomes covered under another dental plan;
- D. the last day of the month in which you fail to pay Premiums; or
- E. the date the Group Contract ends.

You must pay your Group the amount of Premiums plus 2% in advance on a monthly basis. You must make the first premium payment no later than the 45th day following your election for continued coverage. Subsequent premium payments will be considered timely if you make such payments by the 30th day after the date that payment is due.

XVI. Conversion Coverage

If you are no longer eligible for coverage under your Group's Dental Plan, you and your enrolled Dependents may continue your dental coverage by enrolling in the Cigna Dental conversion plan. You must enroll within three months after becoming ineligible for your Group's Dental Plan. Premium payments and coverage will be retroactive to the date your Group coverage ended. 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 by the Subscriber; or
- D. selection of alternate dental coverage by your Group.

Benefits for conversion coverage will be based on the then-current standard conversion plan and may not be the same as those for your Group's Dental Plan. Premiums will be the Cigna Dental conversion premiums in effect at the time of conversion. Conversion premiums may not exceed 200% of Cigna Dental's premiums charged to groups with similar coverage. Please call the Cigna Dental Conversion Department at 1-800-Cigna24 to obtain rates and make arrangements for continuing coverage.

XVII. Confidentiality/Privacy

Cigna Dental is committed to maintaining the confidentiality of your personal and sensitive information. Information about Cigna Dental's confidentiality policies and procedures is made available to you during the enrollment process and/or as part of your customer plan materials. You may obtain additional information about Cigna Dental's confidentiality policies and procedures by calling Customer Service at 1-800-Cigna24 or via the Internet at myCigna.com.

XVIII. Miscellaneous

- A. As a Cigna Dental plan customer you may also be eligible for additional dental benefits during certain health conditions. For example, certain frequency limitations for dental services may be relaxed for pregnant women and customers participating in certain disease management programs. Please review your plan enrollment materials for details.
- B. **Notice:** Any notice required by the Group Contract shall be in writing and mailed with postage fully prepaid and addressed to the entities named in the Group Contract.
- C. **Incontestability:** All statements made by a Subscriber on the enrollment application shall be considered representations and not warranties. The statements are considered to be truthful and are made to the best of the Subscriber's knowledge and belief. A statement may not be used in a contest to void, cancel, or non-renew an enrollee's coverage or reduce benefits unless it is in a written enrollment application signed by you, and a signed copy of the enrollment application is or has been furnished to you or your personal representative.

This Certificate of Coverage may only be contested because of fraud or intentional misrepresentation of material fact on the enrollment application.

- D. **Entire Agreement:** The Contract, Pre-Contract Application, amendments and attachments thereto represent the entire agreement between Cigna Dental Health and your Group. Any change in the Group Contract must be approved by an officer of Cigna Dental Health and attached thereto; no agent has the authority to change the Group Contract or waive any of its provisions. In the event this Certificate contains any provision not in conformity with the Texas Health Maintenance Organization Act (the Act) or other applicable laws, this Certificate shall not be rendered invalid but shall be construed and implied as if it were in full compliance with the Act or other applicable laws.
- E. **Conformity With State Law:** If this Certificate of Coverage contains any provision not in conformity with the Texas Insurance Code Chapter 1271 or other applicable laws, it shall not be rendered invalid but shall be considered and applied as if it were in full compliance with the Texas Insurance Code Chapter 1271 and other applicable laws.

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Cigna Dental Health Texas Service Areas

Amarillo Area:

Armstrong
Briscoe
Carson
Castro
Childress
Collingsworth
Dallam
Deaf Smith
Donley
Gray
Hall
Hansford
Hartley
Hemphill
Hutchinson
Lipscomb
Moore
Ochiltree
Oldham
Parmer
Potter
Randall
Roberts
Sherman
Swisher
Wheeler

Austin Area:

Bastrop
Caldwell
Fayette
Hays
Travis
Williamson

Houston-Beaumont Area:

Austin
Brazoria
Chambers
Colorado
Fort Bend
Galveston
Grimes
Hardin
Harris
Jasper
Jefferson
Liberty
Montgomery
Newton
Orange
Polk
San Jacinto
Tyler
Walker
Waller
Washington
Wharton

San Angelo Area:

Coke
Concho
Irion
Menard
Runnels
Schleicher
Sterling
Tom Greene

Lubbock Area:

Bailey
Borden
Cochran
Cottle
Crosby
Dawson
Dickson
Floyd
Gaines
Garza
Hale
Hockley
Kent
King
Lamb
Lubbock
Lynn
Motley
Scurry
Stonewall
Terry
Yoakum

Lufkin Area:

Angelina
Houston
Leon
Madison
Nacogdoches
Sabine
San Augustine
Shelby
Trinity

Fort Worth Area:

Clay
Collin
Cooke
Dallas
Denton
Ellis
Fannin
Grayson
Hill
Hood
Hunt
Jack
Johnson
Kaufman
Montague
Navarro
Parker
Rockwall
Somerville
Tarrant
Wise

Brownsville, McAllen,

Laredo Area:

Cameron
Dimmit
Hidalgo
Jim Hogg
LaSalle
Maverick
Starr
Web
Willacy
Zapata

**Tyler/Longview Area:**

Anderson
Cherokee
Camp
Cass
Franklin
Gregg
Harrison
Henderson
Hopkins
Marion
Morris
Panola
Rains
Rusk
Smith
Titus
Upshur
Van Zandt
Wood

Victoria Area:

Aransas
Bastrop
Calhoun
DeWitt
Jackson
Lavaca
Lee
Matagorda
Victoria

College Station-Bryan Area:

Brazos
Burleson
Madison

Abilene Area:

Brown
Callahan
Coleman
Comanche
Eastland
Fisher
Hamilton
Llano
Jones
Mason
McCulloch
Mills
Mitchell
Nolan
San Saba
Shackelford
Taylor

Waco Area:

Bell
Bosque
Burnet
Coryell
Falls
Freestone
Lampasas
Limestone
McClennan
Milam
Robertson

Texarkana Area:

Bowie
Delta
Lamar
Red River

San Antonio Area:

Atascosa
Bandera
Bexar
Blanco
Comal
Frio
Gillespie
Gonzales
Guadeloupe
Karnes
Kendall
Kerr
Medina
Wilson

Corpus Christi Area:

Bee
Brooks
Duval
Goliad
Jim Wells
Kennedy
Kleberg
Live Oak
Nueces
Refugio
San Patricio

El Paso Area:

Culberson
El Paso
Hudspeth
Jeff Davis
Reeves

Wichita Falls Area:

Archer
Baylor
Erath
Foard
Hardeman
Haskell
Knox
Palo Pinto
Stephens
Throckmorton
Wichita
Wilbarger
Young

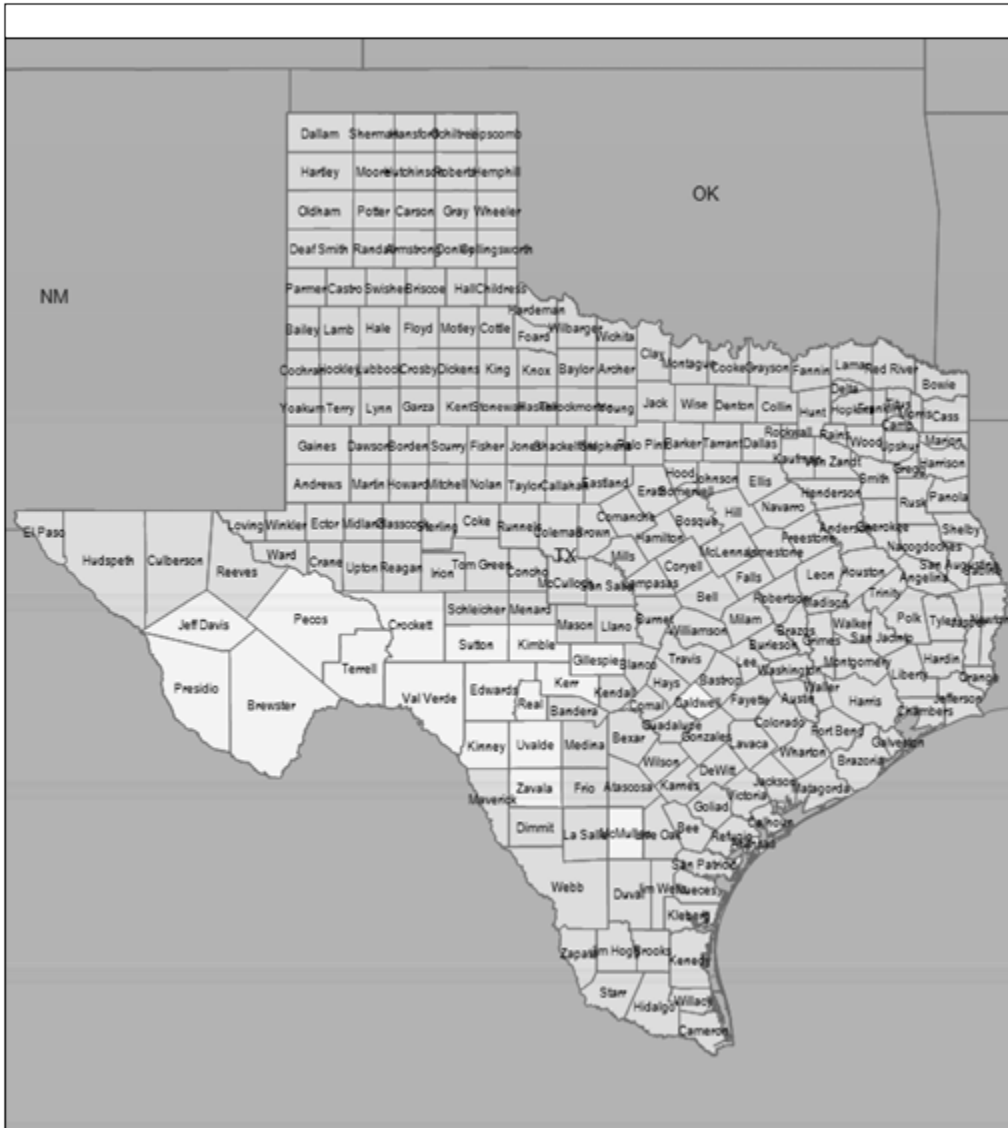
Midland Odessa Area:

Andrews
Crane
Ector
Glasscock
Howard
Loving
Martin
Midland
Reagan
Upton
Ward
Winkler



Network Analysis - Texas Network Adequacy Report

Cigna Network Approval Filing



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Cigna Dental Care – Cigna Dental Health Plan

The following rider applies if you are a resident of: AZ, CO, DE, KS/NE, KY/IL, NJ.

CDO34



Benefit Rider

Cigna Dental Companies

Cigna Dental Health Plan of Arizona, Inc.

Cigna Dental Health of Colorado, Inc.

Cigna Dental Health of Delaware, Inc.

Cigna Dental Health of Florida, Inc. **(a Prepaid Limited Health Services Organization licensed under Chapter 636, Florida Statutes)**

Cigna Dental Health of Kansas, Inc. (Kansas and Nebraska)

Cigna Dental Health of Kentucky, Inc. (Kentucky and Illinois)

Cigna Dental Health of New Jersey, Inc.

Cigna Dental Health of Ohio, Inc.

Cigna Dental Health of Virginia, Inc.

P.O. Box 453099

Sunrise, Florida 33345-3099

This State Rider is attached to and made part of your Plan Booklet/Evidence of Coverage and replaces the following provisions:

D. Choice of Dentist

You and your Dependents should have selected a Dental Office when you enrolled in the Dental Plan. If you did not, you must advise Cigna Dental of your Dental Office selection prior to receiving treatment. The benefits of the Dental Plan are available only at your Dental Office, except in the case of an emergency or when Cigna Dental otherwise approves payment for out-of-network benefits.

You may select a network Pediatric Dentist as the Network General Dentist for your dependent child under age 13 by calling Customer Service at 1.800.Cigna24 to get a list of network Pediatric Dentists in your Service Area or, if your Network General Dentist sends your child under age 13 to a network Pediatric Dentist, the network Pediatric Dentist's office will have primary responsibility for your child's care. For children 13 years and older, your Network General Dentist will provide care. If your child continues to visit the Pediatric Dentist upon the age of 13, you will be fully responsible for the Pediatric Dentist's Usual Fees. Exceptions for medical reasons may be considered on a case-by-case basis.

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 will let you know and will arrange a transfer to another Dental Office. Refer to the Section titled "Office Transfers" if you wish to change your Dental Office.

To obtain a list of Dental Offices near you, visit our website at my.cigna.com, or 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 Customer Service.

F. Emergency Dental Care - Reimbursement

1. Emergency Care Away From Home

If you have an emergency while you are out of your Service Area or you are unable to contact your Network General Dentist, you may receive emergency Covered Services as defined above from any general dentist. Routine restorative procedures or definitive treatment (e.g. root canal) are not considered emergency care. You should return to your Network General Dentist for these procedures. For emergency Covered Services, you will be responsible for the Patient Charges listed on your Patient Charge Schedule. Cigna Dental will reimburse you the difference, if any, between the dentist's Usual Fee for emergency Covered Services and your Patient Charge, up to a total of \$50 per incident. To receive reimbursement, send appropriate reports and x-rays to Cigna Dental at the address listed for your state on the front of this booklet.

G. Limitations On Covered Services

Listed below are limitations on services when covered by your Dental Plan:

- **Pediatric Dentistry** - Coverage for treatment by a Pediatric Dentist ends on your child's 13th birthday. Effective on your child's 13th birthday, dental services must be obtained from a Network General Dentist however, exceptions for medical reasons may be considered on an individual basis.

VII. Office Transfers

If you decide to change Dental Offices, we can arrange a transfer. You should complete any dental procedure in progress before transferring to another Dental Office. To arrange a transfer, call Customer Service at 1.800.Cigna24. To obtain a list of Dental Offices near you, visit our website at my.cigna.com, or call the Dental Office Locator at 1.800.Cigna24.

Your transfer request may take up to 5 days to process. Transfers will be effective the first day of the month after the processing of your request. Unless you have an emergency,



you will be unable to schedule an appointment at the new Dental Office until your transfer becomes effective. You can check the status of your request by visiting myCigna.com, or by calling us at 1.800.Cigna24.

There is no charge to you for the transfer; however, all Patient Charges which you owe to your current Dental Office must be paid before the transfer can be processed.

IX. SPECIALTY REFERRALS

A. IN GENERAL

Preauthorization is not required for coverage of services by a Network Specialty Dentist.

When Cigna Dental approves payment to the Network Specialty Dentist, 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 IX.B., Orthodontics. Treatment by the Network Specialty Dentist must begin within 90 days from the date of Cigna Dental's approval. If you are unable to obtain treatment within the 90 day period, please call Customer Service to request an extension. Your coverage must be in effect when each procedure begins.

For non-Covered Services or if Cigna Dental does not approve payment to the Network Specialty Dentist for Covered Services, including Adverse Determinations, you must pay the Network Specialty Dentist's Usual Fee. If you have a question or concern regarding an approval or a denial, contact Customer Service.

After the Network Specialty Dentist has completed treatment, you should return to your Network General Dentist for cleanings, regular checkups and other treatment. If you visit a Network Specialty Dentist without a referral or if you continue to see a Network Specialty Dentist 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 Specialty Dentist is not available, as determined by Cigna Dental, Cigna Dental will approve a referral to a non-Network Specialty Dentist. 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 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 approved for payment, including Adverse Determinations, you must pay the dentist's Usual Fee.

PB09 Rider GN

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Cigna Dental Care – Cigna Dental Health Plan

The rider(s) listed in the next section are general provisions that apply to residents of:

AZ, CA, CO, CT, DE, IL, KS/NE, KY, MD, MO, NJ, NC, OH, TX

CDO35V1

Domestic Partner Rider

This definition of Domestic Partner applies to residents of: AZ, CA, CO, CT, DE, IL, KS/NE, KY, MD, NC, OH, TX.

A. A person of the same or opposite sex who:

1. shares your permanent residence;
2. has resided with you for no less than one year;
3. is no less than eighteen years of age;
4. 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;
5. is not your blood relative any closer than would be prohibited for a legal marriage; and
6. 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

B. 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 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 disapproved by regulatory authorities.

This insert contains Cigna Dental's standard Domestic Partner definition. Your Group may have purchased one or both

coverages (same/opposite sex partners). Consult your Group Contract for additional information.

Kentucky Residents: Coverage terminates (for the domestic partner and any dependents, if included) when the domestic partnership ends. Domestic Partners are entitled to Conversion rights upon termination of coverage.

DPRIDER02

V13



Domestic Partner Rider

This definition of Domestic Partner applies to residents of:
MO.

- C. A person of the same or opposite sex who:
1. shares your permanent residence;
 2. has resided with you for no less than one year;
 3. is no less than eighteen years of age;
 4. 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 lease hold 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;
 5. is not your blood relative any closer than would be prohibited for a legal marriage; and
 6. 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
- D. 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 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:

- D. has signed a Domestic Partner affidavit or declaration with any other person within twelve months prior to designating each other as Domestic Partners hereunder;
- E. is currently legally married to another person; or
- F. 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 disapproved by regulatory authorities.

Domestic Partner Rider

This definition of Domestic Partner applies to residents of: NJ.

A domestic partnership shall be established when all of the following requirements are met:

- (1) Both persons have a common residence and are otherwise jointly responsible for each other's common welfare as evidenced by joint financial arrangements or joint ownership of real or personal property, which shall be demonstrated by at least one of the following:
 - (a) a joint deed, mortgage agreement or lease;
 - (b) a joint bank account;
 - (c) designation of one of the persons as a primary beneficiary in the other person's will;
 - (d) designation of one of the persons as a primary beneficiary in the other person's life insurance policy or retirement plan; or
 - (e) joint ownership of a motor vehicle;
- (2) Both persons agree to be jointly responsible for each other's basic living expenses during the domestic partnership;
- (3) Neither person is in a marriage recognized by New Jersey law or a member of another domestic partnership;
- (4) Neither person is related to the other by blood or affinity up to and including the fourth degree of consanguinity;
- (5) Both persons are of the same sex and therefore unable to enter into a marriage with each other that is recognized by New Jersey law, except that two persons who are each 62 years of age or older and not of the same sex may establish a domestic partnership if they meet the requirements set forth in this section;
- (6) Both persons have chosen to share each other's lives in a committed relationship of mutual caring;
- (7) Both persons are at least 18 years of age;
- (8) Both persons file jointly an Affidavit of Domestic Partnership; and
- (9) Neither person has been a partner in a domestic partnership that was terminated less than 180 days prior to the filing of the current Affidavit of Domestic Partnership, except that this prohibition shall not apply if one of the partners died; and, in all cases in which a person registered a prior domestic partnership, the domestic partnership shall have been terminated in accordance with the provisions of section 10 of P.L. 2003, c. 246 (C. 26:8A-10).

DPRIDER02

V5

Federal Requirements

The following Federal Requirement section is not part of your group insurance certificate. The following pages explain your rights and responsibilities under federal laws and regulations. Some states may have similar requirements. If a similar provision appears elsewhere in your group insurance certificate, the provision which provides the better benefit will apply.

HC-FED1

10-10
V1

Notice of Provider Directory/Networks

Notice Regarding Provider Directories and Provider Networks

A list of network providers is available to you without charge by visiting the website or by calling the phone number on your ID card. The network consists of dental practitioners, of varied specialties as well as general practice, affiliated or contracted with Cigna or an organization contracting on its behalf.

HC-FED78

10-10

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 Insurance.

You must notify your Employer and elect coverage for that child, and yourself if you are not already enrolled, within 31 days of the QMCSO being issued.

Qualified Medical Child Support Order Defined

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

- 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 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 health insurance policy to provide coverage for any type or form of benefit or option not otherwise provided under the policy, except that an order may require a plan to comply with State laws regarding health care coverage.

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.

HC-FED4

10-10

Effect of Section 125 Tax Regulations on This Plan

Your Employer has chosen to administer this Plan in accordance with Section 125 regulations of the Internal Revenue Code. Per this regulation, you may agree to a pretax

salary reduction put toward the cost of your benefits. Otherwise, you will receive your taxable earnings as cash (salary).

A. Coverage elections

Per Section 125 regulations, you are generally allowed to enroll for or change coverage only before each annual benefit period. However, exceptions are allowed:

- if your Employer agrees, and you meet the criteria shown in the following Sections B through F and enroll for or change coverage within the time period established by your Employer.

B. Change of status

A change in status is defined as:

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

C. Court order

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

D. Medicare or Medicaid eligibility/entitlement

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

E. Change in cost of coverage

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

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

option. When a new benefit option is added, you may change your election to the new benefit option.

F. Changes in coverage of spouse or Dependent under another employer's plan

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

HC-FED95

04-17

Eligibility for Coverage for Adopted Children

Any child who is adopted by you, including a child who is placed with you for adoption, will be eligible for Dependent Insurance, if otherwise eligible as a Dependent, 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.

HC-FED67V1

09-14

Group Plan Coverage Instead of Medicaid

If your income and liquid resources do not exceed certain limits established by law, the state may decide to pay premiums for this coverage instead of for Medicaid, if it is cost effective. This includes premiums for continuation coverage required by federal law.

HC-FED13

10-10



Requirements of Family and Medical Leave Act of 1993 (as amended) (FMLA)

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

Continuation of Health Insurance During Leave

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

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

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

Reinstatement of Canceled Insurance Following Leave

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

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

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

HC-FED93

10-17

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

The Uniformed Services Employment and Re-employment Rights Act of 1994 (USERRA) sets requirements for continuation of health coverage and re-employment in regard to an Employee's military leave of absence. These requirements apply to medical and dental coverage for you and your Dependents. They do not apply to any Life, Short-term or Long-term Disability or Accidental Death & Dismemberment coverage you may have.

Continuation of Coverage

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

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

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

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

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

Reinstatement of Benefits (applicable to all coverages)

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

You and your Dependents will be subject to only the balance of a 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.

If your coverage under this plan terminates as a result of your eligibility for military medical and dental coverage and your order to active duty is canceled before your active duty service commences, these reinstatement rights will continue to apply.

HC-FED18

10-10

Claim Determination Procedures under ERISA Procedures Regarding Medical Necessity Determinations

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

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

When services or benefits are determined to be not covered, you or your representative will receive a written description of the adverse determination, and may appeal the determination.



Appeal procedures are described in the Certificate, in your provider's network participation documents as applicable, and in the determination notices.

Postservice Determinations

When you or your representative requests a coverage determination or a claim payment determination after services have been rendered, Cigna 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 Cigna's control Cigna 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 Cigna within 45 days after receiving the notice. The determination period will be suspended on the date Cigna sends such a notice of missing information, and the determination period 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 a statement of a claimant's rights to bring a civil action under section 502(a) of ERISA following an adverse benefit determination on appeal, if applicable; upon request and free of charge, a copy of any internal rule, guideline, protocol or other similar criterion that was relied upon in making the adverse determination regarding your claim, and an explanation of the scientific or clinical judgment for a determination that is based on a Medical Necessity, experimental treatment or other similar exclusion or limit; and in the case of a claim involving urgent care, a description of the expedited review process applicable to such claim.

COBRA Continuation Rights Under Federal Law

For You and Your Dependents

What is COBRA Continuation Coverage?

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

When is COBRA Continuation Available?

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

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

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

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

Who is Entitled to COBRA Continuation?

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

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

such individuals' coverage will terminate when your COBRA continuation coverage terminates. The sections titled "Secondary Qualifying Events" and "Medicare Extension For Your Dependents" are not applicable to these individuals.

Secondary Qualifying Events

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

Disability Extension

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

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

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

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

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

Medicare Extension for Your Dependents

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

Termination of COBRA Continuation

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

- the end of the COBRA continuation period of 18, 29 or 36 months, as applicable;
- failure to pay the required premium within 30 calendar days after the due date;
- cancellation of the Employer's policy with Cigna;
- after electing COBRA continuation coverage, a qualified beneficiary enrolls in Medicare (Part A, Part B, or both);
- after electing COBRA continuation coverage, a qualified beneficiary becomes covered under another group health plan, unless the qualified beneficiary has a condition for which the new plan limits or excludes coverage under a pre-existing condition provision. In such case coverage will continue until the earliest of: the end of the applicable maximum period; the date the pre-existing condition provision is no longer applicable; or the occurrence of an event described in one of the first three bullets above;
- any reason the Plan would terminate coverage of a participant or beneficiary who is not receiving continuation coverage (e.g., fraud).

Employer's Notification Requirements

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

- An initial notification of COBRA continuation rights must be provided within 90 days after your (or your spouse's) coverage under the Plan begins (or the Plan first becomes subject to COBRA continuation requirements, if later). If you and/or your Dependents experience a qualifying event before the end of that 90-day period, the initial notice must be provided within the time frame required for the COBRA continuation coverage election notice as explained below.
- A COBRA continuation coverage election notice must be provided to you and/or your Dependents within the following timeframes:
 - if the Plan provides that COBRA continuation coverage and the period within which an Employer must notify the

Plan Administrator of a qualifying event starts upon the loss of coverage, 44 days after loss of coverage under the Plan;

- if the Plan provides that COBRA continuation coverage and the period within which an Employer must notify the Plan Administrator of a qualifying event starts upon the occurrence of a qualifying event, 44 days after the qualifying event occurs; or
- in the case of a multi-employer plan, no later than 14 days after the end of the period in which Employers must provide notice of a qualifying event to the Plan Administrator.

How to Elect COBRA Continuation Coverage

The COBRA coverage election notice will list the individuals who are eligible for COBRA continuation coverage and inform you of the applicable premium. The notice will also include instructions for electing COBRA continuation coverage. You must notify the Plan Administrator of your election no later than the due date stated on the COBRA election notice. If a written election notice is required, it must be post-marked no later than the due date stated on the COBRA election notice. If you do not make proper notification by the due date shown on the notice, you and your Dependents will lose the right to elect COBRA continuation coverage. If you reject COBRA continuation coverage before the due date, you may change your mind as long as you furnish a completed election form before the due date.

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

How Much Does COBRA Continuation Coverage Cost?

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

For example: If the Employee alone elects COBRA continuation coverage, the Employee will be charged 102% (or 150%) of the active Employee premium. If the spouse or

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

When and How to Pay COBRA Premiums

First payment for COBRA continuation

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

Subsequent payments

After you make your first payment for COBRA continuation coverage, you will be required to make subsequent payments of the required premium for each additional month of coverage. Payment is due on the first day of each month. If you make a payment on or before its due date, your coverage under the Plan will continue for that coverage period without any break.

Grace periods for subsequent payments

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



You Must Give Notice of Certain Qualifying Events

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

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

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

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

Newly Acquired Dependents

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

COBRA Continuation for Retirees Following Employer’s Bankruptcy

If you are covered as a retiree, and a proceeding in bankruptcy is filed with respect to the Employer under Title 11 of the United States Code, you may be entitled to COBRA continuation coverage. If the bankruptcy results in a loss of coverage for you, your Dependents or your surviving spouse within one year before or after such proceeding, you and your covered Dependents will become COBRA qualified beneficiaries with respect to the bankruptcy. You will be entitled to COBRA continuation coverage until your death. Your surviving spouse and covered Dependent children will be entitled to COBRA continuation coverage for up to 36

months following your death. However, COBRA continuation coverage will cease upon the occurrence of any of the events listed under “Termination of COBRA Continuation” above.

Interaction With Other Continuation Benefits

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

HC-FED66

07-14

ERISA Required Information

The name of the Plan is:

Ensign Facility Services, Inc.

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

Ensign Services, Inc.
29222 Rancho Viejo Road, Suite 127
San Juan Capistrano, CA 92675
949-487-9500

Employer Identification
Number (EIN):

113645368

Plan Number:

504

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

Employer named above

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

Employer named above

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

The Cigna Claim Office responsible for this Plan

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

The Plan’s fiscal year ends on 12/31.

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

Plan Trustees

A list of any Trustees of the Plan, which includes name, title and address, is available upon request to the Plan Administrator.

Plan Type

The plan is a healthcare benefit plan.



Collective Bargaining Agreements

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

Discretionary Authority

The Plan Administrator delegates to Cigna the discretionary authority to interpret and apply plan terms and to make factual determinations in connection with its review of claims under the plan. Such discretionary authority is intended to include, but not limited to, the determination of the eligibility of persons desiring to enroll in or claim benefits under the plan, the determination of whether a person is entitled to benefits under the plan, and the computation of any and all benefit payments. The Plan Administrator also delegates to Cigna the discretionary authority to perform a full and fair review, as required by ERISA, of each claim denial which has been appealed by the claimant or his duly authorized representative.

Plan Modification, Amendment and Termination

The Employer as Plan Sponsor reserves the right to, at any time, change or terminate benefits under the Plan, to change or terminate the eligibility of classes of employees to be covered by the Plan, to amend or eliminate any other plan term or condition, and to terminate the whole plan or any part of it. Contact the Employer for 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. No consent of any participant is required to terminate, modify, amend or change the Plan.

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

Your coverage under the Plan's insurance policy(s) will end on the earliest of the following dates:

- the date you leave Active Service (or later as explained in the Termination Section;)
- the date you are no longer in an eligible class;

- if the Plan is contributory, the date you cease to contribute;
- the date the policy(s) terminates.

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

Statement of Rights

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

Receive Information About Your Plan and Benefits

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

Continue Group Health Plan Coverage

- continue health care coverage for yourself, your spouse or Dependents if there is a loss of coverage under the Plan as a result of a qualifying event. You or your Dependents may have to pay for such coverage. Review the documents governing the Plan on the rules governing your federal continuation coverage rights.

Prudent Actions by Plan Fiduciaries

In addition to creating rights for plan participants, ERISA imposes duties upon the people responsible for the operation of the employee benefit plan. The people who operate your plan, called "fiduciaries" of the Plan, have a duty to do so prudently and in the interest of you and other plan participants and beneficiaries. No one, including your employer, your union, or any other person may fire you or otherwise discriminate against you in any way to prevent you from obtaining a welfare benefit or exercising your rights under ERISA. If your claim for a welfare benefit is denied or ignored you have a right to know why this was done, to obtain



copies of documents relating to the decision without charge, and to appeal any denial, all within certain time schedules.

Enforce Your Rights

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

In addition, if you disagree with the plan's decision or lack thereof concerning the qualified status of a domestic relations order or a medical child support order, you may file suit in federal court. If it should happen that plan fiduciaries misuse the plan's money, or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor, or you may file suit in a federal court. The court will decide who should pay court costs and legal fees. If you are successful the court may order the person you have sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees, for example if it finds your claim is frivolous.

Assistance with Your Questions

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