

Maricopa County

CIGNA DENTAL CARE INSURANCE

EFFECTIVE DATE: July 1, 2013

CN001
2465354

This document printed in May, 2013 takes the place of any documents previously issued to you which described your benefits.

Printed in U.S.A.

Table of Contents

Certification	5
Accident and Health Provisions	7
Eligibility - Effective Date	7
Waiting Period.....	7
Important Information about Your Dental Plan	8
Your Cigna Dental Coverage	8
Coordination of Benefits	13
Conditional Claim Payment	16
Payment of Benefits	16
Termination of Insurance	17
Employees	17
Dependents	17
Federal Requirements	17
Notice of Provider Directory/Networks.....	17
Qualified Medical Child Support Order (QMCSO)	17
Effect of Section 125 Tax Regulations on This Plan	18
Eligibility for Coverage for Adopted Children.....	19
Group Plan Coverage Instead of Medicaid.....	19
Requirements of Medical Leave Act of 1993 (FMLA)	19
Uniformed Services Employment and Re-Employment Rights Act of 1994 (USERRA)	19
COBRA Continuation Rights Under Federal Law	20
Provisions	23
Notice of an Appeal or a Grievance	23
When You Have A Complaint Or An Appeal	23
Definitions	25
Notice of Privacy Practices	28
How We Use and Disclose Your Confidential Information	28
Cigna Dental Care – Cigna Dental Health Plan	33
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, FL, KS/NE, MD, MO, NC, OH, PA, VA	33
State Rider Cigna Dental Health Plan of Arizona, Inc.	43
State Rider Cigna Dental Health of Colorado, Inc.	45
State Rider Cigna Dental Health of Florida, Inc.	47
State Rider CIGNA Dental Health of Maryland, Inc.	48
State Rider Cigna Dental Health of Missouri, Inc.	51

State Rider Cigna Dental Health of North Carolina, Inc.	52
State Rider Cigna Dental Health of Kansas, Inc.....	56
State Rider Cigna Dental Health of Ohio, Inc.....	57
State Rider Cigna Dental Health of Pennsylvania, Inc.	59
State Rider Cigna Dental Health of Virginia, Inc.....	60
Cigna Dental Care – Cigna Dental Health Plan.....	65
The certificate(s) listed in the next section apply if you are a resident of one of the following states: CA, CT, KY, NJ, TX.....	65
Cigna Dental Health of California, Inc.	66
Cigna HealthCare of Connecticut, Inc.....	87
Cigna Dental Companies.....	99
Cigna Dental Health of New Jersey, Inc.	111
Cigna Dental Health of Texas, Inc.....	122
Cigna Dental Care – Cigna Dental Health Plan.....	139
This section describes the CDC Rider(s) for residents of the following states: AZ, CA, CO, CT, DE, FL, KS/NE, KY, MD, MO, NJ, NC, OH, PA, TX, VA.....	139
Alternate Benefit Provision Rider	140
Federal Requirements	141
Notice of Provider Directory/Networks.....	141
Qualified Medical Child Support Order (QMCSO)	141
Effect of Section 125 Tax Regulations on This Plan	141
Eligibility for Coverage for Adopted Children.....	142
Group Plan Coverage Instead of Medicaid.....	142
Requirements of Medical Leave Act of 1993 (as amended) (FMLA)	143
Uniformed Services Employment and Re-Employment Rights Act of 1994 (USERRA)	143
COBRA Continuation Rights Under Federal Law	143

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

CONNECTICUT GENERAL LIFE INSURANCE COMPANY

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

POLICYHOLDER: Maricopa County

GROUP POLICY(S) — COVERAGE
2465354 - DHMO CIGNA DENTAL CARE INSURANCE

EFFECTIVE DATE: July 1, 2013

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

Coordination of Benefits Included — See Table of Contents for Location of Coordination of Benefits Section. Your Benefits may be affected by other Insurance.

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.



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.

Accident and Health Provisions

Claims

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

Notice of Claim

Written notice of claim must be given to CG within 30 days after the occurrence or start of the loss on which claim is based. If notice is not given in that time, the claim will not be invalidated or reduced if it is shown that written notice was given as soon as was reasonably possible.

Claim Forms

When CG receives the notice of claim, it will give to the claimant, or to the Policyholder for the claimant, the claim forms which it uses for filing proof of loss. If the claimant does not get these claim forms within 15 days after CG receives notice of claim, he will be considered to meet the proof of loss requirements of the policy if he submits written proof of loss within 90 days after the date of loss. This proof must describe the occurrence, character and extent of the loss for which claim is made.

If benefits are denied because of an experimental and investigational exclusion the claimant may appeal the denial. The appeal procedure for denial of benefits will be determined by CG as set forth in the denial letter.

Proof of Loss

Written proof of loss must be given to CG within 90 days after the date of the loss for which claim is made. If written proof of loss is not given in that time, the claim will not be invalidated or reduced if it is shown that written proof of loss was given as soon as was reasonably possible.

Physical Examination

CG, at its own expense, will have the right to examine any person for whom claim is pending as often as it may reasonably require.

Legal Actions

Where CG has followed the terms of the policy, no action at law or in equity will be brought to recover on the policy until at least 60 days after proof of loss has been filed with CG. No action will be brought at all unless brought within 3 years after the time within which proof of loss is required.

GM6000 PRO1V7

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Eligibility - Effective Date

Eligibility for Employee Insurance

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

- you are in a Class of Eligible Employees; and
- you are an eligible, full-time Employee; and
- you normally work at least 20 hours a week.

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

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

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

Eligibility for Dependent Insurance

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

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

Waiting Period

Elected Officials: Date of hire

All Others: First day of the third pay period following date of hire; or the date the Employee becomes benefits-eligible.

Classes of Eligible Employees

Each Employee as reported to the insurance company by your Employer, excluding Illinois residents.

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EL15 M

For Dental Insurance - Employees

This plan is offered to you as an Employee.

Effective Date of Your Insurance

You will become insured on the first day of the month after the later of: (a) the date you elect the insurance by signing an approved enrollment form; or (b) the date you become

eligible. If you are a Late Entrant, you may elect the insurance only during an Open Enrollment Period. Your insurance will become effective on the first day of the month after the end of that Open Enrollment Period.

You will become insured on the date you become eligible, including if you are not in Active Service on that date due to your health status.

Late Entrant

You are a Late Entrant if you elect the insurance more than 30 days after you become eligible.

Open Enrollment Period

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

Choice of Participating Dental Facility

When you elect Employee Insurance, you may select a Participating Dental Facility from the list provided by Cigna Dental Health (CDH). If your first choice of a Participating Dental Facility is not available, you will be notified by CDH of your designated Participating Dental Facility based on your alternate selection. You and each of your insured Dependents may select his own designated Participating Dental Facility. A transfer from one Participating Dental Facility to another Participating Dental Facility may be requested by you through CDH. Any such transfer will take effect on the first day of the month after it is authorized by CDH. A transfer will not be authorized if you or your Dependent has an outstanding balance at the Participating Dental Facility.

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For Dental Insurance - Dependents

Effective Date of Dependent Insurance

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

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

Your Dependents will be insured only if you are insured.

Late Entrant

You are a Late Entrant for Dependent Insurance if you elect that insurance more than 30 days after you become eligible for it.

GM6000 ELI302V4

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.

GM6000 DEN198V6

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.

Member Services

If you have any questions or concerns about the Dental Plan, Member Services 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 Member Services 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.

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 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 Member Services 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 7 to a network Pediatric Dentist, the network Pediatric Dentist's office will have primary responsibility for your child's care. Your Network General Dentist will provide care for children 7 years and older. If your child continues to visit the Pediatric Dentist after his/her 7th birthday, 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 www.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 Member Services.

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.

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 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.

Limitations on Covered Services

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

1. **Frequency** – The frequency of certain Covered Services, like cleanings, is limited. Your Patient Charge Schedule lists any limitations on frequency.
2. **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.
3. **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.
4. **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.
5. **Clinical Oral Evaluations** - Periodic oral evaluations, comprehensive oral evaluations, comprehensive periodontal evaluations, and oral evaluations for patients under three years of age are limited to a total of 4 evaluations during a 12 consecutive month period.

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:

1. services not listed on the Patient Charge Schedule.
2. services provided by a non-Network Dentist without Cigna Dental's prior approval (except in emergencies).
3. services related to an injury or illness paid under workers' compensation, occupational disease or similar laws.
4. services provided or paid by or through a federal or state governmental agency or authority, political subdivision or a public program, other than Medicaid.
5. 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.
6. 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 (PCS). If bleaching (tooth whitening) is listed on your PCS, only the use of take-home bleaching gel with trays is covered; other types of bleaching methods are not covered.
7. 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. However, general anesthesia is covered when medically necessary and authorized by your physician because the covered person is under the age of 7 or physically or developmentally disabled.
8. prescription drugs.
9. 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. diagnose or treat conditions or disorders of the temporomandibular joint (TMJ), unless TMJ therapy is covered by your specific plan; or c. restore teeth which have been damaged by attrition, abrasion, erosion and/or abfraction; or d. restore the occlusion.
10. 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.
11. services associated with the placement, repair, removal, or prosthodontic restoration of a dental implant or any other services related to implants.

12. services for or in connection with experimental procedures or treatment methods. In determining whether services are experimental, CG in consultation with our dental consultant, will consider if such services: (a) are approved by the American Dental Association or the appropriate dental specialty society; (b) are in general use in the medical/dental field in the state of Washington; (c) are under continued scientific testing and research; (d) have shown a demonstrable benefit for a particular dental condition or disease; and (e) are proven to be safe and effective.
13. procedures or appliances for minor tooth guidance or to control harmful habits.
14. 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.)
15. the completion of crown and bridge, dentures or root canal treatment already in progress on the effective date of your Cigna Dental coverage.
16. consultations and/or evaluations associated with services that are not covered.
17. endodontic treatment and/or periodontal (gum tissue and supporting bone) surgery of teeth exhibiting a poor or hopeless periodontal prognosis.
18. bone grafting and/or guided tissue regeneration when performed at the site of a tooth extraction; or when performed in conjunction with an apicoectomy or periradicular surgery.
19. intentional root canal treatment in the absence of injury or disease to solely facilitate a restorative procedure.
20. services performed by a prosthodontist.
21. localized delivery of antimicrobial agents when performed alone or in the absence of traditional periodontal therapy.
22. 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.
23. 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.
24. services to correct congenital malformations, including the replacement of congenitally missing teeth.
25. the replacement of an occlusal guard (night guard) beyond one per any 24 consecutive month period.
26. crowns and bridges used solely for splinting.
27. 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 must break an appointment, please provide the Dental Office with at least 24 hours notice.

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 Member Services at 1-800-Cigna24. To obtain a list of Dental Offices near you, visit our website at www.cigna.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.

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

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 Pediatric Dentistry 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 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 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 Member Services 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 Member Services.

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 Specialist 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.

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 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 Periodic Orthodontic Treatment is based upon a maximum of 24 months of interceptive and/or comprehensive treatment. If you require less than 24 months of treatment, your Patient Charge will be reduced on a prorated basis. No coverage is available for Periodic Orthodontic Treatment beyond the initial 24 months.

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 Member Services 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 in the same treatment plan. Using full crowns (caps) and/or fixed bridges which are cemented in place, your Network General Dentist will rebuild natural teeth, fill in spaces where teeth are missing and establish conditions which allow each tooth to function in harmony with 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 charges on your Patient Charge Schedule are for each unit of crown or bridge. You pay the per unit charge for each unit of crown and/or bridge PLUS an additional charge for each unit when 6 or more units are prescribed in your Network General Dentist’s treatment plan.

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Alternate Benefit Provision

The following limiting provision applies to your dental plan.

If more than one service may be used to treat a dental condition, coverage will be limited to the less costly Covered Service provided it is: a professionally accepted; necessary; and appropriate method of treatment.

If treatment is provided by a Network Dentist, and the patient requests or accepts a more costly Covered Service, the specific Patient Charge for such service is equal to:

- A. the Patient Charge for the less costly service; plus
- B. the difference in cost between the Usual Fee for the more costly service and Usual Fee for the less costly service.

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Coordination of Benefits

The Coordination of Benefits (COB) provision applies if you or any one of your Dependents is covered under more than one Plan. If you are covered by more than one health benefit plan, and you do not know which is your primary plan, you or your provider should contact any one of the health plans to verify which plan is primary. The health plan you contact is responsible for working with the other plan to determine which is primary and will let you know within thirty calendar days.

CAUTION: All health plans have timely claim filing requirements. If you or your provider fail to submit your claim to a secondary health plan within that plan’s claim filing time limit, the plan can deny the claim. If you experience delays in the processing of your claim by the primary health plan, you or your provider will need to submit your claim to the secondary health plan within its claim filing time limit to prevent a denial of the claim.

To avoid delays in claims processing, if you are covered by more than one plan you should promptly report to your providers and plans any changes in your coverage.

The order of benefit determination rules govern the order in which each Plan will pay a claim for benefits.

Definitions

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

Plan

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. However, if COB rules do not apply to all contracts, or to all benefits in the same contract, the contract or benefit to which COB does not apply is treated as a separate plan.

- (1) Plan includes: Group, individual or blanket disability insurance contracts, and group-or individual contracts issued by health care service contractors or health maintenance organizations (HMO), closed panel plans or other forms of group coverage; medical care components of long-term care contracts, such as skilled nursing care; and Medicare or any other federal governmental plan, as permitted by law.
- (2) Plan does not include: Hospital indemnity or fixed payment coverage or other fixed indemnity or fixed payment coverage; accident only coverage; specified disease or specified accident coverage; limited benefit health coverage, as defined by state law; school accident type coverage; benefits for non-medical components of long-term care policies; automobile insurance policies required by statute to provide medical benefits; Medicare supplement policies; Medicaid coverage; 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.

This Plan

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.

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 must make payment in an 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 equal 100% of the Total Allowable expense for that claim. This means that when This Plan is Secondary, it must pay the amount which, when combined with what the Primary plan paid, totals 100% of the highest Allowable expense. In addition, if This Plan is Secondary, it must calculate its savings (its amount paid subtracted from the amount it would have paid had it been the Primary plan) and record these savings as a benefit reserve for the covered person. This reserve must be used to pay any expenses during that calendar year, whether or not they are an Allowable expense under This Plan. If This Plan is Secondary, it will not be required to pay an amount in excess of its maximum benefit plus any accrued savings.

Closed Panel Plan

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

Primary Plan

The Plan that pays first is called the Primary Plan. The Primary Plan must pay benefits according to its policy terms without regard to the possibility that another Plan may cover some expenses.

Secondary Plan

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 do not exceed 100% of the total Allowable expense.

GM6000 COB25V1

Allowable Expense

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. When coordinating benefits, any secondary plans must pay an amount which, together with the payment made by the primary plan, totals the higher of the allowable expenses.

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

- (1) An expense or service or a portion of an expense or service that is not covered by any of the Plans is not an Allowable Expense.

- (2) If you are confined to a private Hospital room, and no Plan provides coverage for more than a semiprivate room, the difference in cost between a private and semiprivate room is not an Allowable Expense.
- (3) If you are covered by two or more Plans that compute their benefit payments on the basis of Usual and Prevailing Charges or relative value schedule reimbursement method or other similar reimbursement method, any amount in excess of the highest Usual and Prevailing Charge is not an Allowable Expense.
- (4) If you are covered by two 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.

Claim Determination Period

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

GM6000 COB26WA
COB26V1

Custodial Parent

Custodial Parent means the parent awarded custody by a court decree or, in the absence of a court decree, means the parent with whom the child resides more than one half of the calendar year excluding any temporary visitation.

Reasonable Cash Value

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

Order of Benefit Determination Rules

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

The Primary Plan pays or provides its benefits according to its terms of coverage and without regard to the benefits under any other Plan.

Except as provided in this section, a Plan that does not contain a coordination of benefits provision is always primary unless the provisions of both Plans state that the complying plan is primary.

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 is excess to any other parts of the Plan provided by the contract holder. Examples include major medical coverages that are superimposed over hospital and surgical benefits, and

insurance type coverages that are written in connection with a Closed Panel Plan to provide out-of-network benefits.

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.

Each Plan determines its order of benefits using the first of the following rules that apply:

A. 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.

B. 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:

1. For a dependent child whose parents are married or are living together, whether or not they have ever been married:

- a) The Plan of the parent whose birthday falls earlier in the calendar year is the Primary plan; or
- b) If both parents have the same birthday, the Plan that has covered the parent the longest is the Primary plan.

2. For a dependent child whose parents are divorced or separated or not living together, whether or not they have ever been married:

- a) 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 claim determination periods commencing after the Plan is given notice of the court decree;
- b) If a court decree states one parent is to assume primary financial responsibility for the dependent child but does not mention responsibility for health care expenses, the plan of the parent assuming financial responsibility is primary;
- c) 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 determine the order of benefits;

d) 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 subsection (1) above determine the order of benefits; or

e) 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:

- i) The Plan covering the Custodial parent, first;
- ii) The Plan covering the spouse of the Custodial parent, second;
- iii) The Plan covering the non-custodial parent, third; and then
- iv) The Plan covering the spouse of the non-custodial parent, last

3. For a dependent child covered under more than one Plan of individuals who are not the parents of the child, the provisions of subsection (1) or (2) above determine the order of benefits as if those individuals were the parents of the child.

C. 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 under section A can determine the order of benefits.

D. COBRA or State Continuation Coverage. If a person whose coverage is provided under 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 under section A can determine the order of benefits.

E. 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.

F. If the preceding rules do not determine the order of benefits, the Allowable expenses must 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

When This plan is secondary, it may reduce its benefits so that the total benefits paid or provided by all Plans during a claim determination period are not more than the total Allowable expenses. In determining the amount to be paid for any claim, the Secondary plan must make payment in an 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 equal 100% of the total Allowable expense for that claim. Total Allowable expense is the highest Allowable expense of the Primary plan or the Secondary plan. In addition, the Secondary plan must credit to its plan deductible any amounts it would have credited to its deductible in the absence of other health care coverage.

GM6000 COB14WA
COB14V18

Recovery of Excess Benefits

If This Plan pays charges for benefits that should have been paid by the Primary Plan, This Plan will have the right to recover such payments.

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

Right to Receive and Release Information

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. CG 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. CG need not tell, or get the consent of, any person to do this. Each person claiming benefits under This plan must give CG any facts it needs to apply those rules and determine benefits payable.

Questions about Coordination of Benefits?

Contact Your State Insurance Department

GM6000 COB15V1WA
COB15V6

Conditional Claim Payment

No payment will be made for expenses incurred for injuries received in, or as the result of, an accident for which a third party is liable. However, if the third party liability is satisfied in an amount less than the benefits otherwise payable under the policy, CG will pay the difference.

If you or your Dependent incurs expenses for injuries received in an accident for which, in the opinion of CG, a third party may be liable, CG will pay the amount of benefits otherwise payable under the policy. However, you must first agree in writing to refund the lesser of:

- the amount actually paid for such expenses by CG; or
- an amount equal to the sum actually received from the third party for such expenses;

at the time such third party liability is determined and satisfied; whether by settlement, judgment, arbitration or otherwise.

CG's right to recover its expenses shall apply only after the participant has been fully compensated for his or her loss.

GM6000 CCP1

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CCL26

Payment of Benefits

To Whom Payable

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

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

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

GM6000 POB5

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PMT121

Miscellaneous

Certain Participating Dental Facilities 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 Facility to determine if such discounts are offered.

GM6000 POB2

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.
- with respect to your Dental benefits, the date upon permanent breakdown of your relationship with your Dentist as determined by CDH, after at least one opportunity to transfer to another Participating Dental Facility.
- the date the policy is canceled.
- the last day of the pay period in which premium is paid or in which employees cease to be in a benefit eligible position.

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

Temporary Layoff or Leave of Absence

If your Active Service ends due to temporary layoff or leave of absence, your insurance will be continued until the date your Employer: (a) stops paying premium for you; or (b) otherwise cancels your insurance. However, your insurance will not be continued for more than 60 days past the date your Active Service ends.

Injury or Sickness

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

Retirement (for Medical Insurance)

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

GM6000 TRM15

V3 M

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.

TRM327V6

Federal Requirements

The following pages explain your rights and responsibilities under federal laws and regulations. Some states may have similar requirements. If a similar provision appears elsewhere in this booklet, the provision which provides the better benefit will apply.

FDRL1

V2

Notice of Provider Directory/Networks

Notice Regarding Provider Directories and Provider Networks

If your Plan uses a network of Providers, you will automatically and without charge, receive a separate listing of Participating Providers.

You may also have access to a list of Providers who participate in the network by visiting www.cigna.com; mycigna.com or by calling the toll-free telephone number on your ID card.

Your Participating Provider network consists of a group of local dental practitioners, of varied specialties as well as general practice, who are employed by or contracted with Cigna Dental Health.

FDRL32

V1 M

Qualified Medical Child Support Order (QMCSO)

A. Eligibility for Coverage Under a QMCSO

If a Qualified Medical Child Support Order (QMCSO) is issued for your child, that child will be eligible for coverage as

required by the order and you will not be considered a Late Entrant for Dependent Insurance.

You must notify your Employer and elect coverage for that child, and yourself if you are not already enrolled, within 31 days of the QMCSO being issued.

B. Qualified Medical Child Support Order Defined

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

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

The QMCSO may not require the health insurance policy to provide coverage for any type or form of benefit or option not otherwise provided under the policy, except that an order may require a plan to comply with State laws regarding health care coverage.

FDRL2V2

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 enroll for or change coverage within 30 days of the following:

- the date you meet the criteria shown in the following Sections B through F.

B. Change of Status

A change in status is defined as:

1. change in legal marital status due to marriage, death of a spouse, divorce, annulment or legal separation;
2. change in number of Dependents due to birth, adoption, placement for adoption, or death of a Dependent;
3. 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;
4. changes in employment status of Employee, spouse or Dependent resulting in eligibility or ineligibility for coverage;
5. change in residence of Employee, spouse or Dependent to a location outside of the Employer's network service area; and
6. 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: (a) incurs a change such as adding or deleting a benefit option; (b) allows election changes due to Change in Status, Court Order or Medicare or Medicaid Eligibility/Entitlement; or (c) this Plan and the other plan have different periods of coverage or open enrollment periods.

FDRL70

Eligibility for Coverage for Adopted Children

Any child under the age of 18 who is adopted by you, including a child who is placed with you for adoption, will be eligible for Dependent Insurance upon the date of placement with you. A child will be considered placed for adoption when you become legally obligated to support that child, totally or partially, prior to that child's adoption.

If a child placed for adoption is not adopted, all health coverage ceases when the placement ends, and will not be continued.

The provisions in the "Exception for Newborns" section of this document that describe requirements for enrollment and effective date of insurance will also apply to an adopted child or a child placed with you for adoption.

FDRL6

Group Plan Coverage Instead of Medicaid

If your income and liquid resources do not exceed certain limits established by law, the state may decide to pay premiums for this coverage instead of for Medicaid, if it is cost effective. This includes premiums for continuation coverage required by federal law.

FDRL75

Requirements of Medical Leave Act of 1993 (FMLA)

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

A. Continuation of Health Insurance During Leave

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

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

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

B. Reinstatement of Canceled Insurance Following Leave

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

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

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

FDRL74V1

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.

A. Continuation of Coverage

For leaves of less than 31 days, coverage will continue as described in the Termination section regarding Leave of Absence.

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

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

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

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

Following continuation of health coverage per USERRA requirements, you may convert to a plan of individual

coverage according to any “Conversion Privilege” shown in your certificate.

B. Reinstatement of Benefits (applicable to all coverages)

If your coverage ends during the leave of absence because you do not elect USERRA or an available conversion plan at the expiration of USERRA and you are reemployed by your current Employer, coverage for you and your Dependents may be reinstated if (a) you gave your Employer advance written or verbal notice of your military service leave, and (b) the duration of all military leaves while you are employed with your current Employer does not exceed 5 years.

You and your Dependents will be subject to only the balance of a Pre-Existing Condition Limitation (PCL) or waiting period that was not yet satisfied before the leave began. However, if an injury or Sickness occurs or is aggravated during the military leave, full Plan limitations will apply.

Any 63-day break in coverage rule regarding credit for time accrued toward a PCL waiting period will be waived.

If your coverage under this plan terminates as a result of your eligibility for military medical and dental coverage and your order to active duty is canceled before your active duty service commences, these reinstatement rights will continue to apply.

FDRL58 M

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.

FDRL67V1

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:

1. SSA must determine that the disability occurred prior to or within 60 days after the disabled individual elected COBRA continuation coverage; and
2. 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.

FDRL21

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 CG;
- 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: (a) the end of the applicable maximum period; (b) the date the pre-existing condition provision is no longer applicable; or (c) 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).

FDRL22V3

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:
 - (a) 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;
 - (b) 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
 - (c) 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.

FDRL23

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.

FDRL24V3

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;
- Your child ceases to qualify as a Dependent under the Plan; or
- 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.

FDRL25

V1

Trade Act of 2002

The Trade Act of 2002 created a new tax credit for certain individuals who become eligible for trade adjustment assistance and for certain retired Employees who are receiving pension payments from the Pension Benefit Guaranty Corporation (PBGC) (eligible individuals). Under the new tax provisions, eligible individuals can either take a tax credit or get advance payment of 65% of premiums paid for qualified health insurance, including continuation coverage. If you have questions about these new tax provisions, you may call the Health Coverage Tax Credit Customer Contact Center toll-free at 1-866-628-4282. TDD/TYY callers may call toll-free at 1-866-626-4282. More information about the Trade Act is also available at www.doleta.gov/tradeact/2002act_index.cmf.

In addition, if you initially declined COBRA continuation coverage and, within 60 days after your loss of coverage under the Plan, you are deemed eligible by the U.S. Department of

Labor or a state labor agency for trade adjustment assistance (TAA) benefits and the tax credit, you may be eligible for a special 60 day COBRA election period. The special election period begins on the first day of the month that you become TAA-eligible. If you elect COBRA coverage during this special election period, COBRA coverage will be effective on the first day of the special election period and will continue for 18 months, unless you experience one of the events discussed under “Termination of COBRA Continuation” above. Coverage will not be retroactive to the initial loss of coverage. If you receive a determination that you are TAA-eligible, you must notify the Plan Administrator immediately.

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.

FDRL82

Provisions

Dental Conversion Privilege

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

CG or the Policyholder will give the Employee, on request, further details of the Converted Policy.

Conversion is not available if your insurance ceased due to:

- nonpayment of required premiums;
- selection of alternate dental insurance by your group;
- permanent breakdown of the dentist/patient relationship; or
- fraud or misuse of the Dental Plan.

GM6000 PRO83

Notice of an Appeal or a Grievance

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

GM6000 NOT90

The Following Will Apply To Residents Of Washington

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; and “Physician reviewers” are licensed Physicians or licensed Dentists depending on the care, treatment or service under review.

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 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.

A “Grievance” is a written or an oral complaint submitted by or on behalf of an insured person regarding: (a) denial of health care services or payment for health care services; or (b) issues other than health care services or payment for health care services including, dissatisfaction with health care services, delays in obtaining health care services, conflicts with carrier staff or providers, and dissatisfaction with carrier practices or actions unrelated to health care services.

We will do our best to resolve the matter on your initial contact.

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

GM6000 APL761

Appeals Procedure

CG has a two step appeals procedure for coverage decisions involving Adverse Determinations and Noncertification. An Adverse Determination or Noncertification coverage decision is a decision by CG to deny, modify, reduce, or terminate payment, coverage, authorization, or provision of health care services or benefits including the admission to or continued stay in a facility.

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. We will acknowledge in writing that we have received your request.

GM6000-APL762

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 14 calendar days after we receive an appeal for a required preservice or concurrent care coverage determination (decision). We will respond within 14 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, in this case, the decision will be made within 30 days. For appeals based on experimental treatment exclusions, the decision will be made within 20 working days of receipt of the fully documented appeal. Any extension beyond 20 working days will require your informed written consent.

You may request that the appeal process be expedited if, (a) the time frames under this process would seriously jeopardize your life, health or ability to regain maximum function or in the opinion of your Physician would cause you severe pain which cannot be managed without the requested services; or (b) your appeal involves nonauthorization of an admission or continuing inpatient Hospital stay. Your treating Physician, will decide if an expedited appeal is necessary. When an appeal is expedited, we will respond orally with a decision within 72 hours, followed up in writing.

GM6000-507 WA
APL794

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 Physician or Dentist reviewer in the same or similar specialty as the care under consideration, as determined by

CG's Physician or 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 required preservice and concurrent care coverage determinations, the Committee review will be completed within 14 calendar days. For postservice claims, the Committee review will be completed within 14 calendar days. We may request additional information if needed by the Committee to complete the review. If more time or information is needed to make the determination, we will notify you in writing.

Any extension will not delay the decision beyond 30 days without your informed written consent. In the case of appeals based on experimental treatment exclusions, your informed written consent is needed for any extension beyond 20 working days of receipt of the fully documented appeal. 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.

You may request that the appeal process be expedited if, (a) the time frames under this process would seriously jeopardize your life, health or ability to regain maximum function or in the opinion of your Physician would cause you severe pain which cannot be managed without the requested services; or (b) your appeal involves nonauthorization of an admission or continuing inpatient Hospital stay. Your treating Physician will decide if an expedited appeal is necessary. When an appeal is expedited, we will respond orally with a decision within 72 hours, followed up in writing.

GM6000 APL763 WA

Independent Review Procedure

If you are not fully satisfied with the decision of CG's level two appeal review regarding your issue or if CG has exceeded the timelines without good cause and without reaching a decision, you may request that your appeal be referred to an Independent Review Organization. You may also request that your appeal be referred to an Independent Review Organization if CG does not handle your Level One or Level Two Appeal within the timeframe described for the Level One or Level Two Appeal. The Independent Review Organization is composed of persons who are not employed by CG or any of its affiliates. A decision to use the voluntary level of appeal will not affect the claimant's rights to any other benefits under the plan.

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

To request a review, you must notify the Appeals Coordinator within 180 days of your receipt of CG's level two appeal review denial. CG 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 your Physician or Dentist the review shall be completed within three days.

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

Appeal to the State of Washington

You have the right to contact the Office of the Insurance Commissioner for assistance at any time. The Commissioner may be contacted at the following telephone number:

Washington State Office of the Insurance Commissioner
Toll-Free Number: 1-800-562-6900

GM6000 APL821

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: (1) the specific reason or reasons for the adverse determination; (2) reference to the specific plan provisions on which the determination is based; (3) a statement that the claimant is entitled to receive, upon request and free of charge, reasonable access to and copies of all documents, records, and other Relevant Information as defined; (4) a statement describing any voluntary appeal procedures offered by the plan and the claimant's right to bring an action under ERISA section 502(a); (5) upon request and free of charge, a copy of any internal rule, guideline, protocol or other similar criterion that was relied upon in making the adverse determination regarding your appeal, and an explanation of the scientific or clinical judgment for a determination that is based on a Medical Necessity, experimental treatment or other similar exclusion or limit.

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

Relevant Information

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

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

Legal Action

If your plan is governed by ERISA, you have the right to bring a civil action under Section 502(a) of ERISA if you are not satisfied with the outcome of the Appeals Procedure. In most instances, you may not initiate a legal action against CG until you have completed the 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.

GM6000 APL513
APL795

Definitions

Active Service

You will be considered in Active Service:

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

DFS1

Adverse Determination

An Adverse Determination is a decision made by CG 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 CG based upon the above criteria will be the responsibility of the member at the dentist's Usual Fees.

DFS2182

**Cigna Dental Health
(herein referred to as CDH)**

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

DFS592

Contract Fees

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

DFS2183

Covered Services

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

DFS1948

Dental Office

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

DFS1949

Dentist

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

DFS25

Denturist

The term Denturist means a dental technician who fabricates and fits dentures without supervision of a Dentist and is practicing within the scope of his license.

DFS1536

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 and primarily supported by you and incapable of self-sustaining employment by reason of developmental disability or physical handicap. Proof of the child's condition and dependence must be submitted to CG within 31 days after the date the child ceases to qualify above. From time to time, but not more frequently than once a year, CG may require proof of the continuation of such condition and dependence.

The term child means a child born to you or a child legally adopted by you, including a child for whom you assume legal obligation for total or partial support, in anticipation of adoption, but with no requirement that the adoption be final. It also includes a stepchild. 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.

GM6000 DFS2164

V1

Domestic Partner

A Domestic Partner is defined as a person who has a valid domestic partner registration in Washington or a person of the same or opposite sex who does not have a valid domestic partner registration in Washington and 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 CG 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 which can be made available to CG 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.

GM6000 DFS2165

Employee

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

DFS211

Employer

The term Employer means the Policyholder and all Affiliated Employers.

DFS212

Medicaid

The term Medicaid means a state program of medical aid for needy persons established under Title XIX of the Social Security Act of 1965 as amended.

DFS192

Medicare

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

DFS149

Network General Dentist

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

DFS2184

Network Specialty Dentist

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

DFS2185

Participating Dental Facility

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

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

DFS593

Patient Charge Schedule

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

DFS1102

Service Area

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

DFS2186

Subscriber

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

DFS1953

Usual Fee

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

DFS1834

Notice of Privacy Practices

This notice describes how health information about you may be used and disclosed and how you can get access to this information. Please review it carefully.

This Notice is effective on July 1, 2004

Connecticut General Life Insurance Company (CG) is committed to maintaining and protecting the confidentiality of our members' personal information. We are required by federal and state law to protect the privacy of your personal health information and other personal information about you. In this Notice, we will refer to this information as "confidential information." We also are required to send you this Notice about our policies, safeguards and practices. When we use or disclose your confidential information, we are bound by the terms of this Notice or our revised notice, if we revise it.

How We Protect Your Privacy

To provide you with health insurance benefits, CG receives confidential information from you and from other sources such as your health care providers, insurers and your employer. The information we receive includes personal health information as well as your name and address. CG will not disclose confidential information without your authorization unless it is necessary to provide your health benefits, administer your benefit plan, to support CG programs or services, or as otherwise required or permitted by law. When we need to disclose your confidential information, we will follow the policies described in this Notice to protect your privacy.

CG locations that maintain confidential information have procedures for accessing, labeling and storing confidential records. Access to our facilities is limited to authorized personnel. We restrict internal access to your confidential information to CG employees who need to know that information to conduct our business. CG trains its employees on policies and procedures designed to protect your privacy. Our Privacy Office monitors how we follow those policies and procedures and educates our organization on this important topic.

GM6000 NOT146V1

How We Use and Disclose Your Confidential Information

We will not use your confidential information or disclose it to others without your authorization, except for the following purposes:

- **Treatment.** We may disclose your confidential information to your doctors, hospitals and other health care providers for their provision, coordination or management of your health care and related services - for example, for coordinating your health care with us or for referring you to another provider for care.
- **Payment.** We may use and disclose your confidential information to obtain payment of premiums for your coverage and to determine and fulfill our responsibility to provide your health plan benefits - for example, to make coverage determinations, administer claims and coordinate benefits with other coverage you may have. We also may disclose your confidential information to another health plan or a health care provider for its payment activities - for example, for the other health plan to determine your eligibility or coverage, or for the health care provider to obtain payment for health care services provided to you.
- **Health Care Operations.** We may use and disclose your confidential information for our health care operations - for example, to provide customer service and conduct quality assessment and improvement activities. Other health operations may include providing appointment reminders or sending you information about treatment alternatives or other health-related benefits and services. We also may disclose your confidential information to another health plan or a provider who has a relationship with you, so that it can conduct quality assessment and improvement activities - for example, to perform case management.

GM6000 NOT146V2

- **Disclosure to Persons Involved in Your Care.** We may disclose confidential information about you or your child to persons who are involved in your or your child's care or payment for that care. For example, we might disclose confidential information about you to your spouse or confidential information about your child to your former spouse who is the parent of your child. We will disclose only the information that is relevant to the care or payment. Callers will be asked to provide identifying information and, if they are asking about a claim, they will have to show knowledge of that claim before we will answer their questions. You have the right to stop or limit this kind of disclosure by requesting a restriction on the disclosure of your confidential information as described below under "Right to Request Additional Restrictions."
- **Disclosures to your Employer as Sponsor of Your Health Plan.** We may disclose your confidential information to your employer or to a company acting on your employer's behalf, so that it can monitor, audit and otherwise administer the employee health benefit plan in which you participate. Your employer is not permitted to use the confidential information we disclose for any purpose other than administration of your health benefit plan. See your employer's health benefit plan documents for information on whether your employer receives confidential information and the identity of the employees who are authorized to receive your confidential information.
- **Disclosures to CG Vendors and Accreditation Organizations.** We may disclose your confidential information to companies with whom we contract if they need it to perform the services we've requested - for example, vendors who help us provide important information and guidance to members with chronic conditions like diabetes and asthma. CG also discloses confidential information to accreditation organizations such as the National Committee for Quality Assurance (NCQA) when the NCQA auditors collect Health Plan Employer Data and Information Set (HEDIS®)** data for quality measurement purposes. When we enter into these types of arrangements, we obtain a written agreement to protect your confidential information.

GM6000 NOT147V1

- **Promotional Gifts.** We may use your confidential information or disclose it to a mailing vendor so that we may provide you with a promotional gift of nominal value such as a pen or a calendar. We will not disclose your confidential information to other companies for their marketing purposes.
- **Public Health Activities.** We may disclose your confidential information for the following public health activities and purposes: (1) to report health information to

public health authorities that are authorized by law to receive such information for the purpose of preventing or controlling disease, injury or disability; (2) to report child abuse or neglect to a government authority that is authorized by law to receive such reports; (3) to report information about a product or activity that is regulated by the U.S. Food and Drug Administration (FDA) to a person responsible for the quality, safety or effectiveness of the product or activity; and (4) to alert a person who may have been exposed to a communicable disease, if we are authorized by law to give this notice.

- **Health Oversight Activities.** We may disclose your confidential information to a government agency that is legally responsible for oversight of the health care system or for ensuring compliance with the rules of government benefit programs, such as Medicare or Medicaid, or other regulatory programs that need health information to determine compliance.
- **For Research.** Under very limited circumstances, your confidential information may be used and disclosed for research without an authorization - for example, an authorization would not be necessary if your name, street address and other identifying information were removed.
- **To Comply with the Law.** We may use and disclose your confidential information to comply with the law.
- **Judicial and Administrative Proceedings.** We may disclose your confidential information in a judicial or administrative proceeding or in response to a legal order.

GM6000 NOT147V2

- **Law Enforcement Officials.** We may disclose your confidential information to the police or other law enforcement officials, as required by law or in compliance with a court order or other processes authorized by law.
- **Health or Safety.** We may disclose your confidential information to prevent or lessen a serious and imminent threat to your health or safety or the health and safety of the general public.
- **Government Functions.** We may disclose your confidential information to the U.S. military or to authorized federal officials for purposes specified by federal law.
- **Workers' Compensation.** We may disclose your confidential information when necessary to comply with workers' compensation laws.

Please note that should your coverage with CG terminate, we will continue to protect your confidential information. It will be used and disclosed only for the purposes described above and in accordance with the policies and procedures described in this Notice.

Uses and Disclosures with Your Written Authorization

We will not use or disclose your confidential information for any purpose other than the purposes described in this Notice without your written authorization. For example, we will not supply confidential information to another company for its marketing purposes or to a potential employer with whom you are seeking employment without your signed authorization. You may revoke an authorization that you previously have given by sending a written request to our Privacy Office, but not with respect to any actions we already have taken.

CG complies with state laws that place further restrictions on the disclosure of your personal health information without your authorization. For example, many states have laws that do not permit us to disclose a diagnosis of AIDS or mental illness. These laws have some limited exceptions.

GM6000 NOT148V1

Your Individual Rights

- **Right to Request Additional Restrictions.** You may request restrictions on our use and disclosure of your confidential information for the treatment, payment and health care operations purposes explained in this Notice. While we will consider all requests for restrictions carefully, we are not required to agree to a requested restriction.
- **Right to Receive Confidential Communications.** You may ask to receive communications of your confidential information from us by alternative means of communication or at alternative locations. While we will consider reasonable requests carefully, we are not required to agree to all requests.
- **Right to Inspect and Copy your Confidential Information.** You may ask to inspect or to obtain a copy of your confidential information that is included in certain records we maintain. Under limited circumstances, we may deny you access to all or a portion of your records. If you request copies, we may charge you copying and mailing costs.
- **Right to Amend your Records.** You have the right to ask us to amend your confidential information that is contained in certain records we maintain. If we determine that the record is inaccurate, and the law permits us to amend it, we will correct it. If your doctor or another person created the information that you want to change, you should ask that person to amend the information.

GM6000 NOT148V2

- **Right to Receive an Accounting of Disclosures.** Upon request, you may obtain an accounting of disclosures we have made of your confidential information. The accounting

that we provide will not include disclosures made before April 14, 2003, disclosures made for treatment, payment or health care operations, disclosures made earlier than six years before the date of your request, and certain other disclosures that are excepted by law. If you request an accounting more than once during any 12-month period, we will charge you a reasonable fee for each accounting statement after the first one.

- **Right to Receive Paper Copy of this Notice.** You may call Member Services at the toll-free number on your CG ID card to obtain a paper copy of this Notice, even if you previously agreed to receive this Notice electronically.

If you wish to make any of the requests listed above under “Individual Rights,” you must complete and mail us the appropriate form. To obtain the form please visit our Web site at <http://www.cigna.com/general/misc/privacy.html> and print the appropriate form. Or you can call Member Services at the toll-free number on your CG ID card to request the appropriate form. Forms should be mailed to the address printed on the forms. After we receive your signed, completed form, we will respond to your request.

- **For More Information or Complaints.** If you want more information about your privacy rights, do not understand your privacy rights, are concerned that we have violated your privacy rights or disagree with a decision that we made about access to your confidential information, you may contact our Privacy Office. You may also file written complaints with the Secretary of the U.S. Department of Health and Human Services. Please call our Privacy Office to obtain the correct address for the Secretary. We will not take any action against you if you file a complaint with the Secretary or us.

GM6000 NOT149V1

You may contact our Privacy Office at:

Privacy Office
Connecticut General Life Insurance Company
PO Box 5400
Scranton PA 18505
Telephone Number: 800.762.9940
Fax Number: 860.226.9513

Connecticut General Life Insurance Company

We may change the terms of this Notice at any time. If we change this Notice, we may make the new notice terms effective for all of your confidential information that we maintain, including any information we created or received before we issued the new notice. If we change this Notice, we will send you the new notice if you are enrolled in a CG benefit plan at that time. In addition, we will post any new notice on our Web site at <http://www.cigna.com/general/misc/privacy.html>. You also may obtain any new notice by calling Member Services at the toll-free number on your CG ID card.

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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, FL, KS/NE, MD, MO, NC, OH, PA, VA**

CDO16



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.

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 member has the right to view the Combined Evidence of Coverage and Disclosure Form prior to enrollment. It should be read completely and carefully. Members 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 Member Services at 1-800-Cigna24 if you have any questions. The hearing impaired may call the state TTY toll-free relay service listed in their local telephone directory.

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 member or provider of care; and
- D. not exceed the scope, duration, or intensity of that level of care needed to provide safe and appropriate treatment.

Requests for payment 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. 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 Specialty 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 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) 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 child who falls into category (b) 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 26 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 member 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. Member Services

If you have any questions or concerns about the Dental Plan, Member Services 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 Member Services 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 members 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 Member Services 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 www.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 Member Services.

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 covered by your Dental Plan:

- 1. Frequency** - The frequency of certain Covered Services, like cleanings, is limited. Your Patient Charge Schedule lists any limitations on frequency.
- 2. 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.
- 3. 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.
- 4. 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.
- 5. Clinical Oral Evaluations** - Periodic oral evaluations, comprehensive oral evaluations, comprehensive periodontal evaluations, and oral evaluations for patients under three years of age are

limited to a total of 4 evaluations during a 12 consecutive month period.

General Limitations Dental Benefits

No payment will be made for expense 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:

1. services not listed on the Patient Charge Schedule.
2. services provided by a non-Network Dentist without Cigna Dental's prior approval (except emergencies, as described in Section IV.F).
3. services related to an injury or illness paid under workers' compensation, occupational disease or similar laws.
4. services provided or paid by or through a federal or state governmental agency or authority, political subdivision or a public program, other than Medicaid.
5. 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.
6. 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 PCS, only the use of take-home bleaching gel with trays is covered; all other types of bleaching methods are not covered.
7. 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.

8. prescription drugs.
9. 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. diagnose or treat conditions of the temporomandibular joint (TMJ), unless TMJ therapy is specifically listed on your Patient Charge Schedule; or, if your Patient Charge Schedule ends in "-04" or higher,
 - c. restore teeth which have been damaged by attrition, abrasion, erosion and/or abfraction.
10. 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.
11. services associated with the placement, repair or prosthodontic restoration of a dental implant, or any other services related to implants.
12. services considered to be unnecessary or experimental in nature or do not meet commonly accepted dental standards.
13. procedures or appliances for minor tooth guidance or to control harmful habits.
14. 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.)
15. 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.)

16. the completion of crown and bridge, dentures or root canal treatment already in progress on the effective date of your Cigna Dental coverage. (California and Texas residents: Pre-existing conditions, including the completion of crown and bridge, dentures or root canal treatment already in progress on the effective date of your coverage, are not excluded, if otherwise covered under your Patient Charge Schedule.)
17. consultations and/or evaluations associated with services that are not covered.
18. endodontic treatment and/or periodontal (gum tissue and supporting bone) surgery of teeth exhibiting a poor or hopeless periodontal prognosis.
19. bone grafting and/or guided tissue regeneration when performed at the site of a tooth extraction; or when performed in conjunction with an apicoectomy or periradicular surgery.
20. intentional root canal treatment in the absence of injury or disease to solely facilitate a restorative procedure.
21. services performed by a prosthodontist.
22. localized delivery of antimicrobial agents when performed alone or in the absence of traditional periodontal therapy.
23. any localized delivery of antimicrobial agent procedures when more than eight (8) of these procedures are reported on the same date of service.
24. 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.
25. 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.
26. services to correct congenital malformations, including the replacement of congenitally missing teeth.
27. the replacement of an occlusal guard (night guard) beyond one per any 24 consecutive month period.

In addition to the above, if your Patient Charge Schedule number ends in “-04” or a higher number, there is no coverage for the following:

1. crowns and bridges used solely for splinting.
2. 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 Member Services at 1-800-Cigna24. To obtain a list of Dental Offices near you, visit our website at www.cigna.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 Member Services 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 Member Services.

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:

- 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:

- 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 Member Services 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 and/or bridge in the same treatment plan. Using full crowns (caps) and/or fixed bridges which are cemented in place, your Network General Dentist will rebuild natural teeth, fill in spaces where teeth are missing and establish conditions which allow each tooth to function in harmony with 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 charges on your Patient Charge Schedule are for each unit of crown or bridge. You pay the per unit charge for each unit of crown and/or bridge PLUS an additional charge for each unit when 6 or more units are prescribed in your Network General Dentist’s treatment plan.

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 Member Services

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 Member Services 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 Member Services 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 Level-Two Appeals process does not apply to resolutions made solely on the basis that the Dental Plan does not provide benefits for the service performed or requested.

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.

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 member plan materials. You may obtain additional information about Cigna Dental's confidentiality policies and procedures by calling Member Services at 1-800-Cigna24, or via the Internet at www.cigna.com.

XVIII. Miscellaneous

As a Cigna Dental plan member, 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 www.cigna.com for details.

If you are a Cigna Dental Care member 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 members 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 30 days of life, adoption or placement. If you wish to continue coverage beyond the first 30 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

Exclusion 15. does not apply to Arizona residents.

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 Member Services, 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 Member Services 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:

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.

State Rider Cigna Dental Health of Florida, Inc.

Florida Residents:

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.

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 10-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 1 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.

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State Rider CIGNA Dental Health of Maryland, Inc.

1571 Sawgrass Corporate Parkway,
Suite 140
Sunrise, FL 33323

Maryland Residents:

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

IV. Your CIGNA Dental Coverage

D. Choice of Dentist

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.

H. Services Not Covered Under Your Dental Plan

7. General anesthesia is covered when medically necessary and authorized by your Physician.
12. For Maryland residents, this exclusion should read as follows: Services considered to be unnecessary.
15. This exclusion does not apply to Maryland residents.

IX. Specialty Referrals

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.

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 Member Services

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 Member Services 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 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.

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, 525 St. Paul Place, Baltimore, Maryland, 21202-2272, 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 coverage decision filed under CIGNA Dental's internal appeal process.
 - c. **Coverage Decision** - an initial determination by CIGNA Dental that results in noncoverage of a

dental procedure, including nonpayment of all or any part of a claim. A coverage decision does not include an Adverse Determination, as defined in Section I of your plan booklet.

- 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 Member Services to register your Appeal by calling 1-800-Cigna24.

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 preauthorization, 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 60 working days 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 Life and Health Inquiry and Investigation Unit, 525 St. Paul Place, Baltimore, MD 21202, telephone (410) 468-2244, fax (410) 468-2260, TTY 1-800-735-2258.

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.

1. In General

The CIGNA Dental Appeals Coordinator is responsible for the internal grievance process and may be contacted at P.O. Box 188047, Chattanooga, TN 37422; 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 Preauthorization 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.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.

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 specified 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 time frame 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; TTY 1-800-576-6372; 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 30 working days of receipt of CIGNA Dental's grievance decision, at Maryland Insurance Administration, Chief of Complaints, 525 St. Paul Place, Baltimore, MD 21202; Phone 1-800-492-6116; Fax (410) 468-2270; TTY 1-800-735-2258.

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 Sections 2. and 3. above.

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 with symptoms that cause the member to be a danger to self or others.

XIII. Disenrollment From the Dental Plan – Termination of Benefits

The following supersedes 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.

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03.27.06

State Rider Cigna Dental Health of Missouri, Inc.

Missouri Residents:

I. Definitions

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 old if he or she is both:
- i. a resident of Missouri;
 - 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.

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 Conversion Plan. For a child who falls into category (c) above, you will need to furnish Cigna Dental proof of the child's mental or physical disability within 31 days after the Dependent reaches the age of 19. Cigna Dental may require proof to be furnished at reasonable intervals until the Dependent reaches age 21, and thereafter annually, for as long as the child is claimed as a Dependent.

IV. Your Cigna Dental Coverage

H. Services Not Covered Under Your Dental Plan

#15 – does not apply to Missouri residents.

XI. What To Do If There Is A Problem

B. Appeals Procedure

4. 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

91100.MO

MORIDER01

1/28/2009

State Rider Cigna Dental Health of North Carolina, Inc.

North Carolina Residents:

This State Rider contains information that either replaces, or is in addition to, information contained in your Evidence of Coverage.

III. Eligibility/When Coverage Begins

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

Dependent children for whom you are required by a court or administrative order to provide dental coverage may be enrolled at any time. 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, the newborn or foster child will be automatically covered for the first 31 days following birth or placement. If you wish to continue coverage beyond the first 31 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.

A life status change may also include placement for adoption.

Evidence of good dental health is not required for late enrollees.

IV. Your Cigna Dental Coverage

B. Premiums

The following is in addition to the information in Section IV.B of your Plan Booklet:

No schedule of premiums, or any amendment to the schedule, shall be used in until it has been filed with and

approved by the Commissioner. Premiums are guaranteed for the group for a period of twelve (12) months (unless otherwise extended in the Group Pre-Contract). However, Premiums may be adjusted by Cigna Dental upon approval by the North Carolina Department of Insurance 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.

H. Services Not Covered Under Your Dental Plan

3. 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.

15. This exclusion does not apply to North Carolina residents.
26. This exclusion does not apply to North Carolina residents.

XI. What To Do If There Is A Problem

B. Appeals Procedure

1. Level One Appeals

The following replaces the third sentence of paragraph 2:

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.

2. Level Two Appeals

The following replaces the last sentence of paragraph 2:

If we need more 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 following is in addition to the information contained in your Plan Booklet:

The decision will be provided to you no later than 30 days after the date the appeal is made.

The Level Two Appeals process does not apply to resolutions made solely on the basis that the Dental Plan does not provide benefits for the service performed or requested.

3. Independent Review Procedure

The voluntary independent review process does not apply in North Carolina.

XIII. Disenrollment From The Dental Plan – Termination of Benefits

A. Time Frames For Disenrollment/Termination

The following replaces Item 5 in section XIII.A. of your Plan Booklet:

5. For North Carolina residents, disenrollment due to a continued lack of a Dental Office in your Service Area occurs at the end of your plan year.

XVIII. Miscellaneous

The following provisions are in addition to the information contained in your Plan Booklet:

- A. 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 provisions 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 Health Care and Cigna Dental Health are not liable to enrollees for the negligent provision of such goods and/or services by third party service providers.

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.

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

Post Office Box 10218

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.

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 act also limits the amount the association is obligated to pay out as follows:

- (1) The guaranty association cannot pay out more than the insurance company would owe under the policy or contract.
- (2) Except as provided in (4) and (5) below, the guaranty association will pay a maximum of \$300,000 per individual, per insolvency, no matter the number of policies or types of policies issued by the insolvent company.
- (3) Except as provided in (4) and (5) below, the guaranty association will pay an aggregate maximum of \$500,000 with respect to any one individual affected by multiple insolvencies.
- (4) The guaranty association will pay a maximum of \$1,000,000 with respect to any one structured settlement annuity contract holder.

- (5) The guaranty association will pay a maximum of \$5,000,000 to any one unallocated annuity contract holder.

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State Rider Cigna Dental Health of Kansas, Inc.

Nebraska Residents:

This State Rider contains information that either replaces, or 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.

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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 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.

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

E. Your Payment Responsibility (General Care)

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

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.

XI. What To Do If There Is A Problem

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

A. Start With Member Services

You can reach Member Services by calling 1-800-Cigna24 or by writing to Cigna Dental Health of Ohio, Inc., P.O. Box 453099, Sunrise, Florida 33345-3099, Attention: Member Services. 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

"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 Ohio 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. Coordination of benefits applies only to Specialty Care.

When you or your family members are covered by another group plan in addition to this one, we will follow Ohio 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.

Cigna Dental will not reduce or exclude benefits payable to you or on your behalf because such benefits have also been paid under a supplemental, specified disease or limited plan of coverage for sickness and accident insurance which is entirely paid for by you, your family or guardian.

B. Plans That Do Not Coordinate

Cigna Dental will pay benefits without regard to benefits paid by the following kinds of coverage:

- Medicaid
- Group hospital indemnity plans which pay less than \$100 per day
- School accident coverage
- Some supplemental sickness and accident policies

C. How Cigna Dental Pays As Primary Plan

When we are primary, we will pay the full benefit allowed by your contract as if you had no other coverage.

D. How Cigna Dental Pays as Secondary Plan

1. When we are secondary, our payments will be based on the balance left after the primary plan has paid. We will pay no more than that balance. In no event will we pay more than we would have paid had we been primary.
2. We will pay only for health care expenses that are covered by Cigna Dental.
3. 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; preauthorized referrals are made to network specialists; coverage is in effect when procedures begin; procedures begin within 90 days of referral.
4. We will pay no more than the “allowable expenses” for the health care involved. If our allowable expense is lower than the primary plan’s, we will use the primary plan’s allowable expense. That may be less than the actual bill.

E. Which Plan is Primary?

To decide which plan is primary, we have to consider both the coordination provisions of the other plan and which member of your family is involved in a claim. The Primary Plan will be determined by the first of the following that applies:

1. Non-coordinating Plan

If you have another group plan that does not coordinate benefits, it will always be primary.

2. Employee

The plan that covers you as an employee (neither laid off nor retired) is always primary.

3. Children (Parents Divorced or Separated)

If the court decree makes one parent responsible for health care expenses, that parent’s plan is primary. If the court decree gives joint custody and does not mention health care, we follow the birthday rule. If neither of those rules applies, the order will be determined in accordance with the Ohio Insurance Department rule on Coordination of Benefits.

4. Children & the Birthday Rule

When your children’s health care expenses are involved, we follow the “birthday rule.” The plan of the parent with the first birthday in a calendar year is always primary for the children. If your birthday is in January and your spouse’s birthday is in March, your plan will be primary for all of your children.

However, if your 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.

5. Other Situations

For all other situations not described above, the order of benefits will be determined in accordance with the Ohio Insurance Department rule on Coordination of Benefits.

F. Coordination Disputes

If you believe that we have not paid a claim properly, you should first attempt to resolve the problem by contacting us. If you are still not satisfied, you may call the Ohio Department of Insurance for instructions on filing a consumer complaint. Call (614) 644-2673 or 1-800-686-1526.

G. Subrogation

If another source directly reimburses you more than your Patient Charge for Covered Services, you may be required to reimburse Cigna Dental. Where allowed by law, this section will apply to you or your Dependents who:

1. receive benefit payments under this Dental Plan as the result of a sickness or injury; and
2. have a lawful claim against another party or parties for compensation, damages, or other payment because of that same sickness or injury.

In those instances where this section applies, the rights of the Member or Dependent to claim or receive compensation, damages, or other payment from the other party or parties will be transferred to Cigna Dental, but only to the extent of benefit payments made under this Dental Plan.

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.

91100b.OH

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State Rider Cigna Dental Health of Pennsylvania, Inc.

Pennsylvania Residents:

I. Definitions

Dependent

- 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.
- Any unmarried child of yours who is:
 - 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.

III. Eligibility/When Coverage Begins

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.

IV. Your Cigna Dental Coverage

D. Emergency Dental Care - Reimbursement

If any emergency arises while you are unable to contact your Network General Dentist, the Dental Plan covers the cost of emergency dental services so that you are not

liable for greater out-of-pocket expense than if you were attended by your Network General Dentist. You must submit appropriate reports and x-rays to Cigna Dental Health.

H. Services Not Covered Under Your Dental Plan

Items 12 and 15 are amended as follows:

12. Services considered to be experimental in nature.
15. Services compensated under any group medical plan, no-fault auto insurance policy or insured motorist policy are not excluded.

XI. What To Do If There Is A Problem

The following process is in addition to that described in your Plan Booklet:

You always have the right to file a complaint with or seek assistance from the Pennsylvania Department of Health, Bureau of Managed Care, Room 912 Health & Welfare Building, 625 Forster Street, Harrisburg, Pennsylvania, 17120-0701, (717) 787-5193.

XII. Dual Coverage

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.

XVIII. Miscellaneous

The Group Contract, including the Patient Charge Schedule, Pre-Contracting 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 subsection of the contract will not affect the validity or enforceability of the remaining sections or subsections.

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.

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State Rider Cigna Dental Health of Virginia, Inc.

Virginia Residents:

Your Cigna Dental Care coverage is provided by Cigna Dental Health of Virginia, Inc.

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

I. Definitions:

The following is added to the definition of Dependent:

Any unmarried dependent child who is 19 or older, but less than the plans limiting age, who is a full-time student and is unable to continue school as a full-time student because of a medical condition, coverage shall continue for the child for a period of 12 months or to the date the child no longer qualifies as a dependent under policy terms.

III. Eligibility/When Coverage Begins

The following is added to paragraph 3, immediately after the first sentence:

An adopted child shall be eligible for coverage from the date of adoptive or parental placement in your home.

IV. Your Cigna Dental Coverage

F. Emergency Dental Care - Reimbursement

The following is in addition to the information listed in your Plan Booklet:

1. Emergency Care Away From Home

Cigna Dental 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 accepts your claim, reimbursement for all appropriate emergency services will be made within 5 days of acceptance.

XI. What To Do If There Is A Problem

The following replaces Section XI.B of your Plan Booklet:

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, at the address listed for your state on the cover page of this 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 Member Services to register your appeal by calling 1-800-Cigna24.

Complaints regarding adverse decisions are referred to as reconsiderations under Virginia law. Network dentists may request reconsiderations on your behalf, with your permission. Resolutions to requests for reconsideration of adverse decisions will be communicated to you within 10 business days of Cigna Dental receiving the request.

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 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.

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.

3. Independent External Review Procedure

If you are not fully satisfied with Cigna Dental's Level Two Appeal decision regarding a dental necessity or clinical appropriateness issue, you may appeal the decision to the Virginia Bureau of Insurance, provided the actual cost to you for the health services exceeds \$300. A decision to use the voluntary level of Independent External Review will not affect your rights to any other benefits under the Dental Plan.

To initiate the Independent External Review Procedure, you or your representative should, within 30 days of receipt of Cigna Dental's written Level Two Appeal decision, file a request on the Virginia Bureau of Insurance form enclosed with the decision. The written request should include the \$50 filing fee. The Bureau of Insurance may waive or refund the filing fee if you can demonstrate that paying the fee will cause undue financial hardship or if the appeal is not accepted for review. If the Bureau of Insurance

accepts your request for Independent External Review, the Bureau will assign an impartial Independent External Review entity to review your request. The entity will issue its recommendation within 30 working days of the date it receives all documentation and information necessary to complete its review. The Commissioner of Insurance will issue a written decision, based upon the entity's recommendation, within 10 working days after receipt of the entity's recommendation. If accepted by the Bureau of Insurance for expedited review, the entity will issue its recommendation as soon as possible, consistent with the medical exigencies of the case, but in no event more than 5 working days after receipt of the appeal. As soon as the Commissioner receives the entity's recommendation, the Commissioner will review the recommendation and notify you of his/her decision. The Commissioner's written decision shall bind you and Cigna Dental to the same extent to which each would be bound by a judgment entered in an action at law or in equity, with respect to the issues which the impartial Independent External Review entity may examine when reviewing a final adverse decision.

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

4. Appeals to the State

You have the right to contact the Virginia Bureau 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

The following is in addition to the information listed in your plan booklet:

Under Virginia law, Cigna Dental may not subrogate your right to recover excess benefits.

Under Coordination of Benefits rules, when we are secondary, our payments will be based on the balance left after the primary plan has paid. We will pay no more than that balance. In no event will we pay more than we would have paid had we been primary.

XIII. Disenrollment From the Dental Plan - Termination of Benefits

The following replaces Section XIII of your Plan Booklet:

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 and coverages will occur on the last day of the month:

1. In which Premiums are not remitted to Cigna Dental.
2. There will be a 31-day grace period for the payment of any premium falling due after the first premium, during which coverage shall remain in effect. Coverage shall remain in effect during the grace period unless the Group gives Cigna Dental written notice of termination in accordance with the terms of the Group Contract and in advance of the date of termination. The contract holder may be responsible for payment of a prorated Premium for the time the coverage was in force during the grace period.
3. After 31 days notice from Cigna Dental due to failure to meet eligibility requirements.
4. After 31 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.
5. After 31 days notice from Cigna Dental due to fraud or misuse of dental services and/or Dental Offices.
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.

XVIII. Miscellaneous

The following is in addition to the information listed in your Plan Booklet:

- A. **Assignment** - Your Group Contract provides that the Group may not assign the Contract or its rights under the Contract, nor delegate its duties under the Contract without the prior written consent of Cigna Dental.
- B. **Entire Agreement** - Your Group Contract, including the Evidence of Coverage, State Rider, Patient Charge Schedule, Pre-Contract Application, and any amendments thereto, constitutes the entire contractual agreement between the parties involved. No portion of the charter,

bylaws or other document of Cigna Dental Health of Virginia, Inc. shall constitute part of the contract unless it is set forth in full in the contract.

- C. **Incontestability** - In the absence of fraud, all statements contained in a written application made by a Subscriber are considered representations and not warranties. Coverage can be voided: 1. during the first two years for material misrepresentations contained in a written enrollment form; and, 2. after the first two years, for fraudulent misstatement contained in a written enrollment form.
- D. **Regulation** - Cigna Dental Health of Virginia, Inc. is subject to regulation by both the State Corporation Commission Bureau of Insurance pursuant to Title 38.2 and the Virginia Department of Health pursuant to Title 32.1 of the Virginia Insurance laws.
- E. **Subscriber Input** - Subscriber enrollees shall have the opportunity to provide input into the plan's procedures and processes regarding the delivery of dental services. Input will be solicited in various ways:
- On-going contacts between Customer Service representatives and enrollees;
 - On-going contacts with enrollees during open enrollment meetings;
 - Annual survey of enrollees regarding their experiences in the plan.

Member Rights and Responsibilities

Your Rights

- You have the right to considerate, respectful care, with recognition of your personal dignity, regardless of race, color, religion, sex, age, physical or mental handicap or national origin.
- You have the right to participate in decision making regarding your dental care. With the Cigna Dental Care plan, you and your dentist make decisions about your recommended treatment.
- You have the right to know your costs in advance for routine and emergency care. You have the right to an explanation of the benefits listed in your Patient Charge Schedule. Your dentist can answer questions or call Member Services at 1-800-Cigna24.
- You have the right to tell us when something goes wrong:
 - Start with your dentist. He/she is your primary contact.
 - If you have a problem that cannot be resolved with your dentist, call Member Services. We have an established process to resolve issues that cannot be worked out in other ways.

- You have the right to appeal the decision of your complaint through the Cigna Dental Appeals Process.
- You have the right to know about Cigna Dental, dental services, network providers, and your rights and responsibilities:
 - You have the right to schedule an appointment with your network dental office within a reasonable time.
 - You have the right to receive a recall for an appointment with your dentist.
 - You have the right to see a dentist within 24 hours for emergency care. Emergencies are dental problems that require immediate treatment, (includes control of bleeding, acute infection, or relief of pain, including local anesthesia).
 - You have the right to information from your network dentist regarding appropriate or necessary treatment options without regard to cost or benefit coverage.
 - You have the right to select or change dental offices within the Cigna Dental Care network. It is good dental practice, however, to complete any treatment in progress with your current dentist before transferring.
 - You have the right to receive advance notification if your network general dentist leaves the Cigna Dental Care network.
 - You have the right to call Member Services if you need help choosing a dentist or need more information to help you make that choice.
 - You have the right to know who we are, what services we provide, which dentists are part of our plan and your rights and responsibilities under the plan. If you have any questions or concerns, call Member Services.
- You have the right to receive a Patient Charge Schedule to determine benefits and covered services. If you do not receive one before your plan becomes effective, call Member Services to request one.
- You have the right to privacy and confidential treatment of information and dental records, as provided by law.
- You have the right to obtain information on types of provider payment arrangements used to compensate dentists for dental services rendered.

Cigna Dental wants to hear from you if you believe your rights have been violated.

Your Responsibilities

- Read the details of your Cigna Dental Care Plan Booklet and Patient Charge Schedule.
- Choose a primary care dentist from the Cigna Dental Care network.



- Provide information, to the extent possible, that your dentist needs to provide appropriate dental care.
- Receive care only from the Network General Dentist office you have chosen, unless a transfer has been arranged.
- Be sure your primary care dentist gives you a referral for any specialty care and gets any preauthorization required for that treatment.
- Ask Cigna Dental to address any concerns you may have.
- Let your dentist know whether you understand the treatment plan he/she recommends and follow the treatment plan and instructions for care.
- Pay your Patient Charges as soon as possible for the dental care received so your dentist can continue to serve you.
- Be considerate of the rights of other patients and the dental office personnel.
- Keep appointments or cancel in time for another patient to be seen in your place.

Important Information Regarding Your Dental Plan

In the event you need to contact someone about this Dental Plan for any reason, please contact your Benefit Administrator. If you have additional questions you may contact Cigna Dental at the following address and telephone number:

Cigna Dental Health of Virginia, Inc.
P.O. Box 453099
Sunrise, FL 33345-3099
1-800-Cigna24

Note: We recommend that you familiarize yourself with our grievance procedure, and make use of it before taking any other action.

If you have been unable to contact or obtain satisfaction from Cigna Dental or your Benefit Administrator, you may contact the Virginia State Corporation Commission Bureau of Insurance at:

ADDRESS: Life and Health Division
Bureau of Insurance
P.O. Box 1157
Richmond, VA 23218

TELEPHONE: In-State Calls: 1-800-552-7945
Local Calls: 1-804-371-9741
National Toll Free: 1-877-310-6560

Written correspondence is preferable so that a record of your inquiry is maintained. When contacting your Benefits Administration, company or the Bureau of Insurance, have your policy number available.

If you have any questions regarding an appeal or grievance concerning the health care services that you have been provided which have not been satisfactorily addressed by Cigna Dental, you may contact the Office of the Managed Care Ombudsman for assistance at:

ADDRESS: Office of The Managed Care
Ombudsman
Bureau of Insurance
P.O. Box 1157
Richmond, VA 23218

TELEPHONE: Toll-Free: 1-877-310-6560

E-MAIL: ombudsman@scc.virginia.gov
<http://www.scc.virginia.gov>

If you have quality of care concerns, you may contact the Office of Licensure and Certification at any time, at the following:

ADDRESS: Office of Licensure and Certification
(OLC)
Virginia Department of Health
9960 Mayland Drive, Suite 401
Richmond, VA 23233

TELEPHONE: Toll-Free: 1-800-955-1819

In-state Calls: 1-804-367-2104

Fax Number: 1-804-527-4503

Website: www.vdh.virginia.gov/olc

Email: mchip@vdh.virginia.gov

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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, KY, NJ, TX

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Cigna Dental Health of California, Inc.

400 North Brand Boulevard, Suite 400
Glendale, California 91203

COMBINED EVIDENCE OF COVERAGE AND DISCLOSURE FORM

This Combined Evidence of Coverage and Disclosure Form 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. A specimen copy of the Group Contract will be furnished upon request. If rates or coverages are changed under your Group Contract, your rates and coverage will also change. A prospective member has the right to view the Combined Evidence of Coverage and Disclosure Form prior to enrollment. It should be read completely and carefully. Members 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 DENTAL OFFICES, 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.

Important Cancellation Information - Please Read the Provision Entitled "Disenrollment from the Dental Plan-Termination of Benefits."

The Dental Plan is subject to the requirements of Chapter 2.2 of Division 2 of the Health and Safety Code and of Division 1 of Title 28 of the California Code of Regulations. Any provision required to be in the Group Contract by either of the above will bind the Dental Plan, whether or not provided in the Group Contract.

READ YOUR PLAN BOOKLET CAREFULLY

Please call Member Services at 1-800-Cigna24 if you have any questions. The hearing impaired may call the state TTY toll-free relay service listed in their local telephone directory.

TABLE OF CONTENTS

- I. Definitions**
- II. Introduction to Your Cigna Dental Plan**
- III. Eligibility/When Coverage Begins**
 - A. In General**
 - B. New Enrollee Transition of Care**
 - C. Renewal Provisions**
- IV. Your Cigna Dental Coverage**
 - A. Member Services**
 - B. Prepayment Fees**
 - C. Other Charges – Copayments**
 - D. Facilities - Choice of Dentist**
 - E. Your Payment Responsibility (General Care)**
 - F. Specialty Care**
 - G. Specialty Referrals**
- V. Covered Dental Services**
 - A. Categories of Covered Services**
 - B. Emergency Dental Care - Reimbursement**
- VI. Exclusions**
- VII. Limitations**
- VIII. What To Do If There is a Problem/Grievances**
 - A. Your Rights To File Grievances with Cigna Dental**
 - B. How To File A Grievance**
 - C. You Have Additional Rights Under State Law**
 - D. Voluntary Mediation**
- IX. Coordination of Benefits**
- X. Disenrollment From the Dental Plan – Termination of Benefits**
 - A. For the Group**
 - B. For You and Your Enrolled Dependents**
 - C. Termination Effective Date**
 - D. Effect on Dependents**
 - E. Right to Review**
 - F. Notice of Termination**
- XI. Continuity of Care**
- XII. Continuation of Benefits (COBRA)**
- XIII. Individual Continuation of Benefits**
- XIV. Confidentiality/Privacy**

XV. Miscellaneous

A. Programs Promoting General Health

B. Organ and Tissue Donation

C. 911 Emergency Response System

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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 clinical necessity or appropriateness of care. Requests for payment authorizations that are declined by Cigna Dental based upon clinical necessity or appropriateness of care will be the responsibility of the member at the dentist's Usual Fees. A licensed dentist will make any such denial. Adverse Determinations may be appealed as described in the Section entitled "What To Do If There Is A Problem."

Cigna Dental - Cigna Dental Health of California, Inc.

Clinical Necessity - 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 professionally recognized standards of dental practice;
- C. not be used primarily for the convenience of the member or provider of care; and
- D. not exceed the scope, duration, or intensity of that level of care needed to provide safe and appropriate treatment.

COBRA - Consolidated Omnibus Budget Reconciliation Act of 1986, as amended. The federal law that gives workers who lose their health benefits the right to choose, under certain circumstances, to continue group health benefits provided by the plan under certain circumstances.

Contract Fees - the fees contained in the Network Specialty Dentist agreement with Cigna Dental.

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

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

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

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

Dependent - your lawful spouse; your unmarried child (including newborns, children of the noncustodial parent, 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:
 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 by reason of a physically or mentally disabling injury, illness or condition; and
 2. chiefly dependent upon you (the subscriber) for support and maintenance.

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.

For a child who falls into category B. above, you will need to furnish Cigna Dental evidence of his or her reliance upon you, in the form requested, within 31 days after the Dependent reaches the age of 19 and once a year thereafter during his or her term of coverage.

For a child who falls into category C. above, you will need to furnish Cigna Dental proof of the child's condition and his or her reliance upon you, within sixty (60) days from the date that you are notified by Cigna Dental to provide this information. Cigna Dental will initially request this information at least ninety (90) days prior to the child's nineteenth (19th) birthday, and will subsequently request such proof on an annual basis after the child turns twenty-one (21).

Coverage for dependents living outside a Cigna Dental service area is subject to the availability of an approved network where the dependent resides; provided however, Cigna Dental will not deny enrollment to your dependent who resides outside the Cigna Dental service area if you are required to provide coverage for dental services to your dependent pursuant to a court order or administrative order.

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 Pediatric Dentist - a licensed Network Specialty Dentist who has completed training in a specific program to provide dental health care for children.

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.

Network General Dentist and Network Specialty Dentist include any dental clinic, organization of dentists, or other person or institution licensed by the State of California to deliver or furnish dental care services that has signed an agreement with Cigna Dental to provide general dentistry or specialty care services to you.

Patient Charge Schedule - list of services covered under your Dental Plan and the associated Copayment.

Prepayment Fees - the premium or fees that your Group pays to Cigna Dental, on your behalf, during the term of your Group Contract. These fees may be paid all or in part by you.

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 member 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 dental plan operation purposes.

III. Eligibility/When Coverage Begins

A. In General

To enroll in the Dental Plan, you and your Dependents must live or work in the Service Area and be able to seek treatment for Covered Services within the 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 to be provided 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 Prepayment Fees.

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

B. New Enrollee Transition of Care

If you or your enrolled Dependents are new enrollees currently receiving services for any of the conditions described hereafter from a non-Network Dentist, you may request Cigna Dental to authorize completion of the services by the non-Network Dentist. Cigna Dental does not cover services provided by non-Network Dentists except for the conditions described hereafter that have been authorized by Cigna Dental prior to treatment. Rare instances where prolonged treatment by a non-Network Dentist might be indicated will be evaluated on a case-by-case basis by the Dental Director in accordance with professionally recognized standards of dental practice. Authorization to complete services started by a non-Network Dentist before you or your enrolled Dependents became eligible for Cigna Dental shall be considered only for the following conditions:

- (1) an acute condition. An acute condition is a dental condition that involves a sudden onset of symptoms due to an illness, injury, or other dental problem that requires prompt dental attention and that has a limited duration. Completion of the covered services shall be provided for the duration of the acute condition.
- (2) newborn children between birth and age 36 months. Cigna Dental shall provide for the completion of covered services for newborn children between birth and age 36 months for 12 months from the effective date of coverage for a newly covered enrollee.
- (3) performance of a surgery or other procedure that is authorized by Cigna Dental and has been recommended and documented by the non-Network Dentist to occur within 180 days of the effective date of your Cigna Dental coverage.

C. Renewal Provisions

Your coverage under the Dental Plan will automatically be renewed, except as provided in the section entitled “Disenrollment From The Dental Plan – Termination of Benefits.” All renewals will be in accordance with the terms and conditions of your Group Contract. Cigna Dental reserves any and all rights to change the Prepayment Fees or applicable Copayments during the term of the Group Contract if Cigna Dental determines the Group’s information relied upon by Cigna Dental in setting the Prepayment Fees materially changes or is determined by Cigna Dental to be inaccurate.

IV. Your Cigna Dental Coverage

Cigna Dental maintains its principal place of business at 400 North Brand Boulevard, Suite 400, Glendale, CA 91203, with a telephone number of 1-800-Cigna24.

This section provides information that will help you to better understand your Dental Plan. Included is information about how to access your dental benefits and your payment responsibilities.

A. Member Services

If you have any questions or concerns about the Dental Plan, Member Services 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, emergencies, Covered Services, plan benefits, ID cards, location of Dental Offices, conversion coverage or other matters, call Member Services from any location at 1-800-Cigna24. If you have a question about your treatment plan, we can arrange a second opinion or consultation. The hearing impaired may contact the state TTY toll-free relay service number listed in their local telephone directory.

B. Prepayment Fees

Your Group sends a monthly Prepayment Fee (premium) to Cigna Dental for members participating in the Dental Plan. The amount and term of this prepayment fee is set forth in your Group Contract. You may contact your Benefits Representative for information regarding any part of this Prepayment Fee to be withheld from your salary or to be paid by you to the Group.

C. Other Charges - Copayments

Network General Dentists are typically reimbursed by Cigna Dental through fixed monthly payments and supplemental payments for certain procedures. Network Specialty Dentists are compensated based on a contracted fee arrangement for services rendered. No bonuses or financial incentives are used as inducements to limit services. Network Dentists are also compensated by the Copayments that you pay, as set out in your Patient Charge Schedule. You may request general information about these matters from Member Services or from your Network Dentist.

Your Patient Charge Schedule lists the dental procedures covered under your Dental Plan, subject to plan exclusions and limitations. Some dental procedures are covered at no charge to you. For other Covered Services, the Patient Charge Schedule lists the Copayments 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 is instructed to tell you about Copayments for Covered Services, the amount you must pay for optional or 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 change in accordance with your Group Contract. Cigna Dental will give written notice to your Group of any change in Copayments at least 30 days prior to such change. You will be responsible for the Copayments listed on the Patient Charge Schedule that is in effect on the date a procedure is started.

D. Facilities - Choice of Dentist

1. In General

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 Member Services 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 www.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 Member Services.

2. 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.

3. Office Transfers

If you decide to change Dental Offices, we encourage you to complete any dental procedure in progress first. To arrange a transfer, call Member Services at 1-800-Cigna24. To obtain a list of Dental Offices near you, visit our website at www.cigna.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 Copayments which you owe to your current Dental Office must be paid before the transfer can be processed. Copayments for procedures not completed at the time of transfer may be required to be prorated between your current Dental Office and the new Dental Office, but will not exceed the amount listed on your Patient Charge Schedule.

E. Your Payment Responsibility (General Care)

For Covered Services at your Dental Office, you will be charged the Copayments listed on your Patient Charge Schedule, subject to applicable exclusions and limitations. For services listed on your Patient Charge Schedule provided 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 available in the Service Area to treat you, 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 Copayment for Covered Services. Cigna Dental will pay the non-Network Dentist the difference between his or her Usual Fee and the applicable Copayment. If you seek treatment for Covered Services from a non-Network Dentist without authorization from Cigna Dental, you will be responsible for paying the non-Network Dentist his or her Usual Fee. See Section IV.G, *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. 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. Except for Pediatrics, Orthodontics and Endodontic services, payment authorization is required for coverage of services by a Network Specialty Dentist.

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

G. Specialty Referrals

1. 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 prior to rendering the service. Prior authorization from Cigna Dental is not required for specialty referrals for Pediatrics, Orthodontics and Endodontic services. You should verify with the Network Specialty Dentist that your treatment plan has been authorized for payment by Cigna Dental before treatment begins.

If your Patient Charge Schedule reflects coverage for Orthodontic services, a referral from a Network General Dentist is not required to receive care from a Network Orthodontist. However, your Network General Dentist may be helpful in assisting you to choose or locate a Network Orthodontist.

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 V.A.7, *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 Member Services to request an extension. Your coverage must be in effect when each procedure begins.

If Cigna Dental makes an Adverse Determination of the requested referral (i.e. Cigna Dental does not authorize payment to the Network Specialty Dentist for Covered Services), or if the dental services sought are not Covered Services, you will be responsible to pay the Network Specialty Dentist's Usual Fee for the services rendered. If you have a question or concern regarding an authorization or a denial, contact Member Services.

Specialty referrals will be authorized by Cigna Dental if the services sought are (i) Covered Services; (ii) rendered to an eligible member; (iii) within the scope of the Specialty Dentists skills and expertise; and (iv) meet Clinical Necessity requirements. Cigna Dental may request medical information regarding your condition and the information surrounding the dentist's determination of the Clinical Necessity for the request. Cigna Dental shall respond in a timely fashion appropriate for the nature of your condition, not to exceed five business days from Cigna Dental's receipt of the information reasonably necessary and requested by Cigna Dental to make the determination. When you face imminent and serious threat to your health, including, but not limited to, the potential loss of life, limb, or other major bodily function, or the normal timeframe for the decision making process would be detrimental to your life or health or could jeopardize your ability to regain maximum function, the decision to approve, modify, or deny requests shall be made in a timely fashion appropriate for the nature of your condition, not to exceed 72 hours after receipt of the request. Decisions to approve, modify, or deny requests for authorization prior to the provision of dental services shall be communicated to the requesting dentist within 24 hours of the decision. Decisions resulting in denial, delay, or modification of all or part of the requested dental service shall be communicated to the Member in writing within 2 business days of the decision. Adverse Determinations may be appealed as described in the Section entitled "What To Do If There Is A Problem/Grievances."

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 Copayment for Covered Services. Cigna Dental will reimburse the non-Network Dentist the difference between his or her Usual Fee and the applicable Copayment. For non-Covered Services or services not authorized for payment, including Adverse Determinations, you must pay the dentist's Usual Fee. Or, if you seek treatment for Covered Services from a non-Network Dentist without authorization from Cigna Dental, you will be responsible for paying the dentist's Usual Fee.

You may request from Member Services a copy of the process that Cigna Dental uses to authorize, modify, or deny requests for specialty referrals and services.

2. Second Opinions

If you have questions or concerns about your treatment plan, second opinions are available to you upon request by calling Member Services. Second opinions will generally be scheduled within 5 days. In the case of an imminent and serious health threat, as determined by Cigna Dental clinicians, second opinions will be rendered within 72 hours. Cigna Dental's policy statement on second opinions may be requested from Member Services.

V. Covered Dental Services

A. Categories of Covered Services

Dental procedures in the following categories of Covered Services are covered under your Dental Plan when listed on your Patient Charge Schedule and performed by your Network Dentist. Please refer to your Patient Charge Schedule for the procedures covered under each category and the associated Copayment.

1. Diagnostic/Preventive

Diagnostic treatment consists of the evaluation of a patient's dental needs based upon observation, examination, x-rays and other tests. Preventive dentistry involves the education and treatment devoted to and concerned with preventing the

development of dental disease. Preventive Services includes dental cleanings, oral hygiene instructions to promote good home care and prevent dental disease, and fluoride application for children to strengthen teeth.

a. Limitation

The frequency of certain Covered Services, like cleanings, is limited. Your Patient Charge Schedule lists any limitations on frequency. If your Network Dentist certifies to Cigna Dental that, due to medical necessity you require certain Covered Services more frequently than the limitation allows, Cigna Dental will waive the limitation.

2. Restorative (Fillings)

Restorative dentistry involves materials or devices used to replace lost tooth structure or to replace a lost tooth or teeth.

3. Crown and Bridge

An artificial crown is a restoration covering or replacing the major part, or the whole of the clinical crown of a tooth. A fixed bridge is a prosthetic replacement of one or more missing teeth cemented to the abutment teeth adjacent to the space. The artificial tooth used in a bridge to replace the missing tooth is called a pontic.

a. Complex Rehabilitation/Multiple Crown Units

Complex rehabilitation is extensive dental restoration involving 6 or more "units" of crown and/or bridge in the same treatment plan. Using full crowns (caps) and/or fixed bridges which are cemented in place, your Network General Dentist will rebuild natural teeth, fill in spaces where teeth are missing and establish conditions which allow each tooth to function in harmony with 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 charges on your Patient Charge Schedule are for each unit of crown or bridge. You pay the per unit copayment for each unit of crown and/or bridge PLUS an

additional charge for complex rehabilitation for each unit beginning with the 6th unit when 6 or more units are prescribed in your Network General Dentist's treatment plan. The additional charge for complex rehabilitation will not be applied to the first 5 units of crown or bridge.

b. Limitations

- (1) all charges for crown and bridge are per unit (each replacement or supporting tooth equals one unit).
- (2) limit 1 every 5 years unless Cigna Dental determines that replacement is necessary because the existing crown or bridge is unsatisfactory as a result of poor quality of care, or because the tooth involved has experienced extensive loss or changes in tooth structure or supporting tissues since the placement of the crown or bridge.

c. Exclusion

- (1) if your Patient Charge Schedule number ends in "04" or a higher number, there is no coverage for crowns and bridges used solely for splinting. This exclusion will not apply if a crown or bridge is determined by Cigna Dental to be the treatment most consistent with professionally accepted standards of care.
- (2) if your Patient Charge Schedule number ends in "04" or a higher number, there is no coverage for resin bonded retainers and associated pontics.
- (3) there is no coverage for 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.

4. Endodontics

Endodontics is root canal treatment, which may be required when the nerve of a tooth is damaged due to trauma, infection, or inflammation. Treatment consists of removing the damaged nerve from the root of the tooth and filling the root canal with a rubber-like material. Following endodontic treatment, a crown is usually needed to strengthen the weakened tooth.

Exclusions

1. Coverage is not provided for Endodontic treatment of teeth exhibiting a poor or hopeless periodontal prognosis.
2. Coverage is not provided for intentional root canal treatment in the absence of injury or disease to solely facilitate a restorative procedure.

5. Periodontics

Periodontics is treatment of the gums and bone which support the teeth. Periodontal disease is chronic. It progresses gradually, sometimes without pain or other symptoms, destroying the support of the gums and bone. The disease is a combination of deterioration plus infection.

a. Preliminary Consultation

This consultation by your Network General Dentist is the first step in the care process. During the visit, you and your Network General Dentist will discuss the health of your gums and bone.

b. Evaluation, Diagnosis and Treatment Plan

If periodontal disease is found, your Network General Dentist or Network Specialty Dentist will develop a treatment plan. The treatment plan consists of mapping the extent of the disease around the teeth, charting the depth of tissue and bone damage and listing the procedures necessary to correct the disease.

Depending on the extent of your condition, your Network General Dentist or Network Specialty Dentist may recommend any of the following procedures:

- (1) **Non-surgical Program** - this is a conservative approach to periodontal therapy. Use of this program depends upon how quickly you heal and how consistently you follow instructions for home care. This program may include:
 - scaling and root planing
 - oral hygiene instruction
 - full mouth debridement
- (2) **Scaling and Root Planing** - this periodontal therapy procedure combines scaling of the crown and root surface with root planing to smooth rough areas of the root. This procedure may be performed by the dental hygienist or your Network General Dentist.

- (3) **Osseous Surgery** - bone (osseous) surgery is a procedure used in advanced cases of periodontal disease to restructure the supporting gums and bone. Without this surgery, tooth or bone loss may occur. Two checkups by the Periodontist are covered within the year after osseous surgery.
 - (4) **Occlusal Adjustment** - occlusal adjustment requires the study of the contours of the teeth, how they bite (occlude) and their position in the arch. It consists of a recontouring of biting surfaces so that direct biting forces are along the long axis of the tooth. If the biting forces are not properly distributed, the bone, which supports the teeth, may deteriorate.
 - (5) **Bone Grafts and other regenerative procedures** - this procedure involves placing a piece of tissue or synthetic material in contact with tissue to repair a defect or supplement a deficiency.
- c. Limitations**
1. Periodontal regenerative procedures are limited to one regenerative procedure per site (or per tooth, if applicable), when covered on the Patient Charge Schedule.
 2. 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.
- d. Exclusion**
1. General anesthesia, sedation and nitrous oxide are not covered, unless specifically listed on your Patient Charge Schedule. When listed on your Patient Charge Schedule, IV sedation is covered when medically necessary and provided in conjunction with Covered Services performed by a Periodontist. General anesthesia is not covered when provided by a Periodontist. There is no coverage for general anesthesia or intravenous sedation when used for the purposes of anxiety control or patient management.
 2. There is no coverage for Periodontal (gum tissue and supporting bone) surgery of teeth exhibiting a poor or hopeless periodontal prognosis.
3. There is no coverage for the replacement of an occlusal guard (night guard) beyond one per any 24 consecutive month period.
 4. There is no coverage for bone grafting and/or guided tissue regeneration when performed at the site of a tooth extraction; or when performed in conjunction with an apicoectomy or periradicular surgery.
 5. There is no coverage for localized delivery of antimicrobial agents when performed alone or in the absence of traditional periodontal therapy.
- 6. Oral Surgery**
- Oral surgery involves the surgical removal of teeth or associated surgical procedures by your Network General Dentist or Network Specialty Dentist.
- a. Limitation**
- The surgical removal of a wisdom tooth may not be covered if the tooth is not diseased or if the removal is only for orthodontic reasons. Temporary pain from normal eruption is not considered disease. Your Patient Charge Schedule lists any limitations on oral surgery.
- b. Exclusion**
- General anesthesia, sedation and nitrous oxide are not covered 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. There is no coverage for general anesthesia or intravenous sedation when used for the purposes of anxiety control or patient management.
- 7. Orthodontics** (This section is applicable only when Orthodontics is listed on your Patient Charge Schedule.)
- a. Definitions** - If your Patient Charge Schedule indicates coverage for orthodontic treatment, the following definitions apply:
- (1) **Orthodontic Treatment Plan and Records** - the preparation of orthodontic records and a treatment plan by the Orthodontist.
 - (2) **Interceptive Orthodontic Treatment** - treatment prior to full eruption of the permanent teeth, frequently a first phase preceding comprehensive treatment.

- (3) **Comprehensive Orthodontic Treatment** - treatment after the eruption of most permanent teeth, generally the final phase of treatment before retention.
- (4) **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.

b. Copayments

The Copayment for your entire orthodontic case, including retention, will be based upon the Patient Charge Schedule in effect on the date of your visit for Orthodontic 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 Copayment 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 Copayment will be reduced on a prorated basis.

c. Additional Charges

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

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

d. Orthodontics in Progress

If orthodontic treatment is in progress for you or your Dependent at the time you enroll, call Member Services at 1-800-Cigna24 to find out the benefit to which you are entitled based upon

your individual case and the remaining months of treatment.

e. Exclusion

Replacement of fixed and/or removable orthodontic appliances (including fixed and removable orthodontic appliances) that have been lost, stolen, or damaged due to patient abuse, misuse or neglect.

B. 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. Emergency dental care services may include examination, x-rays, sedative fillings, dispensing of antibiotics or pain relief medication or other palliative services prescribed by the treating dentist. 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 Copayments listed on your Patient Charge Schedule. Cigna Dental will reimburse you the difference between the dentist's usual fee for emergency Covered Services and your Copayment, up to a total of \$50 per incident. To receive reimbursement, send the dentist's itemized statement to Cigna Dental at the address listed for your state on the front of this booklet.

2. Emergency Care After Hours

There is a Copayment listed on your Patient Charge Schedule for emergency care rendered after regularly scheduled office hours. This charge will be in addition to other applicable Copayments.

VI. Exclusions

In addition to the exclusions listed in Section V, listed below are the services or expenses which are also NOT covered under your Dental Plan and which are your responsibility at the dentist's Usual Fees. There is no coverage for:

1. services not listed on the Patient Charge Schedule.
2. services provided by a non-Network Dentist without Cigna Dental's prior approval (except emergencies, as described in Section V.B.).
3. services to the extent you, or your Dependent, are compensated for them under any group medical plan.
4. services considered to be unnecessary or experimental in nature or do not meet commonly accepted dental standards.
5. services associated with the placement, repair or Prosthodontic restoration of a dental implant, or any other services related to implants.
6. 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 PCS, only the use of take-home bleaching gel with trays is covered; all other types of bleaching methods are not covered.
7. prescription drugs.
8. 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. If special circumstances arise where a Network Dentist is not available, the Plan will make special arrangements for the provision of covered benefits as necessary for the dental health of the member.)
9. procedures, appliances or restorations if the main purpose is to:
 - (1) change vertical dimension (degree of separation of the jaw when teeth are in contact); (2) diagnose or treat abnormal conditions of the temporo-mandibular joint (TMJ), unless TMJ therapy is specifically listed on your Patient Charge Schedule; or if your Patient Charge Schedule ends in "04" or a higher number;
 - (3) restore asymptomatic teeth where loss of tooth structure was caused by attrition, abrasion, erosion and/or abfraction and the primary purpose of the restoration is: (a) to change the vertical dimension of occlusion; (b) to diagnose or treat abnormal condition

of the temporomandibular joint; or (c) for cosmetic purposes.

10. procedures or appliances for minor tooth guidance or to control harmful habits.
11. charges by dental offices for failing to cancel an appointment or canceling an appointment with less than 24 hours notice (i.e. a broken appointment). You will be responsible for paying any broken appointment fee unless your broken appointment was unavoidable due to emergency or exigent circumstances.
12. consultations and/or evaluations associated with services that are not covered.
13. infection control and/or sterilization. Cigna Dental considers this to be incidental to an part of the charges for services provided and not separately chargeable.
14. services to correct congenital malformations, including the replacement of congenitally missing teeth.

As noted in Section V, the following exclusions also apply:

15. if your Patient Charge Schedule number ends in "04" or a higher number, there is no coverage for crowns and bridges used solely for splinting. This exclusion will not apply if a crown or bridge is determined by Cigna Dental to be the treatment most consistent with professionally accepted standards of care.
16. if your Patient Charge Schedule number ends in "04" or a higher number, there is no coverage for resin bonded retainers and associated pontics.
17. general anesthesia, sedation and nitrous oxide are not covered, unless specifically listed on your Patient Charge Schedule. There is no coverage for general anesthesia or intravenous sedation when used for the purposes of anxiety control or patient management.
18. replacement of fixed and/or removable orthodontic appliances (including fixed and removable orthodontic appliances) that have been lost, stolen, or damaged due to patient abuse, misuse or neglect.
19. endodontic treatment and/or periodontal (gum tissue and supporting bone) surgery of teeth exhibiting a poor or hopeless periodontal prognosis.
20. 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.

21. the replacement of an occlusal guard (night guard) beyond one per any 24 consecutive month period.
22. intentional root canal treatment in the absence of injury or disease to solely facilitate a restorative procedure.
23. bone grafting and/or guided tissue regeneration when performed at the site of a tooth extraction; or when performed in conjunction with an apicoectomy or periradicular surgery.
24. localized delivery of antimicrobial agents when performed alone or in the absence of traditional periodontal therapy.

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

VII. Limitations

In addition to the limitations listed in Section V, listed below are the services or expenses which have limited coverage under your Dental Plans. No payment will be made for expense incurred or services received:

1. for or in connection with an injury arising out of, or in the course of, any employment for wage or profit;
2. 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;
3. to the extent that payment is unlawful where the person resides when the expenses are incurred or the services are received;
4. for the charges which the person is not legally required to pay;
5. for charges which would not have been made if the person had no insurance;
6. due to injuries which are intentionally self-inflicted;
7. periodic oral evaluations, comprehensive oral evaluations, comprehensive periodontal evaluations, and oral evaluations for patients under three years of age are limited to a total of 4 evaluations during a 12 consecutive month period.

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

VIII. What To Do If There Is A Problem/Grievances

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. Your Rights to File Grievances With Cigna Dental

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

Grievances include both complaints and appeals. Complaints may include concerns about people, quality of service, quality of care, benefit interpretations or eligibility. Appeals are requests to reverse a prior denial or modified decision about your care. You may contact us by telephone or in writing with a grievance.

B. How to File a Grievance

To contact us by phone, call us toll-free at 1-800-Cigna24 or the toll-free telephone number on your Cigna identification card. The hearing impaired may call the state TTY toll-free service listed in their local telephone directory.

Send written grievances to:

Cigna Dental Health of California, Inc.
P.O. Box 188047
Chattanooga, TN 37422-8047

We will provide you with a grievance form upon request, but you are not required to use the form in order to make a written grievance.

You may also submit a grievance online through the following Cigna website:
<http://www.cigna.com/health/consumer/medical/state/ca.html#dental>.

If the Member is a minor, is incompetent or unable to exercise rational judgment or give consent, the parent, guardian, conservator, relative, or other legal representative acting on behalf of the Member, as appropriate, may submit a grievance to Cigna Dental or the California Department of Managed Health Care (DMHC or “Department”), as the agent of the Member. Also, a participating provider may join with or assist you or your agent in submitting a grievance to Cigna Dental or the DMHC.

1. Complaints

If you are concerned about the quality of service or care you have received, a benefit interpretation, or have an eligibility issue, you should contact us to file a verbal or written complaint. If you contact us by telephone to file a complaint, we will attempt to document and/or resolve your complaint over the telephone. If we receive your complaint in writing, we will send you a letter confirming that we received the complaint within 5 calendar days of receiving your notice. This notification will tell you whom to contact should you have questions or would like to submit additional information about your complaint. We will investigate your complaint and will notify you of the outcome within 30 calendar days.

2. Appeals

If your grievance does not involve a complaint about the quality of service or care, a benefit interpretation or an eligibility issue, but instead involves dissatisfaction with the outcome of a decision that was made about your care and you want to request Cigna Dental to reverse the previous decision, you should contact us within one year of receiving the denial notice to file a verbal or written appeal. Be sure to share any new information that may help justify a reversal of the original decision. Within 5 calendar days from when we receive your appeal, we will confirm with you, in writing, that we received it. We will tell you whom to contact at Cigna Dental should you have questions or would like to submit additional information about your appeal. We will make sure your appeal is handled by someone who has authority to take action and who was not involved in the original decision. We will investigate your appeal and notify you of our decision, within 30 calendar days. You may request that the appeal process be expedited, if there is an imminent and serious threat to your health, including severe pain, potential loss of life, limb or major bodily function. A Dental Director for Cigna Dental, in consultation with your treating dentist, will decide if an expedited appeal is necessary. When an appeal is expedited, Cigna Dental will respond orally and in writing with a decision within 72 hours.

C. You Have Additional Rights Under State Law

Cigna Dental is regulated by the California Department of Managed Health Care (DMHC or the “Department”). If you are dissatisfied with the resolution of your complaint or appeal, the law states that you have the right to submit the grievance to the department for review as follows:

The California Department of Managed Health Care is responsible for regulating health care service plans. If you

have a grievance against your health plan, you should first telephone your health plan at 1-800-Cigna24 and use your health plan’s grievance process before contacting the department. Utilizing this grievance procedure does not prohibit any potential legal rights or remedies that may be available to you. If you need help with a grievance involving an emergency, a grievance that has not been satisfactorily resolved by your health plan, or a grievance that has remained unresolved for more than 30 days, you may call the department for assistance. You may also be eligible for an Independent Medical Review (IMR). If you are eligible for IMR, the IMR process will provide an impartial review of medical decisions made by a health plan related to the medical necessity of a proposed service or treatment, coverage decisions for treatments that are experimental or investigational in nature and payment disputes for emergency or urgent medical services. The department also has a toll-free telephone number (1-888-HMO-2219) and a TDD line (1-877-688-9891) for the hearing and speech impaired. The department’s Internet Web site <http://www.hmohelp.ca.gov> has complaint forms, IMR application forms and instructions online.

You may file a grievance with the DMHC if Cigna Dental has not completed the complaint or appeal process described above within 30 days of receiving your grievance. You may immediately file an appeal with Cigna Dental and/or the DMHC in a case involving an imminent and serious threat to the health, including, but not limited to, severe pain, the potential loss of life, limb, or major bodily function, or in any other case where the DMHC determines that an earlier review is warranted.

D. Voluntary Mediation

If you have received an appeal decision from Cigna Dental with which you are not satisfied, you may also request voluntary mediation with us before exercising the right to submit a grievance to the DMHC. In order for mediation to take place, you and Cigna Dental each have to voluntarily agree to the mediation. Cigna Dental will consider each request for mediation on a case by case basis. Each side will equally share the expenses of the mediation. To initiate mediation, please submit a written request to the Cigna Dental address listed above. If you request voluntary mediation, you may elect to submit your grievance directly to the DMHC after participating in the voluntary mediation process for at least 30 days.

For more specific information regarding these grievance procedures, please contact our Member Services Department.

IX. Coordination of Benefits

Coordination of benefit rules explain the payment process when you are covered by more than one dental plan. 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, 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. Coordination of Benefits should result in lowering or eliminating your out-of-pocket expenses. It should not result in reimbursement for more than 100% of your expenses.

The following is a more detailed explanation of the rules used to determine which plan must pay first (your "primary" plan) and which plan must pay second (your "secondary" plan):

- A. A member may be covered as an employee by his/her employer and as a dependent by his/her spouse's employer. The plan that covers the Member as an employee (the policyholder) is the primary plan.
- B. Under most circumstances, if a child is covered as a dependent under both parents' coverage (and parents are not separated or divorced), the plan of the parent with the earliest birthday in the year is the primary plan.
- C. If a child of divorced or separated parents is covered as a dependent under at least one of the parents' (or stepparents') coverage, benefits are determined in the following order:
 1. According to a court decree that designates the person financially responsible for the dental care coverage; or without such decree,
 2. The plan of the parent who has custody of the child;
 3. If the parent with custody of the child is remarried; then the stepparent's plan; and finally,
 4. The plan of the parent without custody of the child.
- D. The benefits of a plan that covers an active employee (and any dependents) are determined before those of a program which covers an inactive employee (laid-off or retired). However, if one of the plans does not have a provision regarding retired or laid-off employees, this section may not apply. Please contact the Plan at the number below for further instruction.

- E. If a Member is covered under a continuation plan (e.g. COBRA) AND has coverage under another plan, the following determines the order of benefits:
 1. The plan that covers the member as an employee (or dependent of employee) will be primary;
 2. The continuation plan will be secondary.However, if the plan that covers the person as an employee does not follow these guidelines and the plans disagree about the order of determining benefits, then this rule may be ignored. Please contact Cigna Dental at the number below for further instructions.
- F. If none of the above rules determines the order of benefits, the plan that has been in effect longer is the primary plan. To determine which plan has been in effect longer, we will take into consideration the coverage you had previously with the same employer, even if it was a different plan, as long as there was no drop in eligibility during the transition between plans.
- G. Workers' Compensation – Should any benefit or service rendered result from a Workers' Compensation Injury Claim, the Member shall assign his/her right to reimbursement from other sources to Cigna Dental or to the Participating Provider who rendered the service.
- H. When Cigna Dental is primary, we will provide or pay dental benefits without considering any other plan's benefits. When Cigna Dental is secondary, we shall pay the lesser of either the amount that we would have paid in the absence of any other dental coverage, or your total out of pocket cost payable under the primary dental plan for benefits covered by Cigna Dental.
- I. Please call Cigna Dental at 1-800-Cigna24 if you have questions about which plan will act as your primary plan or if you have other questions about coordination of benefits.

Additional 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.

X. Disenrollment From the Dental Plan – Termination of Benefits

Except for extensions of coverage 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. For the Group

The Dental Plan is renewable with respect to the Group except as follows:

1. for nonpayment of the required Prepayment Fees;

2. for fraud or other intentional misrepresentation of material fact by the Group;
3. low participation (i.e. less than ten enrollees);
4. if the Dental Plan ceases to provide or arrange for the provision of dental services for new Dental Plans in the state; provided, however, that notice of the decision to cease new or existing dental plans shall be provided as required by law at least 180 days prior to discontinuation of coverage; or
5. if the Dental Plan withdraws a Group Dental Plan from the market; provided, however, that notice of withdrawal shall be provided as required by law at least 90 days prior to the discontinuation and that any other Dental Plan offered is made available to the Group.

B. For You and Your Enrolled Dependents

The Dental Plan may not be canceled or not renewed except as follows:

1. failure to pay the charge for coverage if you have been notified and billed for the charge and at least 15 days have elapsed since the date of notification.
2. fraud or deception in the use of services or Dental Offices or knowingly permitting such fraud or deception by another.
3. your behavior is disruptive, unruly, abusive or uncooperative to such an extent that the Dental Plan or the Network Dental Office is materially impaired in its ability to provide services to you or another Member. Cigna Dental will provide reasonable opportunities to transfer to another Dental Office prior to such termination. In the event of such termination, Cigna Dental will cooperate as needed to help you establish a relationship with a non-participating dental office.
4. you threaten the life or well-being of any Dental Plan employee, Network Dentist, Dental Office employee or another Member and the Dental Office is materially impaired in its ability to provide services to you. Cigna Dental will provide reasonable opportunities to transfer to another Dental Office prior to such termination.

C. Termination Effective Date

The effective date of the termination shall be as follows:

1. in the case of nonpayment of Prepayment Fees, enrollment will be canceled as of the last day of the month in which payment was received, subject to compliance with notice requirements.
2. in the case of failure to meet eligibility requirements or for disruptive or threatening behavior described

above, enrollment will be canceled as of the date of termination specified in the written notice, provided that at least 15 days have expired since the date of notification.

3. on the last day of the month after voluntary disenrollment.
4. termination of Benefits due to fraud or deception shall be effective immediately upon receipt of notice of cancellation.

D. Effect on Dependents

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

For you and your Dependents, disenrollment will be effective the last day of the month in which Prepayment Fees are not paid to Cigna Dental. Cigna Dental will provide at least 15 days notice to your Group as to the date your coverage will be discontinued.

E. Right to Review

If you believe that your termination from the Dental Plan is due to your dental health status or requirements for dental care services, you may request review of the termination by the Director of the Department of Managed Health Care.

F. Notice of Termination

If the Group Contract is terminated for any reason described in this section, the notice of termination of the Group Contract or your coverage under the Group Contract shall be mailed by the Dental Plan to your Group or to you, as applicable. Such notice shall be dated and shall state:

1. the cause for termination, with specific reference to the applicable provision of the Group Contract or Plan Booklet;
2. the cause for termination was not the Subscriber's or a Member's health status or requirements for health care services;
3. the time the termination is effective;
4. the fact that a Subscriber or Member alleging that the termination was based on health status or requirements for health care services may request a review of the termination by the Director of the California Department of Managed HealthCare;
5. in instances of termination of the Group Contract for non-payment of fees, that receipt by the Dental Plan of any such past due fees within 15 days following receipt of notice of termination will reinstate the Group Contract as though it had never been

terminated; if payment is not made within such 15 day period a new application will be required and the Dental Plan shall refund such payment within 20 business days;

6. any applicable rights you may have under the “Continuation of Benefits” Section.

XI. Continuity of Care

If you are receiving care from a Network Dentist who has been terminated from the Cigna Dental network, Cigna Dental will arrange for you to continue to receive care from that dentist if the dental services you are receiving are for one of the following conditions:

- (1) an acute condition. An acute condition is a dental condition that involves a sudden onset of symptoms due to an illness, injury, or other dental problem that requires prompt dental attention and that has a limited duration. Completion of the covered services shall be provided for the duration of the acute condition.
- (2) newborn children between birth and age 36 months. Cigna Dental shall provide for the completion of covered services for newborn children between birth and age 36 months for 12 months from the termination date of the Network Dentist’s contract.
- (3) performance of a surgery or other procedure that is authorized by Cigna Dental and has been recommended and documented by the terminated dentist to occur within 180 days of the effective date of termination of the dentist’s contract.

Cigna Dental is not obligated to arrange for continuation of care with a terminated dentist who has been terminated for medical disciplinary reasons or who has committed fraud or other criminal activities.

In order for the terminated Participating Provider to continue to care for you, the terminated dentist must comply with the Cigna Dental’s contractual and credentialing requirements and must meet the Cigna Dental’s standards for utilization review and quality assurance. The terminated dentist must also agree with Cigna Dental to a mutually acceptable rate of payment. If these conditions are not met, Cigna Dental is not required to arrange for continuity of care.

If you meet the necessary requirements for continuity of care as described above, and would like to continue your care with the terminated Dentist, you should call Member Services.

If you do not meet the requirements for continuity of care or if the terminated dentist refuses to render care or has been determined unacceptable for quality or contractual reasons, Cigna Dental will work with you to accomplish a timely transition to another qualified Network Dentist.

XII. 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 Prepayment Fees to the Group. Additional information is available through your Benefits Representative.

XIII. Individual Continuation of Benefits

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 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 Prepayment Fees 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.

XIV. 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 member plan materials. You may obtain additional information about Cigna Dental’s confidentiality policies and procedures by calling Member Services at 1-800-Cigna24, or via the Internet at www.cigna.com.

A STATEMENT DESCRIBING Cigna DENTAL’S POLICIES AND PROCEDURES FOR PRESERVING THE CONFIDENTIALITY OF MEDICAL RECORDS IS AVAILABLE AND WILL BE FURNISHED TO YOU UPON REQUEST.

XV. Miscellaneous

A. Programs Promoting General Health

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

If you are a Cigna Dental Care member you may also 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. Please review your plan enrollment materials for details.

B. Organ and Tissue Donation

Donating organ and tissue provides many societal benefits. Organ and tissue donation allows recipients of transplants to go on to lead fuller and more meaningful lives. Currently, the need for organ transplants far exceeds availability. The California Health and Safety Code states that an anatomical gift may be made by one of the following ways:

- a document of gift signed by the donor.
- a document of gift signed by another individual and by two witnesses, all of whom have signed at the direction and in the presence of the donor and of each other and state that it has been so signed.
- a document of gift orally made by a donor by means of a tape recording in his or her own voice.

One easy way individuals can make themselves eligible for organ donation is through the Department of Motor Vehicles (DMV). Every time a license is renewed or a new one is issued to replace one that was lost, the DMV will automatically send an organ donor card. Individuals may complete the card to indicate that they are willing to have their organs donated upon their death. They will then be given a small dot to stick on their driver's license, indicating they have an organ donor card on file. For more information, contact your local DMV office and request an organ donor card.

C. 911 Emergency Response System

You are encouraged to use appropriately the '911' emergency response system, in areas where the system is established and operating, when you have an emergency medical condition that requires an emergency response.

CALIFORNIA LANGUAGE ASSISTANCE PROGRAM NOTICE

IMPORTANT INFORMATION ABOUT FREE LANGUAGE ASSISTANCE

If you have a limited ability to speak or read English you have the right to the following services at no cost to you:

- Access to an interpreter when you call Cigna's Member Services Department.
- Access to an interpreter when you talk to your doctor or health care provider.
- If you read Spanish or Traditional Chinese, you also have the right to request that we read certain documents that Cigna has mailed to you, in your preferred language. You may also request written translation of these documents.

To inform Cigna of your preferred written and spoken languages, your race and/or ethnicity, or to request assistance from someone who speaks your language, please call us at the telephone number on your Identification (ID) card or your customer service phone number.

We are pleased to assist you in the language you prefer and understand.

INFORMACIÓN IMPORTANTE SOBRE LA ASISTENCIA GRATUITA CON EL IDIOMA

Si su dominio para hablar o leer en inglés es limitado, usted tiene derecho a acceder a los siguientes servicios, sin ningún costo para usted:

- Acceso a un intérprete cuando se comunica con el Departamento de Servicios a los miembros de Cigna.
- Acceso a un intérprete cuando habla con su médico o con el proveedor de atención médica.
- Si usted lee español o chino tradicional, también tiene derecho a solicitar que le leamos ciertos documentos que Cigna le ha enviado a usted por correo, en el idioma que usted prefiera. También puede solicitar la traducción por escrito de estos documentos.

Para informarle a Cigna el idioma escrito u oral que usted prefiere, su raza y/o origen étnico, o para solicitar ayuda de alguien que hable su idioma, por favor, llámenos al teléfono que figura en su Tarjeta de identificación (ID) o al teléfono del servicio de atención al cliente.

Nos complace ayudarle en el idioma que usted prefiere y entiende.

有關免費語言協助的重要訊息

如果您的英語說話或閱讀能力有限，您有權可免費取得下列服務：

- 您打電話給 CIGNA 的會員服務部門時，由口譯員為您翻譯。
- 您與您的醫生或醫療保健提供者溝通時，由口譯員為您翻譯。
- 如果您能閱讀西班牙文或繁體中文，您也有權可要求我們把 CIGNA 郵寄給您的部分文件，用您熟悉的語言朗讀給您聽。您也可以索取這些文件的書面翻譯。

如果您想告訴 CIGNA 您習慣閱讀和說的語言、您的種族和(或)族裔，或想申請由和您說同樣語言的人來協助您，請您撥您的會員卡上的電話，或撥我們的顧客服務電話與我們聯絡。

我們十分樂意用您熟悉且能清楚瞭解的語言來協助您。

THÔNG TIN QUAN TRỌNG VỀ DỊCH VỤ TRỢ GIÚP NGÔN NGỮ MIỄN PHÍ

Nếu quý vị không nói hoặc đọc tiếng Anh thông thạo, quý vị có quyền được nhận các dịch vụ miễn phí sau đây:

- Có thông dịch viên trợ giúp khi quý vị gọi Ban Dịch Vụ Hội Viên của CIGNA.
- Có thông dịch viên trợ giúp khi quý vị nói chuyện với bác sĩ hoặc nhà cung cấp dịch vụ chăm sóc sức khỏe của quý vị.
- Nếu quý vị biết đọc tiếng Tây ban nha hoặc tiếng Hoa truyền thống, quý vị cũng có quyền yêu cầu chúng tôi đọc một số tài liệu mà CIGNA đã gửi cho quý vị, bằng ngôn ngữ mà quý vị ưa dùng. Quý vị cũng có thể yêu cầu bản chuyển ngữ của các tài liệu này.

Để cho CIGNA biết về các ngôn ngữ viết và nói mà quý vị ưa dùng, sắc tộc và/hoặc chủng tộc của quý vị, hoặc nhờ người nói được ngôn ngữ của quý vị giúp đỡ, xin gọi cho chúng tôi tại số điện thoại ghi trên thẻ hội viên của quý vị hoặc số điện thoại của ban dịch vụ khách hàng.

Chúng tôi luôn sẵn lòng trợ giúp quý vị bằng ngôn ngữ mà quý vị ưa dùng.

無料言語支援サービスに関する重要情報

英語による読み書きにご不自由を感じるお客様のために、以下のサービスを無料でご提供しています。

- CIGNA 会員サービス部に電話をする際の通訳サービス。
- 担当医または医療保険プロバイダとの会話を支援する通訳サービス。
- スペイン語または繁体字中国語をお話しになる方を対象に、CIGNA がお手元にお送りする特定の文書をご希望の言語でお読みするサービス。該当文書の翻訳もご請求いただけます。

CIGNA にご希望言語 (書面および会話)、または、該当する人種・民族の通知を行う場合、または、言語サービスをご希望の場合には、お手持ちの身分証明(ID)カード記載の電話番号、または、カスタマー・サービスの電話番号までご連絡ください。

お客様のご希望の言語で、サービスをご提供いたします。

무료 통번역 서비스에 대한 중요 정보 사항

영어로 읽고 말하는데 어려움을 겪는 분이 계시다면 다음의 무료 통번역 서비스를 받으실 수 있습니다:

- CIGNA 고객 서비스 센터에 전화하실 때 통역사 서비스를 받으실 수 있습니다.
- 본인의 의사나 헬스 케어 제공자와 대화하실 때 통역사 서비스를 받으실 수 있습니다.
- 스페인어나 중문 번체를 읽으실 수 있는 분은 CIGNA가 우편으로 보낸 특정 서류에 대해 선호하는 언어로 번역해 줄 것을 요청하실 수 있습니다. 또한 이러한 서류 등에 대해 번역본을 요청하실 수도 있습니다.

CIGNA 에게 본인이 선호하는 문어 및 구어, 인종 및/또는 민족에 대해 알려주고 싶으신 분이나, 혹은 본인이 사용하는 언어를 구사할 수 있는 도우미를 요청하고 싶으신 분은 가입자님의 ID 카드에 기재된 전화번호나 해당 고객 서비스 센터의 안내번호로 전화해 주십시오.

CIGNA 는 항상 여러분에게 편리하고 이해하기 쉬운 언어 서비스를 제공하기 위해 최선을 다하고 있습니다.

NOT199



Cigna HealthCare of Connecticut, Inc.

**Cigna HealthCare of Connecticut, Inc.
900 Cottage Grove Road
Hartford, CT 06152-1118**

**Cigna Dental Health, Inc.
1571 Sawgrass Corporate Parkway, Suite 140
Sunrise, FL 33323
Phone: 1-800-Cigna24**

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 HealthCare of Connecticut, Inc. 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.

Consumer Notice: Your out-of-pocket expense for certain complex procedures may exceed 50% of a dentist’s usual charge for those procedures. Please read your plan documents carefully and discuss your treatment options and financial obligations with your dentist. If you have any questions about your plan, please call Member Services or visit <http://www.cigna.com> for additional information.

READ YOUR PLAN BOOKLET CAREFULLY

Please call Member Services at 1-800-Cigna24 if you have any questions. The hearing impaired may call the state TTY toll-free relay service listed in their local telephone directory.

TABLE OF CONTENTS

- I. Definitions**
- II. Introduction to Your Cigna Dental Plan**
- III. Eligibility/When Coverage Begins**
- IV. Your Cigna Dental Coverage**
 - A. Member Services**
 - B. Premiums/Prepayment Fees**
 - C. Other Charges - Patient Charges**
 - D. Choice of Dentist**
 - E. Your Payment Responsibility (General Care)**
 - F. Emergency Dental Care - Reimbursement**
 - G. Limitations on Covered Services**
 - H. Services Not Covered Under Your Dental Plan**
- V. Appointments**
- VI. Broken Appointments**
- VII. Office Transfers**
- VIII. Specialty Care**
- IX. Specialty Referrals**
 - A. In General**
 - B. Orthodontics**
- X. Complex Rehabilitation/Multiple Crown Units**
- XI. What To Do If There Is A Problem**
 - A. Start With Member Services**
 - B. Appeals Procedure**
- XII. Dual Coverage**
- XIII. Disenrollment From the Dental Plan - Termination of Benefits**
 - A. Time Frames For Disenrollment/Termination**
 - B. Effect On Dependents**
- XIV. Extension of Benefits**
- XV. Continuation of Benefits (COBRA)**
- XVI. Conversion Coverage**
- XVII. Confidentiality/Privacy**
- XVIII. Miscellaneous**

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 member or provider of care; and
- D. not exceed the scope, duration, or intensity of that level of care needed to provide safe and appropriate treatment.

Requests for payment 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. A licensed dentist will make any such denial.

Cigna Dental - Cigna Dental Health, Inc., on behalf of Cigna HealthCare of Connecticut, Inc. (said corporations are affiliates and are herein after referred to as "Cigna Dental"), contracts with participating general dentists for the provision of dental care. Cigna Dental Health, Inc. also provides management and information services to members and participating dental offices.

Contract Fees - the fees contained in the Network Specialty 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 HealthCare of Connecticut, Inc. and your Group.

Dependent - your lawful spouse; 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:
 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.

For a child who falls into category (b) or (c) above, you will need to furnish Cigna Dental evidence of his or her reliance upon you, in the form requested, within 31 days after the Dependent reaches the age of 19 and once a year thereafter during his or her term of coverage.

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 State Rider or Group Contract.

Group - employer, labor union or other organization that has entered into a Group Contract with Cigna HealthCare of Connecticut, Inc. 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 directly or indirectly to Cigna HealthCare of Connecticut, Inc., 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 member 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 61 days of life. If you wish to continue coverage beyond the first 61 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. Member Services

If you have any questions or concerns about the Dental Plan, Member Services 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 Member Services 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/Prepayment Fees

Your Group sends a monthly fee to Cigna Dental for members 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 Member Services 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 www.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 Member Services.

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 Charges. To receive reimbursement, send appropriate reports and x-rays to Cigna Dental at the address listed 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 covered by your Dental Plan:

- 1. Frequency** - The frequency of certain Covered Services, like cleanings, is limited. Your Patient Charge Schedule lists any limitations on frequency.
- 2. 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.

3. **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.
4. **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.
5. **Clinical Oral Evaluations** – Periodic oral evaluations, comprehensive oral evaluations, comprehensive periodontal evaluations, and oral evaluations for patients under three years of age are limited to a total of 4 evaluations during a 12 consecutive month period.

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:

1. services not listed on the Patient Charge Schedule.

2. services provided by a non-Network Dentist without Cigna Dental's prior approval (except emergencies, as described in Section IV.F.)
3. services related to an injury or illness paid under workers' compensation, occupational disease or similar laws.
4. services provided or paid by or through a federal or state governmental agency or authority, political subdivision or a public program, other than Medicaid.
5. 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.
6. 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 PCS, only the use of take-home bleaching gel with trays is covered; all other types of bleaching methods are not covered.
7. 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.
8. prescription drugs.
9. 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. diagnose or treat abnormal conditions of the temporomandibular joint (TMJ) unless TMJ therapy is specifically listed on your Patient Charge Schedule or if your Patient Charge Schedule ends in "-04" or higher; or c. restore teeth which have been damaged by attrition, abrasion, erosion, and/or abfraction or d. restore the occlusion.
10. 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.
11. services associated with the placement, repair, removal or prosthodontic restoration of a dental implant or any other services related to implants.
12. services considered to be unnecessary or experimental in nature or do not meet commonly accepted dental standards.

13. procedures or appliances for minor tooth guidance or to control harmful habits.
14. 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.)
15. 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.
16. the completion of crown and bridge, dentures or root canal treatment already in progress on the effective date of your Cigna Dental coverage.
17. consultations and/or evaluations associated with services that are not covered.
18. endodontic treatment and/or periodontal (gum tissue and supporting bone) surgery of teeth exhibiting a poor or hopeless periodontal prognosis, unless dentally necessary.
19. bone grafting and/or guided tissue regeneration when performed at the site of a tooth extraction or when performed in conjunction with an apicoectomy or periradicular surgery.
20. intentional root canal treatment in the absence of injury or disease to solely facilitate a restorative procedure.
21. service performed by a prosthodontist.
22. localized delivery of antimicrobial agents when performed alone or in the absence of traditional periodontal therapy.
23. any localized delivery of antimicrobial agent procedures when more than eight (8) of these procedures are reported on the same date of service.
24. 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.
25. 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.
26. services to correct congenital malformation, including the replacement of congenitally missing teeth.

27. the replacement of an occlusal guard (night guard) beyond on per any 24 consecutive month period.

In addition to the above, if your Patient Charge Schedule ends in “-04” or a higher number, there is no coverage for the following:

1. crowns and bridges used solely for splinting.
2. resin bonded retainers and associated pontics.

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 Member Services at 1-800-Cigna24. To obtain a list of Dental Offices near you, visit our website at www.cigna.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 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 Member Services 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 Member Services.

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:

- 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 Member Services 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 and/or bridge in the same treatment plan. Using full crowns (caps) and/or fixed bridges which are cemented in place, your Network General Dentist will rebuild natural teeth, fill in spaces where teeth are missing and establish conditions which allow each tooth to function in harmony with 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 charges on your Patient Charge Schedule are for each unit of crown or bridge. You pay the per unit charge for each unit of crown and/or bridge PLUS an additional charge for each unit when 6 or more units are prescribed in your Network General Dentist's treatment plan.

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 Member Services

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 Member Services Representatives. You can also express that concern in writing to Cigna Dental at P.O. Box 188047, Chattanooga, TN 37422-8047. 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.

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 receipt 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 Member Services 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 in the field related to the care under consideration, under the authority of a Connecticut licensed dentist.

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 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 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, Cigna Dental will respond orally with a decision within the lesser of 72 hours after the appeal is received, or 2 business days after the required information is received, 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. For postservice claim or administrative appeals, your request must be received before the 14th calendar day following our mailing of the level one determination. 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 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 preauthorization, 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 60 calendar days after receipt of your original level one request for appeal, unless you request an extension. If we receive a request for a Level Two appeal post service claim appeal on or after the 14th calendar day following our mailing of the level one determination:

- it will be deemed as a request by you for an extension; and
- the 60 day review period will be suspended on the 14th day we receive no Level Two appeal, then resume on the day we receive your Level Two appeal.

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 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 the lesser of 72 hours or 2 business days after the required information is received, followed up in writing.

3. Appeals to the Commissioner of Insurance

If coverage has been denied on the basis of dental necessity and you have exhausted the Cigna Dental appeals process, you or a provider acting on your behalf, may within 60 days of receiving Cigna Dental's final written determination, file a written appeal with the Connecticut Commissioner of Insurance. You may contact the Commissioner at the Connecticut Insurance Department, P.O. Box 816, Hartford, CT 06142-0816, Telephone 860-297-3910. Instructions and filing forms are available from the Connecticut Insurance Department at the above address or from the Department's website: www.state.ct.us/cid. The appeal must include a \$25 filing fee and a general release signed by you for all clinical records pertinent to the appeal. The Commissioner may waive the filing fee if you are unable to pay.

The Connecticut Insurance Department will assign an impartial external review entity to make a determination within 30 days (or longer if a review extension is granted by the Department and communicated to you). The external review decision is binding on Cigna Dental.

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

If you and your spouse are employed by the same employer and by reason of that employment are participating in this Dental Plan, you may be covered as an employee under this plan in addition to being covered as a Dependent.

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

Coordination of benefit rules are attached to the Group Contract and may be reviewed by contacting your Benefit Administrator. Benefits are coordinated 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/Prepayment Fees 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/Prepayment Fees.

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/Prepayment Fees.

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. This provision also applies to any group subject to continuation of benefit coverage under Connecticut state law. 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 Premium/Prepayment Fees 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 HealthCare is committed to maintaining the confidentiality of your personal and sensitive information. You may obtain additional information about Cigna HealthCare's privacy policies and procedures by calling Member Services at 1-800-Cigna24 or via the Internet at www.cigna.com.

XVIII. Miscellaneous

As a Cigna HealthCare plan member, 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 www.cigna.com for details.

If you are a Cigna Dental Care member 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 members participating in certain disease management programs. Please review your plan enrollment materials for details.

- (3) Not primarily for the convenience of the patient, physician/dentist or other health care provider and not more costly than an alternative service or sequence of services at least as likely to produce equivalent therapeutic or diagnostic results as to the diagnosis or treatment of that patient's illness, injury or disease.

For the purposes of this definition, "generally accepted standards of medical/dental practice" means standards that are based on credible scientific evidence published in peer-reviewed medical/dental literature generally recognized by the relevant medical/dental community or otherwise consistent with the standards set forth in policy issues involving clinical judgment.

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State Rider

Cigna HealthCare of Connecticut, Inc.

Connecticut Residents:

Your Cigna Dental Care coverage is provided by Cigna HealthCare of Connecticut, Inc.

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

I. Definitions

The following Medical Necessity definition is added to the definition section of your plan booklet immediately following the definition of "Group".

Medically necessary or medical necessity - means health care services that a physician/dentist, exercising prudent clinical judgment, would provide to a patient for the purpose of preventing, evaluating, diagnosing or treating an illness, injury, disease or its symptoms, and that are:

- (1) In accordance with generally accepted standards of medical/dental practice;
- (2) Clinically appropriate, in terms of type, frequency, extent, site and duration and considered effective for the patient's illness, injury or disease; and



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.

Cigna Dental Health of Pennsylvania, Inc.

Cigna Dental Health of Virginia, 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 member has the right to view the Combined Evidence of Coverage and Disclosure Form prior to enrollment. It should be read completely and carefully. Members 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 Member Services at 1-800-Cigna24 if you have any questions. The hearing impaired may call the state TTY toll-free relay service listed in their local telephone directory.

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 member or provider of care; and
- D. not exceed the scope, duration, or intensity of that level of care needed to provide safe and appropriate treatment.

Requests for payment 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. 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 Specialty 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, 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 26 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 member 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. Member Services

If you have any questions or concerns about the Dental Plan, Member Services 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 Member Services 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 members 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 Member Services 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 www.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 Member Services.

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 covered by your Dental Plan:

- 1. Frequency** - The frequency of certain Covered Services, like cleanings, is limited. Your Patient Charge Schedule lists any limitations on frequency.
- 2. 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.
- 3. 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.

4. **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.

5. **Clinical Oral Evaluations** – Periodic oral evaluations, comprehensive oral evaluations, comprehensive periodontal evaluations, and oral evaluations for patients under three years of age are limited to a total of 4 evaluations during a 12 consecutive month period.

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 of 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:

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

4. services provided or paid by or through a federal or state governmental agency or authority, political subdivision or a public program, other than Medicaid.
5. 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.
6. 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 PCS, only the use of take-home bleaching gel with trays is covered; all other types of bleaching methods are not covered.
7. 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.
8. prescription drugs.
9. 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. diagnose or treat conditions of the temporomandibular joint (TMJ), unless TMJ therapy is specifically listed on your Patient Charge Schedule; or, if your Patient Charge Schedule ends in "-04" or higher, c. restore teeth which have been damaged by attrition, abrasion, erosion and/or abfraction.
10. 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.
11. services associated with the placement, repair or prosthodontic restoration of a dental implant, or any other services related to implants.
12. services considered to be unnecessary or experimental in nature or do not meet commonly accepted dental standards.
13. procedures or appliances for minor tooth guidance or to control harmful habits.
14. 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.)

15. 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.)
16. the completion of crown and bridge, dentures or root canal treatment already in progress on the effective date of your Cigna Dental coverage. (California and Texas residents: Pre-existing conditions, including the completion of crown and bridge, dentures or root canal treatment already in progress on the effective date of your coverage, are not excluded, if otherwise covered under your Patient Charge Schedule.)
17. consultations and/or evaluations associated with services that are not covered.
18. endodontic treatment and/or periodontal (gum tissue and supporting bone) surgery of teeth exhibiting a poor or hopeless periodontal prognosis.
19. bone grafting and/or guided tissue regeneration when performed at the site of a tooth extraction; or when performed in conjunction with an apicoectomy or periradicular surgery.
20. intentional root canal treatment in the absence of injury or disease to solely facilitate a restorative procedure.
21. services performed by a prosthodontist.
22. localized delivery of antimicrobial agents when performed alone or in the absence of traditional periodontal therapy.
23. any localized delivery of antimicrobial agent procedures when more than eight (8) of these procedures are reported on the same date of service.
24. 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.
25. 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.

26. services to correct congenital malformations, including the replacement of congenitally missing teeth.
27. the replacement of an occlusal guard (night guard) beyond one per any 24 consecutive month period.

In addition to the above, if your Patient Charge Schedule number ends in “-04” or a higher number, there is no coverage for the following:

1. crowns and bridges used solely for splinting.
2. 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 Member Services at 1-800-Cigna24. To obtain a list of Dental Offices near you, visit our website at www.cigna.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 Member Services 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 Member Services.

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 Member Services 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 and/or bridge in the same treatment plan. Using full crowns (caps) and/or fixed bridges which are cemented in place, your Network General Dentist will rebuild natural teeth, fill in spaces where teeth are missing and establish conditions which allow each tooth to function in harmony with 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 charges on your Patient Charge Schedule are for each unit of crown or bridge. You pay the per unit charge for each unit of crown and/or bridge PLUS an additional charge for each unit when 6 or more units are prescribed in your Network General Dentist's treatment plan.

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 Member Services

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 Member Services 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 Member Services 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 Level-Two Appeals process does not apply to resolutions made solely on the basis that the Dental Plan does not provide benefits for the service performed or requested.

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.

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 member plan materials. You may obtain additional information about Cigna Dental’s confidentiality policies and procedures by calling Member Services at 1-800-Cigna24, or via the Internet at www.cigna.com.

XVIII. Miscellaneous

As a Cigna Dental plan member, 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 www.cigna.com for details.



If you are a Cigna Dental Care member 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 members participating in certain disease management programs. Please review your plan enrollment materials for details.

SEE YOUR STATE AMENDMENT FOR ADDITIONAL DETAILS.

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CDC-07-KYV1

State Amendment Cigna Dental Health of Kentucky, Inc.

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

Kentucky Residents:

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

IV. Your Cigna Dental Coverage

H. Services Not Covered Under Your Dental Plan

15. Services compensated under no-fault auto insurance policies or insured motorist policies are not excluded.

This following information is in addition to the first paragraph under:

XI. What To Do If There Is A Problem

B. Appeals Procedure

A member is entitled to an internal appeal 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 member, authorized person, or provider acting on behalf of the member 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 with thirty (30) days following receipt of a request for an internal appeal.

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Cigna Dental Health of New Jersey, Inc.

**P.O. Box 453099
Sunrise, FL 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 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 Member Services at 1-800-Cigna24 if you have any questions. The hearing impaired may call the state TTY toll-free relay service listed in their local telephone directory.

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TABLE OF CONTENTS

- I. Definitions**
- II. Introduction to Your Cigna Dental Plan**
- III. Eligibility/When Coverage Begins**
- IV. Your Cigna Dental Coverage**
 - A. Member Services**
 - B. Premiums**
 - C. Other Charges - Patient Charges**
 - D. Choice of Dentist**
 - E. Your Payment Responsibility (General Care)**
 - F. Emergency Dental Care - Reimbursement**
 - G. Limitations on Covered Services**
 - H. Services Not Covered Under Your Dental Plan**
- V. Appointments**
- VI. Broken Appointments**
- VII. Office Transfers**
- VIII. Specialty Care**
- IX. Specialty Referrals**
 - A. In General**
 - B. Orthodontics**
- X. Complex Rehabilitation/Multiple Crown Units**
- XI. What To Do If There Is A Problem**
 - A. Start With Member Services**
 - B. Appeals Procedure**
- XII. Dual Coverage**
- XIII. Disenrollment From the Dental Plan - Termination of Benefits**
 - A. Time Frames For Disenrollment/Termination**
 - B. Effect On Dependents**
- XIV. Extension of Benefits**
- XV. Continuation of Benefits (COBRA)**
- XVI. Conversion Coverage**
- XVII. Confidentiality/Privacy**
- XVIII. Miscellaneous**

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 member or provider of care; and
- D. not exceed the scope, duration, or intensity of that level of care needed to provide safe and appropriate treatment.

Requests for payment 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. 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 Specialty 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 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:
 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.

For a child who falls into category (b) or (c) above, you will need to furnish Cigna Dental evidence of his or her reliance upon you, in the form requested, within 31 days after the Dependent reaches the age of 19 and once a year thereafter during his or her term of coverage.

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 member 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. Member Services

If you have any questions or concerns about the Dental Plan, Member Services 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 Member Services 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 members 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 Member Services 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 www.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 Member Services.

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.

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 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 covered by your Dental Plan:

1. **Frequency** - The frequency of certain Covered Services, like cleanings, is limited. Your Patient Charge Schedule lists any limitations on frequency.
2. **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. Your Network General Dentist will provide care after your child's 7th birthday.
3. **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.
4. **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.

5. **Clinical Oral Evaluations** – Periodic oral evaluations, comprehensive oral evaluations, comprehensive periodontal evaluations, and oral evaluations for patients under three years of age are limited to a total of 4 evaluations during a 12 consecutive month period.

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:

1. services not listed on the Patient Charge Schedule.
2. services provided by a non-Network Dentist without Cigna Dental's prior approval (except emergencies, as described in Section IV. F.).
3. services related to an injury or illness paid under workers' compensation, occupational disease or similar laws.
4. services provided or paid by or through a federal or state governmental agency or authority, political subdivision or a public program, other than Medicaid.
5. 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.
6. cosmetic dentistry or cosmetic dental surgery (dentistry or dental surgery performed solely to improve appearance) unless specifically listed on your Patient Charge Schedule.
7. 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.
8. prescription drugs.
9. 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. diagnose or treat abnormal conditions of the temporomandibular joint (TMJ), unless TMJ therapy is specifically listed on your Patient Charge Schedule; or, if your Patient Charge Schedule ends in "-04" or a higher number, c. restore teeth which have been damaged by attrition, abrasion, erosion and/or abfraction.
10. 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.
11. services associated with the placement, repair or prosthodontic restoration of a dental implant, or any other services related to implants.
12. services considered to be unnecessary or experimental in nature or do not meet commonly accepted dental standards.
13. procedures or appliances for minor tooth guidance or to control harmful habits.
14. 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.)
15. the completion of crown and bridge, dentures or root canal treatment already in progress on the effective date of your Cigna Dental coverage.
16. consultations and/or evaluations associated with services that are not covered.

17. endodontic treatment and/or periodontal (gum tissue and supporting bone) surgery of teeth exhibiting a poor or hopeless periodontal prognosis.
18. bone grafting and/or guided tissue regeneration when performed at the site of a tooth extraction; or when performed in conjunction with an apicoectomy or periradicular surgery.
19. intentional root canal treatment in the absence of injury or disease to solely facilitate a restorative procedure.
20. services performed by a prosthodontist.
21. localized delivery of antimicrobial agents when performed alone or in the absence of traditional periodontal therapy.
22. any localized delivery of antimicrobial agent procedures when more than eight (8) of these procedures are reported on the same date of service.
23. 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.
24. 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.
25. services to correct congenital malformations, including the replacement of congenitally missing teeth.
26. the replacement of an occlusal guard (night guard) beyond one per any 24 consecutive month period.

In addition to the above, if your Patient Charge Schedule number ends in “-04” or higher number, there is no coverage for the following:

27. crowns and bridges used solely for splinting.
28. 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 Member Services at 1-800-Cigna24. To obtain a list of Dental Offices near you, visit our website at www.cigna.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 Member Services 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 Member Services.

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.)

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 Member Services 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 and/or bridge in the

same treatment plan. Using full crowns (caps) and/or fixed bridges which are cemented in place, your Network General Dentist will rebuild natural teeth, fill in spaces where teeth are missing and establish conditions which allow each tooth to function in harmony with 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 charges on your Patient Charge Schedule are for each unit of crown or bridge. You pay the per unit charge for each unit of crown and/or bridge PLUS an additional charge for each unit when 6 or more units are prescribed in your Network General Dentist’s treatment plan.

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 Member Services

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 Member Services 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 Member Services 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.

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.

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 Level-Two Appeal process does not apply to resolutions made solely on the basis that the Dental Plan does not provide benefits for the service performed or requested.

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.

3. 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

1. 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.
2. 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.
3. 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.
4. We will pay only for health care expenses that are covered by Cigna Dental.
5. 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:

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 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:

1. permanent breakdown of the dentist-patient relationship;
2. fraud or misuse of dental services and/or Dental Offices;
3. nonpayment of Premiums by the Subscriber;
4. selection of alternate dental coverage by your Group; or
5. 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 member plan materials. You may obtain additional information about Cigna Dental’s confidentiality policies and procedures by calling Member Services at 1-800-Cigna24, or via the Internet at www.cigna.com.

XVIII. Miscellaneous

As a Cigna Dental plan member, 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 www.cigna.com for details.

If you are a Cigna Dental Care member 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 members participating in certain disease management programs. Please review your plan enrollment materials for details.



Cigna Dental Health of Texas, Inc.

1640 Dallas Parkway
Plano, TX 75093

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 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 Member Services 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 Member Services and request this booklet in a larger print type or Braille.

PB07TX

01.19.09

CDC-07-TXV2



IMPORTANT NOTICE

To obtain information to make a complaint;

You may call Cigna Dental Health's toll-free telephone number for information or to make a complaint at:

1-800-Cigna24

You may also write to:

Cigna Dental Health of Texas, Inc.
1640 Dallas Parkway
Plano, TX 75093

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

1-800-252-3439

You may write the Texas Department of Insurance, P.O. Box 149104, Austin, TX 78714-9104, Fax No. (512) 475-1771.

Claim Disputes:

Should you have a dispute about a claim, you should contact Cigna Dental Health first. If the dispute is not resolved, you may contact the Texas Department of Insurance.

Attach This Notice to Your Policy:

This notice is for information only and does not become a part or condition of the attached document.

PB07TX

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CDC-07-TXV2



AVISO IMPORTANTE

Para obtener información o para someter una queja;

Usted pueda llamar al número de teléfono gratis de Cigna Dental Health para información o para someter una queja al:

1-800-Cigna24

Usted también puede escribir a:

Cigna Dental Health of Texas, Inc.
1640 Dallas Parkway
Plano, TX 75093

Puede comunicarse con el Departamento de Seguros de Texas para obtener información acerca de compañías, coberturas, de-rechos o quejas al:

1-800-252-3439

Puede escribir al Departamento de Seguros de Texas, P.O. Box 149104, Austin, TX 78714-9104, Fax No. (512) 475-1771.

Disputas sobre reclamos:

Si tiene una disputa concerniente a un reclamo, debe comunicarse primero con Cigna Dental Health. Si no se resuelve la disputa, puede entonces comunicarse con el Departamento de Seguros de Texas.

Adjunte este aviso a su póliza:

Este aviso es sólo para propósito de información y no se convierte en parte o condición del documento adjunto.

TABLE OF CONTENTS

- I. Definitions**
- II. Introduction to Your Cigna Dental Plan**
- III. Eligibility/When Coverage Begins**
- IV. Your Cigna Dental Coverage**
 - A. Member Services**
 - B. Premiums**
 - C. Other Charges - Patient Charges**
 - D. Choice of Dentist**
 - E. Your Payment Responsibility (General Care)**
 - F. Emergency Dental Care - Reimbursement**
 - G. Limitations on Covered Services**
 - H. Services Not Covered Under Your Dental Plan**
- V. Appointments**
- VI. Broken Appointments**
- VII. Office Transfers**
- VIII. Specialty Care**
- IX. Specialty Referrals**
 - A. In General**
 - B. Orthodontics**
- X. Complex Rehabilitation/Multiple Crown Units**
- XI. What To Do If There Is A Problem**
 - A. Start With Member Services**
 - B. Appeals Procedure**
- XII. Disenrollment From the Dental Plan - Termination of Benefits**
 - A. Termination of Your Group**
 - B. Termination of Benefits For You and/or Your Dependents**
- XIII. Extension of Benefits**
- XIV. Continuation of Benefits (COBRA)**
- XV. Conversion Coverage**
- XVI. Confidentiality/Privacy**
- XVII. Miscellaneous**

I. Definitions

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

Adverse Determination - a determination that the dental care services furnished or proposed to be furnished to you or your Dependents are not medically necessary or are not appropriate. Adverse Determinations do not affect services rendered by a Network General Dentist but apply only to limited specialty referral procedures. 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 member or provider of care; and
- D. not exceed the scope, duration, or intensity of that level of care needed to provide safe and appropriate treatment.

Requests for payment 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. 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 Specialty 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, 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 25 years old; or
- B. 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.

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 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.

Spouse - the individual of the opposite sex with whom you have entered into a marriage relationship which would be considered valid under the Texas Family Code.

Subscriber/You - the enrolled employee or member 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 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. Member Services

If you have any questions or concerns about the Dental Plan, Member Services 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 Member Services from any location at 1-800-Cigna24. The hearing impaired may contact Member Services through the State Relay Service located in your local telephone directory.

B. Premiums

Your Group sends a monthly fee to Cigna Dental for members 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 member's premiums from the time the member is no longer eligible for coverage under the contract until the end of the month in which the Group notifies Cigna Dental that the member 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 member 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 authorizes payment for out-of-network benefits.

You may select a network Pediatric Dentist as the Network General Dentist for your dependent children under age 7 by calling Member Services 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 www.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 Member Services.

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

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 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 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.

G. Limitations on Covered Services

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

1. **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.
2. **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.
3. **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.
4. **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.
5. **Clinical Oral Evaluations** – Periodic oral evaluations, comprehensive oral evaluations, comprehensive periodontal evaluations, and oral evaluations for patients under three years of age are limited to a total of 4 evaluations during a 12 consecutive month period.

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:

1. services not listed on the Patient Charge Schedule.
2. services provided by a non-Network Dentist without Cigna Dental's prior approval (except emergencies, as described in Section IV. F.).
3. services related to an injury or illness paid under workers' compensation, occupational disease or similar laws.
4. services provided or paid by or through a federal or state governmental agency or authority, political subdivision or a public program, other than Medicaid.
5. 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.
6. 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 PCS, only the use of take-home trays is covered; all other types of bleaching methods are not covered.
7. 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.
8. prescription drugs.
9. procedures, appliances or restorations if the main purpose is to:
 - a. change vertical dimension (degree of separation of the jaw when the teeth are in contact);
 - b. diagnose or treat abnormal conditions of the temporomandibular joint (TMJ), unless TMJ therapy is specifically listed on your Patient Charge

- Schedule; or c*. restore teeth which have been damaged by attrition, abrasion, erosion and/or abfraction; or d. restore the occlusion.
10. 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.
 11. services associated with the placement, repair, removal or prosthodontic restoration of a dental implant or any other services related to implants.
 12. services considered to be unnecessary or experimental in nature or do not meet commonly accepted dental standards.
 13. procedures or appliances for minor tooth guidance or to control harmful habits.
 14. 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.)
 15. services to the extent you or your enrolled Dependent are compensated for them under any group medical plan, no-fault auto insurance policy, or uninsured motorist policy.
 16. crowns and bridges used solely for splinting.*
 17. resin bonded retainers and associated pontics.*
 18. consultations and/or evaluations associated with services that are not covered.
 19. endodontic treatment and/or periodontal (gum tissue and supporting bone) surgery of teeth exhibiting a poor or hopeless prognosis.
 20. bonegrafting and/or guided tissue regeneration when performed at the site of a tooth extraction; or when performed in conjunction with an apicoectomy or periradicular surgery.
 21. intentional root canal treatment in the absence of injury or disease to solely facilitate a restorative procedure.
 22. services performed by a prosthodontist.
 23. localized delivery of antimicrobial agents when performed alone or in the absence of traditional periodontal therapy.
 24. any localized delivery of antimicrobial agent procedures when more than eight (8) of these procedures are reported on the same date of service.

25. 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.
26. 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.
27. services to correct congenital malformations, including the replacement of congenitally missing teeth.
28. the replacement of an occlusal guard (night guard) beyond one per any 24 consecutive month period.

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.

*If you are on an “-03” Patient Charge Schedule, these exclusions do 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 Member Services at 1-800-Cigna24. To obtain a list of Dental Offices near you, visit our website at www.cigna.com, or call the Dental Office Locator at 1-800-Cigna24.

Your transfer will take about 5 days to process. Unless you have an emergency, you will be unable to schedule an

appointment at the new Dental Office until your transfer becomes effective.

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

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 Member Services 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 Member Services.

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 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 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 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 Member Services 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 and/or bridge in the same treatment plan. Using full crowns (caps) and/or fixed bridges which are cemented in place, your Network General Dentist will rebuild natural teeth, fill in spaces where teeth are missing and establish conditions which allow each tooth to function in harmony with 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 charges on your Patient Charge Schedule are for each unit of crown or bridge. You pay the per unit charge for each unit of crown and/or bridge PLUS an additional charge for each unit when 6 or more units are prescribed in your Network General Dentist's treatment plan.

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 Member Services

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 Member Services 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 Member Services at 1-800-Cigna24 or you may write P.O. Box 188047, Chattanooga, TN 37422-8047.

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 provider'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 Member Services 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, Member Services 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, 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 provider 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 for the denial;
- (2) the specialty of the dentist making the denial; and
- (3) 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 provider 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 Member Services 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 provider, 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. 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 members 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 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.

XIII. 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.

XIV. 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 31 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. 6 months after the date you choose continuation coverage;
- B. the date you and/or your Dependent becomes covered under another dental plan;
- C. the last day of the month in which you fail to pay Premiums; or
- D. the date the Group Contract ends.

You must pay your Group the amount of Premiums plus 2% in advance on a monthly basis.

XV. 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.

XVI. 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 member plan materials. You may obtain additional information about Cigna Dental's confidentiality policies and procedures by calling Member Services at 1-800-Cigna24 or via the Internet at www.cigna.com.

XVII. Miscellaneous

- A. As a Cigna Dental plan member, 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 www.cigna.com for details.
If you are a Cigna Dental Care member 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 members 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
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
 McClellan
 Milam
 Robertson

Texarkana Area:

Bowie
 Delta
 Lamar
 Red River

San Antonio Area:

Atascosa
 Bandera
 Bexar
 Blanco
 Comal
 Frio
 Gillespie
 Gonzales
 Guadalupe
 Karnes
 Kendall
 Kerr
 Medina
 Wilson

Corpus Christi Area:

Bee
 Brooks
 Duval
 Goliad
 Jim Wells
 Kennedy
 Kleberg
 Live Oak
 McMullen
 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
 Stephins
 Throckmorton
 Wichita
 Wilbarger
 Young

Midland Odessa Area:

Andrews
 Crane
 Ector
 Glasscock
 Howard
 Loving
 Martin
 Midland
 Reagan
 Upton
 Ward
 Winkler

Cigna Dental Care – Cigna Dental Health Plan

This section describes the CDC Rider(s) for residents of the following states: AZ, CA, CO, CT, DE, FL, KS/NE, KY, MD, MO, NJ, NC, OH, PA, TX, VA

CDO12 M

Alternate Benefit Provision Rider

The following limiting provision applies to your dental plan.

Alternate Benefit Provision – If more than one service may be used to treat a dental condition, coverage will be limited to the less costly Covered Service provided it is: a professionally accepted; a necessary; and an appropriate method of treatment.

If treatment is provided by a Network Dentist, and the patient requests or accepts a more costly Covered Service, the specific Patient Charge for such service is equal to:

- A. the Patient Charge for the less costly service, plus
- B. the difference in cost between the Usual Fee for the more costly service and Usual Fee for the less costly service.

ABRIDER

Federal Requirements

The following pages explain your rights and responsibilities under federal laws and regulations. Some states may have similar requirements. If a similar provision appears elsewhere in this booklet, the provision which provides the better benefit will apply.

FDRL1

V2

Notice of Provider Directory/Networks

Notice Regarding Provider Directories and Provider Networks

If your Plan uses a network of Providers, a separate listing of Participating Providers who participate in the network is available to you without charge by visiting www.cigna.com; mycigna.com or by calling the toll-free telephone number on your ID card.

Your Participating Provider network consists of a group of local dental practitioners, of varied specialties as well as general practice, who are employed by or contracted with Cigna HealthCare or Cigna Dental Health.

FDRL79 M

Qualified Medical Child Support Order (QMCSO)

A. Eligibility for Coverage Under a QMCSO

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

You must notify your Employer and elect coverage for that child and yourself, if you are not already enrolled, within 31 days of the QMCSO being issued.

B. Qualified Medical Child Support Order Defined

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

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

The QMCSO may not require the health insurance policy to provide coverage for any type or form of benefit or option not otherwise provided under the policy, except that an order may require a plan to comply with State laws regarding health care coverage.

C. Payment of Benefits

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

FDRL2

V1

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 enroll for or change coverage within 30 days of the date you meet the criteria shown in the following Sections B through F.

B. Change of Status

A change in status is defined as:

1. change in legal marital status due to marriage, death of a spouse, divorce, annulment or legal separation;
2. change in number of Dependents due to birth, adoption, placement for adoption, or death of a Dependent;
3. 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;
4. changes in employment status of Employee, spouse or Dependent resulting in eligibility or ineligibility for coverage;
5. change in residence of Employee, spouse or Dependent to a location outside of the Employer's network service area; and
6. 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: (a) incurs a change such as adding or deleting a benefit option; (b) allows election changes due to Change in Status, Court Order or Medicare or Medicaid Eligibility/Entitlement; or (c) this Plan and the other plan have different periods of coverage or open enrollment periods.

FDRL70

Eligibility for Coverage for Adopted Children

Any child under the age of 18 who is adopted by you, including a child who is placed with you for adoption, will be eligible for Dependent Insurance upon the date of placement with you. A child will be considered placed for adoption when you become legally obligated to support that child, totally or partially, prior to that child's adoption.

If a child placed for adoption is not adopted, all health coverage ceases when the placement ends, and will not be continued.

The provisions in the "Exception for Newborns" section of this document that describe requirements for enrollment and effective date of insurance will also apply to an adopted child or a child placed with you for adoption.

FDRL6

Group Plan Coverage Instead of Medicaid

If your income and liquid resources do not exceed certain limits established by law, the state may decide to pay premiums for this coverage instead of for Medicaid, if it is cost effective. This includes premiums for continuation coverage required by federal law.

FDRL75

Requirements of Medical Leave Act of 1993 (as amended) (FMLA)

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

A. Continuation of Health Insurance During Leave

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

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

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

B. Reinstatement of Canceled Insurance Following Leave

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

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

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

FDRL74

Uniformed Services Employment and Re-Employment Rights Act of 1994 (USERRA)

The Uniformed Services Employment and Re-employment Rights Act of 1994 (USERRA) sets requirements for continuation of health coverage and re-employment in regard to an Employee's military leave of absence. These requirements apply to medical and dental coverage for you and your Dependents.

A. Continuation of Coverage

For leaves of less than 31 days, coverage will continue as described in the Termination section regarding Leave of Absence.

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

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

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

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

Following continuation of health coverage per USERRA requirements, you may convert to a plan of individual coverage according to any "Conversion Privilege" shown in your certificate.

B. Reinstatement of Benefits (applicable to all coverages)

If your coverage ends during the leave of absence because you do not elect USERRA or an available conversion plan at the expiration of USERRA and you are reemployed by your current Employer, coverage for you and your Dependents may be reinstated if (a) you gave your Employer advance written or verbal notice of your military service leave, and (b) the duration of all military leaves while you are employed with your current Employer does not exceed 5 years.

You and your Dependents will be subject to only the balance of a Pre-Existing Condition Limitation (PCL) or waiting period that was not yet satisfied before the leave began. However, if an Injury or Sickness occurs or is aggravated during the military leave, full Plan limitations will apply.

Any 63-day break in coverage rule regarding credit for time accrued toward a PCL waiting period will be waived.

If your coverage under this plan terminates as a result of your eligibility for military medical and dental coverage and your order to active duty is canceled before your active duty service commences, these reinstatement rights will continue to apply.

FDRL58 M

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 Basic Benefits 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, same sex spouses, 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.

FDRL85

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:

1. SSA must determine that the disability occurred prior to or within 60 days after the disabled individual elected COBRA continuation coverage; and
2. 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.

FDRL21

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: (a) the end of the applicable maximum period; (b) the date the pre-existing condition provision is no longer applicable; or (c) the occurrence of an event described in one of the first three bullets above; or
- any reason the Plan would terminate coverage of a participant or beneficiary who is not receiving continuation coverage (e.g., fraud).

FDRL22

v1

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:
 - (a) 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;
 - (b) 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
 - (c) 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.

FDRL23

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.

FDRL24

V2

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;
- Your child ceases to qualify as a Dependent under the Plan; or
- 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.

FDRL25

V1

Trade Act of 2002

The Trade Act of 2002 created a new tax credit for certain individuals who become eligible for trade adjustment assistance and for certain retired Employees who are receiving pension payments from the Pension Benefit Guaranty Corporation (PBGC) (eligible individuals). Under the new tax provisions, eligible individuals can either take a tax credit or get advance payment of 72.5% of premiums paid for qualified health insurance, including continuation coverage. If you have questions about these new tax provisions, you may call the Health Coverage Tax Credit Customer Contact Center toll-free at 1-866-628-4282. TDD/TYY callers may call toll-free at 1-866-626-4282. More information about the Trade Act is also available at www.doleta.gov/tradeact.

In addition, if you initially declined COBRA continuation coverage and, within 60 days after your loss of coverage under the Plan, you are deemed eligible by the U.S. Department of Labor or a state labor agency for trade adjustment assistance (TAA) benefits and the tax credit, you may be eligible for a special 60 day COBRA election period. The special election period begins on the first day of the month that you become TAA-eligible. If you elect COBRA coverage during this

special election period, COBRA coverage will be effective on the first day of the special election period and will continue for 18 months, unless you experience one of the events discussed under "Termination of COBRA Continuation" above. Coverage will not be retroactive to the initial loss of coverage. If you receive a determination that you are TAA-eligible, you must notify the Plan Administrator immediately.

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.

FDRL87