Maricopa County

CIGNA DENTAL CARE INSURANCE

EFFECTIVE DATE: July 1, 2021

CN010
2465354

This document printed in May, 2021 takes the place of any documents previously issued to you which described your benefits.

Printed in U.S.A.

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

CIGNA HEALTH AND LIFE INSURANCE COMPANY

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

POLICYHOLDER: Maricopa County

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

EFFECTIVE DATE: July 1, 2021

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

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

Anna Krishtul, Corporate Secretary

Explanation of Terms

You will find terms starting with capital letters throughout your certificate. To help you understand your benefits, most of these terms are defined in the Definitions section of your certificate.

Important Notices

Discrimination is Against the Law

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

Cigna:

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

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

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

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

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

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

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

HC-NOT96 07-17

Proficiency of Language Assistance Services

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

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

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

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

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

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

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

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

French Creole – ATANSYON: Gen sèvis èd nan lang ki disponib gratis pou ou. Pou kliyan Cigna yo, rele nimewo ki

dèyè kat ID ou. Sinon, rele nimewo 1.800.244.6224 (TTY: Rele 711).

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

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

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

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

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

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

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

HC-NOT97 07-17

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

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

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

The basic protections provided by the Association are:

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

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

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

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

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

Utah Life and Health Insurance Guaranty Assoc.	Utah Insurance Department
32 West 200 South, #150	State Office Bldg., Rm 3110
Salt Lake City, UT 84101	Salt Lake City, UT 84114
(801) 320-9955	(801) 538-3800

HC-NOT120 07-19

Eligibility - Effective Date

Employee Insurance

This plan is offered to you as an Employee.

Eligibility for Employee Insurance

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

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

If you were previously insured and your insurance ceased, you may be required to satisfy a Waiting Period to become insured again. If rehired within 30 calendar days of job termination effective date and rehire effective date, reinstated in benefits with no gap in coverage. If rehired within greater than 30 calendar days of job termination date and rehire effective date, benefits are effective on the first day of the month following the rehire effective date.

Eligibility for Dependent Insurance

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

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

Waiting Period

The first day of the month following date of hire.

Classes of Eligible Employees

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

Effective Date of Employee Insurance

You will become insured on the date you elect the insurance by signing an approved payroll deduction or enrollment form, as applicable, but no earlier than the date you become eligible. If you are a Late Entrant, you may elect the insurance only during an Open Enrollment Period. Your insurance will become effective on the first day of the month after the end of that Open Enrollment Period in which you elect it.

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

Late Entrant – Employee

You are a Late Entrant if:

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

Open Enrollment Period

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

Dependent Insurance

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

Effective Date of Dependent Insurance

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

Late Entrant – Dependent

You are a Late Entrant for Dependent Insurance if:

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

Choice of Dental Office for Cigna Dental Care

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

such transfer will take effect on the first day of the month after it is authorized by CDH. A transfer will not be authorized if you or your Dependent has an outstanding balance at the Dental Office.

HC-ELG4 04-10
V1

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.

HC-IMP2 04-10
HC-IMP74 V1

Dental Benefits – Cigna Dental Care

Your Cigna Dental Coverage

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

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. Timely payment is important. It is possible that the Dental Office may add late charges to overdue balances.

Your Patient Charge Schedule is subject to annual change. Cigna Dental will give written notice to your Group of any change in Patient Charges at least 60 days prior to such change. You will be responsible for the Patient Charges listed on the Patient Charge Schedule that is in effect on the date a procedure is started.

Choice Of Dentist

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

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.

- **Emergency Care Away From Home**

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

- **Emergency Care After Hours**

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

Limitations On Covered Services

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

- **Frequency** – The frequency of certain Covered Services, like cleanings, is limited. Your Patient Charge Schedule lists any limitations on frequency.
- **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.
- **Periodontal (gum tissue and supporting bone) Services** - Periodontal regenerative procedures are limited to one regenerative procedure per site (or per tooth, if applicable), when covered on the Patient Charge Schedule.

  Localized delivery of antimicrobial agents is limited to eight teeth (or eight sites, if applicable) per 12 consecutive months, when covered on the Patient Charge Schedule.
- **Clinical Oral Evaluations** - 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.
- Specialty Care – Payment for care received from a Network Specialty Dentist is not provided by this Plan. You will be responsible for Contract Fees for care received from a Network Specialty Dentist.

General Limitations - Dental Benefits

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

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

Services Not Covered Under Your Dental Plan

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

- services not listed on the Patient Charge Schedule.

- services provided by a non-Network Dentist without Cigna Dental's prior approval (except in emergencies).
- services related to an injury or illness paid under workers' compensation, occupational disease or similar laws.
- services provided or paid by or through a federal or state governmental agency or authority, political subdivision or a public program, other than Medicaid.
- services required while serving in the armed forces of any country or international authority or relating to a declared or undeclared war or acts of war.
- cosmetic dentistry or cosmetic dental surgery (dentistry or dental surgery performed solely to improve appearance) unless the service is specifically listed on your Patient Charge Schedule (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.
- general anesthesia, sedation and nitrous oxide, unless specifically listed on your Patient Charge Schedule. When listed on your Patient Charge Schedule, general anesthesia and IV Sedation are covered when medically necessary and provided in conjunction with Covered Services performed by an Oral Surgeon or Periodontist. There is no coverage for general anesthesia or intravenous sedation when used for the purposes of anxiety control or patient management.
- prescription drugs.
- procedures, appliances or restorations if the main purpose is to: change vertical dimension (degree of separation of the jaw when teeth are in contact); diagnose or treat conditions or disorders 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 restore teeth which have been damaged by attrition, abrasion, erosion and/or abfraction; or d. restore the occlusion.
- replacement of fixed and/or removable appliances (including fixed and removable orthodontic appliances) that have been lost, stolen, or damaged due to patient abuse, misuse or neglect.
- services associated with the placement, repair, removal, or prosthodontic restoration of a dental implant or any other services related to implants.
- services considered to be unnecessary or experimental in nature or do not meet commonly accepted dental standards.
- procedures or appliances for minor tooth guidance or to control harmful habits.
- hospitalization, including any associated incremental charges for dental services performed in a hospital. (Benefits are available for Network Dentist charges for covered services performed at a hospital. Other associated charges are not covered and should be submitted to the medical carrier for benefit determination.)
- the completion of crown and bridge, dentures or root canal treatment already in progress on the effective date of your Cigna Dental coverage.
- consultations and/or evaluations associated with services that are not covered.
- endodontic treatment and/or periodontal (gum tissue and supporting bone) surgery of teeth exhibiting a poor or hopeless periodontal prognosis.
- bone grafting and/or guided tissue regeneration when performed at the site of a tooth extraction; or when performed in conjunction with an apicoectomy or periradicular surgery.
- intentional root canal treatment in the absence of injury or disease to solely facilitate a restorative procedure.
- services performed by a prosthodontist.
- localized delivery of antimicrobial agents when performed alone or in the absence of traditional periodontal therapy.
- infection control and/or sterilization. Cigna Dental considers this to be incidental to and part of the charges for services provided and not separately chargeable.
- the recementation of any inlay, onlay, crown, post and core, or fixed bridge within 180 days of initial placement. Cigna Dental considers recementation within this timeframe to be incidental to and part of the charges for the initial restoration.
- services to correct congenital malformations, including the replacement of congenitally missing teeth.
- the replacement of an occlusal guard (night guard) beyond one per any 24 consecutive month period.
- crowns and bridges used solely for splinting.
- resin bonded retainers and associated pontics.

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

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

Appointments

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

Broken Appointments

The time your Network Dentist schedules for your appointment is valuable to you and the dentist. Broken

appointments make it difficult for your Dental Office to schedule time with other patients.

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

Office Transfers

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

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 you are entitled to receive a discount for services listed on your Patient Charge Schedule when rendered by a Network Specialty Dentist. If you see a Network Specialty Dentist, you will be responsible for paying total Contract Fees, which are a discount from the dentist's Usual Fees, to the Network Specialty Dentist. The dollar amounts listed on your Patient Charge Schedule are not applicable to treatment performed by Network Specialty Dentists. Under your plan, preauthorization from CIGNA Dental is not necessary for care received from a Network Specialty Dentist. CIGNA Dental will not make payments toward specialty care.

After the Network Specialty Dentist has completed treatment, you should return to your Network General Dentist for cleanings, regular checkups and other treatment.

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

Definitions –

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

Patient Charges

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

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

Additional Charges

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

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

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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This Patient Charge Schedule lists the benefits of the Dental Plan including covered procedures and patient charges.

Important **Highlights**

› This Patient Charge Schedule applies only when covered dental services are performed by your Network General Dentist, unless otherwise authorized by Cigna Dental as described in your plan documents. Not all Network Dentists perform all listed services and it is suggested to check with your Network Dentist in advance of receiving services.

› The dollar amounts listed on the Patient Charge Schedule are only applicable to treatment performed by your selected Network General Dentist. If you receive care from a Network Specialty Dentist, you are responsible to pay for that care. You are entitled to pay at the Contract Fees negotiated by Cigna Dental rather than the Network Specialty Dentists' usual fees. Under this plan, referrals and preauthorization for payment by Cigna Dental are not necessary for care received at a Network Specialty Dentist. Cigna Dental will not make payments toward this treatment.

› Cigna Dental considers infection control and/or sterilization to be incidental to and part of the charges for services provided and not separately chargeable.

› Procedures not listed on this Patient Charge Schedule are not covered and are the patient's responsibility at the dentist's usual fees.

› This Patient Charge Schedule is subject to annual change in accordance with the terms of the group agreement.

› All patient charges must correspond to the Patient Charge Schedule in effect on the date the procedure is initiated.

› Procedures listed on the Patient Charge Schedule are subject to the plan limitations and exclusions described in your plan book/certificate of coverage and/ or group contract.

› The American Dental Association may periodically change CDT Codes or definitions. Different codes may be used to describe these covered procedures.

Cigna

Patient Charge Schedule

Code	Procedure Description	Patient Charge
Office visit fee (Per patient, per office visit in addition to any other applicable patient charges)		
Office visit fee	$3.00	
Diagnostic/preventive – Oral evaluations are limited to a combined total of 4 of the following evaluations during a 12 consecutive month period: Periodic oral evaluations (D0120), comprehensive oral evaluations (D0150), comprehensive periodontal evaluations (D0180), and oral evaluations for patients under 3 years of age (D0145). 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 applicable limitation. The relevant covered services are identified with a ✪.		
D9430	Office visit for observation – No other services performed	$0.00
D0120	Periodic oral evaluation – Established patient ✪	$0.00
D0140	Limited oral evaluation – Problem focused	$12.00
D0145	Oral evaluation for a patient under 3 years of age and counseling with primary caregiver ✪	$0.00
D0150	Comprehensive oral evaluation – New or established patient ✪	$0.00
D0160	Detailed and extensive oral evaluation – Problem focused, by report	$55.00
D0170	Re-evaluation – Limited, problem focused (Not post-operative visit)	$15.00
D0210	X-rays Intraoral – Complete series (Including bitewings) (Limit 1 every 3 years) ✪	$0.00
D0220	X-rays intraoral periapical, first film	$0.00
D0230	X-rays intraoral periapical, each additional film	$0.00
D0240	X-rays intraoral – Occlusal radiographic image	$0.00
D0270	X-rays (Bitewing) – Single radiographic image	$0.00
D0272	X-rays (Bitewings) – 2 radiographic images	$0.00
D0273	X-rays (Bitewings) – 3 radiographic images	$0.00
D0274	X-rays (Bitewings) – 4 radiographic images	$0.00
D0330	X-rays (Panoramic film) – (Limit 1 every 3 years) ✪	$0.00
D0460	Pulp vitality tests	$0.00
D0470	Diagnostic casts	$10.00
D1110	Prophylaxis (Cleaning) – Adult (Limit 2 per calendar year) ✪	$0.00
D1120	Prophylaxis (Cleaning) – Child (Limit 2 per calendar year) ✪	$0.00
D1206	Topical application of fluoride varnish (Limit 2 per calendar year). There is a combined limit of a total of 2 D1206s and/or D1208s per calendar year. ✪	$0.00
D1208	Topical application of fluoride (Limit 2 per calendar year) There is a combined limit of a total of 2 D1208s and/or D1206s per calendar year. ✪	$0.00
D1310	Nutritional counseling for control of dental disease	$0.00
D1330	Oral hygiene instructions	$0.00

D1351	Sealant – Per tooth	$12.00
D1510	Space maintainer – Fixed – Unilateral	$20.00
D1515	Space maintainer – Fixed – Bilateral	$20.00
D1520	Space maintainer – Removable – Unilateral	$20.00
D1525	Space maintainer – Removable – Bilateral	$20.00
D1550	Recementation of space maintainer	$20.00
D1555	Removal of fixed space maintainer	$25.00
Restorative (Fillings, including polishing)		
D2140	Amalgam – 1 surface, primary or permanent	$9.00
D2150	Amalgam – 2 surfaces, primary or permanent	$13.00
D2160	Amalgam – 3 surfaces, primary or permanent	$17.00
D2161	Amalgam – 4 or more surfaces, primary or permanent	$21.00
D2330	Resin-based composite – 1 surface, anterior	$22.00
D2331	Resin-based composite – 2 surfaces, anterior	$28.00
D2332	Resin-based composite – 3 surfaces, anterior	$40.00
D2335	Resin-based composite – 4 or more surfaces or involving incisal angle, anterior	$52.00
D2390	Resin-based composite crown, anterior	$70.00
D2391	Resin-based composite – 1 surface, posterior	$22.00
D2392	Resin-based composite – 2 surfaces, posterior	$28.00
D2393	Resin-based composite – 3 surfaces, posterior	$44.00
D2394	Resin-based composite – 4 or more surfaces, posterior	$44.00
Crown and Bridge – All charges for crown and bridge (Fixed partial denture) are per unit (Each replacement or supporting tooth equals one unit) – Replacement limit 1 every 5 years. The charges below include the cost of base metal. Noble metal and high noble metal (Precious) or titanium metal, if used, will be charged to the member at an additional maximum amount of $150.00 per tooth. If a cast post and core is made of high noble metal, an additional fee up to $100.00 per tooth may be charged for the upgraded post and core. Porcelain, if used on molar teeth, will be charged to the Member at an additional maximum amount of $75.00 per tooth. Porcelain/Ceramic substrate crowns on molar teeth are not covered.		
D2510	Inlay – Metallic – 1 surface	$135.00
D2520	Inlay – Metallic – 2 surfaces	$150.00
D2530	Inlay – Metallic – 3 or more surfaces	$170.00
D2710	Crown – Resin-based composite (Indirect)	$250.00
D2712	Crown – 3/4 resin-based composite (Indirect)	$250.00
D2720	Crown – Resin with high noble metal	$250.00
D2721	Crown – Resin based with predominantly base metal	$250.00
D2722	Crown – Resin with noble metal	$250.00
D2740	Crown – Porcelain/ceramic substrate	$260.00
D2750	Crown – Porcelain fused to high noble metal	$250.00
D2751	Crown – Porcelain fused to predominantly base metal	$250.00
D2752	Crown – Porcelain fused to noble metal	$250.00
D2780	Crown – 3/4 cast high noble metal	$250.00

D2781	Crown – 3/4 cast predominantly base metal	$250.00

D2782	Crown – 3/4 cast noble metal	$250.00
D2783	Crown – 3/4 porcelain/ceramic	$250.00
D2790	Crown – Full cast high noble metal	$250.00
D2791	Crown – Full cast predominantly base metal	$250.00
D2782	Crown – 3/4 cast noble metal	$250.00
D2783	Crown – 3/4 porcelain/ceramic	$250.00
D2790	Crown – Full cast high noble metal	$250.00
D2791	Crown – Full cast predominantly base metal	$250.00
D2792	Crown – Full cast noble metal	$250.00
D2794	Crown – Titanium	$250.00
D2799	Provisional crown	$38.00
D2910	Recement inlay – Onlay or partial coverage restoration	$20.00
D2920	Recement crown	$20.00
D2930	Prefabricated stainless steel crown – Primary tooth	$50.00
D2931	Prefabricated stainless steel crown – Permanent tooth	$50.00
D2940	Protective restoration	$0.00
D2950	Core buildup, including any pins	$40.00
D2951	Pin retention – Per tooth – In addition to restoration	$40.00
D2952	Post and core – In addition to crown, indirectly fabricated	$70.00
D2953	Each additional indirectly fabricated post – Same tooth	$45.00
D2954	Prefabricated post and core – In addition to crown	$60.00
D2960	Labial veneer (Resin laminate) – Chairside	$175.00
D2961	Labial veneer (Resin laminate) – Laboratory	$175.00
D2962	Labial veneer (Porcelain laminate) – Laboratory	$250.00
D2970	Temporary crown (Fractured tooth)	$40.00
D6210	Pontic – Cast high noble metal	$250.00
D6211	Pontic – Cast predominantly base metal	$250.00
D6212	Pontic – Cast noble metal	$250.00
D6240	Pontic – Porcelain fused to high noble metal	$250.00
D6241	Pontic – Porcelain fused to predominantly base metal	$250.00
D6242	Pontic – Porcelain fused to noble metal	$250.00
D6245	Pontic – Porcelain/ceramic	$235.00
D6251	Pontic – Resin with predominantly base metal	$250.00
D6545	Retainer – Cast metal for resin bonded fixed prosthesis	$165.00
D6721	Crown – Resin with predominantly base metal	$250.00
D6740	Crown – Porcelain/ceramic	$235.00
D6750	Crown – Porcelain fused to high noble metal	$250.00
D6751	Crown – Porcelain fused to predominantly base metal	$250.00

D6752	Crown – Porcelain fused to noble metal	$250.00
D6780	Crown – 3/4 cast high noble metal	$250.00
D6781	Crown – 3/4 cast predominantly base metal	$250.00
D6782	Crown – 3/4 cast noble metal	$250.00
D6783	Crown – 3/4 porcelain/ceramic	$250.00
D6790	Crown – Full cast high noble metal	$250.00
D6791	Crown – Full cast predominantly base metal	$250.00
D6792	Crown – Full cast noble metal	$250.00
Complex rehabilitation – An additional $125 charge per unit for multiple crown units/ complex rehabilitation (6 or more units of crown and/or bridge in same treatment plan requires complex rehabilitation for each unit – Ask your dentist for the guidelines)		
D6930	Recement fixed partial denture	$30.00
Endodontics (Root canal treatment, excluding final restorations)		
D3110	Pulp cap – Direct (Excluding final restoration)	$5.00
D3120	Pulp cap – Indirect (Excluding final restoration)	$5.00
D3220	Pulpotomy – Removal of pulp, not part of a root canal	$30.00
D3221	Pulpal debridement (Not to be used when root canal is done on the same day)	$55.00
D3230	Pulpal therapy with resorbable filling – Primary anterior teeth	$75.00
D3240	Pulpal therapy with resorbable filling – Primary posterior teeth	$85.00
D3310	Anterior root canal – Permanent tooth (Excluding final restoration)	$170.00
D3320	Bicuspid root canal – Permanent tooth (Excluding final restoration)	$190.00
D3330	Molar root canal – Permanent tooth (Excluding final restoration)	$265.00
D3346	Retreatment of previous root canal therapy – Anterior	$320.00
D3347	Retreatment of previous root canal therapy – Bicuspid	$350.00
D3348	Retreatment of previous root canal therapy – Molar	$450.00
D3351	Apexification/recalcification – Initial visit	$90.00
D3352	Apexification/recalcification – Interim visit	$90.00
D3353	Apexification/recalcification – Final visit	$90.00
D3410	Apicoectomy/periradicular surgery – Anterior	$170.00
D3421	Apicoectomy/periradicular surgery – Bicuspid (First root)	$170.00
D3425	Apicoectomy/periradicular surgery – Molar (First root)	$170.00
D3430	Retrograde filling – Per root	$90.00
D3450	Root amputation – Per root	$90.00
D3920	Hemisection – Including root removal (Excluding root canal therapy)	$90.00

Periodontics (Treatment of supporting tissues [gum and bone] of the teeth) periodontal regenerative procedures are limited to 1 regenerative procedure per site (Or per tooth, if applicable), when covered on the patient charge schedule. The relevant procedure codes are D4263, D4264, D4266 and D4267. Localized delivery of antimicrobial agents is limited to 8 teeth (Or 8 sites, if applicable) per 12 consecutive months, when covered on the patient charge schedule.		
D0180	Comprehensive periodontal evaluation – New or established patient	$0.00
D4210	Gingivectomy or gingivoplasty – 4 or more teeth per quadrant	$225.00
D4211	Gingivectomy or gingivoplasty – 1 to 3 teeth per quadrant	$150.00
D4240	Gingival flap (Including root planing) – 4 or more teeth per quadrant	$250.00
D4241	Gingival flap (Including root planing) – 1 to 3 teeth per quadrant	$200.00
D4249	Clinical crown lengthening – Hard tissue	$250.00
D4260	Osseous surgery – 4 or more teeth per quadrant	$365.00
D4261	Osseous surgery – 1 to 3 teeth per quadrant	$300.00
D4320	Provisional splinting – Intracoronal	$75.00
D4321	Provisional splinting – Extracoronal	$80.00
D4341	Periodontal scaling and root planing – 4 or more teeth per quadrant (Limit 4 quadrants per consecutive 12 months)	$90.00
D4342	Periodontal scaling and root planing – 1 to 3 teeth per quadrant (Limit 4 quadrants per consecutive 12 months)	$75.00
D4355	Full mouth debridement to allow evaluation and diagnosis (1 per lifetime)	$80.00
D4381	Localized delivery of antimicrobial agents per tooth	$25.00
D4910	Periodontal maintenance (Limited to 2 per calendar year) only covered after active therapy.	$60.00
D9940	Occlusal guard – By report (Limit 1 per 24 months)	$90.00
D9951	Occlusal adjustment limited	$45.00
D9952	Occlusal adjustment complete	$120.00
Prosthetics (Removable tooth replacement – Dentures) includes up to 4 adjustments within first 6 months after insertion – Replacement limit 1 every 5 years. Characterization is considered an upgrade with maximum additional charge to the member of $200.00 per denture.		
D5110	Full upper denture	$325.00
D5120	Full lower denture	$325.00
D5130	Immediate full upper denture	$350.00
D5140	Immediate full lower denture	$350.00
D5211	Upper partial denture – Resin base (Including clasps, rests and teeth)	$375.00
D5212	Lower partial denture – Resin base (Including clasps, rests and teeth)	$375.00
D5213	Upper partial denture – Cast metal framework (Including clasps, rests and teeth)	$400.00
D5214	Lower partial denture – Cast metal framework (Including clasps, rests and teeth)	$400.00
D5281	Removable unilateral partial denture one piece cast metal (Including clasps and teeth)	$160.00

D5410	Adjust complete denture – Upper	$25.00
D5411	Adjust complete denture – Lower	$25.00
D5421	Adjust partial denture – Upper	$25.00
D5422	Adjust partial denture – Lower	$25.00
D5510	Repair broken complete denture base	$10.00
D5520	Replace missing or broken teeth – Complete denture (Each tooth)	$10.00
D5610	Repair resin denture base	$10.00
D5620	Repair cast framework	$10.00
D5630	Repair or replace broken clasp	$10.00
D5640	Replace broken teeth – Per tooth	$10.00
D5650	Add tooth to existing partial denture	$10.00
D5660	Add clasp to existing partial denture	$10.00
Denture relining (Limit 1 every 36 months)		
D5710	Rebase complete upper denture	$20.00
D5711	Rebase complete lower denture	$20.00
D5720	Rebase upper partial denture	$20.00
D5721	Rebase lower partial denture	$20.00
D5730	Reline complete upper denture – Chairside	$69.00
D5731	Reline complete lower denture – Chairside	$69.00
D5740	Reline upper partial denture – Chairside	$69.00
D5741	Reline lower partial denture – Chairside	$69.00
D5750	Reline complete upper denture – Laboratory	$10.00
D5751	Reline complete lower denture – Laboratory	$10.00
D5760	Reline upper partial denture – Laboratory	$10.00
D5761	Reline lower partial denture – Laboratory	$10.00
Interim dentures (Limit 1 every 5 years)		
D5820	Interim partial denture – Upper	$150.00
D5821	Interim partial denture – Lower	$150.00
D5850	Tissue conditioning – Upper	$20.00
D5851	Tissue conditioning – Lower	$20.00
Oral surgery (Includes routine postoperative treatment) Surgical removal of impacted tooth – Not covered for ages below 15 unless pathology (Disease) exists.		
D7111	Extraction of coronal remnants – Deciduous tooth	$35.00
D7140	Extraction, erupted tooth or exposed root – Elevation and/or forceps removal	$55.00
D7210	Surgical removal of erupted tooth – Removal of bone and/or section of tooth	$60.00
D7220	Removal of impacted tooth – Soft tissue	$85.00
D7230	Removal of impacted tooth – Partially bony	$100.00
D7240	Removal of impacted tooth – Completely bony	$120.00

D7250	Surgical removal of residual tooth roots – Cutting procedure	$70.00
D7270	Tooth stabilization of accidentally evulsed or displaced tooth	$150.00
D7310	Alveoloplasty in conjunction with extractions – 4 or more teeth or tooth spaces per quadrant	$110.00
D7320	Alveoloplasty not in conjunction with extractions – 4 or more teeth or tooth spaces per quadrant	$110.00
D7510	Incision and drainage of abscess – Intraoral soft tissue	$80.00
D7960	Frenulectomy – Also known as frenectomy or frenotomy – Separate procedure not incidental to another	$90.00
D7971	Excision of periocoronal gingiva	$90.00
Orthodontics (Tooth movement) **Orthodontic treatment (Maximum benefit of 24 months of interceptive and/or comprehensive treatment. Atypical cases or cases beyond 24 months require an additional payment by the patient.)**		
D8050	Interceptive orthodontic treatment of the primary dentition – Banding	$448.00
D8060	Interceptive orthodontic treatment of the transitional dentition – Banding	$448.00
D8070	Comprehensive orthodontic treatment of the transitional dentition – Banding	$798.00
D8080	Comprehensive orthodontic treatment of the adolescent dentition – Banding	$1,025.00
D8090	Comprehensive orthodontic treatment of the adult dentition – Banding	$1,125.00
D8660	Pre-orthodontic treatment visit	$120.00
D8670	Periodic orthodontic treatment visit – As part of contract Children – Up to 19th birthday: 24 Month treatment fee Charge per month for 24 months	 $3,264.00 $136.00
	Adults: 24 Month treatment fee Charge per month for 24 months	 $3,936.00 $164.00
D8680	Orthodontic retention – Removal of appliances, construction and placement of retainer(s)	$230.00
D8999	Unspecified orthodontic procedure – By report (Orthodontic treatment plan and records)	$228.00
General Anesthesia/IV Sedation		
D9230	Inhalation of nitrous oxide/analgesia, anxiolysis	$25.00
D9430	Office visit for observation (During regularly scheduled hours)	$0.00
D9920	Behavior management, by report	$35.00
Emergency services		
D9110	Palliative (Emergency) treatment of dental pain – Minor procedure	$5.00
D9440	Office visit – After regularly scheduled hours	$45.00

Miscellaneous services		
D9973	External bleaching – Per tooth	$60.00
D9974	Internal bleaching – Per tooth	$60.00
D9975	External bleaching for home application, per arch; includes materials and fabrication of custom trays (All other methods of bleaching are not covered)	$125.00
Missed appointment		$25.00

This may contain CDT codes and/or portions of, or excerpts from the Nomenclature contained within the Current Dental Terminology, a copyrighted publication provided by the American Dental Association. The American Dental Association does not endorse any codes which are not included in its current publication.

After your enrollment is effective:

Call the dental office identified in your Welcome Kit. If you wish to change dental offices, a transfer can be arranged at no charge by calling Cigna Dental at the toll free number listed on your ID card or plan materials.

Multiple ways to locate a *DHMO Network General Dentist include:

› Online provider directory at Cigna.com

› Online provider directory on myCigna.com

› Call the number located on your ID card to:

– Use the Dental Office Locator via Speech Recognition

– Speak to a Customer Service Representative

EMERGENCY: If you have a dental emergency as defined in your group's plan documents, contact your Network General Dentist as soon as possible. If you are out of your service area or unable to contact your Network Office, emergency care can be rendered by any licensed dentist. Definitive treatment (e.g., root canal) is not considered emergency care and should be performed or referred by your Network General Dentist. Consult your group's plan documents for a complete definition of dental emergency, your emergency benefit and a listing of Exclusions and Limitations.

The term "DHMO" is used to refer to product designs that may differ by state of residence of enrollee, including but not limited to, prepaid plans, managed care plans, and plans with open access features.

Coordination of Benefits

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

This section describes what this Plan will pay for covered expenses that are also covered under one or more other Plans. You should file all claims with each Plan.

Definitions

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

Plan

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

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

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

Closed Panel Plan does not include:

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

Primary Plan

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

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

Secondary Plan

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

Allowable Expense

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

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

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

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

Claim Determination Period

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

Order of Benefit Determination Rules

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

- The Plan that covers you as an enrollee or an Employee shall be the Primary Plan and the Plan that covers you as a Dependent shall be the Secondary Plan.
- If you are a Dependent child whose parents are not divorced or legally separated, the Primary Plan shall be the Plan which covers the parent whose birthday falls first in the calendar year as an enrollee or Employee.

- If you are the Dependent of divorced or separated parents, the Primary Plan for the Dependent shall be determined in the following order:
  - if a court decree states that one parent is responsible for the child's healthcare expenses or health coverage and the Plan for that parent has actual knowledge of the terms of the order, then it shall be Primary, but only from the time of actual knowledge. If the parent with responsibility has no health care coverage for the child's health care expenses, but the spouse of the responsible parent does have health care coverage for the child's health care expenses the responsible parent's spouse's plan shall be Primary;
  - the Plan of the parent with custody of the child;
  - the Plan of the spouse of the parent with custody of the child;
  - the Plan of the parent not having custody of the child; and
  - the Plan of the spouse of the parent not having custody of the child.
- The Plan that covers you as an active Employee (or as that Employee's Dependent) shall be the Primary Plan and the Plan that covers you as a laid-off or retired Employee (or as that Employee's Dependent) shall be the secondary Plan. If the other Plan does not have a similar provision and, as a result, the Plans do not reach an agreement on the order of benefit determination, this paragraph shall not apply.
- The Plan that covers you under a right of continuation which is provided by federal or state law shall be the Secondary Plan and the Plan that covers you as an active Employee or retiree (or as that Employee's Dependent) shall be the Primary Plan. If the other Plan does not have a similar provision and, as a result, the Plans do not reach an agreement on the order of benefit determination, this paragraph shall not apply.
- If the preceding rules do not determine the order of benefits, the Plan that has covered you for the longer period of time is the Primary Plan and the Plan that has covered you for the shorter period of time is the Secondary Plan.

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

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

Effect on the Benefits Payable

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

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

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

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

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

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

Other Cigna Coverage

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

Recovery of Excess Benefits

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

Right to Receive and Release Information

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

HC-COB130 01-16
V1

Expenses For Which A Third Party May Be Responsible

This plan does not cover:

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

Right Of Reimbursement

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

Lien Of The Plan

By accepting benefits under this plan, a Participant:

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

Additional Terms

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

- Any reference to state law in any other provision of this plan shall not be applicable to this provision, if the plan is governed by ERISA. By acceptance of benefits under the plan, the Participant agrees that a breach hereof would cause irreparable and substantial harm and that no adequate remedy at law would exist. Further, the plan shall be entitled to invoke such equitable remedies as may be necessary to enforce the terms of the plan, including, but not limited to, specific performance, restitution, the imposition of an equitable lien and/or constructive trust, as well as injunctive relief.

HC-SUB2 04-10
V1

Payment of Benefits

To Whom Payable

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

Cigna may, at its option, make payment to you for the cost of any Covered Expenses from a Non-Participating Provider even if benefits have been assigned. When benefits are paid to you or your Dependent, you or your Dependents are responsible for reimbursing the provider.

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

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

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

Recovery of Overpayment

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

HC-POB4 04-10
V1

Miscellaneous

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

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

HC-POB27 04-10
V1

Termination of Insurance

Employees

Your insurance will cease on the earliest date below:

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

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

Injury or Sickness

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

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

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

Dependents

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

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

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

HC-TRM72 04-10
V1 M

Dental Benefits Extension

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

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

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

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

HC-BEX38 04-10
V1

Dental Conversion Privilege

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

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

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

HC-CNV2 04-10
V1

Notice of an Appeal or a Grievance

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

HC-SPP4 04-10
V1

The Following Will Apply To Residents of Utah

When You Have A Complaint or an Appeal

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

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

Start With Member Services

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

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

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

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

Appeals Procedure

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

Level-One Appeal

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

For level-one appeals, we will respond in writing with a decision within 30 calendar days after we receive an appeal for a postservice coverage determination. If more time or information is needed to make the determination, we will notify you in writing to request an extension of up to 15 calendar days and to specify any additional information needed to complete the review.

Level Two Appeal

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

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

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

Independent Review Procedure

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

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

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

To request a review, you must notify the Appeals Coordinator within 180 days of your receipt of Cigna's level two appeal review denial. Cigna will then forward the file to the Independent Review Organization.

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

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

Appeal to the State of Utah

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

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

Notice of Benefit Determination on Appeal

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

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

Relevant Information

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

Legal Action

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

HC-APL92 04-10
V1

Definitions

Active Service

You will be considered in Active Service:

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

HC-DFS1 04-10
V1

Cigna Dental Health
(herein referred to as CDH)

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

HC-DFS352 04-10
V1

Contract Fees

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

HC-DFS353 04-10
V1

Covered Services

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

HC-DFS354 04-10
V1

Dental Office

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

HC-DFS355 04-10
V1

Dental Plan

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

HC-DFS356 04-10
V2

Dentist

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

HC-DFS125 04-10
V3

Dependent

Dependents are:

- your lawful spouse; and
- any child of yours who is
  - less than 26 years old.
  - 26 or more years old, unmarried, and primarily supported by you and incapable of self-sustaining employment by reason of mental or physical disability. Proof of the child's condition and dependence must be submitted to Cigna within 31 days after the date the child ceases to qualify above. From time to time, but not more frequently than once a year, Cigna may require proof of the continuation of such condition and dependence.

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

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

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

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

It also includes a stepchild or a child for whom you are the legal guardian.

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

If you and your spouse are both covered under the Plan, you may each be enrolled as a Participant or be covered as a Dependent of the other person, but not both. In addition, if you and your spouse are both covered under the Plan, only one parent may enroll your child as a Dependent.

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

HC-DFS820 01-16
V1 M

Employee

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

HC-DFS7 04-10
V3

Employer

The term Employer means the Policyholder and all Affiliated Employers.

HC-DFS8 04-10
V1

Group

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

HC-DFS357 04-10
V1

Medicaid

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

HC-DFS16 04-10
V1

Medicare

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

HC-DFS17 04-10
V1

Network General Dentist

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

HC-DFS358 04-10
V1

Network Specialty Dentist

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

HC-DFS359 04-10
V1

Patient Charge Schedule

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

HC-DFS360 04-10
V1

Service Area

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

HC-DFS361 04-10
V1

Specialist

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

HC-DFS362 04-10
V1

Subscriber

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

HC-DFS363 04-10
V1

Usual Fee

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

HC-DFS138 04-10
V1

Federal Requirements

The following Federal Requirement section is not part of your group insurance certificate. The following pages explain your rights and responsibilities under federal laws and regulations. Some states may have similar requirements. If a similar provision appears elsewhere in your group insurance certificate, the provision which provides the better benefit will apply.

HC-FED1 10-10
V1

Notice of Provider Directory/Networks

Notice Regarding Provider Directories and Provider Networks

A list of network providers is available to you without charge by visiting the website or by calling the phone number on your ID card. The network consists of dental practitioners, of varied specialties as well as general practice, affiliated or contracted with Cigna or an organization contracting on its behalf.

HC-FED78 10-10

Qualified Medical Child Support Order (QMCSO)

Eligibility for Coverage Under a QMCSO

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

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

Qualified Medical Child Support Order Defined

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

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

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

Payment of Benefits

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

HC-FED4 10-10

Effect of Section 125 Tax Regulations on This Plan

Your Employer has chosen to administer this Plan in accordance with Section 125 regulations of the Internal Revenue Code. Per this regulation, you may agree to a pretax salary reduction put toward the cost of your benefits.

Otherwise, you will receive your taxable earnings as cash (salary).

A. Coverage elections

Per Section 125 regulations, you are generally allowed to enroll for or change coverage only before each annual benefit period. However, exceptions are allowed:

- if your Employer agrees, and you meet the criteria shown in the following Sections B through F and enroll for or change coverage within the time period established by your Employer.

B. Change of status

A change in status is defined as:

- change in legal marital status due to marriage, death of a spouse, divorce, annulment or legal separation;
- change in number of Dependents due to birth, adoption, placement for adoption, or death of a Dependent;
- change in employment status of Employee, spouse or Dependent due to termination or start of employment, strike, lockout, beginning or end of unpaid leave of absence, including under the Family and Medical Leave Act (FMLA), or change in worksite;
- changes in employment status of Employee, spouse or Dependent resulting in eligibility or ineligibility for coverage;
- change in residence of Employee, spouse or Dependent to a location outside of the Employer's network service area; and
- changes which cause a Dependent to become eligible or ineligible for coverage.

C. Court order

A change in coverage due to and consistent with a court order of the Employee or other person to cover a Dependent.

D. Medicare or Medicaid eligibility/entitlement

The Employee, spouse or Dependent cancels or reduces coverage due to entitlement to Medicare or Medicaid, or enrolls or increases coverage due to loss of Medicare or Medicaid eligibility.

E. Change in cost of coverage

If the cost of benefits increases or decreases during a benefit period, your Employer may, in accordance with plan terms, automatically change your elective contribution.

When the change in cost is significant, you may either increase your contribution or elect less-costly coverage. When a significant overall reduction is made to the benefit option you have elected, you may elect another available benefit option. When a new benefit option is added, you may change your election to the new benefit option.

F. Changes in coverage of spouse or Dependent under another employer's plan

You may make a coverage election change if the plan of your spouse or Dependent: incurs a change such as adding or deleting a benefit option; allows election changes due to Change in Status, Court Order or Medicare or Medicaid Eligibility/Entitlement; or this Plan and the other plan have different periods of coverage or open enrollment periods.

HC-FED95 04-17

Eligibility for Coverage for Adopted Children

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

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

HC-FED67V1 09-14

Group Plan Coverage Instead of Medicaid

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

HC-FED13 10-10

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

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

Continuation of Health Insurance During Leave

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

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

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

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

HC-FED93 M 10-17

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

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

Continuation of Coverage

For leaves of less than 30 days, coverage will continue as described in the Termination section regarding Leave of Absence.

For leaves of 30 days or more, you may continue coverage for yourself and your Dependents check with your Employer for more information.

HC-FED18 M 10-10

Claim Determination Procedures

Procedures Regarding Medical Necessity Determinations

In general, health services and benefits must be medically necessary to be covered under the plan. The procedures for determining Medical Necessity vary, according to the type of service or benefit requested, and the type of health plan.

You or your authorized representative (typically, your health care professional) must request Medical Necessity determinations according to the procedures described below, in the Certificate, and in your provider's network participation documents as applicable.

When services or benefits are determined to be not covered, you or your representative will receive a written description of the adverse determination, and may appeal the determination. Appeal procedures are described in the Certificate, in your provider's network participation documents as applicable, and in the determination notices.

Postservice Determinations

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

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

Notice of Adverse Determination

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

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COBRA Continuation Rights Under Federal Law

For You and Your Dependents

What is COBRA Continuation Coverage?

Under federal law, you and/or your Dependents must be given the opportunity to continue health insurance when there is a "qualifying event" that would result in loss of coverage under the Plan. You and/or your Dependents will be permitted to continue the same coverage under which you or your Dependents were covered on the day before the qualifying event occurred, unless you move out of that plan's coverage area or the plan is no longer available. You and/or your Dependents cannot change coverage options until the next open enrollment period.

When is COBRA Continuation Available?

For you and your Dependents, COBRA continuation is available for up to 18 months from the date of the following qualifying events if the event would result in a loss of coverage under the Plan:

- your termination of employment for any reason, other than gross misconduct; or
- your reduction in work hours.

For your Dependents, COBRA continuation coverage is available for up to 36 months from the date of the following qualifying events if the event would result in a loss of coverage under the Plan:

- your death;
- your divorce or legal separation; or
- for a Dependent child, failure to continue to qualify as a Dependent under the Plan.

Who is Entitled to COBRA Continuation?

Only a "qualified beneficiary" (as defined by federal law) may elect to continue health insurance coverage. A qualified beneficiary may include the following individuals who were covered by the Plan on the day the qualifying event occurred: you, your spouse, and your Dependent children. Each qualified beneficiary has their own right to elect or decline COBRA continuation coverage even if you decline or are not eligible for COBRA continuation.

The following individuals are not qualified beneficiaries for purposes of COBRA continuation: domestic partners, grandchildren (unless adopted by you), stepchildren (unless adopted by you). Although these individuals do not have an independent right to elect COBRA continuation coverage, if you elect COBRA continuation coverage for yourself, you may also cover your Dependents even if they are not considered qualified beneficiaries under COBRA. However, such individuals' coverage will terminate when your COBRA continuation coverage terminates. The sections titled "Secondary Qualifying Events" and "Medicare Extension For Your Dependents" are not applicable to these individuals.

Secondary Qualifying Events

If, as a result of your termination of employment or reduction in work hours, your Dependent(s) have elected COBRA continuation coverage and one or more Dependents experience another COBRA qualifying event, the affected Dependent(s) may elect to extend their COBRA continuation coverage for an additional 18 months (7 months if the secondary event occurs within the disability extension period) for a maximum of 36 months from the initial qualifying event. The second qualifying event must occur before the end of the initial 18 months of COBRA continuation coverage or within the disability extension period discussed below. Under no circumstances will COBRA continuation coverage be available for more than 36 months from the initial qualifying event. Secondary qualifying events are: your death; your divorce or legal separation; or, for a Dependent child, failure to continue to qualify as a Dependent under the Plan.

Disability Extension

If, after electing COBRA continuation coverage due to your termination of employment or reduction in work hours, you or one of your Dependents is determined by the Social Security Administration (SSA) to be totally disabled under Title II or XVI of the SSA, you and all of your Dependents who have

elected COBRA continuation coverage may extend such continuation for an additional 11 months, for a maximum of 29 months from the initial qualifying event.

To qualify for the disability extension, all of the following requirements must be satisfied:

- SSA must determine that the disability occurred prior to or within 60 days after the disabled individual elected COBRA continuation coverage; and
- A copy of the written SSA determination must be provided to the Plan Administrator within 60 calendar days after the date the SSA determination is made AND before the end of the initial 18-month continuation period.

If the SSA later determines that the individual is no longer disabled, you must notify the Plan Administrator within 30 days after the date the final determination is made by SSA. The 11-month disability extension will terminate for all covered persons on the first day of the month that is more than 30 days after the date the SSA makes a final determination that the disabled individual is no longer disabled.

All causes for "Termination of COBRA Continuation" listed below will also apply to the period of disability extension.

Medicare Extension for Your Dependents

When the qualifying event is your termination of employment or reduction in work hours and you became enrolled in Medicare (Part A, Part B or both) within the 18 months before the qualifying event, COBRA continuation coverage for your Dependents will last for up to 36 months after the date you became enrolled in Medicare. Your COBRA continuation coverage will last for up to 18 months from the date of your termination of employment or reduction in work hours.

Termination of COBRA Continuation

COBRA continuation coverage will be terminated upon the occurrence of any of the following:

- the end of the COBRA continuation period of 18, 29 or 36 months, as applicable;
- failure to pay the required premium within 30 calendar days after the due date;
- cancellation of the Employer's policy with Cigna;
- after electing COBRA continuation coverage, a qualified beneficiary enrolls in Medicare (Part A, Part B, or both);
- after electing COBRA continuation coverage, a qualified beneficiary becomes covered under another group health plan, unless the qualified beneficiary has a condition for which the new plan limits or excludes coverage under a pre-existing condition provision. In such case coverage will continue until the earliest of: the end of the applicable maximum period; the date the pre-existing condition provision is no longer applicable; or the occurrence of an event described in one of the first three bullets above;
- any reason the Plan would terminate coverage of a participant or beneficiary who is not receiving continuation coverage (e.g., fraud).

Employer's Notification Requirements

Your Employer is required to provide you and/or your Dependents with the following notices:

- An initial notification of COBRA continuation rights must be provided within 90 days after your (or your spouse's) coverage under the Plan begins (or the Plan first becomes subject to COBRA continuation requirements, if later). If you and/or your Dependents experience a qualifying event before the end of that 90-day period, the initial notice must be provided within the time frame required for the COBRA continuation coverage election notice as explained below.
- A COBRA continuation coverage election notice must be provided to you and/or your Dependents within the following timeframes:
  - if the Plan provides that COBRA continuation coverage and the period within which an Employer must notify the Plan Administrator of a qualifying event starts upon the loss of coverage, 44 days after loss of coverage under the Plan;
  - if the Plan provides that COBRA continuation coverage and the period within which an Employer must notify the Plan Administrator of a qualifying event starts upon the occurrence of a qualifying event, 44 days after the qualifying event occurs; or
  - in the case of a multi-employer plan, no later than 14 days after the end of the period in which Employers must provide notice of a qualifying event to the Plan Administrator.

How to Elect COBRA Continuation Coverage

The COBRA coverage election notice will list the individuals who are eligible for COBRA continuation coverage and inform you of the applicable premium. The notice will also include instructions for electing COBRA continuation coverage. You must notify the Plan Administrator of your election no later than the due date stated on the COBRA election notice. If a written election notice is required, it must be post-marked no later than the due date stated on the COBRA election notice. If you do not make proper notification by the due date shown on the notice, you and your Dependents will lose the right to elect COBRA continuation coverage. If you reject COBRA continuation coverage before the due date, you may change your mind as long as you furnish a completed election form before the due date.

Each qualified beneficiary has an independent right to elect COBRA continuation coverage. Continuation coverage may be elected for only one, several, or for all Dependents who are qualified beneficiaries. Parents may elect to continue coverage

on behalf of their Dependent children. You or your spouse may elect continuation coverage on behalf of all the qualified beneficiaries. You are not required to elect COBRA continuation coverage in order for your Dependents to elect COBRA continuation.

How Much Does COBRA Continuation Coverage Cost?

Each qualified beneficiary may be required to pay the entire cost of continuation coverage. The amount may not exceed 102% of the cost to the group health plan (including both Employer and Employee contributions) for coverage of a similarly situated active Employee or family member. The premium during the 11-month disability extension may not exceed 150% of the cost to the group health plan (including both employer and employee contributions) for coverage of a similarly situated active Employee or family member.

For example: If the Employee alone elects COBRA continuation coverage, the Employee will be charged 102% (or 150%) of the active Employee premium. If the spouse or one Dependent child alone elects COBRA continuation coverage, they will be charged 102% (or 150%) of the active Employee premium. If more than one qualified beneficiary elects COBRA continuation coverage, they will be charged 102% (or 150%) of the applicable family premium.

When and How to Pay COBRA Premiums

First payment for COBRA continuation

If you elect COBRA continuation coverage, you do not have to send any payment with the election form. However, you must make your first payment no later than 45 calendar days after the date of your election. (This is the date the Election Notice is postmarked, if mailed.) If you do not make your first payment within that 45 days, you will lose all COBRA continuation rights under the Plan.

Subsequent payments

After you make your first payment for COBRA continuation coverage, you will be required to make subsequent payments of the required premium for each additional month of coverage. Payment is due on the first day of each month. If you make a payment on or before its due date, your coverage under the Plan will continue for that coverage period without any break.

Grace periods for subsequent payments

Although subsequent payments are due by the first day of the month, you will be given a grace period of 30 days after the first day of the coverage period to make each monthly payment. Your COBRA continuation coverage will be provided for each coverage period as long as payment for that coverage period is made before the end of the grace period for that payment. However, if your payment is received after the due date, your coverage under the Plan may be suspended during this time. Any providers who contact the Plan to confirm coverage during this time may be informed that coverage has been suspended. If payment is received before the end of the grace period, your coverage will be reinstated back to the beginning of the coverage period. This means that any claim you submit for benefits while your coverage is suspended may be denied and may have to be resubmitted once your coverage is reinstated. If you fail to make a payment before the end of the grace period for that coverage period, you will lose all rights to COBRA continuation coverage under the Plan.

You Must Give Notice of Certain Qualifying Events

If you or your Dependent(s) experience one of the following qualifying events, you must notify the Plan Administrator within 60 calendar days after the later of the date the qualifying event occurs or the date coverage would cease as a result of the qualifying event:

- Your divorce or legal separation; or
- Your child ceases to qualify as a Dependent under the Plan.
- The occurrence of a secondary qualifying event as discussed under “Secondary Qualifying Events” above (this notice must be received prior to the end of the initial 18- or 29-month COBRA period).

(Also refer to the section titled “Disability Extension” for additional notice requirements.)

Notice must be made in writing and must include: the name of the Plan, name and address of the Employee covered under the Plan, name and address(es) of the qualified beneficiaries affected by the qualifying event; the qualifying event; the date the qualifying event occurred; and supporting documentation (e.g., divorce decree, birth certificate, disability determination, etc.).

Newly Acquired Dependents

If you acquire a new Dependent through marriage, birth, adoption or placement for adoption while your coverage is being continued, you may cover such Dependent under your COBRA continuation coverage. However, only your newborn or adopted Dependent child is a qualified beneficiary and may continue COBRA continuation coverage for the remainder of the coverage period following your early termination of COBRA coverage or due to a secondary qualifying event. COBRA coverage for your Dependent spouse and any Dependent children who are not your children (e.g., stepchildren or grandchildren) will cease on the date your COBRA coverage ceases and they are not eligible for a secondary qualifying event.

COBRA Continuation for Retirees Following Employer’s Bankruptcy

If you are covered as a retiree, and a proceeding in bankruptcy is filed with respect to the Employer under Title 11 of the United States Code, you may be entitled to COBRA

continuation coverage. If the bankruptcy results in a loss of coverage for you, your Dependents or your surviving spouse within one year before or after such proceeding, you and your covered Dependents will become COBRA qualified beneficiaries with respect to the bankruptcy. You will be entitled to COBRA continuation coverage until your death. Your surviving spouse and covered Dependent children will be entitled to COBRA continuation coverage for up to 36 months following your death. However, COBRA continuation coverage will cease upon the occurrence of any of the events listed under “Termination of COBRA Continuation” above.

Interaction With Other Continuation Benefits

You may be eligible for other continuation benefits under state law. Refer to the Termination section for any other continuation benefits.

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