

Group Contract

City of Newport Beach

and

Cigna Dental Health

Member Services 1.800.Cigna24
(Reaches all Regional locations)

Cigna Dental Health Plan of Arizona, Inc.

Cigna Dental Health of Colorado, Inc.

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

Cigna Dental Health of Kentucky, Inc. (Illinois)

Regional Offices

P.O. Box 453099

Sunrise, Florida 33345-3099

**THIS IS A LEGAL CONTRACT BETWEEN THE ABOVE MENTIONED GROUP AND THE CIGNA
DENTAL COMPANIES LISTED ABOVE. IT IS ISSUED IN CONSIDERATION OF THE PRE-
CONTRACT APPLICATION AND PAYMENT OF THE PREMIUMS/PREPAYMENT FEES AS THEY ARE
DUE. READ YOUR GROUP CONTRACT CAREFULLY.**

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08.11.05

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A. DEFINITIONS

Capitalized terms in this contract (the "Contract"), unless otherwise defined, shall have the meanings set forth below.

Cigna Dental: The Cigna Dental Health organization that provides dental benefits in your state as listed on the face page of this Contract.

Covered Persons: Subscribers and their Dependents who are enrolled in the Dental Plan.

Dental Plan: Managed dental care plan to be provided pursuant to this Contract.

Dependent: Those Covered Persons which are named as Dependents of a Subscriber, as further defined in the applicable Plan Booklet, Evidence of Coverage and/or Certificate of Coverage.

Evidence of Coverage: Subscriber's dental plan booklet or certificate of coverage which summarizes the dental plan and covered benefits. The Evidence of Coverage is attached hereto and made a part of this Contract as if fully set forth herein.

Group: Employer, labor union, association, or other organization named on the title page of this Contract.

Patient Charge Schedule: List of covered services and associated patient charges, which is attached hereto and incorporated herein by reference, and as it may be revised during the term of this Contract.

Pre-Contract: The Cigna Dental Pre-Contract Application which designates certain terms and conditions of coverage and which is attached hereto and made a part hereof by reference.

Premiums/Prepayment Fees: The fees/premiums stated in the Pre-Contract which the Group must remit to Cigna Dental for Covered Persons each calendar month during the term of this Contract.

Subscriber: Employee or member of the Group who is enrolled in the Dental Plan.

B. THE DENTAL PLAN

1. Cigna Dental shall provide dental benefits to Subscribers and Dependents in accordance with the terms of this Contract and as set out in the attached Pre-Contract, Evidence of Coverage, applicable State Riders, and Patient Charge Schedule.

2. The terms and conditions of the Evidence of Coverage including State Riders, applicable Patient Charge Schedule, and any amendments or revisions thereto, are incorporated into this Contract by reference and made a part hereof as if fully set forth herein. Each Subscriber shall receive an Evidence of Coverage outlining the terms, exclusions and limitations of the coverage provided hereunder. Any conflicts between the Group Contract and

Evidence of Coverage shall be resolved according to the terms most favorable to the Subscriber.

3. The relationship between Cigna Dental Health and a Network Dentist is an independent contractor relationship. All contracts between Cigna Dental Health and Network Dentists state that under no circumstances shall any Covered Person be liable to any Network Dentist for any sums owed to the Network Dentist by Cigna Dental Health, notwithstanding any delay by Cigna Dental Health in paying the Network Dentist any such sums. Cigna Dental Health shall provide reasonable notice to the Group of any termination, breach of contract, or inability to perform of any Network Dentist if Cigna Dental Health determines that Covered Persons may be materially and adversely affected thereby.

C. PREMIUMS/PREPAYMENT FEES

In consideration of the services to be rendered and made available by Cigna Dental pursuant to this Contract, the Group shall remit to Cigna Dental the Premium/Prepayment Fee for the initial month of coverage on or before the first day of said month accompanied by a list of persons to be covered under the Dental Plan. On or before the twelfth (12th) day of each month during the term of this Contract, Cigna Dental will send the Group an alphabetized list of Subscribers and a statement of Premiums/Prepayment Fees due for that month of coverage. On or before the twenty-fifth (25th) day of each month during the term of this Contract, the Group shall remit the Premium/Prepayment Fee to Cigna Dental with an updated list indicating Covered Persons to be added to or deleted from the Dental Plan and any changes in type of coverage. Alternative payment mechanisms developed for the Group by Cigna Dental shall supersede the terms of this Paragraph.

Premiums/Prepayment Fees are guaranteed for an initial period of twelve (12) months (unless otherwise extended in the Pre-Contract). However, Premiums/Prepayment Fees may be adjusted by Cigna Dental upon 30 days' notice to the Group if, in Cigna Dental's sole opinion, its liability is altered by any state or federal law.

D. GRACE PERIOD/REINSTATEMENT

1. Cigna Dental shall provide written notice of non-receipt of payment on or before the twelfth (12th) day of the month following the month for which Premiums/Prepayment Fees remain due and owing. Group shall have an additional thirty-one (31) days for the payment of any Premium/Prepayment Fee except the first. The Contract shall remain in full force and effect during this Grace Period. If the Premium/Prepayment Fees are not remitted by the end of the Grace Period, the Contract will terminate on the last day of the Grace Period. The Group will remain liable to Cigna Dental for any Premium/Prepayment Fees accrued during the Grace Period.

2. If proper payment is received by Cigna Dental on or before the expiration of the Grace Period, the Contract shall remain in full force and effect. If the Contract terminates due to non-payment of the required Premiums/Prepayment Fees, the Group may request that Cigna Dental reinstate the Contract. The Group must make this request and pay all past due and current Premiums/Prepayment Fees to Cigna Dental within fifteen (15) days after the expiration of the applicable Grace Period.

3. If Cigna Dental elects to reinstate this Contract, the coverage provided herein will resume as of the date of termination with no gap in coverage. If Cigna Dental elects not to reinstate the Contract, it will notify the Group of such decision in writing. In such event, any unearned Premium/Prepayment Fees submitted with the request for reinstatement will be returned to the Group.

4. Cigna Dental's reinstatement of the Contract or waiver of the right to terminate this Contract pursuant to this Section shall not constitute a waiver of any future right to terminate for nonpayment of Premium/Prepayment Fees.

E. EFFECTIVE DATE/TERM & RENEWAL

The Group's effective date of coverage under the Dental Plan (the "Effective Date") shall be the date listed on the Pre-Contract, for and in consideration of Cigna Dental's receipt of the Premium/Prepayment Fees.

The original term of this Contract shall extend from the Effective Date until the expiration of the initial Premium/Prepayment Fee Guarantee as set forth in the Pre-Contract (the "Expiration Date"). This Contract shall be automatically renewed on an annual basis effective the day following the Expiration Date (the "Renewal Date") unless otherwise terminated as provided herein. The Patient Charge Schedule shall be in effect for a minimum of one year.

The Premium/Prepayment Fee and Patient Charge Schedule shall be reviewed and may be adjusted on an annual basis at the anniversary of the Renewal Date upon sixty (60) days' notice from CIGNA Dental.

F. ELIGIBILITY

1. The Group shall determine which of its employees, associates or members are eligible to enroll in the Dental Plan. The Group shall be responsible for providing eligibility information to CIGNA Dental on a timely basis as provided in Section C hereinabove. Where the Group provides eligibility information of any kind, including but not limited to electronic data, tapes or software, the data must be accurate and accessible.

2. The Group will have at least one open enrollment period every eighteen (18) months. Such open enrollment periods are required for as long as the Contract exists unless Cigna Dental and the Group mutually agree to a shorter period of time. Subscribers and Dependents may be disenrolled only during the Group's open enrollment periods unless there has been a life status change such as divorce or termination.

3. In the event a Covered Person is eligible for benefits pursuant to the requirements of the Family and Medical Leave Act of 1993 or the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA), the Group shall be responsible for collecting the Subscriber's portion of the Premium/Prepayment Fees, if any, for which the Subscriber would have been responsible if Subscriber had not taken the leave or become qualified for COBRA coverage.

G. COMPLIANCE WITH THE FEDERAL OMNIBUS BUDGET RECONCILIATION ACT OF 1993

The parties agree, as follows, to perform the terms of this Contract in accordance with the requirements of the Federal Omnibus Budget Reconciliation Act of 1993:

1. Cigna Dental shall not take into account that a Covered Person is eligible for or is provided medical assistance under 12 U.S.C. §1396a (section 1902 of the Social Security Act) in covering or providing benefits to or on behalf of said Covered Person under the Dental Plan.

2. If a Subscriber who is eligible for family coverage under the Dental Plan is required by a court or administrative order to provide dental coverage for his or her child:

(a) Cigna Dental Health and the Group:

(i) Shall not deny enrollment of the child in the Dental Plan on any of the following grounds:

a) The child was born out of wedlock,

b) The child is not claimed as a dependent on the Subscriber's federal income tax return, or

c) The child does not reside with the Subscriber or in the Dental Plan's service area.

(ii) Shall allow the Subscriber to enroll the child in the Dental Plan under family coverage, without regard to any enrollment season restrictions, provided that the child is otherwise eligible for Dental Plan coverage.

(iii) Shall enroll the child in the Dental Plan under the family coverage upon application of the child's other parent or the Department of Human Resources in connection with its administration of the Medical Assistance or Child Support Enforcement Program if the Subscriber fails to enroll the child.

(iv) Except as otherwise provided herein, shall not terminate the child's Dental Plan coverage unless Cigna Dental and the Group are provided satisfactory written evidence that:

a) The court or administrative order is no longer in effect, or

b) The child is or will be enrolled in comparable dental coverage through another dental plan, which coverage will take effect no later than the effective date of termination.

(b) The Group shall withhold from Subscriber's compensation the Subscriber's share, if any, of Premiums for Dental Plan

coverage and shall pay the appropriate Premiums to Cigna Dental pursuant to the terms of this Contract.

(c) If the Subscriber is not the child's custodial parent, Cigna Dental and the Group shall:

(i) Provide such information to the custodial parent as may be necessary for the child to obtain benefits under the Dental Plan.

(ii) Permit the custodial parent or dentist (with custodial parent's approval) to submit claims for Covered Services without the approval of the non-custodial parent.

(iii) Make payments, pursuant to this Contract, on the claims submitted under clause (b) of this paragraph directly to the custodial parent, the dentist, or the Department of Human Resources.

(d) Cigna Dental shall not impose on any State agency that has been assigned the rights of an individual eligible for medical assistance under Medicaid and covered under the Dental Plan requirements that are different from requirement applicable to an agent or assignee of any other individual covered under the Dental Plan.

3. If a Subscriber who is eligible for family coverage under the Dental Plan is required by a court or administration order to provide dental coverage for his or her child who does not reside in the Dental Plan's service area, the following alternatives for coverage are available:

(a) If the Group offers its employees a choice between the Dental Plan or indemnity dental coverage, the family shall be covered under the Dental Plan and the child shall be treated at the Subscriber's Dental Office in the Dental Plan's service area, except as provided herein for emergencies and specialty referrals; or the family shall be covered under the indemnity dental coverage.

(b) If the Group does not offer its employees any indemnity dental coverage and an affiliate of Cigna Dental has a network of dentists in the service area within which the child resides, the child shall be covered under a contract between the Group and the affiliate of Cigna Dental and the Subscriber shall be covered under a contract between the Group and Cigna Dental.

(c) If the Group does not offer its employees any indemnity dental coverage and an affiliate of Cigna Dental does not have a network in the service area within which the child resides, the family shall be covered by an indemnity dental policy which the Group shall obtain or the family shall be covered under the Dental Plan and the child shall be treated at the Subscriber's Dental Office in the Dental Plan's

service area, except as provided herein for emergencies and specialty referrals.

- (d) Except as otherwise restricted by federal law, the Subscriber shall be permitted to change his or her dental coverage election (between the Dental Plan and indemnity dental coverage) without regard to any enrollment reason restrictions.
4. A child who is less than 18 years of age and is placed for adoption with a Subscriber shall be entitled to benefits under the same terms and conditions that apply to the Subscriber's natural, Dependent children, irrespective of whether the adoption has become final. Cigna Dental shall not restrict Dental Plan coverage of any dependent child adopted by or placed for adoption with a Subscriber solely on the basis of any pre-existing condition of the child at the time that the child would otherwise become eligible for coverage under the Dental Plan if the adoption or placement for adoption occurs while the Subscriber is eligible for coverage under the Dental Plan. As used in this paragraph, "placement for adoption" means the assumption and retention by a Subscriber of a legal obligation for total or partial support of a child in anticipation of the adoption of the child. The child's placement with Subscriber terminates upon the termination of such legal obligations.
5. A subscriber's foster child shall be treated the same as a newborn child and shall be eligible for coverage on the same basis, under the terms of this Contract, upon placement in Subscriber's home. As used in this paragraph, "Foster child" means a minor over whom a Subscriber has been appointed (1) guardian by a court of competent jurisdiction in the state or (2) the primary or sole custodian by order of a court of competent jurisdiction. As used in this paragraph, "placement in the Subscriber's home" means physically residing with a Subscriber who has been appointed guardian or custodian as long as that Subscriber has assumed the legal obligation for total or partial support of the foster child with the intent that the foster child reside with the Subscriber on a more than temporary or short-term basis.

H. ADMINISTRATION AND RECORDS

1. The Group shall cooperate with Cigna Dental with respect to soliciting and enrolling persons eligible to enroll in the Dental Plan and in obtaining authorized payroll withholding from Subscribers to the extent that the applicable Premium/Prepayment Fees exceed the Group's contribution, if any, on Subscriber's behalf.

2. The Group shall provide to Cigna Dental enrollment information, including copies of all signed enrollment and change forms. Cigna Dental shall be permitted to inspect the Group's records which have a bearing on coverage of Covered Persons hereunder, including but not limited to records pertaining to eligibility, enrollment, payment of Premiums/Prepayment Fees

and administration of benefits hereunder, and shall be permitted to make copies thereof at any reasonable time upon reasonable prior notice to the Group.

3. Cigna Dental shall keep administrative records of all Covered Persons, but shall not be liable for any obligation dependent upon information from the Group prior to the receipt of such information in a form satisfactory to Cigna Dental. Incorrect information furnished by the Group may be corrected if Cigna Dental shall not have acted in reliance upon such information to its prejudice.

4. Cigna Dental is entitled to receive from each dentist who renders service to a Covered Person hereunder all information reasonably necessary to fulfill the terms of this Contract. Covered Persons, by their enrollment in the Dental Plan, authorize each dentist who renders service to the Covered Person to disclose to Cigna Dental all facts pertaining to such service and to render to Cigna Dental reports and/or copies of records pertaining to such service for Cigna Dental administrative or quality management purposes.

I. TERMINATION OF CONTRACT

In addition to termination for nonpayment of Premium/Prepayment Fees as set out in Section D hereinabove, either the Group or Cigna Dental may terminate this Contract for any reason, including low participation, effective as of any Renewal Date by providing a minimum of sixty (60) days' prior written notice to the other party.

In the event of termination of this Contract by either Cigna Dental or the Group, the Group shall provide a notice of termination to each Covered Person. Upon the request of Cigna Dental, Group agrees to provide Cigna Dental proof of such notice and the date of such notice.

In the event of termination of this Contract, Cigna Dental shall within thirty (30) days return to the Group the pro rata portion of Premium/Prepayment Fees, if any, which correspond to any unexpired period for which payment has been received, if any, less amounts due to Cigna Dental. Cigna Dental will pay covered claims incurred by Covered Persons prior to termination. This subsection shall not apply to termination by Cigna Dental made as a result of fraud or deception in the use of services or facilities, or knowingly permitting such fraud or deception by another.

J. NOTICE

Any notice required by this Contract shall be in writing and mailed with postage fully prepaid and addressed to the Group at the address listed on the Pre-Contract and to Cigna Dental at:

P.O. Box 453099
Sunrise, Florida 33345-3099
Attn: Contracts Administration

The Group shall disseminate to Covered Persons any notice from Cigna Dental of material matters no later than thirty (30) days after receipt thereof.

K. ASSIGNMENT

Group shall not assign this Contract or its rights hereunder nor delegate its duties hereunder without the prior written consent of Cigna Dental.

L. AMENDMENTS TO CONTRACT

Except as otherwise provided herein, Cigna Dental may amend this Contract by giving the Group sixty (60) days' prior written notice of the proposed amendment. Failure of the Group to object in writing to any such proposed amendment within such notice period shall constitute the Group's acceptance of the amendment as of its effective date. Except as otherwise provided herein, changes in the Premium/Prepayment Fees or Patient Charge Schedule shall be effective as of the Renewal Date following proper notice.

In the event that federal, state, or municipal laws or regulations should change, alter or modify the present services, levels of premiums to Cigna Dental, standards of eligibility of Covered Persons, or any operations of Cigna Dental such that the terms, benefits and conditions of this Contract must be modified accordingly, CIGNA Dental shall have the right to amend this Contract upon 30 days' written notice to the Group.

Except as otherwise provided herein, this Contract may be amended only in writing as approved by both the Group and Cigna Dental. Only a duly authorized officer of Cigna Dental has the authority to amend this Contract.

M. ENTIRE CONTRACT

This Contract, including the attached Plan Booklet/Evidence of Coverage/Certificate of Coverage, State Riders, Patient Charge Schedule, Pre-Contract Application, and any amendments thereto, represents the entire agreement between the parties with respect to the subject matter. Having executed the Pre-Contract, the Group shall be deemed to have accepted the terms of this Contract unless written notice is given to Cigna Dental within twenty (20) days of receipt hereof. The invalidity or unenforceability of any Section or sub-Section of this Contract shall not affect the validity or enforceability of the remaining Sections or sub-Sections hereof.

N. GOVERNING LAW

This Contract shall be construed for all purposes as a legal document and shall be interpreted and enforced in accordance with laws of the state in which the Subscriber receives services under the Dental Plan and with pertinent federal laws and regulations. Any provision required to be in the Contract by relevant state statute or regulation shall bind Cigna Dental whether or not contained herein. In the event this Contract contains any provisions not in conformity with relevant and applicable state or federal laws, the Contract shall not be rendered invalid but shall be construed and applied as if it were in full compliance with the applicable law.

O. INCONTESTABILITY

In the absence of fraud, all statements contained in a written application made by a Subscriber are considered representations and not warranties. Coverage can be voided: (a) during the first two years for material misrepresentations contained in a written enrollment form; and, (b) after the first two years, for fraudulent misstatement contained in a written enrollment form.

CIGNA DENTAL HEALTH PLAN OF ARIZONA, INC.

BY: Matthew G. Menden
TITLE: President DATE: January 1, 2016

CIGNA DENTAL HEALTH OF COLORADO, INC.

BY: Matthew G. Menden
TITLE: President DATE: January 1, 2016

CIGNA DENTAL HEALTH OF FLORIDA, INC.

BY: Matthew G. Menden
TITLE: President
DATE: January 1, 2016

CIGNA DENTAL HEALTH OF KENTUCKY, INC. (Illinois)

BY: Matthew G. Menden
TITLE: President
DATE: January 1, 2016

08/11/05

Group Contract

City of Newport Beach

and

Cigna Dental Health of California, Inc.

Member Services 1.800.CIGNA24

Cigna Dental Health of California, Inc.

400 North Brand Boulevard, Suite 400

Glendale, California 91203

THIS IS A LEGAL CONTRACT BETWEEN THE ABOVE MENTIONED GROUP AND CIGNA DENTAL HEALTH OF CALIFORNIA, INC. IT IS ISSUED IN CONSIDERATION OF THE PRE-CONTRACT APPLICATION AND PAYMENT OF THE PREPAYMENT FEES AS THEY ARE DUE. READ YOUR GROUP CONTRACT CAREFULLY.

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A. DEFINITIONS

Capitalized terms in this contract (the "Contract"), unless otherwise defined, shall have the meanings set forth below.

Cigna Dental: Cigna Dental Health of California, Inc.

Combined Evidence of Coverage and Disclosure Form: Subscriber's dental plan booklet which summarizes the Dental Plan and Covered Services.

Covered Persons: Subscribers and their Dependents who are enrolled in the Dental Plan.

Covered Services: The dental procedures listed on the applicable Patient Charge Schedule to be provided by Cigna Dental in consideration for the payment of the Prepayment Fees.

Dental Plan: The plan of managed dental care benefits to be provided pursuant to this Contract.

Dependent: Those Covered Persons which are named as Dependents of a Subscriber, as further defined in the Combined Evidence of Coverage and Disclosure Form.

Group: Employer, labor union, association, or other organization named on the title page of this Contract.

Patient Charge Schedule: List of Covered Services and associated copayments, which is attached to the Combined Evidence of Coverage and Disclosure Form.

Pre-Contract: The Cigna Dental Pre-Contract Application which designates certain Group-specific terms and conditions of coverage.

Prepayment Fees: The premium or fees stated in the Pre-Contract which the Group must pay to Cigna Dental for Covered Persons each calendar month during the term of this Contract.

Subscriber: Employee or member of the Group who is enrolled in the Dental Plan.

B. THE DENTAL PLAN

1. Cigna Dental shall provide Covered Services to Subscribers and Dependents in accordance with the terms of this Contract and as set out in the attached Pre-Contract, Combined Evidence of Coverage and Disclosure Form, and Patient Charge Schedule.

2. The terms and conditions of the Pre-Contract, Combined Evidence of Coverage and Disclosure Form including the applicable Patient Charge Schedule, and any amendments or revisions thereto, are incorporated into this Contract by reference and made a part hereof as if fully set forth herein. Each Subscriber shall receive a Combined Evidence of Coverage and Disclosure Form outlining the terms and conditions, exclusions and limitations of the

coverage provided hereunder. Any conflicts between the Group Contract and Combined Evidence of Coverage and Disclosure Form shall be resolved according to the terms most favorable to the Subscriber.

3. The relationship between Cigna Dental and its Network Dentists is an independent contractor relationship. All contracts between Cigna Dental and Network Dentists state that under no circumstances shall any Covered Person be liable to any Network Dentist for any sums owed to the Network Dentist by Cigna Dental, notwithstanding any delay by Cigna Dental in paying the Network Dentist any such sums. Cigna Dental shall provide reasonable notice to the Group of any termination, breach of contract, or inability to perform of any Network Dentist if Cigna Dental determines that Covered Persons may be materially and adversely affected thereby.

C. PREPAYMENT FEES

In consideration of the services to be rendered and made available by Cigna Dental pursuant to this Contract, the Group shall remit to Cigna Dental the Prepayment Fee for the initial month of coverage on or before the first day of said month accompanied by a list of persons to be covered under the Dental Plan. On or before the twelfth (12th) day of each month during the term of this Contract, Cigna Dental will send the Group an alphabetized list of Subscribers and a statement of Prepayment Fees due for that month of coverage. On or before the twenty-fifth (25th) day of each month during the term of this Contract, the Group shall remit the Prepayment Fee to Cigna Dental with an updated list indicating Covered Persons to be added to or deleted from the Dental Plan and any changes in type of coverage. Alternative payment mechanisms developed for the Group by Cigna Dental shall supersede the terms of this Paragraph.

Prepayment Fees are guaranteed for an initial period of twelve (12) months (unless otherwise extended in the Pre-Contract). However, Prepayment Fees may be adjusted by Cigna Dental upon 30 days' notice to the Group if, in Cigna Dental's sole opinion, its liability is altered by any state or federal law. Additionally, Cigna Dental reserves any and all rights to change the Prepayment Fees or applicable Copayments during the term of the Group Contract if Cigna Dental determines Group's information relied upon by Cigna Dental in setting the Prepayment Fees materially changes or is determined by Cigna Dental to be inaccurate.

D. GRACE PERIOD/REINSTATEMENT

1. Cigna Dental shall provide written notice of non-receipt of payment and intent to terminate the Contract on or before the twelfth (12th) day of the month following the month for which Prepayment Fees remain due and owing. Group shall have an additional thirty-one (31) days for the payment of any Prepayment Fee except the initial Prepayment Fee. The Contract shall remain in full force and effect during this Grace Period. If the Prepayment Fees are not remitted by the end of the Grace Period, the Contract will terminate on the last day of the Grace Period. The Group will remain liable to Cigna Dental for any Prepayment Fees accrued during the Grace Period.

2. If proper payment is received by Cigna Dental on or before the expiration of the Grace Period, the Contract shall remain in full force and

effect. If the Contract terminates due to non-payment of the required Prepayment Fees, the Group may request that Cigna Dental reinstate the Contract. The Group must make this request and pay all past due and current Prepayment Fees to Cigna Dental within fifteen (15) days after the expiration of the applicable Grace Period.

3. If Cigna Dental elects to reinstate this Contract, the coverage provided herein will resume as of the date of termination with no gap in coverage. If Cigna Dental elects not to reinstate the Contract, it will notify the Group of such decision in writing. In such event, any unearned Prepayment Fees submitted with the request for reinstatement will be returned to the Group.

4. Cigna Dental's reinstatement of the Contract or waiver of the right to terminate this Contract pursuant to this Section shall not constitute a waiver of any future right to terminate for nonpayment of Prepayment Fees.

E. EFFECTIVE DATE/TERM & RENEWAL

The Group's effective date of coverage under the Dental Plan (the "Effective Date") shall be the date listed on the Pre-Contract, for and in consideration of Cigna Dental's receipt of the Prepayment Fees.

The original term of this Contract shall extend from the Effective Date until the expiration of the initial Prepayment Fee Guarantee as set forth in the Pre-Contract (the "Expiration Date"). This Contract shall be automatically renewed on an annual basis effective the day following the Expiration Date (the "Renewal Date") unless otherwise terminated as provided herein. The Patient Charge Schedule shall be in effect for a minimum of one year, except as otherwise provided in Section C.

The Prepayment Fee and Patient Charge Schedule shall be reviewed and may be adjusted on an annual basis at the anniversary of the Renewal Date upon sixty (60) days' notice from Cigna Dental.

F. ELIGIBILITY

1. The Group shall determine which of its employees, associates or members are eligible to enroll in the Dental Plan. The Group shall be responsible for providing eligibility information to Cigna Dental on a timely basis as provided in Section C hereinabove. Where the Group provides eligibility information of any kind, including but not limited to electronic data, tapes or software, the data must be accurate and accessible.

2. The Group will have at least one open enrollment period every eighteen (18) months. Such open enrollment periods are required for as long as the Contract exists unless Cigna Dental and the Group mutually agree to a shorter period of time. Subscribers and Dependents may be disenrolled only during the Group's open enrollment periods unless there has been a life status change such as divorce or termination.

3. In the event a Covered Person is eligible for benefits pursuant to the requirements of the Family and Medical Leave Act of 1993 or the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA), the Group

shall be responsible for collecting the Subscriber's portion of the Prepayment Fees, if any, for which the Subscriber would have been responsible if Subscriber had not taken the leave or become qualified for COBRA coverage.

G. COMPLIANCE WITH THE FEDERAL OMNIBUS BUDGET RECONCILIATION ACT OF 1993

The parties agree, as follows, to perform the terms of this Contract in accordance with the requirements of the Federal Omnibus Budget Reconciliation Act of 1993:

1. Cigna Dental shall not take into account that a Covered Person is eligible for or is provided medical assistance under 12 U.S.C. §1396a (section 1902 of the Social Security Act) in covering or providing benefits to or on behalf of said Covered Person under the Dental Plan.

2. If a Subscriber who is eligible for family coverage under the Dental Plan is required by a court or administrative order to provide dental coverage for his or her child:

(a) Cigna Dental and the Group:

(i) Shall not deny enrollment of the child in the Dental Plan on any of the following grounds:

a) The child was born out of wedlock,

b) The child is not claimed as a dependent on the Subscriber's federal income tax return, or

c) The child does not reside with the Subscriber or in the Dental Plan's service area.

(ii) Shall allow the Subscriber to enroll the child in the Dental Plan under family coverage, without regard to any enrollment season restrictions, provided that the child is otherwise eligible for Dental Plan coverage.

(iii) Shall enroll the child in the Dental Plan under the family coverage upon application of the child's other parent or the Department of Human Resources in connection with its administration of the Medical Assistance or Child Support Enforcement Program if the Subscriber fails to enroll the child.

(iv) Except as otherwise provided herein, shall not terminate the child's Dental Plan coverage unless Cigna Dental and the Group are provided satisfactory written evidence that:

a) The court or administrative order is no longer in effect, or

b) The child is or will be enrolled in comparable dental coverage through another dental plan, which

coverage will take effect no later than the effective date of termination.

- (b) The Group shall withhold from Subscriber's compensation the Subscriber's share, if any, of Premiums for Dental Plan coverage and shall pay the appropriate Prepayment Fees to Cigna Dental pursuant to the terms of this Contract.
 - (c) If the Subscriber is not the child's custodial parent, Cigna Dental and the Group shall:
 - (i) Provide such information to the custodial parent as may be necessary for the child to obtain benefits under the Dental Plan.
 - (ii) Permit the custodial parent or dentist (with custodial parent's approval) to submit claims for Covered Services without the approval of the non-custodial parent.
 - (iii) Make payments, pursuant to this Contract, on the claims submitted under clause (b) of this paragraph directly to the custodial parent, the dentist, or the Department of Human Resources.
 - (d) Cigna Dental shall not impose on any State agency that has been assigned the rights of an individual eligible for medical assistance under Medicaid and covered under the Dental Plan requirements that are different from requirement applicable to an agent or assignee of any other individual covered under the Dental Plan.
3. If a Subscriber who is eligible for family coverage under the Dental Plan is required by a court or administration order to provide dental coverage for his or her child who does not reside in the Dental Plan's service area, the following alternatives for coverage are available:
- (a) If the Group offers its employees a choice between the Dental Plan or indemnity dental coverage, the family shall be covered under the Dental Plan and the child shall be treated at the Subscriber's Dental Office in the Dental Plan's service area, except as provided herein for emergencies and specialty referrals; or the family shall be covered under the indemnity dental coverage.
 - (b) If the Group does not offer its employees any indemnity dental coverage and an affiliate of Cigna Dental has a network of dentists in the service area within which the child resides, the child shall be covered under a contract between the Group and the affiliate of Cigna Dental and the Subscriber shall be covered under a contract between the Group and Cigna Dental.

- (c) If the Group does not offer its employees any indemnity dental coverage and an affiliate of Cigna Dental does not have a network in the service area within which the child resides, the family shall be covered by an indemnity dental policy which the Group shall obtain or the family shall be covered under the Dental Plan and the child shall be treated at the Subscriber's Dental Office in the Dental Plan's service area, except as provided herein for emergencies and specialty referrals.
 - (d) Except as otherwise restricted by federal law, the Subscriber shall be permitted to change his or her dental coverage election (between the Dental Plan and indemnity dental coverage) without regard to any enrollment reason restrictions.
4. A child who is less than 18 years of age and is placed for adoption with a Subscriber shall be entitled to benefits under the same terms and conditions that apply to the Subscriber's natural, Dependent children, irrespective of whether the adoption has become final. Cigna Dental shall not restrict Dental Plan coverage of any dependent child adopted by or placed for adoption with a Subscriber solely on the basis of any pre-existing condition of the child at the time that the child would otherwise become eligible for coverage under the Dental Plan if the adoption or placement for adoption occurs while the Subscriber is eligible for coverage under the Dental Plan. As used in this paragraph, "placement for adoption" means the assumption and retention by a Subscriber of a legal obligation for total or partial support of a child in anticipation of the adoption of the child. The child's placement with Subscriber terminates upon the termination of such legal obligations.
5. A subscriber's foster child shall be treated the same as a newborn child and shall be eligible for coverage on the same basis, under the terms of this Contract, upon placement in Subscriber's home. As used in this paragraph, "Foster child" means a minor over whom a Subscriber has been appointed (1) guardian by a court of competent jurisdiction in the state or (2) the primary or sole custodian by order of a court of competent jurisdiction. As used in this paragraph, "placement in the Subscriber's home" means physically residing with a Subscriber who has been appointed guardian or custodian as long as that Subscriber has assumed the legal obligation for total or partial support of the foster child with the intent that the foster child reside with the Subscriber on a more than temporary or short-term basis.

H. ADMINISTRATION AND RECORDS

1. The Group shall cooperate with Cigna Dental with respect to soliciting and enrolling persons eligible to enroll in the Dental Plan and in obtaining authorized payroll withholding from Subscribers to the extent that

the applicable Prepayment Fees exceed the Group's contribution, if any, on Subscriber's behalf.

2. The Group shall provide to Cigna Dental enrollment information, including copies of all signed enrollment and change forms. Cigna Dental shall be permitted to inspect the Group's records which have a bearing on coverage of Covered Persons hereunder, including but not limited to records pertaining to eligibility, enrollment, payment of Prepayment Fees and administration of benefits hereunder, and shall be permitted to make copies thereof at any reasonable time upon reasonable prior notice to the Group.

3. Cigna Dental shall keep administrative records of all Covered Persons, but shall not be liable for any obligation dependent upon information from the Group prior to the receipt of such information in a form satisfactory to Cigna Dental. Incorrect information furnished by the Group may be corrected if Cigna Dental shall not have acted in reliance upon such information to its prejudice.

4. Cigna Dental is entitled to receive from each dentist who renders service to a Covered Person hereunder all information reasonably necessary to fulfill the terms of this Contract. Covered Persons, by their enrollment in the Dental Plan, authorize each dentist who renders service to the Covered Person to disclose to Cigna Dental all facts pertaining to such service and to render to Cigna Dental reports and/or copies of records pertaining to such service for Cigna Dental administrative or quality management purposes.

I. TERMINATION OF CONTRACT

The Group may terminate this Contract for any reason, effective as of any Renewal Date by providing a minimum of sixty (60) days' prior written notice to the other party. In addition to termination for nonpayment of Premium/Prepayment Fees as set out in Section D hereinabove, Cigna Dental may terminate this Contract for the following reasons:

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

In the event of termination of this Contract by either Cigna Dental or the Group, the Group shall provide a notice of termination to each Covered Person at least fifteen (15) days in advance of the effective date of termination. Upon the request of Cigna Dental, Group agrees to provide Cigna Dental proof of such notice and the date of such notice.

In the event of termination of this Contract, Cigna Dental shall within thirty (30) days return to the Group the pro rata portion of Premium/Prepayment Fees, if any, which correspond to any unexpired period for which payment has been received, if any, less amounts due to Cigna Dental. Cigna Dental will pay covered claims incurred by Covered Persons prior to termination. This subsection shall not apply to termination by Cigna Dental made as a result of fraud or deception in the use of services or facilities, or knowingly permitting such fraud or deception by another.

The Group, a Subscriber or a Dependent may request the Director of the California Department of Managed Health Care to review the termination of an enrollment under this Contract in accordance with California Health and Safety Code Section 1365(b).

J. NOTICE

Any notice required by this Contract shall be in writing and mailed with postage fully prepaid and addressed to the Group at the address listed on the Pre-Contract and to Cigna Dental at:

P.O. Box 453099
Sunrise, Florida 33345-3099
Attn: Contracts Administration

The Group shall disseminate to Covered Persons any notice from Cigna Dental of material matters no later than thirty (30) days after receipt thereof.

K. ASSIGNMENT

Group shall not assign this Contract or its rights hereunder nor delegate its duties hereunder without the prior written consent of Cigna Dental.

L. AMENDMENTS TO CONTRACT

Except as otherwise provided herein, Cigna Dental may amend this Contract by giving the Group sixty (60) days' prior written notice of the proposed amendment. Failure of the Group to object in writing to any such proposed amendment within such notice period shall constitute the Group's acceptance of the amendment as of its effective date. Except as otherwise provided herein, changes in the Prepayment Fees or Patient Charge Schedule shall be effective as of the Renewal Date following proper notice.

In the event that federal, state, or municipal laws or regulations should change, alter or modify the present services, levels of premiums to Cigna Dental, standards of eligibility of Covered Persons, or any operations of Cigna Dental such that the terms, benefits and conditions of this Contract must be modified accordingly, Cigna Dental shall have the right to amend this Contract upon 30 days' written notice to the Group.

Except as otherwise provided herein, this Contract may be amended only in writing as approved by both the Group and Cigna Dental. Only a duly authorized officer of Cigna Dental has the authority to amend this Contract.

M. ENTIRE CONTRACT

This Contract, including the Combined Evidence of Coverage and Disclosure Form, Patient Charge Schedule, Pre-Contract Application, and any amendments thereto, represents the entire agreement between the parties with respect to the subject matter. Having executed the Pre-Contract, the Group shall be deemed to have accepted the terms of this Contract unless written notice is given to Cigna Dental within twenty (20) days of receipt hereof. The invalidity or unenforceability of any Section or sub-Section of this Contract shall not affect the validity or enforceability of the remaining Sections or sub-Sections hereof.

N. GOVERNING LAW

This Contract shall be construed for all purposes as a legal document and shall be interpreted and enforced in accordance with laws of the state in which the Subscriber receives services under the Dental Plan and with pertinent federal laws and regulations. Any provision required to be in the Contract by relevant state statute or regulation shall bind Cigna Dental whether or not contained herein. In the event this Contract contains any provisions not in conformity with relevant and applicable state or federal laws, the Contract shall not be rendered invalid but shall be construed and applied as if it were in full compliance with the applicable law.

O. INCONTESTABILITY

In the absence of fraud, all statements contained in a written application made by a Subscriber are considered representations and not warranties. Coverage can be voided: (a) during the first two years for material misrepresentations contained in a written enrollment form; and, (b) after the first two years, for fraudulent misstatement contained in a written enrollment form.

CIGNA DENTAL HEALTH OF CALIFORNIA, INC.

BY:
TITLE: President

DATE: January 1, 2016

2/20/04

EXHIBITS

Cigna Dental Health of California, Inc.
400 North Brand Boulevard, Suite 400
Glendale, California 91203

COMBINED EVIDENCE OF COVERAGE AND DISCLOSURE FORM

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

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

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

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

READ YOUR PLAN BOOKLET CAREFULLY

Please call Customer Service at [1.800.Cigna24] if you have any questions. The hearing impaired may call the state TTY toll-free relay service listed in their local telephone directory.

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I. DEFINITIONS

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

Adverse Determination - a decision by Cigna Dental not to authorize payment for certain limited specialty care procedures on the basis of clinical necessity or appropriateness of care. Requests for payment authorizations that are declined by Cigna Dental based upon clinical necessity or appropriateness of care will be the responsibility of the customer at the dentist's Usual Fees. A licensed dentist will make any such denial. Adverse Determinations may be appealed as described in the Section entitled " What To Do If There Is A Problem."

Cigna Dental - CIGNA Dental Health of California, Inc.

Clinical Necessity- to be considered clinically necessary, the treatment or service must be reasonable and appropriate and meet the following requirements:

- A. be consistent with the symptoms, diagnosis or treatment of the condition present;
- B. conform to professionally recognized standards of dental practice;
- C. not be used primarily for the convenience of the customer or dentist of care; and
- D. not exceed the scope, duration, or intensity of that level of care needed to provide safe and appropriate treatment.

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

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

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

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

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

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

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

- A. less than 26 years old; or
- B. less than 26 years old if he or she is both:
 - 1. a full-time student enrolled at an accredited educational institution, and
 - 2. reliant upon you for maintenance and support; or
- C. any age if he or she is both:
 - 1. incapable of self-sustaining employment by reason of a physically or mentally disabling injury, illness or condition; and
 - 2. chiefly dependent upon you (the subscriber) for support and maintenance.

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

For a child who falls into category B above, you will need to furnish Cigna Dental evidence of his or her reliance upon you, in the form requested, within 31 days after the Dependent reaches the age of 26 and once a year thereafter during his or her term of coverage.

For a child who falls into category C above, you will need to furnish Cigna Dental proof of the child's condition and his or her reliance upon you, within sixty (60) days from the date that you are notified by Cigna Dental to provide this information.

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

This definition of "Dependent" applies unless modified by your Group Contract.

Domestic Partner - A person of the same sex who has either properly filed a Declaration of Domestic Partnership with the California Secretary of State pursuant to Section 298 of the Family Code or who has a legal union validly formed in another state that is substantially equivalent to a California registered domestic partnership.

Domestic Partner -

- A. a person of the same or opposite sex who:
 - 1. shares your permanent residence;
 - 2. has resided with you for no less than one year;
 - 3. is no less than eighteen years of age;
 - 4. is financially interdependent with you and has proven such interdependence by providing documentation of at least two of the following arrangements: common ownership of real property or a

common leasehold interest in such property, common ownership of a motor vehicle, a joint bank account or a joint credit account, designation as a beneficiary for life insurance or retirement benefits or under your partner's will, assignment of durable power of attorney or health care power of attorney, or such other proof as is considered by Cigna Dental to be sufficient to establish financial interdependency under the circumstances of your particular case;

5. is not your blood relative any closer than would be prohibited for a legal marriage; and
 6. has signed jointly with you a notarized affidavit in form and content satisfactory to Cigna Dental which shall be made available to Cigna Dental upon request; or
- B. a person of the same or opposite sex who has registered jointly with you as a Domestic Partner with a governmental entity pursuant to a state or local law authorizing such registration and who has signed jointly with you a notarized affidavit of such registration which can be made available to Cigna Dental upon request.

The above definition applies so long as neither you nor your Domestic Partner hereunder:

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

Domestic Partner coverage cannot be transferred to states in which such coverage has been disapproved by regulatory authorities.

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

Network Dentist - a licensed dentist who has signed an agreement with Cigna Dental to provide general dentistry or specialty care services to you. The term, when used, includes both Network General Dentists and Network Specialty Dentists.

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

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

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

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

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

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

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

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

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

II. INTRODUCTION TO YOUR CIGNA DENTAL PLAN

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

III. ELIGIBILITY/WHEN COVERAGE BEGINS

A. IN GENERAL

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

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

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

If you have family coverage, a newborn child is automatically covered during the first 31 days of life. If you wish to continue coverage beyond the first 31 days, your baby must be enrolled in the Dental Plan and you must begin paying Prepayment Fees, if any additional are due, during that period.

Under the Family and Medical Leave Act of 1993, you may be eligible to continue coverage during certain leaves of absence from work. During such leaves, you will be responsible for paying your Group the portion of the Prepayment Fees, if any, which you would have paid if you had not taken the leave. Additional information is available through your Benefits Representative.

B. NEW ENROLLEE TRANSITION OF CARE

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

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

C. RENEWAL PROVISIONS

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

IV. YOUR CIGNA DENTAL COVERAGE

Cigna Dental maintains its principal place of business at 400 North Brand Boulevard, Suite 400, Glendale, CA 91203, with a telephone number of 1.800.Cigna24.

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

A. CUSTOMER SERVICE

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

B. PREPAYMENT FEES

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

C. OTHER CHARGES - COPAYMENTS

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

Your Patient Charge Schedule lists the dental procedures covered under your Dental Plan, subject to plan exclusions and limitations. Some dental procedures are covered at no charge to you. For other Covered Services, the Patient Charge Schedule lists the Copayments you must pay when you visit your Dental Office. There are no deductibles and no annual dollar limits for services covered by your Dental Plan.

Your Network General Dentist is instructed to tell you about Copayments for Covered Services, the amount you must pay for optional or non-Covered Services and the Dental Office's payment policies. Timely payment is important. It is possible that the Dental Office may add late charges to overdue balances.

IMPORTANT: If you opt to receive dental services that are not covered services under this plan, a participating dental dentist may charge you his or her usual and customary rate for those services. Prior to providing a patient with dental services that are not a covered benefit, the dentist should provide to the patient a treatment plan that includes each anticipated service to be provided and the estimated cost of each service. If you would like more information about dental coverage options, you may call customer services at 1-800-Cigna24 or your insurance broker. To fully understand your coverage, you may wish to carefully review this evidence of coverage document.

Your Patient Charge Schedule is subject to change in accordance with your Group Contract. Cigna Dental will give written notice to your Group of any change in Copayments at least 30 days prior to such change. You will be responsible for the Copayments listed on the Patient Charge Schedule that is in effect on the date a procedure is started.

D. FACILITIES- CHOICE OF DENTIST

1. In General

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

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

If for any reason your selected Dental Office cannot provide your dental care, or if your Network General Dentist terminates from the network, Cigna Dental will let you know and will arrange a transfer to another Dental Office. Refer to the section titled "Office Transfers" if you wish to change your Dental Office.

To obtain a list of Dental Offices near you, visit our website at my.cigna.com, or call the Dental Office Locator at 1.800.Cigna24. It is available 24 hours a day, 7 days per week. If you would like to have the list faxed to you,

enter your fax number, including your area code. You may always obtain a current Dental Office Directory by calling Customer Service.

2. Appointments

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

3. Office Transfers

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

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

There is no charge to you for the transfer; however, all Copayments which you owe to your current Dental Office must be paid before the transfer can be processed. Copayments for procedures not completed at the time of transfer may be required to be prorated between your current Dental Office and the new Dental Office, but will not exceed the amount listed on your Patient Charge Schedule.

E. YOUR PAYMENT RESPONSIBILITY (General Care)

For Covered Services at your Dental Office, you will be charged the Copayments listed on your Patient Charge Schedule, subject to applicable exclusions and limitations. For services listed on your Patient Charge Schedule provided at any other dental office, you may be charged Usual Fees. For non-Covered Services, you are responsible for paying Usual Fees.

If, on a temporary basis, there is no Network General Dentist available in the Service Area to treat you, Cigna Dental will let you know and you may obtain Covered Services from a non-Network Dentist. You will pay the non-Network Dentist the applicable Copayment for Covered Services. Cigna Dental will pay the non-Network Dentist the difference between his or her Usual Fee and the applicable Copayment. If you seek treatment for Covered Services from a non-Network Dentist without authorization from Cigna Dental, you will be responsible for paying the non-Network Dentist his or her Usual Fee.

See Section IV.G, Specialty Referrals, regarding payment responsibility for specialty care.

All contracts between Cigna Dental and Network Dentists state that you will not be liable to the Network Dentist for any sums owed to the Network Dentist by Cigna Dental.

F. SPECIALTY CARE

Your Network General Dentist at your Dental Office has primary responsibility for your professional dental care. Because you may need specialty care, the Cigna Dental Network includes the following types of specialty dentists:

- Pediatric Dentists - children's dentistry.
- Endodontists - root canal treatment.
- Periodontists - treatment of gums and bone.
- Oral Surgeons - complex extractions and other surgical procedures.
- Orthodontists - tooth movement.

When specialty care is needed, your Network General Dentist must start the referral process. X-rays taken by your Network General Dentist should be sent to the Network Specialty Dentist. Except for Pediatrics, Orthodontics and Endodontic services, payment authorization is required for coverage of services by a Network Specialty Dentist.

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

G. SPECIALTY REFERRALS

1. IN GENERAL

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

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

When Cigna Dental authorizes payment to the Network Specialty Dentist, the fees or no-charge services listed on the Patient Charge Schedule in effect on the date each procedure is started will apply, except as set out in Section V.A.7, Orthodontics.

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

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

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

After the Network Specialty Dentist has completed treatment, you should return to your Network General Dentist for cleanings, regular checkups and other treatment. If you visit a Network Specialty Dentist without a referral or if you continue to see a Network Specialty Dentist after you have completed specialty care, it will be your responsibility to pay for treatment at the dentist's Usual Fees.

When your Network General Dentist determines that you need specialty care and a Network Specialty Dentist is not available, as determined by Cigna Dental, Cigna Dental will authorize a referral to a non-Network Specialty Dentist. The referral procedures applicable to specialty care will apply. In such cases, you will be responsible for the applicable Copayment for Covered Services. Cigna Dental will reimburse the non-Network Dentist the difference between his or her Usual Fee and the applicable Copayment. For non-Covered Services or services not authorized for payment, including Adverse Determinations, you must pay the dentist's Usual Fee. Or, if you seek treatment for Covered Services from a non-Network Dentist without authorization from Cigna Dental, you will be responsible for paying the dentist's Usual Fee.

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

2. SECOND OPINIONS

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

V. COVERED DENTAL SERVICES

A. CATEGORIES OF COVERED SERVICES

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

1. DIAGNOSTIC/PREVENTIVE

Diagnostic treatment consists of the evaluation of a patient's dental needs based upon observation, examination, x-rays and other tests. Preventive dentistry involves the education and treatment devoted to and concerned with preventing the development of dental disease. Preventive Services includes dental cleanings, oral hygiene instructions to promote good home care and prevent dental disease, and fluoride application for children to strengthen teeth.

a. Limitation

The frequency of certain Covered Services, like cleanings, is limited. Your Patient Charge Schedule lists any limitations on frequency. If your Network Dentist certifies

to Cigna Dental that, due to medical necessity you require certain Covered Services more frequently than the limitation allows, Cigna Dental will waive the limitation.

2. RESTORATIVE (Fillings)

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

3. CROWN AND BRIDGE

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

a. Complex Rehabilitation/Multiple Crown Units

Complex rehabilitation is extensive dental restoration involving 6 or more "units" of crown, bridge and/or implant supported prosthesis (including crowns and bridges) in the same treatment plan. Using full crowns (caps), fixed bridges and/or implant supported prosthesis (including crowns and bridges) which are cemented in place, your Network General Dentist will rebuild natural teeth, fill in spaces where teeth are missing and establish conditions which allow each tooth to function in harmony with the occlusion (bite). The extensive procedures involved in complex rehabilitation require an extraordinary amount of time, effort, skill and laboratory collaboration for a successful outcome.

Complex rehabilitation will be covered when performed by your Network General Dentist after consultation with you about diagnosis, treatment plan and charges. Each tooth or tooth replacement included in the treatment plan is referred to as a "unit" on your Patient Charge Schedule. The crown, bridge and/or implant supported prosthesis (including crowns and bridges) charges on your Patient Charge Schedule are for each unit of crown or bridge. You pay the per unit copayment for each unit of crown, bridge and/or implant supported prosthesis (including crowns and bridges) PLUS an additional charge for complex rehabilitation for each unit beginning with the 6th unit when 6 or more units are prescribed in your Network General Dentist's treatment plan. The additional charge for complex rehabilitation will not be applied to the first 5 units of crown or bridge.

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

b. Limitations

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

c. Exclusion

- (1) there is no coverage for crowns, bridges used solely for splinting. This exclusion will not apply if a crown or bridge is determined by Cigna Dental to be the treatment most consistent with professionally accepted standards of care.
- (2) there is no coverage for implant supported prosthesis used solely for splinting unless specifically listed on your Patient Charge Schedule.
- (3) there is no coverage for resin bonded retainers and associated pontics.
- (4) there is no coverage for the recementation of any inlay, onlay, crown, post and core, 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.
- (5) the recementation of any implant supported prosthesis (including crowns, bridges and dentures) within 180 days of initial placement. Cigna Dental considers recementation within this timeframe to be incidental to and part of the charges for the initial restoration unless specifically listed on your Patient Charge Schedule.

4. ENDODONTICS

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

Exclusions

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

5. PERIODONTICS

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

a. Preliminary Consultation

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

b. Evaluation, Diagnosis and Treatment Plan

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

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

- (1) **Non-surgical Program-** this is a conservative approach to periodontal therapy. Use of this program depends upon how quickly you heal and how consistently you follow instructions for home care. This program may include:
 - scaling and root planning
 - oral hygiene instruction
 - full mouth debridement
- (2) **Scaling and Root Planning-** this periodontal therapy procedure combines scaling of the crown and root surface with root planning to smooth rough areas of the root. This procedure may be performed by the dental hygienist or your Network General Dentist.
- (3) **Osseous Surgery-** bone (osseous) surgery is a procedure used in advanced cases of periodontal disease to restructure the supporting gums and bone. Without this surgery, tooth or bone loss may occur. Two checkups by the Periodontist are covered within the year after osseous surgery.
- (4) **Occlusal Adjustment-** occlusal adjustment requires the study of the contours of the teeth, how they bite (occlude) and their position in the arch. It consists of a recontouring of biting surfaces so that direct biting forces are along the long axis of the tooth. If the biting forces are not properly distributed, the bone which supports the teeth may deteriorate.
- (5) **Bone Grafts and other regenerative procedures-** this procedure involves placing a piece of tissue or synthetic material in contact with tissue to repair a

defect or supplement a deficiency.

c. Limitations

1. Periodontal regenerative procedures are limited to one regenerative procedure per site (or per tooth, if applicable), when covered on the Patient Charge Schedule.
2. Localized delivery of antimicrobial agents is limited to eight teeth (or eight sites, if applicable) per 12 consecutive months, when covered on the Patient Charge Schedule.

d. Exclusions

1. General anesthesia, sedation and nitrous oxide are not covered, unless specifically listed on your Patient Charge Schedule. When listed on your Patient Charge Schedule, IV sedation is covered when medically necessary and provided in conjunction with Covered Services performed by a Periodontist. General anesthesia is not covered when provided by a Periodontist. There is no coverage for general anesthesia or intravenous sedation when used for the purposes of anxiety control or patient management.
2. There is no coverage for Periodontal (gum tissue and supporting bone) surgery of teeth exhibiting a poor or hopeless periodontal prognosis.
3. There is no coverage for the replacement of an occlusal guard (night guard) beyond one per any 24 consecutive month period, when this limitation is noted on the Patient Charge Schedule.
4. There is no coverage for bone grafting and/or guided tissue regeneration when performed at the site of a tooth extraction, unless specifically listed on your Patient Charge Schedule.
5. There is no coverage for bone grafting and/or guided tissue regeneration when performed in conjunction with an apicoectomy or periradicular surgery.
6. There is no coverage for localized delivery of antimicrobial agents when performed alone or in the absence of traditional periodontal therapy.

6. ORAL SURGERY

Oral surgery involves the surgical removal of teeth or associated surgical procedures by your Network General Dentist or Network Specialty Dentist.

a. Limitation

The surgical removal of a wisdom tooth may not be covered if the tooth is not diseased or if the removal is only for orthodontic reasons. Temporary pain from normal eruption is not considered disease. Your Patient Charge Schedule lists any limitations on oral surgery.

b. Exclusion

General anesthesia, sedation and nitrous oxide are not covered unless specifically listed on your Patient Charge Schedule. When listed on your Patient Charge Schedule, general anesthesia and IV sedation are covered when medically necessary and provided in conjunction with Covered Services performed by an Oral Surgeon. There is no coverage for general anesthesia or intravenous sedation when used for the purposes of anxiety control or patient management.

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

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

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

b. Copayments

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

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

c. Additional Charges

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

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

d. Orthodontics in Progress

If orthodontic treatment is in progress for you or your Dependent at the time you enroll, call Customer Service at [1.800.Cigna24] to find out the benefit to which you are entitled based upon your individual case and the remaining months of treatment.

e. Exclusion

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

B. EMERGENCY DENTAL CARE - REIMBURSEMENT

An emergency is a dental condition of recent onset and severity which would lead a prudent layperson possessing an average knowledge of dentistry to believe the condition needs immediate dental procedures necessary to control excessive bleeding, relieve severe pain, or eliminate acute infection. Emergency dental care services may include examination, x-rays, sedative fillings, dispensing of antibiotics or pain relief medication or other palliative services prescribed by the treating dentist. You should contact your Network General Dentist if you have an emergency in your Service Area.

1. Emergency Care Away From Home

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

Cigna Dental at the address listed for your state on the front of this booklet.

2. Emergency Care After Hours

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

VI. EXCLUSIONS

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

- services not listed on the Patient Charge Schedule.
- services provided by a non-Network Dentist without Cigna Dental's prior approval (except emergencies, as described in Section V.B.).
- services to the extent you, or your Dependent, are compensated for them under any group medical plan.
- services considered to be unnecessary or experimental in nature or do not meet commonly accepted dental standards..
- surgical placement of a dental implant; repair, maintenance, or removal of a dental implant; implant abutment(s); or any services related to the surgical placement of a dental implant, unless specifically listed on your Patient Charge Schedule.
- cosmetic dentistry or cosmetic dental surgery (dentistry or dental surgery performed solely to improve appearance) unless specifically listed on your Patient Charge Schedule. If bleaching (tooth whitening) is listed on your Patient Charge Schedule, only the use of take-home bleaching gel with trays is covered; all other types of bleaching methods are not covered.
- prescription medications.
- hospitalization, including any associated incremental charges for dental services performed in a hospital. (Benefits are available for Network Dentist charges for Covered Services performed at a hospital. Other associated charges are not covered and should be submitted to the medical carrier for benefit determination. If special circumstances arise where a Network Dentist is not available, the Plan will make special arrangements for the provision of covered benefits as necessary for the dental health of the customer.)
- procedures, appliances or restorations if the main purpose is to:
(1) change vertical dimension (degree of separation of the jaw when teeth are in contact); (2) restore asymptomatic teeth where loss of

tooth structure was caused by attrition, abrasion, erosion and/or abfraction and the primary purpose of the restoration is (a) to change the vertical dimension of occlusion; or (b) for cosmetic purposes.

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

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

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

- the recementation of any inlay, onlay, crown, post and core or fixed bridge within 180 days of initial placement. Cigna Dental considers recementation within this timeframe to be incidental to and part of the charges for the initial restoration.
- the recementation of any implant supported prosthesis (including crowns, bridges and dentures) within 180 days of initial placement. Cigna Dental considers recementation within this timeframe to be incidental to and part of the charges for the initial restoration unless specifically listed on your Patient Charge Schedule.
- the replacement of an occlusal guard (night guard) beyond one per any 24 consecutive month period., when this limitation is noted on the Patient Charge Schedule.
- intentional root canal treatment in the absence of injury or disease to solely facilitate a restorative procedure.
- bone grafting and/or guided tissue regeneration when performed at the site of a tooth extraction, unless specifically listed on your Patient Charge Schedule.
- bone grafting and/or guided tissue regeneration when performed in conjunction with an apicoectomy or periradicular surgery.
- localized delivery of antimicrobial agents when performed alone or in the absence of traditional periodontal therapy.

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

VII. LIMITATIONS

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

- 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 run by the United States Government or by a state or municipal government if the person had no insurance;
- to the extent that payment is unlawful where the person resides when the expenses are incurred or the services are received;
- for the charges which the person is not legally required to pay;
- for charges which would not have been made of the person had no insurance;

□ due to injuries which are intentionally self-inflicted.

In addition to the above the following limitations will also apply.

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

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

VIII. WHAT TO DO IF THERE IS A PROBLEM/GRIEVANCES

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

Most problems can be resolved between you and your dentist. However, we want you to be completely satisfied with the Dental Plan. That is why we have established a process for addressing your concerns and complaints. The complaint procedure is voluntary and will be used only upon your request. No Plan employee shall retaliate or discriminate against a customer (including seeking disenrollment of the customer) solely on the basis that the customer filed a grievance. Instances of such retaliation or discrimination shall be grounds for disciplinary action, (including termination) against the employee.

A. YOUR RIGHTS TO FILE GRIEVANCES WITH CIGNA DENTAL

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

Grievances include both complaints and appeals. Complaints may include concerns about people, quality of service, quality of care, benefit interpretations or eligibility. Appeals are

requests to reverse a prior denial or modified decision about your care. You may contact us by telephone or in writing with a grievance.

B. HOW TO FILE A GRIEVANCE

To contact us by phone, call us toll-free at 1.800.Cigna24 or the toll-free telephone number on your CIGNA identification card. The hearing impaired may call the state TTY toll-free service listed in their local telephone directory.

Send written grievances to:

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

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

You may also submit a grievance online through the following CIGNA website:

<http://my.cigna.com/health/consumer/medical/state/ca.html#dental>.

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

1. Complaints

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

2. Appeals

If your grievance does not involve a complaint about the quality of service or care, a benefit interpretation or an eligibility issue, but instead involves dissatisfaction with the outcome of a decision that was made about your care and you want to request Cigna Dental to reverse the

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

C. YOU HAVE ADDITIONAL RIGHTS UNDER STATE LAW

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

The California Department of Managed Health Care is responsible for regulating health care service plans. If you have a grievance against your health plan, you should first telephone your health plan at 1.800.Cigna24 and use your health plan's grievance process before contacting the department. Utilizing this grievance procedure does not prohibit any potential legal rights or remedies that may be available to you. If you need help with a grievance involving an emergency, a grievance that has not been satisfactorily resolved by your health plan, or a grievance that has remained unresolved for more than 30 days, you may call the department for assistance. You may also be eligible for an Independent Medical Review (IMR). If you are eligible for IMR, the IMR process will provide an impartial review of medical decisions made by a health plan related to the medical necessity of a proposed service or treatment, coverage decisions for treatments that are experimental or investigational in nature and payment disputes for emergency or urgent medical services. The department also has a toll-free telephone number (1-888-HMO-2219) and a TDD line (1-877-688-9891) for the hearing and speech impaired. The department's Internet Web site <http://www.hmohelp.ca.gov> has complaint forms, IMR application forms and instructions online.

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

D. VOLUNTARY MEDIATION

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

For more specific information regarding these grievance procedures, please contact our Customer Service Department.

IX. COORDINATION OF BENEFITS

Coordination of benefit rules explain the payment process when you are covered by more than one dental plan. You and your Dependents may not be covered twice under this Dental Plan. If you and your spouse have enrolled each other or the same Dependents twice, please contact your Benefit Administrator.

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

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

- A.** A customer may be covered as an employee by his/her employer and as a dependent by his/her spouse's employer. The plan that covers the Customer as an employee (the policyholder) is the primary plan.
- B.** Under most circumstances, if a child is covered as a dependent under both parents' coverage (and parents are not separated or

divorced), the plan of the parent with the earliest birthday in the year is the primary plan.

- C.** If a child of divorced or separated parents is covered as a dependent under at least one of the parents' (or stepparents') coverage, benefits are determined in the following order:
1. According to a court decree that designates the person financially responsible for the dental care coverage; or without such decree,
 2. The plan of the parent who has custody of the child;
 3. If the parent with custody of the child is remarried, then the stepparent's plan; and finally,
 4. The plan of the parent without custody of the child.
- D.** The benefits of a plan that covers an active employee (and any dependents) are determined before those of a program which covers an inactive employee (laid-off or retired). However, if one of the plans does not have a provision regarding retired or laid-off employees, this section may not apply. Please contact the Plan at the number below for further instruction.
- E.** If a Customer is covered under a continuation plan (e.g. COBRA) AND has coverage under another plan, the following determines the order of benefits:
1. The plan that covers the customer as an employee (or dependent of employee) will be primary;
 2. The continuation plan will be secondary.
- However, if the plan that covers the person as an employee does not follow these guidelines and the plans disagree about the order of determining benefits, then this rule may be ignored. Please contact Cigna Dental at the number below for further instructions.
- F.** If none of the above rules determines the order of benefits, the plan that has been in effect longer is the primary plan. To determine which plan has been in effect longer, we will take into consideration the coverage you had previously with the same employer, even if it was a different plan, as long as there was no drop in eligibility during the transition between plans.
- G.** WORKERS' COMPENSATION - Should any benefit or service rendered result from a Workers' Compensation Injury Claim, the Customer shall assign his/her right to reimbursement from other sources to Cigna Dental or to the Participating Dentist who rendered the service.
- H.** When Cigna Dental is primary, we will provide or pay dental benefits without considering any other plan's benefits. When Cigna Dental is secondary, we shall pay the lesser of either the amount that we would have paid in the absence of any other dental coverage, or your total out of pocket cost payable under the primary dental plan for benefits covered by Cigna Dental.

- I. Please call Cigna Dental at 1.800.Cigna24 if you have questions about which plan will act as your primary plan or if you have other questions about coordination of benefits.

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

X. DISENROLLMENT FROM THE DENTAL PLAN - TERMINATION OF BENEFITS

Except for extensions of coverage as otherwise provided in the sections titled " Extension/Continuation of Benefits " or in your Group Contract, disenrollment from the Dental Plan/termination of benefits and coverages will be as follows:

A. FOR THE GROUP

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

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

B. FOR YOU AND YOUR ENROLLED DEPENDENTS

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

1. failure to pay the charge for coverage if you have been notified and billed for the charge and at least 15 days have elapsed since the date of notification.
2. fraud or deception in the use of services or Dental Offices or knowingly permitting such fraud or deception by another.

C. TERMINATION EFFECTIVE DATE

The effective date of the termination shall be as follows:

1. Cigna Dental shall provide written notice of non-receipt of payment on or before the twelfth (12th) day of the month following the month for which Premiums/Prepayment Fees remain due and owing. The Group shall have an additional thirty-one (31) days for the payment of any Premium/Prepayment Fee. The Contract shall remain in full force and effect during this Grace Period. If the Premium/Prepayment Fees are not remitted by the end of the Grace Period, the Contract will terminate on the last day of the Grace Period.
2. in the case of failure to meet eligibility requirements

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

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

D. EFFECT ON DEPENDENTS

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

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

E. RIGHT TO REVIEW

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

F. NOTICE OF TERMINATION

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

1. the cause for termination, with specific reference to the applicable provision of the Group Contract or Plan Booklet;
2. the cause for termination was not the Subscriber's or a Customer's health status or requirements for health care services;
3. the time the termination is effective;
4. the fact that a Subscriber or Customer alleging that the termination was based on health status or requirements for health care services may request a review of the termination by the Director of the California Department of Managed HealthCare;
5. in instances of termination of the Group Contract for non-payment of fees, that receipt by the Dental Plan of any such past due fees within 15 days following receipt of notice of termination will reinstate the Group Contract as though it had never been terminated; if payment is not made within such 15 day period a new application will be required and the Dental Plan shall refund such payment within 20 business days;
6. any applicable rights you may have under the "Continuation of Benefits" Section.

XI. CONTINUITY OF CARE

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

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

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

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

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

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

XII. CONTINUATION OF BENEFITS (COBRA)

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

XIII. INDIVIDUAL CONTINUATION OF BENEFITS

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

- permanent breakdown of the dentist-patient relationship,
- fraud or misuse of dental services and/or Dental Offices,
- nonpayment of Prepayment Fees by the Subscriber,
- selection of alternate dental coverage by your Group, or
- lack of network/service area.

Benefits and rates for Cigna Dental conversion coverage and any succeeding renewals will be based on the Covered Services listed in the then-current standard conversion plan and may not be the same as those for your Group's Dental Plan. Please call the Cigna Dental Conversion Department at [1.800.Cigna24] to obtain current rates and make arrangements for continuing coverage.

XIV. CONFIDENTIALITY/PRIVACY

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

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

XV. MISCELLANEOUS

A. PROGRAMS PROMOTING GENERAL HEALTH

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

As a Cigna Dental plan customer, you may also be eligible for additional dental benefits during certain episodes of care. For example, certain frequency limitations for dental services may be relaxed for [pregnant women] [for other medical conditions]. Please review your plan enrollment materials for details.

B. ORGAN AND TISSUE DONATION

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

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

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

C. 911 EMERGENCY RESPONSE SYSTEM

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

CALIFORNIA LANGUAGE ASSISTANCE PROGRAM NOTICE

IMPORTANT INFORMATION ABOUT FREE LANGUAGE ASSISTANCE

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

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

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

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

INFORMACIÓN IMPORTANTE SOBRE LA ASISTENCIA GRATUITA CON EL IDIOMA

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

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

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

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

有關免費語言協助的重要訊息

如果您的英語說話或閱讀能力有限，您有權可免費取得下列服務：

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

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

我們十分樂意用您熟悉且能清楚瞭解的語言來協助您。

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

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

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

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

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

無料言語支援サービスに関する重要情報

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

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

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

お客様のご希望の言語で、サービスをご提供いたします。

무료 통번역 서비스에 대한 중요 정보 사항

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

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

Cigna Dental Companies

Cigna Dental Health Plan of Arizona, Inc.
Cigna Dental Health of Colorado, Inc.
Cigna Dental Health of Florida, Inc. (a Prepaid Limited Health Services
Organization licensed under Chapter 636, Florida Statutes)
P.O. Box 453099
Sunrise, Florida 33345-3099

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

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

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

READ YOUR PLAN BOOKLET CAREFULLY

Please call Customer Service at [1.800.Cigna24] if you have any questions. The hearing impaired may call the state TTY toll-free relay service listed in their local telephone directory.

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

I. DEFINITIONS

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

Adverse Determination - a decision by Cigna Dental not to authorize payment for certain limited specialty care procedures on the basis of necessity or appropriateness of care. To be considered clinically necessary, the treatment or service must be reasonable and appropriate and meet the following requirements:

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

Requests for payment authorizations that are declined by Cigna Dental based upon the above criteria will be the responsibility of the customer at the dentist's Usual Fees. A licensed dentist will make any such denial.

Cigna Dental - the Cigna Dental Health organization that provides dental benefits in your state as listed on the face page of this booklet.

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

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

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

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

Dependent - your lawful spouse or your domestic partner;

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

- (a) less than 19 years old; or
- (b) less than 23 years old if he or she is both:
 - i. a full-time student enrolled at an accredited educational institution, and
 - ii. reliant upon you for maintenance and support; or
- (c) any age if he or she is both:
 - i. incapable of self-sustaining employment due to mental or physical disability, and

- ii. reliant upon you for maintenance and support.

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

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

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

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

The following definition of Domestic Partner applies:

A. A person of the same or opposite sex who:

1. shares your permanent residence;
2. has resided with you for no less than one year;
3. is no less than eighteen years of age;
4. is financially interdependent with you and has proven such interdependence by providing documentation of at least two of the following arrangements: common ownership of real property or a common leasehold interest in such property, common ownership of a motor vehicle, a joint bank account or a joint credit account, designation as a beneficiary for life insurance or retirement benefits or under your partner's will, assignment of durable power of attorney or health care power of attorney, or such other proof as is considered by Cigna Dental Health to be sufficient to establish financial interdependency under the circumstances of your particular case;
5. is not your blood relative any closer than would be prohibited for a legal marriage; and
6. has signed jointly with you a notarized affidavit in form and content satisfactory to Cigna Dental Health which shall be made available to Cigna Dental Health upon request; or

B. A person of the same or opposite sex who has registered jointly with you as Domestic Partners with a governmental entity pursuant to a state or local law authorizing such registration and signed jointly with you a notarized affidavit of such registration which can be made available to Cigna Dental Health upon request.

The above definition applies so long as neither you nor your Domestic Partner hereunder:

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

Domestic Partner coverage cannot be transferred to states in which such coverage has been disapproved by regulatory authorities.

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

Network Dentist - a licensed dentist who has signed an agreement with Cigna Dental to provide general dentistry or specialty care services to you. The term, when used, includes both Network General Dentists and Network Specialty Dentists.

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

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

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

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

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

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

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

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

II. INTRODUCTION TO YOUR CIGNA DENTAL PLAN

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

III. ELIGIBILITY/WHEN COVERAGE BEGINS

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

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

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

If you have family coverage, a newborn child is automatically covered during the first 31 days of life. If you wish to continue coverage beyond the first 31 days, your baby must be enrolled in the Dental Plan and you must begin paying Premiums, if any additional are due, during that period.

Under the Family and Medical Leave Act of 1993, you may be eligible to continue coverage during certain leaves of absence from work. During such leaves, you will be responsible for paying your Group the portion of the Premiums, if any, which you would have paid if you had not taken the leave. Additional information is available through your Benefits Representative.

IV. YOUR CIGNA DENTAL COVERAGE

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

A. CUSTOMER SERVICE

If you have any questions or concerns about the Dental Plan, Customer Service Representatives are just a toll-free phone call away. They can explain your benefits or help with matters regarding your Dental Office or Dental Plan. For assistance with transfers, specialty referrals, eligibility, second opinions, emergencies, Covered Services, plan benefits, ID cards, location of Dental Offices, conversion coverage or other matters, call Customer Service from any location at [1.800.Cigna24]. The

hearing impaired may contact the state TTY toll-free relay service number listed in their local telephone directory.

B. PREMIUMS

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

C. OTHER CHARGES - PATIENT CHARGES

Network General Dentists are typically reimbursed by Cigna Dental through fixed monthly payments and supplemental payments for certain procedures. No bonuses or financial incentives are used as an inducement to limit services. Network Dentists are also compensated by the fees which you pay, as set out in your Patient Charge Schedule.

Your Patient Charge Schedule lists the dental procedures covered under your Dental Plan. Some dental procedures are covered at no charge to you. For other Covered Services, the Patient Charge Schedule lists the fees you must pay when you visit your Dental Office. There are no deductibles and no annual dollar limits for services covered by your Dental Plan.

Your Network General Dentist should tell you about Patient Charges for Covered Services, the amount you must pay for non-Covered Services and the Dental Office's payment policies. Timely payment is important. It is possible that the Dental Office may add late charges to overdue balances.

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

D. CHOICE OF DENTIST

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

You may select a network Pediatric Dentist as the Network General Dentist for your dependent child under age 7 by calling Customer Service at [1.800.Cigna24] to get a list of network Pediatric Dentists in your Service Area or if your Network General Dentist sends your child under the age of 7 to a network Pediatric Dentist, the network Pediatric Dentist's office will have primary responsibility for your child's care. For children 7 years and

older, your Network General Dentist will provide care. If your child continues to visit the Pediatric Dentist upon the age of 7, you will be fully responsible for the Pediatric Dentist's Usual Fees. Exceptions for medical reasons may be considered on a case-by-case basis.

If for any reason your selected Dental Office cannot provide your dental care, or if your Network General Dentist terminates from the network, Cigna Dental will let you know and will arrange a transfer to another Dental Office. Refer to the Section titled "Office Transfers" if you wish to change your Dental Office.

To obtain a list of Dental Offices near you, visit our website at my.cigna.com, or call the Dental Office Locator at [1.800.Cigna24]. It is available 24 hours a day, 7 days per week. If you would like to have the list faxed to you, enter your fax number, including your area code. You may always obtain a current Dental Office Directory by calling Customer Service.

E. YOUR PAYMENT RESPONSIBILITY (General Care)

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

If, on a temporary basis, there is no Network General Dentist in your Service Area, Cigna Dental will let you know and you may obtain Covered Services from a non-Network Dentist. You will pay the non-Network Dentist the applicable Patient Charge for Covered Services. Cigna Dental will pay the non-Network Dentist the difference, if any, between his or her Usual Fee and the applicable Patient Charge.

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

All contracts between Cigna Dental and Network Dentists state that you will not be liable to the Network Dentist for any sums owed to the Network Dentist by Cigna Dental.

F. EMERGENCY DENTAL CARE - REIMBURSEMENT

An emergency is a dental condition of recent onset and severity which would lead a prudent layperson possessing an average knowledge of dentistry to believe the condition needs immediate dental procedures necessary to control excessive bleeding, relieve severe pain, or eliminate acute infection. You should contact your Network General Dentist if you have an emergency in your Service Area.

1. Emergency Care Away From Home

If you have an emergency while you are out of your Service Area or you are unable to contact your Network General Dentist, you may receive emergency Covered Services as

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

2. Emergency Care After Hours

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

G. LIMITATIONS ON COVERED SERVICES

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

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

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

- **Clinical Oral Evaluations** - When this limitation is noted on the Patient Charge Schedule, periodic oral evaluations, comprehensive oral evaluations, comprehensive periodontal evaluations, and oral evaluations for patients under 3 years of age, are limited to a combined total of 4 evaluations during a 12 consecutive month period.

- **Surgical Placement of Implant Services** - When covered on the Patient Charge Schedule, surgical placement of a dental implant; repair, maintenance, or removal of a dental implant; implant abutment(s); or any services related to the surgical placement of a dental implant are limited to one per year with replacement of a surgical implant frequency limitation of one every 10 years.
- **Prosthesis Over Implant** - When covered on the Patient Charge Schedule, a prosthetic device, supported by an implant or implant abutment is considered a separate distinct service(s) from surgical placement of an implant. Replacement of any type of prosthesis with a prosthesis supported by an implant or implant abutment is only covered if the existing prosthesis is at least 5 calendar years old, is not serviceable and cannot be repaired.

GENERAL LIMITATIONS DENTAL BENEFITS

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

H. SERVICES NOT COVERED UNDER YOUR DENTAL PLAN

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

- services not listed on the Patient Charge Schedule.
- services provided by a non-Network Dentist without Cigna Dental's prior approval (except emergencies, as described in Section IV.F).
- services related to an injury or illness paid under workers' compensation, occupational disease or similar laws.
- services provided or paid by or through a federal or state governmental agency or authority, political subdivision or a public program, other than Medicaid.

- services required while serving in the armed forces of any country or international authority or relating to a declared or undeclared war or acts of war.
- cosmetic dentistry or cosmetic dental surgery (dentistry or dental surgery performed solely to improve appearance) unless specifically listed on your Patient Charge Schedule. If bleaching (tooth whitening) is listed on your Patient Charge Schedule, only the use of take-home bleaching gel with trays is covered; all other types of bleaching methods are not covered.
- general anesthesia, sedation and nitrous oxide, unless specifically listed on your Patient Charge Schedule. When listed on your Patient Charge Schedule, general anesthesia and IV sedation are covered when medically necessary and provided in conjunction with Covered Services performed by an Oral Surgeon or Periodontist. (Maryland residents: General anesthesia is covered when medically necessary and authorized by your physician.) There is no coverage for general anesthesia or intravenous sedation when used for the purposes of anxiety control or patient management.
- prescription medications.
- procedures, appliances or restorations if the main purpose is to: a. change vertical dimension (degree of separation of the jaw when teeth are in contact); b. restore teeth which have been damaged by attrition, abrasion, erosion and/or abfraction.
- replacement of fixed and/or removable appliances (including fixed and removable orthodontic appliances) that have been lost, stolen, or damaged due to patient abuse, misuse or neglect.
- Surgical placement of a dental implant; repair, maintenance, or removal of a dental implant; implant abutment(s); or any services related to the surgical placement of a dental implant, unless specifically listed on your Patient Charge Schedule.
- services considered to be unnecessary or experimental in nature or do not meet commonly accepted dental standards..
- procedures or appliances for minor tooth guidance or to control harmful habits.
- hospitalization, including any associated incremental charges for dental services performed in a hospital. (Benefits are available for Network Dentist charges for Covered Services performed at a hospital. Other associated charges are not covered and should be submitted to the

medical carrier for benefit determination.)

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

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

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

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

V. APPOINTMENTS

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

VI. BROKEN APPOINTMENTS

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

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

VII. OFFICE TRANSFERS

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

website at my.cigna.com, or call the Dental Office Locator at [1.800.Cigna24].

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

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

VIII. SPECIALTY CARE

Your Network General Dentist at your Dental Office has primary responsibility for your professional dental care. Because you may need specialty care, the Cigna Dental Network includes the following types of specialty dentists:

- Pediatric Dentists - children's dentistry.
- Endodontists - root canal treatment.
- Periodontists - treatment of gums and bone.
- Oral Surgeons - complex extractions and other surgical procedures.
- Orthodontists - tooth movement.

There is no coverage for referrals to prosthodontists or other specialty dentists not listed above.

When specialty care is needed, your Network General Dentist must start the referral process. X-rays taken by your Network General Dentist should be sent to the Network Specialty Dentist.

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

IX. SPECIALTY REFERRALS

A. IN GENERAL

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

When Cigna Dental authorizes payment to the Network Specialty Dentist, the fees or no-charge services listed on the Patient Charge Schedule in effect on the date each procedure is started will apply, except as set out in Section IX.B., Orthodontics. Treatment by the Network Specialty Dentist must begin within 90 days from the date of Cigna Dental's authorization. If you are unable to obtain treatment within the 90 day period, please call

Customer Service to request an extension. Your coverage must be in effect when each procedure begins.

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

After the Network Specialty Dentist has completed treatment, you should return to your Network General Dentist for cleanings, regular checkups and other treatment. If you visit a Network Specialty Dentist without a referral or if you continue to see a Network Specialty Dentist after you have completed specialty care, it will be your responsibility to pay for treatment at the dentist's Usual Fees.

When your Network General Dentist determines that you need specialty care and a Network Specialty Dentist is not available, as determined by Cigna Dental, Cigna Dental will authorize a referral to a non-Network Specialty Dentist. The referral procedures applicable to specialty care will apply. In such cases, you will be responsible for the applicable Patient Charge for Covered Services. Cigna Dental will reimburse the non-Network Dentist the difference, if any, between his or her Usual Fee and the applicable Patient Charge. For non-Covered Services or services not authorized for payment, including Adverse Determinations, you must pay the dentist's Usual Fee.

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

1. **Definitions** - If your Patient Charge Schedule indicates coverage for orthodontic treatment, the following definitions apply:
 - a. **Orthodontic Treatment Plan and Records** - the preparation of orthodontic records and a treatment plan by the Orthodontist.
 - b. **Interceptive Orthodontic Treatment** - treatment prior to full eruption of the permanent teeth, frequently a firstphase preceding comprehensive treatment.
 - c. **Comprehensive Orthodontic Treatment** - treatment after the eruption of most permanent teeth, generally the final phase of treatment before retention.
 - d. **Retention (Post Treatment Stabilization)** - the period following orthodontic treatment during which you may wear an appliance to maintain and stabilize the new position of the teeth.

2. **Patient Charges**

The Patient Charge for your entire orthodontic case, including retention, will be based upon the Patient Charge Schedule in effect on the date of your visit for Treatment Plan and Records. However, if a. banding/appliance insertion does not occur within 90 days of such visit, b.

your treatment plan changes, or c. there is an interruption in your coverage or treatment, a later change in the Patient Charge Schedule may apply.

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

3. Additional Charges

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

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

4. Orthodontics In Progress

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

X. COMPLEX REHABILITATION/MULTIPLE CROWN UNITS

Complex rehabilitation is extensive dental restoration involving 6 or more "units" of crown, bridge and/or implant supported prosthesis (including crowns and bridges) in the same treatment plan. Using full crowns (caps), fixed bridges and/or implant supported prosthesis (including crowns and bridges) which are cemented in place, your Network General Dentist will rebuild natural teeth, fill in spaces where teeth are missing and establish conditions which allow each tooth to function in harmony with the occlusion (bite). The extensive procedures involved in complex rehabilitation require an extraordinary amount of time, effort, skill and laboratory collaboration for a successful outcome.

Complex rehabilitation will be covered when performed by your Network General Dentist after consultation with you about diagnosis, treatment plan and charges. Each tooth or tooth replacement included in the treatment plan is referred to as a "unit" on your Patient Charge Schedule. The crown, bridge and/or implant supported prosthesis (including crowns and bridges) charges on your Patient Charge Schedule are for each unit of crown or bridge. You pay the per unit charge for each unit of crown, bridge and/or implant supported prosthesis

(including crowns and bridges) PLUS an additional charge for each unit when 6 or more units are prescribed in your Network General Dentist's treatment plan.

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

XI. WHAT TO DO IF THERE IS A PROBLEM

For the purposes of this section, any reference to " you " or " your " also refers to a representative or provider designated by you to act on your behalf. **Time frames or requirements may vary depending on the laws in your State. Consult your State Rider for further details.**

Most problems can be resolved between you and your dentist. However, we want you to be completely satisfied with the Dental Plan. That is why we have established a process for addressing your concerns and complaints. The complaint procedure is voluntary and will be used only upon your request.

A. START WITH CUSTOMER SERVICE

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

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

B. APPEALS PROCEDURE

Cigna Dental has a two-step appeals procedure for coverage decisions. To initiate an appeal, you must submit a request in writing to Cigna Dental, P.O. Box 188047, Chattanooga, TN 37422-8047, within 1 year from the date of the initial Cigna Dental decision. You should state the reason you feel your appeal should be approved and include any information to support your appeal. If you are unable or choose not to write, you may ask Customer Service to register your appeal by calling 1.800.Cigna24.

1. Level-One Appeals

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

If your appeal concerns a denied pre-authorization, we will respond with a decision within 15 calendar days after we

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

You may request that the appeal resolution be expedited if the time frames under the above process would seriously jeopardize your life or health or would jeopardize your ability to regain the dental functionality that existed prior to the onset of your current condition. A dental professional, in consultation with the treating dentist, will decide if an expedited review is necessary. When a review is expedited, Cigna Dental will respond orally with a decision within 72 hours, followed up in writing.

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

2. Level Two Appeals

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

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

You may request that the appeal resolution be expedited if the time frames under the above process would seriously jeopardize your life or health or would jeopardize your ability to regain the dental functionality that existed prior to the onset of your current condition. A dental professional, in consultation with the treating dentist, will decide if an expedited review is necessary. When a review is expedited, the Dental Plan will respond orally with a decision within 72 hours, followed up in writing.

3. Independent Review Procedure

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

4. Appeals to the State

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

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

XII. DUAL COVERAGE

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

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

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

XIII. DISENROLLMENT FROM THE DENTAL PLAN - TERMINATION OF BENEFITS

A. TIME FRAMES FOR DISENROLLMENT/TERMINATION

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

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

6. after voluntary disenrollment.

B. EFFECT ON DEPENDENTS

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

XIV. EXTENSION OF BENEFITS

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

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

XV. CONTINUATION OF BENEFITS (COBRA)

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

XVI. CONVERSION COVERAGE

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

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

Benefits and rates for Cigna Dental conversion coverage and any succeeding renewals will be based on the Covered Services listed in the then-current standard conversion plan and may not be the same as those for your Group's Dental Plan. Please call the Cigna Dental Conversion Department at [1.800.Cigna24] to obtain current rates and make arrangements for continuing coverage.

XVII. CONFIDENTIALITY/PRIVACY

Cigna Dental is committed to maintaining the confidentiality of your personal and sensitive information. Information about Cigna Dental's

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

XVIII . MISCELLANEOUS

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

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

SEE YOUR STATE RIDER FOR ADDITIONAL DETAILS.

STATE RIDER
Cigna Dental Health Plan of Arizona, Inc.

Arizona Residents:

I. DEFINITIONS

Dependent -

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

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

III. ELIGIBILITY/WHEN COVERAGE BEGINS

Employees may enroll within 31 days of becoming eligible.

If you have family coverage, a newly born child, newly adopted child, or a child newly placed in your home for adoption by you, is automatically covered during the first 31 days of life, adoption or placement. If you wish to continue coverage beyond the first 31 days, you should enroll your child in the Dental Plan and you need to begin to pay any additional Premiums during that period.

IV. YOUR CIGNA DENTAL COVERAGE

F. EMERGENCY DENTAL CARE - REIMBURSEMENT

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

H. SERVICES NOT COVERED UNDER YOUR DENTAL PLAN

The following bullet does not apply to Arizona residents.

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

XI. WHAT TO DO IF THERE IS A PROBLEM

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

B. PROBLEMS CONCERNING DENIED PREAUTHORIZATIONS OR DENIED CLAIMS FOR SERVICES ALREADY PROVIDED

If your problem concerns a specialty referral pre-authorization that is not approved for payment or a claim for services already provided that is denied by Cigna Dental, you or your designated representative may request a review as set out below by contacting Member Services, P.O. Box 188047, Chattanooga, Tennessee 37422, Telephone 1.800.CIGNA24 (244.6224).

1. Expedited Review Process (Pre-authorizations Only)

a. Expedited Review

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

b. Expedited Appeal

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

c. Expedited External Independent Review

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

2. Informal Reconsideration (Pre-authorizations Only)

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

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

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

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

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

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

Further information concerning the above Appeal Process is contained in the Appeals Information Packet. You may obtain a replacement packet by contacting Member Services at 1.800.Cigna24.

5. Appeals to the State

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

XII. DUAL COVERAGE

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

REQUIRED FORMS DIRECTORY

This Required Forms Directory is for the Cigna Dental Care Product

Section Number	Section Names	Please refer to the Table of Contents to cross-reference Section Names with the following Titles:
1.	Schedule of Benefits (Who Pays What)	Cigna Dental Care - Cigna Dental Health Plan, IV. Your Cigna Dental Coverage, E. Your Payment Responsibility
2.	Title Page (Cover Page)	Cigna Dental Care - Cigna Dental Health Plan, Please see page immediately in front of I. Definitions
3.	Contact Us	Please call the toll-free number shown on your ID card.
4.	Table of Contents	Table of Contents
5.	Eligibility	Cigna Dental Care - Cigna Dental Health Plan, III. Eligibility – When Coverage Begins
6.	How to Access Your Services and Obtain Approval of Benefits	Cigna Dental Care - Cigna Dental Health Plan, IV. Your Cigna Dental Coverage, A. Member Services; D. Choice of Dentist, VIII. Specialty Care, IX. Specialty Referrals
7.	Benefits/Coverage (What is Covered)	Cigna Dental Care - Cigna Dental Health Plan, IV. Your Cigna Dental Coverage
8.	Limitations/Exclusions (What is Not Covered and Pre-Existing Conditions)	Cigna Dental Care - Cigna Dental Health Plan, IV. Your Cigna Dental Coverage, G. Limitations on Covered Services, H. Services Not Covered Under Your Dental Plan
9.	Member Payment Responsibility	Cigna Dental Care - Cigna Dental Health Plan, IV. Your Cigna Dental Coverage, E. Your Payment Responsibility (General Care)
10.	Claims Procedure (How to File a Claim)	Cigna Dental Care - Cigna Dental Health Plan, IV. Your Cigna Dental Coverage, E. Your Payment Responsibility (General Care), F. Emergency Dental Care - Reimbursement
11.	General Policy Provisions	Cigna Dental Care - Cigna Dental Health Plan, XII. Dual Coverage
12.	Termination/Nonrenewal/Continuation	Cigna Dental Care - Cigna Dental Health Plan, XII Disenrollment from the Dental Plan - Termination of Benefits, A. Timeframes for Disenrollment/Termination, B. Effect on Dependents, XIV. Extension of Benefits, XV. Continuation of Benefits (COBRA), XVII. Conversion Coverage
13.	Appeals and Complaints	Cigna Dental Care - Cigna Dental Health Plan, X1. What to do if there is a Problem
14.	Information on Policy and Rate Changes	Cigna Dental Care - Cigna Dental Health Plan, Please see page immediately in front of I. Definitions
15.	Definitions	Cigna Dental Care - Cigna Dental Health Plan , I. Definitions

STATE RIDER

Cigna Dental Health of Colorado, Inc.

Colorado Residents:

I. DEFINITIONS

Dependent - your lawful spouse, partner in a civil union or domestic partner;

IV. YOUR CIGNA DENTAL HEALTH COVERAGE

D. CHOICE OF DENTIST

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

IX. SPECIALTY REFERRALS

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

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

XI. WHAT TO DO IF THERE IS A PROBLEM

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

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

The Appeals Committee will schedule and hold a review within 45 working days of receipt of your request. You will be notified in writing at least 15 working days prior to the review date of your right to: be present at the review; present your case to the Grievance Committee, in person or in writing; submit supporting documentation; ask questions of the reviewers prior to or at the review; and be represented by a person of your choice. If you wish

to be present, the review will be held during regular business hours at a location reasonably accessible to you. If a face-to-face meeting is not practical for geographic reasons, you will have the opportunity to be present by conference call at Cigna Dental's expense. Please notify Cigna Dental within 5 working days prior to the review if you intend to have an attorney present.

The Appeals Committee's decision will include: the names, titles and qualifying credentials of the reviewers; a statement of the reviewers' understanding of the nature of the appeal and the pertinent facts; the rationale for the decision; reference to any documentation used in making the decision; instructions for requesting the clinical rationale, including the review criteria used to make the determination; additional appeal rights, if any; and the right to contact the Department of Insurance, including the address and telephone number of the Commissioner's office.

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

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

If the Appeals Committee upholds a denial based on clinical necessity, and you have exhausted Cigna Dental's Appeal Process, you may request that your appeal be referred to an Independent Review Organization (IRO). In order to request a referral to an IRO, the reason for the denial must be based on a dental necessity determination by Cigna Dental. Administrative, eligibility or benefit coverage limits are not eligible for additional review under this process.

There is no charge for you to initiate this independent review process; however, you must provide written authorization permitting Cigna Dental to release the information to the Independent Reviewer selected. The IRO is composed of persons who are not employed by Cigna Dental or any of its affiliates. Cigna Dental will abide by the decision of the IRO.

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

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

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

request another 10 working days, or another 5 working days for expedited requests, to consider additional information.

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

XVIII . MISCELLANEOUS

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

STATE RIDER

Cigna Dental Health of Florida, Inc.

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

I. DEFINITIONS

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

Domestic Partner definition is replaces as follows:

The following definition of Domestic Partner applies:

A. A person of the same or opposite sex who:

1. shares your permanent residence;
2. is no less than eighteen years of age;
3. is financially interdependent with you and has proven such interdependence by providing documentation of at least two of the following arrangements: common ownership of real property or a common leasehold interest in such property, common ownership of a motor vehicle, a joint bank account or a joint credit account, designation as a beneficiary for life insurance or retirement benefits or under your partner's will, assignment of durable power of attorney or health care power of attorney, or such other proof as is considered by Cigna Dental Health to be sufficient to establish financial interdependency under the circumstances of your particular case;
4. is not your blood relative any closer than would be prohibited for a legal marriage; and
5. has signed jointly with you a notarized affidavit in form and content satisfactory to Cigna Dental Health which shall be made available to Cigna Dental Health upon request; or

The above definition applies so long as neither you nor your Domestic Partner hereunder:

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

Domestic Partner coverage cannot be transferred to states in which such coverage has been disapproved by regulatory authorities.]

III. ELIGIBILITY/WHEN COVERAGE BEGINS

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

If you have family coverage, your newly-born child, or a newly-born child of a covered family member, is automatically covered during the first 31 days of life if the child is pre-enrolled in the Dental Plan at the time of birth. If you wish to continue coverage beyond the first 31 days, you need to begin to pay Premiums, if any additional are due, during that period.

IV. YOUR CIGNA DENTAL COVERAGE

B. PREMIUMS/PREPAYMENT FEES

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

D. CHOICE OF DENTIST

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

XI. WHAT TO DO IF THERE IS A PROBLEM

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

B. APPEALS PROCEDURE

The Appeals Coordinator can be reached at 1-800-Cigna24 (244.6224) or by writing to P.O. Box 188047, Chattanooga, Tennessee 37422.

1. Level One Appeals

Your written complaint will be processed within 60 days of receipt unless the complaint involves the collection of information outside the service area, in which case Cigna Dental Health will have an additional 30 days to process the complaint. You may file a complaint up to 1 year from the date of occurrence.

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

4. Appeals to the State

You always have the right to file a complaint with or seek assistance from the Department of Insurance, 200 East Gaines Street, Tallahassee, Florida 32399, 1-800-342-2762.

XIII. DISENROLLMENT FROM THE DENTAL PLAN/TERMINATION

A. CAUSES FOR DISENROLLMENT/TERMINATION

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

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

XIV. EXTENSION OF BENEFITS

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

XVI. CONVERTING FROM YOUR GROUP COVERAGE

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

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

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

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

In addition the following provisions apply to your plan:

EXPENSES FOR WHICH A THIRD PARTY MAY BE RESPONSIBLE

This plan does not cover:

1. Expenses incurred by you or your Dependent (hereinafter individually and collectively referred to as a "Participant,") for which another party may be responsible as a result of having caused or contributed to an Injury or Sickness.
2. Expenses incurred by a Participant to the extent any payment is received for them either directly or indirectly from a third party tortfeasor or as a result of a settlement, judgment or arbitration award in connection

with any automobile medical, automobile no-fault, uninsured or underinsured motorist, homeowners, workers' compensation, government insurance (other than Medicaid), or similar type of insurance or coverage.

RIGHT OF REIMBURSEMENT

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

CIGNA DENTAL HEALTH OF FLORIDA, INC.

BY: Matthew G. Menden

TITLE: President

Cigna Dental Health of Kentucky, Inc.
P.O. Box 453099
Sunrise, Florida 33345-3099

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

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

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

READ YOUR PLAN BOOKLET CAREFULLY

Please call Customer Service at [1.800.Cigna24] if you have any questions. The hearing impaired may call the state TTY toll-free relay service listed in their local telephone directory.

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

I. DEFINITIONS

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

Adverse Determination - a decision by Cigna Dental not to authorize payment for certain limited specialty care procedures on the basis of necessity or appropriateness of care. To be considered clinically necessary, the treatment or service must be reasonable and appropriate and meet the following requirements:

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

Requests for payment authorizations that are declined by Cigna Dental based upon the above criteria will be the responsibility of the customer at the dentist's Usual Fees. A licensed dentist will make any such denial.

Cigna Dental - the Cigna Dental Health organization that provides dental benefits in your state as listed on the face page of this booklet.

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

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

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

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

Dependent - your lawful spouse, or your domestic partner;

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

- (a) less than 19-30 years old; or
- (b) less than 23-30 years old if he or she is both:
 - i. a full-time student enrolled at an accredited educational institution, and
 - ii. reliant upon you for maintenance and support; or
- (c) any age if he or she is both:
 - i. incapable of self-sustaining employment due to mental or physical disability, and
 - ii. reliant upon you for maintenance and support.

For a dependent child 19-30 years of age or older who is a full-time student at an educational institution, coverage will be provided for an entire academic term during which the child begins as a full-time student and remains enrolled, regardless of whether the number of hours of instruction for which the child is enrolled is reduced to a level that changes the child's academic status to less than that of a full-time student.

For a child who falls into category (b) or (c) above, you will need to furnish Cigna Dental evidence of the child's reliance upon you, in the form requested, within 31 days after the Dependent reaches the age of 19-30 and once a year thereafter for as long as the child is claimed as a Dependent under the Plan.

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

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

The following definition of Domestic Partner applies:

A. A person of the same or opposite sex who:

1. shares your permanent residence;
2. has resided with you for no less than one year;
3. is no less than eighteen years of age;
4. is financially interdependent with you and has proven such interdependence by providing documentation of at least two of the following arrangements: common ownership of real property or a common leasehold interest in such property, common ownership of a motor vehicle, a joint bank account or a joint credit account, designation as a beneficiary for life insurance or retirement benefits or under your partner's will, assignment of durable power of attorney or health care power of attorney, or such other proof as is considered by Cigna Dental Health to be sufficient to establish financial interdependency under the circumstances of your particular case;
5. is not your blood relative any closer than would be prohibited for a legal marriage; and
6. has signed jointly with you a notarized affidavit in form and content satisfactory to Cigna Dental Health which shall be made available to Cigna Dental Health upon request; or

B. A person of the same or opposite sex who has registered jointly with you as Domestic Partners with a governmental entity pursuant to a state or local law authorizing such registration and signed jointly with you a notarized affidavit of such registration which can be made available to Cigna Dental Health upon request.

The above definition applies so long as neither you nor your Domestic Partner hereunder:

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

Domestic Partner coverage cannot be transferred to states in which such coverage has been disapproved by regulatory authorities. Coverage terminates (for the domestic partner and any dependents, if included) when the domestic partnership ends. Domestic Partners are entitled to Conversion rights upon termination of coverage.

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

Network Dentist - a licensed dentist who has signed an agreement with Cigna Dental to provide general dentistry or specialty care services to you. The term, when used, includes both Network General Dentists and Network Specialty Dentists.

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

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

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

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

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

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

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

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

II. INTRODUCTION TO YOUR CIGNA DENTAL PLAN

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

III. ELIGIBILITY/WHEN COVERAGE BEGINS

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

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

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

If you have family coverage, a newborn child is automatically covered during the first 31 days of life. If you wish to continue coverage beyond the first 31 days, your baby must be enrolled in the Dental Plan and you must begin paying Premiums, if any additional are due, during that period.

Under the Family and Medical Leave Act of 1993, you may be eligible to continue coverage during certain leaves of absence from work. During such leaves, you will be responsible for paying your Group the portion of the Premiums, if any, which you would have paid if you had not taken the leave. Additional information is available through your Benefits Representative.

IV. YOUR CIGNA DENTAL COVERAGE

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

A. CUSTOMER SERVICE

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

B. PREMIUMS

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

C. OTHER CHARGES - PATIENT CHARGES

Network General Dentists are typically reimbursed by Cigna Dental through fixed monthly payments and supplemental payments for certain procedures. No bonuses or financial incentives are used as an inducement to limit services. Network Dentists are also compensated by the fees which you pay, as set out in your Patient Charge Schedule.

Your Patient Charge Schedule lists the dental procedures covered under your Dental Plan. Some dental procedures are covered at no charge to you. For other Covered Services, the Patient Charge Schedule lists the fees you must pay when you visit your Dental Office. There are no deductibles and no annual dollar limits for services covered by your Dental Plan.

Your Network General Dentist should tell you about Patient Charges for Covered Services, the amount you must pay for non-Covered Services and the Dental Office's payment policies. Timely payment is important. It is possible that the Dental Office may add late charges to overdue balances.

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

D. CHOICE OF DENTIST

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

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

Fees. Exceptions for medical reasons may be considered on a case-by-case basis.

If for any reason your selected Dental Office cannot provide your dental care, or if your Network General Dentist terminates from the network, Cigna Dental will let you know and will arrange a transfer to another Dental Office. Refer to the Section titled "Office Transfers" if you wish to change your Dental Office.

To obtain a list of Dental Offices near you, visit our website at my.cigna.com, or call the Dental Office Locator at [1.800.Cigna24]. It is available 24 hours a day, 7 days per week. If you would like to have the list faxed to you, enter your fax number, including your area code. You may always obtain a current Dental Office Directory by calling Customer Service.

E. YOUR PAYMENT RESPONSIBILITY (General Care)

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

If, on a temporary basis, there is no Network General Dentist in your Service Area, Cigna Dental will let you know and you may obtain Covered Services from a non-Network Dentist. You will pay the non-Network Dentist the applicable Patient Charge for Covered Services. Cigna Dental will pay the non-Network Dentist the difference, if any, between his or her Usual Fee and the applicable Patient Charge.

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

All contracts between Cigna Dental and Network Dentists state that you will not be liable to the Network Dentist for any sums owed to the Network Dentist by Cigna Dental.

F. EMERGENCY DENTAL CARE - REIMBURSEMENT

An emergency is a dental condition of recent onset and severity which would lead a prudent layperson possessing an average knowledge of dentistry to believe the condition needs immediate dental procedures necessary to control excessive bleeding, relieve severe pain, or eliminate acute infection. You should contact your Network General Dentist if you have an emergency in your Service Area.

1. Emergency Care Away From Home

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

emergency Covered Services, you will be responsible for the Patient Charges listed on your Patient Charge Schedule. Cigna Dental will reimburse you the difference, if any, between the dentist's Usual Fee for emergency Covered Services and your Patient Charge, up to a total of \$50 per incident. To receive reimbursement, send appropriate reports and x-rays to Cigna Dental at the address listed for your state on the front of this booklet.

2. Emergency Care After Hours

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

G. LIMITATIONS ON COVERED SERVICES

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

- Frequency** - The frequency of certain Covered Services, like cleanings, is limited. Your Patient Charge Schedule lists any limitations on frequency.
- **Pediatric Dentistry** - Coverage for treatment by a Pediatric Dentist ends on your child's 7th birthday. Effective on your child's 7th birthday, dental services must be obtained from a Network General Dentist however, exceptions for medical reasons may be considered on an individual basis.
- Oral Surgery** - The surgical removal of an impacted wisdom tooth may not be covered if the tooth is not diseased or if the removal is only for orthodontic reasons. Your Patient Charge Schedule lists any limitations on oral surgery.
- **Periodontal (gum tissue and supporting bone) Services** - Periodontal regenerative procedures are limited to one regenerative procedure per site (or per tooth, if applicable), when covered on the Patient Charge Schedule. Localized delivery of antimicrobial agents is limited to eight teeth (or eight sites, if applicable) per 12 consecutive months, when covered on the Patient Charge Schedule.
- **Clinical Oral Evaluations** - When this limitation is noted on the Patient Charge Schedule, periodic oral evaluations, comprehensive oral evaluations, comprehensive periodontal evaluations, and oral evaluations for patients under 3 years of age are, limited to a combined total of 4 evaluations during a 12 consecutive month period.
- **Surgical Placement of Implant Services** - When covered on the Patient Charge Schedule, surgical placement of a dental implant; repair, maintenance, or removal of a dental implant; implant abutment(s); or any services related to the surgical placement of a dental implant are limited to one per year with replacement of a surgical implant frequency limitation of one

every 10 years.

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

GENERAL LIMITATIONS

DENTAL BENEFITS

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

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

H. SERVICES NOT COVERED UNDER YOUR DENTAL PLAN

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

- services not listed on the Patient Charge Schedule.
- services provided by a non-Network Dentist without Cigna Dental's prior approval (except emergencies, as described in Section IV.F).
- services related to an injury or illness paid under workers' compensation, occupational disease or similar laws.
- services provided or paid by or through a federal or state governmental agency or authority, political subdivision or a public program, other than Medicaid.
- services required while serving in the armed forces of any country or international authority or relating to a declared or undeclared war or acts of war.

- cosmetic dentistry or cosmetic dental surgery (dentistry or dental surgery performed solely to improve appearance) unless specifically listed on your Patient Charge Schedule. If bleaching (tooth whitening) is listed on your Patient Charge Schedule, only the use of take-home bleaching gel with trays is covered; all other types of bleaching methods are not covered.
- general anesthesia, sedation and nitrous oxide, unless specifically listed on your Patient Charge Schedule. When listed on your Patient Charge Schedule, general anesthesia and IV sedation are covered when medically necessary and provided in conjunction with Covered Services performed by an Oral Surgeon or Periodontist. There is no coverage for general anesthesia or intravenous sedation when used for the purposes of anxiety control or patient management.
- prescription medications.
- procedures, appliances or restorations if the main purpose is to: a. change vertical dimension (degree of separation of the jaw when teeth are in contact); b. restore teeth which have been damaged by attrition, abrasion, erosion and/or abfraction.
- replacement of fixed and/or removable appliances (including fixed and removable orthodontic appliances) that have been lost, stolen, or damaged due to patient abuse, misuse or neglect.
- surgical placement of a dental implant; repair, maintenance, or removal of a dental implant; implant abutment(s); or any services related to the surgical placement of a dental implant, unless specifically listed on your Patient Charge Schedule.
- services considered to be unnecessary or experimental in nature or do not meet commonly accepted dental standards..
- procedures or appliances for minor tooth guidance or to control harmful habits.
- hospitalization, including any associated incremental charges for dental services performed in a hospital. (Benefits are available for Network Dentist charges for Covered Services performed at a hospital. Other associated charges are not covered and should be submitted to the medical carrier for benefit determination.)
- services to the extent you or your enrolled Dependent are compensated under any group medical plan, no-fault auto insurance policy, or uninsured motorist policy. Kentucky Residents: Services compensated under no-fault auto insurance policies or uninsured motorist policies are not

excluded.

- the completion of crowns, bridges, dentures, or root canal treatment, already in progress on the effective date of your Cigna Dental coverage.
- the completion of implant supported prosthesis (including crowns, bridges and dentures) already in progress on the effective date of your Cigna Dental coverage, unless specifically listed on your Patient Charge Schedule.
- consultations and/or evaluations associated with services that are not covered.
- endodontic treatment and/or periodontal (gum tissue and supporting bone) surgery of teeth exhibiting a poor or hopeless periodontal prognosis.
- bone grafting and/or guided tissue regeneration when performed at the site of a tooth extraction unless specifically listed on your Patient Charge Schedule.
- bone grafting and/or guided tissue regeneration when performed in conjunction with an apicoectomy or periradicular surgery.
- intentional root canal treatment in the absence of injury or disease to solely facilitate a restorative procedure.
- services performed by a prosthodontist.
- localized delivery of antimicrobial agents when performed alone or in the absence of traditional periodontal therapy.
- any localized delivery of antimicrobial agent procedures when more than eight (8) of these procedures are reported on the same date of service.
- infection control and/or sterilization. CIGNA dental considers this to be incidental to and part of the charges for services provided and not separately chargeable.
- the recementation of any inlay, onlay, crown, post and core or fixed bridge within 180 days of initial placement. Cigna Dental considers recementation within this timeframe to be incidental to and part of the charges for the initial restoration.
- the recementation of any implant supported prosthesis (including crowns, bridges and dentures) within 180 days of initial placement. Cigna Dental considers recementation within this timeframe to be incidental to and part of the charges for the initial restoration unless specifically listed on your Patient Charge Schedule.

- services to correct congenital malformations, including the replacement of congenitally missing teeth.
- the replacement of an occlusal guard (night guard) beyond one per any 24 consecutive month period, when this limitation is noted on the Patient Charge Schedule.
- crowns, bridges and/or implant supported prosthesis used solely for splinting.
- resin bonded retainers and associated pontics.

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

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

V. APPOINTMENTS

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

VI. BROKEN APPOINTMENTS

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

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

VII. OFFICE TRANSFERS

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

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

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

VIII. SPECIALTY CARE

Your Network General Dentist at your Dental Office has primary responsibility for your professional dental care. Because you may need specialty care, the Cigna Dental Network includes the following types of specialty dentists:

- Pediatric Dentists - children's dentistry.
- Endodontists - root canal treatment.
- Periodontists - treatment of gums and bone.
- Oral Surgeons - complex extractions and other surgical procedures.
- Orthodontists - tooth movement.

There is no coverage for referrals to prosthodontists or other specialty dentists not listed above.

When specialty care is needed, your Network General Dentist must start the referral process. X-rays taken by your Network General Dentist should be sent to the Network Specialty Dentist.

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

IX. SPECIALTY REFERRALS

A. IN GENERAL

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

When Cigna Dental authorizes payment to the Network Specialty Dentist, the fees or no-charge services listed on the Patient Charge Schedule in effect on the date each procedure is started will apply, except as set out in Section IX.B., Orthodontics. Treatment by the Network Specialty Dentist must begin within 90 days from the date of Cigna Dental's authorization. If you are unable to obtain treatment within the 90 day period, please call Customer Service to request an extension. Your coverage must be in effect when each procedure begins.

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

After the Network Specialty Dentist has completed treatment, you should return to your Network General Dentist for cleanings, regular checkups and other treatment. If you visit a Network Specialty Dentist without a referral or if you continue to see a

Network Specialty Dentist after you have completed specialty care, it will be your responsibility to pay for treatment at the dentist's Usual Fees.

When your Network General Dentist determines that you need specialty care and a Network Specialty Dentist is not available, as determined by Cigna Dental, Cigna Dental will authorize a referral to a non-Network Specialty Dentist. The referral procedures applicable to specialty care will apply. In such cases, you will be responsible for the applicable Patient Charge for Covered Services. Cigna Dental will reimburse the non-Network Dentist the difference, if any, between his or her Usual Fee and the applicable Patient Charge. For non-Covered Services or services not authorized for payment, including Adverse Determinations, you must pay the dentist's Usual Fee.

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

1. **Definitions** - If your Patient Charge Schedule indicates coverage for orthodontic treatment, the following definitions apply:
 - a. **Orthodontic Treatment Plan and Records** - the preparation of orthodontic records and a treatment plan by the Orthodontist.
 - b. **Interceptive Orthodontic Treatment** - treatment prior to full eruption of the permanent teeth, frequently a first phase preceding comprehensive treatment.
 - c. **Comprehensive Orthodontic Treatment** - treatment after the eruption of most permanent teeth, generally the final phase of treatment before retention.
 - d. **Retention (Post Treatment Stabilization)** - the period following orthodontic treatment during which you may wear an appliance to maintain and stabilize the new position of the teeth.

2. Patient Charges

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

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

3. Additional Charges

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

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

4. Orthodontics In Progress

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

X. COMPLEX REHABILITATION/MULTIPLE CROWN UNITS

Complex rehabilitation is extensive dental restoration involving 6 or more "units" of crown, bridge and/or implant supported prosthesis (including crowns and bridges) in the same treatment plan. Using full crowns (caps), fixed bridges and/or implant supported prosthesis (including crowns and bridges) which are cemented in place, your Network General Dentist will rebuild natural teeth, fill in spaces where teeth are missing and establish conditions which allow each tooth to function in harmony with the occlusion (bite). The extensive procedures involved in complex rehabilitation require an extraordinary amount of time, effort, skill and laboratory collaboration for a successful outcome.

Complex rehabilitation will be covered when performed by your Network General Dentist after consultation with you about diagnosis, treatment plan and charges. Each tooth or tooth replacement included in the treatment plan is referred to as a "unit" on your Patient Charge Schedule. The crown, bridge and/or implant supported prosthesis (including crowns and bridges) charges on your Patient Charge Schedule are for each unit of crown or bridge. You pay the per unit charge for each unit of crown, bridge and/or implant supported prosthesis (including crowns and bridges) PLUS an additional charge for each unit when 6 or more units are prescribed in your Network General Dentist's treatment plan.

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

XI. WHAT TO DO IF THERE IS A PROBLEM

For the purposes of this section, any reference to " you " or " your " also refers to a representative or provider designated by you to act on your behalf. **Time frames or requirements may vary depending on the laws in your State.**

Most problems can be resolved between you and your dentist. However,

we want you to be completely satisfied with the Dental Plan. That is why we have established a process for addressing your concerns and complaints. The complaint procedure is voluntary and will be used only upon your request.

A. START WITH CUSTOMER SERVICE

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

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

B. APPEALS PROCEDURE

Cigna Dental has a one-step appeals procedure for coverage decisions. To initiate an appeal, you must submit a request in writing to Cigna Dental, P.O. Box 188047, Chattanooga, TN 37422-8047, within 1 year from the date of the initial Cigna Dental decision. You should state the reason you feel your appeal should be approved and include any information to support your appeal. If you are unable or choose not to write, you may ask Customer Service to register your appeal by calling [1.800.Cigna24].

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

1. Level-One Appeals

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

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

You may request that the appeal resolution be expedited if the time frames under the above process would seriously jeopardize your life or health or would jeopardize your ability to regain the dental functionality that existed prior to the onset of your current condition. A dental professional, in consultation with the treating dentist, will decide if an expedited review is necessary. When a review is expedited, Cigna Dental will respond orally with a decision within 72 hours, followed up in writing.

2. Independent Review Procedure

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

3. Appeals to the State

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

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

XII. DUAL COVERAGE

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

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

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

XIII. DISENROLLMENT FROM THE DENTAL PLAN - TERMINATION OF BENEFITS

A. TIME FRAMES FOR DISENROLLMENT/TERMINATION

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

1. in which Premiums are not remitted to Cigna Dental.

2. in which eligibility requirements are no longer met.
3. after 30 days notice from Cigna Dental due to permanent breakdown of the dentist-patient relationship as determined by Cigna Dental, after at least two opportunities to transfer to another Dental Office.
4. after 30 days notice from Cigna Dental due to fraud or misuse of dental services and/or Dental Offices.
5. after 60 days notice by Cigna Dental, due to continued lack of a Dental Office in your Service Area.
6. after voluntary disenrollment.

B. EFFECT ON DEPENDENTS

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

XIV. EXTENSION OF BENEFITS

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

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

XV. CONTINUATION OF BENEFITS (COBRA)

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

XVI. CONVERSION COVERAGE

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

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

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

Benefits and rates for Cigna Dental conversion coverage and any succeeding renewals will be based on the Covered Services listed in the then-current standard conversion plan and may not be the same as those for your Group's Dental Plan. Please call the Cigna Dental Conversion Department at [1.800.Cigna24] to obtain current rates and make arrangements for continuing coverage.

XVII. CONFIDENTIALITY/PRIVACY

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

XVIII. MISCELLANEOUS

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

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

STATE Amendment
Cigna Dental Health of Kentucky, Inc. (Illinois)
P.O. Box 453099
Sunrise, Florida 33345-3099

Illinois Residents:

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

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

I. DEFINITIONS

- The Religious Freedom Protection and Civil Union Act, 750 ILCS 75, allows both same-sex and different-sex couples to enter into a civil union with all of the obligations, protections, and legal rights that Illinois provides to married heterosexual couples. The definition of " Dependent " is amended to include civil union partners and a child acquired through a civil union who meets the eligibility requirements outlined in your Plan Booklet.

Dependent - your lawful spouse [or your domestic partner];

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

- (a) less than [19-30] years old; or
- (b) less than [23-30] years old if he or she is both:
 - i. a full-time student enrolled at an accredited educational institution, and
 - ii. reliant upon you for maintenance and support; or
- (c) any age if he or she is both:
 - i. incapable of self-sustaining employment due to mental or physical disability, and
 - ii. reliant upon you for maintenance and support.

For a dependent child [19-30] years of age or older who is a full-time student at an educational institution, coverage will be provided for an entire academic term during which the child begins as a full-time student and remains enrolled, regardless of whether the number of hours of instruction for which the child is enrolled is reduced to a level that changes the child's academic status to less than that of a full-time student.

IV. YOUR CIGNA DENTAL COVERAGE

H. SERVICES NOT COVERED UNDER YOUR DENTAL PLAN

Illinois Residents: This exclusion does not apply to your Plan.

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

Cigna Dental Health Plan of Arizona, Inc.
Cigna Dental Health of California, Inc.
Cigna Dental Health of Colorado, Inc.
Cigna Dental Health of Florida, Inc.
Cigna Dental Health of Kentucky, Inc. (Illinois)

COORDINATION OF SERVICES AND BENEFITS

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

If a Covered Person is covered by this Contract and another Plan, the Order of Benefit Determination Rules described below determine whether this Contract or the other Plan is Primary. The benefits of this Contract:

1. shall not be reduced when, under the Order of Benefit Determination Rules, this Contract is Primary; but
2. may be reduced for the Reasonable Cash Value of any service provided under this Contract that may be recovered from another Plan when, under the Order of Benefit Determination Rules, the other Plan is Primary. (The above reduction is described in the subsection below entitled "Effect on the Benefits of this Plan.")

Definitions. "Plan" means this Contract or any of the following which provides benefits or services for, or because of, dental care or treatment:

1. Group insurance or group-type coverage, whether insured or uninsured. This includes prepayment or group practice coverage.
2. Coverage under a governmental plan or coverage required or provided by law. This does not include a state plan under Medicaid (Title XIX of the United States Social Security Act, as amended from time to time). It also does not include any plan when, by law, its benefits are excess to those of any private insurance program or other non-governmental program.
3. Dental benefits coverage of all group and group-type contracts.

"Plan" does not include coverage under individual policies or contracts. Each contract or other arrangement for coverage under subparagraphs 1, 2, or 3 above is a separate Plan. Also, if an arrangement has two parts and COB rules apply only to one of the two, each of the parts is a separate Plan.

"Primary" means that a Plan's benefits are to be provided or paid without considering any other Plan's benefits. (The Order of Benefit Determination Rules below determine whether a Plan is Primary or Secondary to another Plan.)

"Secondary" means that a Plan's benefits may be reduced and it may recover the Reasonable Cash Value of the services it provided from the Primary Plan. (The

Order of Benefit Determination Rules below determine whether a Plan is Primary or Secondary to another Plan.)

"Allowable Expense" means a necessary, reasonable, and customary item of expense for dental care, when the item of expense is covered at least in part by one or more Plans covering the person for whom the claim is made.

1. When a Plan provides benefits in the form of services, the Reasonable Cash Value of each service rendered is an Allowable Expense and a benefit paid.
2. When benefits are reduced under a Primary Plan because a Covered Person does not comply with the Plan provisions, the amount of such reduction will not be considered an Allowable Expense.

"Claim Determination Period" means a calendar year. However, it does not include any part of a year during which a Covered Person has no coverage under this Plan, or any part of a year before the date this COB provision or a similar provision takes effect.

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

Order of Benefit Determination Rules. When a Covered Person receives services through this Plan or is otherwise entitled to claim benefits under this Plan, and the services or benefits are a basis for a claim under another Plan, this Plan shall be Secondary and the other Plan shall be Primary, unless:

1. The other Plan has rules coordinating its benefits with those of this Plan; and
2. both the other Plan's rules and this Plan's rules, as stated below, require that this Plan's benefits be determined before those of the other Plan.

This Plan determines its Order of Benefits using the first of the following rules that applies:

1. The Plan under which the Covered Person is an employee shall be Primary.
2. If the Covered Person is not an employee under a Plan, then the Plan which covers the Covered Person's parent (as an employee) whose birthday occurs earlier in a calendar year shall be Primary.

NOTE: The word "birthday" as used in this subparagraph refers only to month and day in a calendar year, not to the year in which the person was born. To aid in the interpretation of this paragraph, the following example is given: If a Covered Person's mother has a birthday on January 1 and the Covered Person's father has a birthday on January 2, the Plan which covers the Covered Person's mother would be Primary.

3. If two or more Plans cover a Covered Person as a dependent child of divorced or separated parents, benefits for the Covered Person shall be determined in the following order:
 - a. First, the Plan of the parent with custody of the child;
 - b. Then, the Plan of the spouse of the parent with custody of the child;
and
 - c. Finally, the Plan of the parent not having custody of the child.
4. Notwithstanding subparagraph 3 above, if the specific terms of a court decree state that one of the parents is responsible for the health care expenses of the child, and the entity obligated to pay or provide the benefits of the Plan of that parent has actual knowledge of those terms, the benefits of that Plan shall be

Primary. This subparagraph 4 does not apply with respect to any Claim Determination Period or Plan year in which benefits are paid or provided before the entity has that actual knowledge.
5. The benefits of a Plan which covers a Covered Person as an employee (or as that employee's dependent) shall be determined before those of a Plan which covers that Covered Person as a laid off or retired employee (or as that employee's dependent). If the other Plan does not have this provision and if, as a result, the Plans do not agree on the order of benefit determination, this paragraph shall not apply.
6. If a Covered Person whose coverage is provided under a right of continuation pursuant to federal or state law is also covered under another Plan, the benefits of the Plan covering the Covered Person as an employee (or as that employee's dependent) shall be determined before those of a Plan under continuation coverage. If the other Plan does not have this provision and if, as a result, the Plans do not agree on the order of benefit determination, this paragraph shall not apply.
7. If one of the Plans which covers a Covered Person is issued out of the state whose laws govern this Contract and determines the order of benefits based upon the gender of a parent, and as result, the Plans do not agree on the order of benefit determination, the Plan with the gender rules shall determine the order of benefits.
8. If none of the above rules determines the order of benefits, the Plan which has covered the Covered Person for the longer period of time shall be Primary.

Effect on the Benefits of this Plan. This subsection applies when, in accordance with the Order of Benefit Determination Rules, this Plan is Secondary to one or more other Plans. In that event, the benefits of this Plan may be reduced under this subsection. Such other Plan or Plans are referred to as "the other Plans" in the subparagraphs below.

This Plan may reduce benefits payable or may recover the Reasonable Cash Value of services provided when the sum of:

1. The benefits that would be payable for the Allowable Expenses under this Plan, in the absence of this COB provision; and
2. The benefits that would be payable for the Allowable Expenses under the other Plans, in the absence of provisions with a purpose like that of this COB provision, whether or not claim is made, exceeds those Allowable Expenses in a Claim Determination Period. In that case, the benefits of this Plan will be reduced, or the Reasonable Cash Value of any services provided by this Plan may be recovered from the other Plan, so that they and the benefits payable under the other Plans do not total more than those Allowable Expenses.

When the benefits of this Plan are reduced as described above, each benefit is reduced in proportion. It is then charged against any applicable benefit limit of this Plan.

Recovery of Excess Benefits. In the event a service or benefit is provided by Cigna Dental Health which is not required by this Contract, or if it has provided a service or benefit which should have been paid by the Primary Plan, that service or benefit shall be considered an excess benefit. Cigna Dental Health shall have the right to recover to the extent of the excess benefit. If the excess benefit is a service, recovery shall be based upon the Reasonable Cash Value for that service. If the excess benefit is a payment, recovery shall be based upon the actual payment made. Recovery may be sought from among one or more of the following, as Cigna Dental Health shall determine: any person to, or for, or with respect to whom, such services were provided or such payments were made; any insurance company; health care plan or other organization. This right of recovery shall be Cigna Dental Health's alone and at its sole discretion. If determined necessary by Cigna Dental Health, the Covered Person (or his or her legal representative if a minor or legally incompetent), upon request, shall execute and deliver to Cigna Dental Health such instruments and papers required and do whatever else is necessary to secure Cigna Dental Health's rights hereunder.

Medicare Benefits. Except as otherwise provided by applicable federal law, the services and benefits under this Plan for Covered Persons aged sixty-five (65) and older, or for Covered Persons otherwise eligible for Medicare payments, shall not duplicate any services or benefits to which such Covered Persons are eligible under Parts A or B of the Medicare Act. Where Medicare is the responsible payor, all amounts payable pursuant to the Medicare program for services and benefits provided hereunder to Covered Persons are payable to and shall be retained by Cigna Dental Health. Covered Persons enrolled in Medicare shall cooperate with and assist Cigna Dental Health in its efforts to obtain reimbursement from Medicare.

Right to Receive and Release Information. Cigna Dental Health may, without consent of or notice to any Covered Person, and to the extent permitted by law, release to or obtain from any person or organization or governmental entity any information with respect to the administering of this Section. A Covered Person shall provide to Cigna Dental Health any information it requests to implement this provision.

**CIGNA DENTAL HEALTH
GROUP DENTAL PLAN
PRE-CONTRACT APPLICATION**

- Cigna Dental Health Plan of Arizona, Inc.
- Cigna Dental Health of California, Inc.
- Cigna Dental Health of Colorado, Inc.
- Cigna HealthCare of Connecticut, Inc.
- Cigna Dental Health of Delaware, Inc.
- Cigna Dental Health of Florida, Inc.
- Cigna Dental Health of Kansas, Inc. (Nebraska)
- Cigna Dental Health of Kansas, Inc.
- Cigna Dental Health of Kentucky, Inc.
- Cigna Dental Health of Kentucky, Inc. (Illinois)
- Cigna Dental Health of Maryland, Inc.
- Cigna Dental Health of Missouri, Inc.
- Cigna Dental Health of North Carolina, Inc.
- Cigna Dental Health of New Jersey, Inc.
- Cigna Dental Health of Ohio, Inc.
- Cigna Dental Health of Pennsylvania, Inc.
- Cigna Dental Health of Texas, Inc.
- Cigna Dental Health of Virginia, Inc.

FILL IN EVERY LINE – Information must be completed by Applicant.

APPLICANT

- A. APPLICANT'S FULL LEGAL NAME: City of Newport Beach
- B. ADDRESS: 100 Civic Center Drive, Newport Beach, CA 92660 PHONE: 949.644.3307
- C. BILLING ADDRESS, IF DIFFERENT: _____
- D. NAME OF CONTACT: Ms. Cheryl Anderson TITLE: _____
- E. THE APPLICANT IS: EMPLOYER • LABOR UNION • ASSOCIATION
- F. NATURE OF BUSINESS: _____
- G. PRIOR DENTAL COVERAGE: YES • NO
- H. ERISA APPLIES: YES • NO
- I. I.R.C. SECTION 125 APPLIES: YES • NO

ELIGIBILITY

- A. TOTAL NO. OF EMPLOYEES: 102 TOTAL NUMBER OF ELIGIBLE EMPLOYEES: 102
- B. ALL CLASSES OF FULL-TIME EMPLOYEES WILL BE ELIGIBLE EXCEPT:
EXCLUDED CLASS(ES) _____
- C. CURRENT EMPLOYEES WILL BE ELIGIBLE UPON: _____ Months of Service or X Other Date of hire _____
- D. FUTURE EMPLOYEES WILL BE ELIGIBLE UPON: _____ Months of Service or X Other Date of hire _____
- E. AGE LIMITATIONS FOR DEPENDENTS: All unmarried children of Employees are eligible to enroll if (a) less than 19 years of age; or (b) full-time students less than 23 years of age. Please indicate changes, if any, applicable to: (a) 26 (b) 26

DENTAL PLAN

- A. EFFECTIVE DATE: The proposed Effective Date of group coverage is January 1, 2016, or the first day of the month after which enrollment information and payment for the first month's coverage are received and accepted by Cigna Dental Health. If this Pre-Contract Application is not accepted by Cigna Dental Health, no coverage will become effective, and any premium advanced by the Applicant will be refunded. Employees who enroll after the Effective Date will be covered: as of the first day of the month after processing of enrollment by Cigna Dental Health or Other _____.
- B. CONTRACT TERM: The initial term of the Group Contract shall extend from the Effective Date until the expiration of the initial premium guarantee period shown below. The Group Contract shall be automatically renewed on an annual basis in accordance with the Group Contract, unless terminated in accordance with the Group Contract.
- C. PREMIUMS: Cigna Dental Health Premiums will be: 01- 12.82 02- 23.07 03- 34.73 04- _____ Composite _____. Premiums are guaranteed through December 31, 2017; however, premiums may be adjusted upon 30 days written notice* to the Group if, in Cigna Dental Health's sole opinion, its liability (e.g., for taxes or benefits) is altered by any state or federal law.
- D. EMPLOYER CONTRIBUTION: Employee Only 0% Dependents 0%. If no employer contribution, plan must be funded on a pre-tax basis under I.R.C. Section 125.
- E. PATIENT CHARGE SCHEDULE: P3X00. The Patient Charge Schedule of the Dental Plan is subject to annual change in accordance with the terms of the Group Contract. Please indicate expiration of guarantee period for the Patient Charge Schedule if other than one year from the Effective Date of coverage: December 31, 2017
- F. DENTAL OFFICE: Enrolled employees and their enrolled dependents must select a Dental Office. All family members must use the same Dental Office, or Each family member may select a different Dental Office.

***North Carolina Groups Only: North Carolina law requires 45-days' notice to group.**

Applicant declares that he/she has read these statements and the answers to these questions are complete and true. Applicant agrees that: (1) this Pre-Contract Application is offered as an inducement for the group coverage applied for; (2) this Pre-Contract Application will form a part of any Group Contract issued; (3) no information given to or acquired by any representative of Cigna Dental Health will bind Cigna Dental Health unless it appears in writing on this Pre-Contract Application; and (4) no waiver or change will bind Cigna Dental Health unless signed by an officer of Cigna Dental Health. Group coverage will only be provided for persons eligible under the Group Contract issued.

APPLICANT: _____ TITLE: _____ AGENT/BROKER: _____
(PRINT NAME OF APPLICANT'S REPRESENTATIVE) (PRINT NAME)

(SIGNATURE OF REPRESENTATIVE) DATE: _____ (SIGNATURE OF AGENT/BROKER) DATE: _____

The following notice is required by Ohio and Kentucky Law:

Any person who, with intent to defraud or knowing that he is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement is guilty of insurance fraud.

**Statement
to be signed
by
Applicant
upon
payment of
the
premium or
any part
thereof**

I HEREBY DECLARE that I have paid to _____ Agent
_____ Dollars for which I hold his or her receipt bearing the same number as this Pre-
Contract Application.

Date: _____ No. _____ Applicant _____

----- CIGNA DENTAL HEALTH

No. _____

**CONDITIO
NAL
RECEIPT**

Received of _____ / _____ Dollars to be applied against the first premium on the
proposed Group Dental Plan under this Pre-Contract Application. This payment is made and accepted subject to the following
conditions. Group coverage at Cigna Dental Health rates applied for will take effect
as of the Effective Date requested if the Pre-Contract Application is accepted at the Cigna Dental Health Home Office. If certain
persons eligible are to contribute to the cost of the Group Dental Plan, such Group coverage will take effect on the later of: the date
the required number have enrolled, or on the Effective Date requested. If the
Pre-Contract Application is not accepted, no coverage will become effective. Any premium payment advanced by the Applicant will
be refunded upon surrender of this Conditional Receipt.

Date: _____ Agent

**Detach This
Receipt
When
Payment is
Made**

80085GE2.95
10195897
8/30/2016