Cigna Health and Life Insurance Company

Dental Insurance

THIS IS A LIMITED BENEFITS PLAN
BENEFITS PROVIDED ARE SUPPLEMENTAL AND ARE NOT INTENDED TO COVER ALL MEDICAL EXPENSES

Outline of Coverage

Read Your Certificate Carefully—This outline of coverage provides a very brief description of the important features of Your policy. This is not the insurance contract and only the actual policy provisions will control. The policy itself sets forth in detail the rights and obligations of both You and Your insurance company. It is, therefore, important that You READ YOUR CERTIFICATE CAREFULLY!

This IS NOT A MEDICARE SUPPLEMENT policy. If you are eligible for Medicare review the Guide to Health Insurance for People With Medicare available from the company.

Dental coverage is designed to provide, to persons insured, Preventive & Diagnostic Care such as Oral Exams, Cleanings and X-Rays. Your Plan may also include Basic Restorative Care, such as fillings and anesthetics, as well as Major Restorative Care, such as Crowns, Dentures and Bridges, subject to any limitations set forth in the policy or certificate. Coverage is not provided for any benefits other than the specific dental benefits described and any additional benefit described below:

New Hampshire mandated coverage of charges for general anesthesia administered by a licensed dentist for dental procedures performed in a dentist's office (a) for a covered person under the age of 13who is determined by a licensed Dentist in conjunction with a licensed Physician to have a dental condition of significant complexity that requires the child to receive general anesthesia for the treatment of the condition,; or (b) for a covered person who has exceptional medical circumstances or developed disability, as determined by a Physician.

CIGNA DENTAL CARE NETWORK BENEFITS	IN-NETWORK ONLY
Calendar Year Maximum (Class I, II, III, IV, V and IX expenses)	No Dollar Maximum
Annual Deductible (Individual, Family)	None
Reimbursement Levels	Based on Reduced Contract Fees
	PLAN PAYS
Class I Preventive	100%
Class II – Basic restorative	90-100%
Class III – Major restorative*	50-100%

For a complete listing of covered services under Your plan, please refer to Your plan documents.

There are frequency limitations on certain services covered under Your Cigna dental plan. In addition, the exclusions on services not covered under Your plan are listed below.

Dental Plan General Limitations and Exclusions*

***This is a complete list of all possible exclusion. For a list of services which apply to your plan, refer to your plan documents or call Customer service at 1-800-CIGNA24 (1-800-244-6224), or login to myCigna.com if you have questions or need more information.**

- any treatment received outside of the United States is not covered except for treatment received as an Emergency Service.
- replacement of a partial denture, complete denture, fixed bridge, any prosthesis over implant, or the addition of teeth to a partial denture is not covered, unless the replacement is needed due to a Necessary extraction of an additional functioning Natural Tooth while the person is covered under this plan (alternate benefits of adding a tooth to an existing appliance may be applied);
- replacement of a crown, bridge, onlay, post/post and core, or other laboratory prepared or CAD/CAM prepared restoration, partial denture, or complete denture within the frequency limitation stated on the Schedule is not covered unless:
- the replacement is made Necessary by the placement of an original opposing complete denture or the Necessary extraction of Natural Teeth; or
- the crown, bridge, onlay, post/post and core, other laboratory prepared or CAD/CAM prepared restoration, partial denture, or complete denture while in the mouth, has been damaged beyond repair as a result of an injury received while a person is insured for these benefits;
- replacement of any amalgam or resin-based composite restoration involving the same surface(s) on the same tooth by the same Dentist or a different Dentist in the same office within the frequency limitation stated on the Schedule is not covered;
- a combination of radiographic images (such as ten or more periapical radiographic images; or a panoramic radiographic image with bite-wing radiographic images) completed on the same date of service will not be covered when the allowance meets or exceeds the allowance for an intraoral complete series of radiographic images. Plan reimbursement will be based on an intraoral complete series;
- localized Delivery of Antimicrobial Agents via a controlled release vehicle into diseased crevicular tissue, per tooth. Allowable only on teeth with both periodontal pocket depths of 5 mm or greater and a prior history of Periodontal Therapy. Not allowable when more than eight (8) of these procedures are reported on the same date of service;
- tissue preparation such as gingivectomy/gingivoplasty or crown lengthening as a separate allowance on the same date as a restoration on the same tooth;
- when covered by Your plan, any prosthesis over an implant is subject to the same exclusions, limitations, alternate benefit provisions, time limitations, and missing tooth limitations as standard traditional restorative, fixed and removable prosthetics;
- covered Services to the extent that billed charges exceed the rate of reimbursement as described in The Schedule;
- any replacement of a crown, bridge, partial denture, or complete denture which is or can be made usable according to commonly accepted dental standards;

- crowns, inlays, cast restorations, or other laboratory prepared or CAD/CAM prepared restorations on teeth unless the tooth cannot be restored with an amalgam or resin-based composite restoration due to major decay or fracture;
- fixed bridges and/or removable partial dentures with a cast metal framework for patients;
- periodontal soft tissue surgery is limited to an allowance of three (3) qualifying teeth per quadrant in a twelve month period (or per calendar year); and to one benefit per tooth every 36 months.
- The benefits provided under this plan will be reduced so that the total payment will not be more than 100% of the charge made for the dental service if benefits are provided for that service under this plan and any medical expense plan or prepaid treatment program sponsored or made available.
- any services not stated under Covered Dental Services and The Schedule;
- procedures that are a covered expense under any other medical plan which provides group hospital, surgical, or medical benefits whether or not on an insured basis
- charges incurred due to injuries which are intentionally self-inflicted;
- charges for or in connection with an injury or illness arising out of, or in the course of any employment for wage or profit;
- charges for or in connection with an injury or illness which is covered under any workers' compensation or similar law;
- charges made by a hospital owned or operated by or which provides care or performs services for, the United States Government, if such charges are directly related to a military-service-connected condition;
- services or supplies received as a result of dental disease, defect or injury due to an act of war, declared or undeclared;
- consultations and/or evaluations associated with services that are not covered;
- cosmetic dentistry or cosmetic dental surgery (dentistry or dental surgery performed solely to improve appearance) which may include but is not limited to the following: bleaching (tooth whitening), facings, repairs to facings or replacement of facings on crowns or bridge units on molar teeth will always be considered cosmetic;
- replacement of fixed and/or removable appliances (including fixed and removable orthodontic appliances, if orthodontics is covered) that have been lost, stolen, or damaged due to patient abuse, misuse, or neglect;
- procedures, services, supplies, restorations, or appliances (except complete dentures), whose sole or primary purpose is to change or maintain vertical dimension;
- procedures, services, supplies, restorations or appliances whose main purpose is to diagnose or treat jaw joint problems, including dysfunction of the temporomandibular joint and craniomandibular disorders, or other conditions of the joints linking the jawbone and skull, including the complex muscles, nerves and other tissues related to that joint;
- occlusal adjustment or the alteration or restoration of occlusion;
- the restoration of teeth which have been damaged by erosion, attrition, abfraction or abrasion;
- bite registration or bite analysis;
- porcelain, ceramic, resin, or acrylic materials on crowns or pontics on, or replacing the upper or lower first, second and/or third molars;

- services to correct congenital malformations, including the replacement of congenitally missing teeth;
- procedures, restorations, appliances or services to stabilize periodontally involved teeth;
- the initial placement of a complete denture or partial denture unless it includes the replacement of a functioning Natural Tooth extracted while the person is covered under this plan (the removal of only a permanent third molar will not satisfy this requirement and therefore will not qualify a complete or partial denture as a benefit under this provision);
- the initial placement of a fixed bridge, unless it includes the replacement of a functioning Natural Tooth extracted while the person is covered under this plan. If a bridge replaces teeth that were missing prior to the date the person's coverage became effective and also teeth that are extracted after the person's effective date, benefits are payable only for the pontics replacing those teeth which are extracted while the person was insured under this plan. The removal of only a permanent third molar will not satisfy this requirement and therefore will not qualify a fixed bridge as a benefit under this provision;
- when Surgical Implants are covered by the plan, the initial surgical placement of a dental implant unless it is intended to replace a functioning Natural Tooth extracted while the person is covered under this plan. The removal of only a permanent third molar will not satisfy this requirement and therefore will not qualify an implant for benefit under this provision;
- services associated with the diagnosis, placement, treatment, repair, removal or replacement of a dental implant, or any other services related to implants, unless covered by Your specific plan, including but not limited to: the surgical placement of a dental implant body; the surgical implant index or template guide used for implant surgery; implant abutment(s) and/or connecting bar(s); periodontal/peri-implant and/or maintenance services specifically related to a dental implant; and/or removal of an existing implant(s);
- fixed or removable space maintainers;
- myofunctional therapy;
- the recementation and/or repair of any inlay, onlay, crown, post and core, or fixed bridge within the specified time since initial placement by the same Dentist or a different Dentist in the same office. We consider recementation and/or repair within this timeframe to be incidental to and part of the charges for the initial restoration;
- replacement of a partial denture or complete denture which can be made serviceable;
- prescription drugs;
- treatment of jaw fractures and/or orthognathic surgery;
- orthodontic treatment;
- the treatment of cleft lip and cleft palate;
- charges for sterilization of equipment, infection control processes and procedures, disposal of medical waste or other requirements mandated or recommended by the Centers for Disease Control and Prevention (CDC), OSHA or other regulatory agencies; We consider these to be incidental to and part of the charges for services provided and not separately chargeable;

- charges for travel time; transportation costs; or professional advice given on the phone;
- temporary, transitional or interim dental services;
- diagnostic casts, diagnostic models or study models;
- personal supplies, including but not limited to toothbrushes, rotary toothbrushes, floss holders, and water irrigation devices.
- charges for broken appointments; completion of claim forms; duplication of x-rays and/or exams required by a third party;
- services that are deemed to be medical services;
- any charges, including ancillary charges, for services and supplies received from a hospital, outpatient facility, ambulatory surgical center or similar facility;
- charges for treatment or surgery that does not meet plan guidelines;
- intravenous sedation when used for the purposes of anxiety control or patient management; general anesthesia when used for the purposes of anxiety control or patient management unless it is medically necessary and authorized by your provider because the covered person is under the age of 13 or physically or developmentally disabled;
- indirect pulp capping on the same date of service as a permanent restoration, We consider this to be incidental to and part of the charges for services provided and not separately chargeable;
- additional/incremental costs associated with optional/elective orthodontic materials including but not limited to ceramic, clear, or lingual brackets, or other cosmetic appliances including clear aligners; orthognathic surgery and associated incremental costs; appliances to guide minor tooth movement; and services which are not typically included in orthodontic treatment. These services will be identified on a case-by-case basis. This exclusion applies when orthodontics is covered under Your plan;
- endodontic treatment and/or periodontal (gum tissue and supporting bone) surgery of teeth exhibiting a poor or hopeless periodontal prognosis;
- harmful habits treatment;
- intentional root canal treatment in the absence of injury or disease solely to facilitate a restorative procedure;
- services to the extent You or Your enrolled Dependent(s) are compensated under any group medical plan.
- house/extended care facility calls; hospital calls; office visits for observation (during regularly scheduled hours) when no other services are performed; office visits after regularly scheduled hours; and case presentations;
- procedures performed by a Dentist who is a member of the Covered Person's family except in the case of a dental emergency when no other Dentist is available. (Covered Person's family is limited to a Spouse, siblings, parents, children, grandparents, and the Spouse's siblings and parents);
- dental services that do not meet commonly accepted dental standards;
- replacement of teeth beyond the normal adult dentition of thirty-two (32) teeth;
- services not included in the list of Covered Services, unless We agree to accept such expense as a Covered Dental Expense, in which case payment will be made consistent

with similar services which would provide the least expensive professionally satisfactory result;

- to the extent that You or any of Your Dependents are in any way paid or entitled to payment for those expenses by or through a public program, other than Medicaid;
- charges in excess of the Maximum Allowed by Your plan;
- procedures for which a charge would not have been made if the person had no insurance or for which the person is not legally required to pay. For example, if We determine that a provider is or has waived, reduced, or forgiven any portion of its charges and/or any portion of the Copayment, Deductible, and/or Coinsurance amount(s) You are required to pay for a Covered Service (as shown on The Schedule) without Our express consent, We shall have the right to deny the payment of benefits in connection with the Covered Service, or reduce the benefits in proportion to the amount of the Copayment, Deductible, and/or Coinsurance amounts waived, forgiven or reduced, regardless of whether the provider represents that You remain responsible for any amounts that Your plan does not cover. We shall have the right to require You to provide proof sufficient to Us that You have made Your required cost share payment(s) prior to the payment of any benefits by Us. This exclusion includes, but is not limited to, charges of a Non-Participating Provider who has agreed to charge You or charged You at an In-Network benefits level or some other benefits level not otherwise applicable to the services received;
- charges arising out of or relating to any violation of a healthcare-related state or federal law or which themselves are a violation of a healthcare-related state or federal law;
- covered Services to the extent that payment is unlawful where the Covered Person resides when the expenses are incurred;
- charges for or in connection with experimental procedures or treatment methods not recognized and approved by the American Dental Association or the appropriate dental specialty organization;
- 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;
- services for which benefits are not payable according to the "General Limitations" section;
- procedures which are not included in the list of Covered Dental Expenses.
- procedures which are not necessary and which do not have uniform professional endorsement;
- for charges for unnecessary care, treatment or surgery;
- athletic mouth guards.

Provisions regarding insurer's right to change premium rates

The initial premium rate is guaranteed for the first year. After this initial period, We may change the premium rates. We will send a written notice of any such change at least 60 days before the change becomes effective, Rates will not change more than once in any 12-month period.

Provision regarding renewability or continuation of coverage

If You have been employed and You or Your Dependent's insurance would otherwise cease because of termination of employment, other than for gross misconduct, or carrier termination, Your Dental insurance will be continued for up to 18 months upon payment of the required premium by You to Your Employer.

If You or Your Dependent is disabled within 60 days of the date of termination of employment, You may continue health insurance for up to an additional 11 months beyond the 18 month period.

If coverage for a former Spouse ends under this continuation provision for any of the reasons described, he or she is eligible to obtain up to an additional 36 months of continuation under the provision.

Your insurance will cease on the earliest date of either: the date You cease to be in a Class of Eligible Employees or cease to qualify for the insurance or; the last day for which You have made any required contribution for the insurance or; the date the Policy is canceled or lapses due to a nonpayment of premium.

If Your or Your Dependent(s) Dental Insurance ceases for a reason other than failure to pay any required contribution or cancellation of the Policy, You and Your Dependent(s) may be eligible for coverage under another Dental Insurance Policy underwritten by Us; provided that: You apply in writing and pay the first premium to Us within 31 days after Your insurance ceases; and You are not considered to be over insured. We will notify You of the right to elect continuation coverage, based upon Your eligibility; We will give You further details of the converted policy. Conversion is not available if Your insurance ceased due to nonpayment of required premiums or; selection of alternate dental insurance by Your group or; fraud or misuse of the Dental Plan.