Summary Plan Description and Plan Document:

Cigna Dental Plan

EFFECTIVE DATE: JANUARY 1, 2016

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INTRODUCTION

The Cigna Dental Plan (Dental Plan or Plan) is an employer-sponsored health and welfare employee benefit plan. It is designed to help you achieve and maintain healthy teeth and gums, and cover you when you need oral care. The Dental Plan provides coverage for a wide range of dental services. You can receive benefits for preventive, routine, basic, major, and orthodontic services.

This document and its Appendices serve as the Summary Plan Description (SPD) and Plan document for the Cigna Dental Plan. Other benefits offered through the Cigna Benefits Program are described in other SPDs that are available on the *Your Cigna Life* website.

Dental Benefit Chart At-A-Glance

The Chart At-A-Glance in Appendix I shows the Plan options that are available to you and explain how the Plan works. This Chart is also available on the *Your Cigna Life* website. The Chart is part of this SPD and you should refer to the version of the Chart available on the website for the most up to date information about your benefits. If you are enrolled in the Dental Plan, you should take some time to review this document and keep it as a reference.

You will notice that certain terms are printed in **bold** throughout the document. They are defined in the "GLOSSARY."

Throughout this document, "you" refers to both you and your **covered dependents** unless the context indicates that it means you as an employee. This SPD provides details on:

- Eligibility, enrollment and costs,
- What's covered,
- What's not covered,
- How to access care,
- Coordination of benefits,
- Claims,
- The appeals process, and
- COBRA and **ERISA** rights.

Cigna Corporation changes the Plan from time to time. You will be notified about Plan changes through SPD updates, announcements and information on the *Your Cigna Life* website and written correspondence.

If you have any questions about the Dental Plan, see "WHO TO CONTACT."

WHO TO CONTACT

The *Your Cigna Life* website has information about the Dental Plan and how to get the most from your Plan coverage. If you need more help, use the following chart to find out who to call for answers to questions about the Plan.

For More Information About…	Contact…
• Initial enrollment • Enrollment changes • Verification of coverage • Life status changes • Eligibility information • Dental care coverage continuation (COBRA) general information • Converting managed dental care coverage • Direct billing	Your Cigna Life Service Center P.O. Box 62825 Phoenix, AZ 85082 1.800.551.3539 FAX: 855.674.5282 E-mail: YCLServiceCenter@Cigna.com
• Plan coverage and benefit information • Claims • Pre-treatment review	Cigna Customer Service Center 1.888.99Cigna (1.888.992.4462) Live chat with a representative at *myCigna.com*
• COBRA (health care coverage continuation) administration	CONEXIS, a division of WageWorks P.O. Box 223684 Dallas, TX 75222-3684 1.888.678.4881

ELIGIBILITY

Who Is Eligible

You are eligible for Dental Plan coverage on your first day of employment as a **regular employee** of **Cigna**.

You will receive information about all the Cigna Benefit Program options that are available to you, including the Dental Plan, when you first become eligible and then during annual benefits open enrollment periods.

Members of the Cigna Corporation Board of Directors are also eligible for Dental Plan coverage.

Who Can Be Covered

You may choose Dental Plan coverage for:

- Yourself only;
- Yourself and your **spouse** or **partner**;
- Yourself and your **eligible dependent** children with no **spouse** or **partner**; or
- Yourself and your **spouse** or **partner** and your **eligible dependent** children.

The **plan administrator** has the right to require proof from you at any time of the eligibility of anyone you claim as an **eligible dependent**.

COSTS

Your Cost

You and **Cigna** share in the cost of Dental Plan coverage. **Cigna** pays for the benefits provided by the Plan from its general assets, subject to the limitations described in this SPD, and except to the extent that participant contributions are required. You pay no deductible for preventive services, and when you use network **dentists**, you'll save money on dental costs while protecting one of your most valuable personal and professional assets, your smile.

Your **payroll cost** is the part of your share of the Plan cost that you pay with pre-tax dollars through payroll deductions – **pre-tax contributions**. (If you work in Puerto Rico, you make after-tax contributions.)

The amount of your **payroll cost** depends on the Dental Plan option you choose, who you cover and whether you are a full-time or part-time employee. **Payroll costs** for part-time employees are higher than the **payroll costs** for full-time employees because **Cigna** provides a larger company subsidy for these employees. Refer to the **Chart At a Glance** or the *Your Cigna Life* website for **payroll cost** information for the current Cigna Dental Plan options. You will receive **payroll cost** information for the upcoming **plan year** during the annual enrollment period.

You may also pay part of your share of the Plan's cost through **deductibles** and **coinsurance**.

ENROLLMENT

When and How You Enroll

Dental Plan coverage is optional. That is, except as described in the "During the Annual Enrollment Period" section below, you are not covered automatically; you must enroll to have Plan coverage. There are three occasions when you can enroll:

- When you become a **regular employee**;
- During any annual enrollment period; or
- After you have a **life status change**.

If You Are Newly Eligible

You become eligible for Dental Plan coverage on your first day of employment as a **regular employee**. This is the date you are hired or rehired, or the date your employment classification changes to **regular employee** status.

You have 30 days after the date you first become eligible for Dental Plan coverage to elect and enroll in a Dental Plan option. If you do enroll, your coverage is effective from the first day you are eligible; for example, if your hire date as a **regular employee** is March 15 and you enroll on April 1, your coverage begins as of March 15. Your **payroll cost** contributions will start to be deducted from your paycheck in the first pay processed after you make your election. If you do not enroll within 30 days of your date of hire, you cannot enroll in the Plan until the next annual enrollment or if you experience a **life status change** event. See the "If You Have a Life Status Change" section of this SPD for further details.

You can find information about the Dental Plan and enrolling online through the *Your Cigna Life* website. To enroll, follow the instructions in the online enrollment materials.

During the Annual Enrollment Period

If you are a **regular employee**, you can enroll in the Dental Plan during the annual enrollment period. The coverage you elect during annual enrollment is effective the following January 1 for the entire **plan year**.

During the annual enrollment period, you may make changes to your Plan elections. For example, you may:

- Add, drop or change dental coverage; or
- Increase or reduce the number of **eligible dependents** you enroll for dental coverage.

Once the enrollment period ends, you cannot change your election until the next annual enrollment period or until you have a qualified **life status change**. However, you may be allowed to change your election after the end of the enrollment period but before the beginning of the new **plan year** if the **plan administrator** determines that, due to unusual circumstances, the enrollment period deadline creates a hardship for you.

You can find information about enrollment in the Dental Plan, at or before the beginning of the annual enrollment period, online through the *Your Cigna Life* website. To enroll in the Plan, follow the instructions in the online enrollment materials.

If You Have a Life Status Change

You can enroll in the Dental Plan outside the annual enrollment period if you have a qualifying **life status change**. To enroll in the Plan on account of a **life status change**, you must request a coverage change within 30 days after the qualifying **life status change** event by going to the *Life Events* section of the *Your Cigna Life* website or contacting the Your Cigna Life Service Center at 1.800.551.3539. You may enroll in the Dental Plan when you have a **life status change** only if your enrollment is due to and consistent with the **life status change** event.

Enrolling Dependents

If you enroll yourself in the Dental Plan, you may also enroll anyone who qualifies as your **eligible dependent**, including your **spouse/partner** and your child under age 26. If you are enrolling a child for whom you are a legal guardian or a child who is being placed with you for adoption, you must submit proof of this relationship to the Your Cigna Life Service Center. The child's enrollment will be processed once proof of eligible dependent status is received and accepted by the Your Cigna Life Service Center. Coverage is retroactive to the event date.

If you wish to elect coverage for your **partner** and/or your **partner's** children, you must submit a notarized copy of a completed **Affidavit of Domestic Partnership** and required documentation to the Your Cigna Life Service Center. The enrollment will be processed once the Affidavit and required documentation is received and accepted by the Your Cigna Life Service Center. Coverage is retroactive to the event date.

EVENTS AFFECTING YOUR PLAN COVERAGE, ELIGIBILITY OR COSTS

The information that follows describes events that may affect your Dental Plan coverage, eligibility or costs.

If You Have a Life Status Change

You can change or cancel certain Dental Plan coverage elections outside the annual enrollment period if you have a qualifying **life status change**.

You will be permitted to change your election based on the following events if, in the determination of the **plan administrator**, the change satisfies the requirements set forth in IRS regulations governing mid-year changes in election:

- You marry, divorce or have an annulment or a legal separation;
- You enter into or end a **partnership**;
- You have a new **eligible dependent** child by marriage, birth, adoption, placement for adoption, or legal guardianship;
- Your **eligible dependent** dies (including your **spouse**);
- Your or your **eligible dependent's** employment starts or terminates;
- You or your **eligible dependent** changes work location or residence, but only if it results in the need to change health care networks as determined by **Cigna**;
- You or your **eligible dependent** has a reduction or increase in hours of employment (including a switch between full-time and part-time status), the beginning or ending of an unpaid leave of absence, a strike or a lockout); or

- Your dependent satisfies or ceases to satisfy the requirements for eligible dependent status because of age, financial dependency, or any similar circumstances as provided under the Dental Plan.

In addition, you may be allowed to change your election based on the following events in the sole discretion of the **plan administrator**, and/or as legally required:

- Your **spouse** experiences a significant change in his or her group dental coverage;
- Service of a Qualified Medical Child Support Order (**QMCSO**) issued under **ERISA** Section 609, as approved by the **plan administrator**;
- Eligibility to participate in a government-sponsored premium assistance program; and
- Enrollment in [Medicare] or Medicaid (or loss of eligibility for [Medicare] or Medicaid).

To make a change in your Dental Plan coverage within 30 days after a qualifying **life status change** event, you must go to the *Life Events* section of the *Your Cigna Life* website or contact the Your Cigna Life Service Center at 1.800.551.3539 for assistance. The change will take effect on the date of the **life status change** event and any necessary payroll deduction contribution changes will be made during the next available payroll processing cycle.

If you experience any of the **life status change** events noted above, any changes to your benefit selections must be on account of and correspond with a change in status that affects eligibility under the Plan. This means that you can make only those changes that directly relate to the event and are consistent with the event. For example, if you get divorced, you must delete your **spouse** from the Plan, but may not delete your dependent. Permissible election changes on account of a **life status change** event are:

- Elect, cancel or change dental coverage; or
- Add or delete **eligible dependents**.

If you are on an approved unpaid leave of absence (other than a family and medical leave) when you have a **life status change** event, you may change your election only if:

- You have or adopt a child -- then you may add the child to your coverage;
- You marry or enter a **partnership** -- then you may add your **spouse** or **partner** to your coverage;
- You get a divorce or annulment or end a **partnership** – then you may remove your **spouse** or **partner** from your coverage; or
- Your **eligible dependent** dies – then you may change your coverage tier, if appropriate.

If the Plan Has a Change in Cost or Coverage

If the cost or coverage of a Dental Plan option changes, the **plan administrator** may allow each affected participant to change his or her election during the **plan year**, subject to applicable legal requirements.

If You Are Eligible for Coverage Under Another Dental Plan with a Different Plan Year

You can change certain Dental Plan coverage elections outside of the open enrollment period if you have an **eligible dependent** who is also eligible for coverage under another employer’s dental plan -- but only if that dental plan has a **plan year** that is not the calendar year and your Dental Plan election change is on account of and corresponds with a coverage change made by your **eligible dependent** under the other plan. To change your coverage election, contact the Your Cigna Life Service Center at 1.800.551.3539 within 30 days of the event.

If You Are Subject to a Qualified Medical Child Support Order

The Plan will comply with the terms of a **QMCSO**. If you are subject to a **QMCSO**, your noncustodial child will be enrolled as an **eligible dependent** (and, if you are not already covered under the Dental Plan, you will also be enrolled for coverage.) You must continue your Plan coverage while the **QMCSO** is in effect.

If your **eligible dependent** child is enrolled for Cigna Dental Plan coverage, and a **QMCSO** is issued requiring another individual to provide dental plan coverage for the child and that coverage is provided, you may make a change to cancel Cigna Dental Plan coverage for the child. To do so, you must send, fax or e-mail a copy of this **QMCSO** to the Your Cigna Life Service Center, who will update your election for you. See "WHO TO CONTACT" for the address and fax number of the Your Cigna Life Service Center.

If you have questions about or wish to obtain a copy of the procedures governing a **QMCSO** determination (at no charge), contact the **plan administrator**.

If You Move

If you move, you must update your personal information on the *Your Cigna Life* website under *Self Service*. You will then be sent instructions for changing your dental coverage option only if you move to an area where there is no network access.

If Your Employment Status Changes

If your employment status changes from regular full-time to regular part-time, or vice versa, or if you are a regular part-time employee and the number of hours you are regularly scheduled to work changes from less than 33 to 33 or more or vice versa, the cost for your Dental Plan coverage will change automatically. The new rates will automatically be sent to you.

If your employment status changes from **regular employee** to anything else, you will no longer be eligible for Dental Plan coverage, but you will be offered COBRA coverage.

If your employment status changes from an ineligible status to **regular employee**, you will be eligible to enroll in the Dental Plan. You will automatically be provided enrollment materials and instructions on how to enroll.

If You Take a Leave of Absence

During a paid leave of absence, you continue to make Dental Plan **payroll cost** contributions through payroll deduction.

During an approved unpaid leave of absence, including an unpaid **FMLA leave** (unless you elect otherwise as described later in this section), you will be billed monthly on an after-tax basis for your Dental Plan contributions. You will have a 31-day grace period following the due date to make payment and your Dental Plan coverage will continue as long as you make the required contributions. If you do not make the required contributions before the end of the grace period, or you stop payments at any time during the leave, your Dental Plan coverage will end on the last day of the month for which you make the required contributions, and you will not be able to enroll for Dental Plan coverage again while you remain on leave.

Alternatively, with respect to approved unpaid **FMLA leave** only, you may elect to continue Dental Plan coverage and suspend **payroll cost** payments until you return to active employment. You must make this election before the start of your leave. When you return to active employment, your **payroll cost** will be adjusted to cover the amount of missed payments during your leave. If you fail to return to active employment, you will be billed for the amount of missed payments.

If you continue to be eligible for an approved leave of absence in a new calendar year, you may change your coverage election during the annual enrollment period. If you do not change your coverage election during annual enrollment, your current Dental Plan election will automatically continue in the new calendar year (to the extent it is still available) if you continue to make the required contributions.

- If you return to work as an active employee and you continued to make payments during your leave, your Dental Plan elections will automatically continue unless you request a change based on a **life status change**.
- If you return to work as an active employee and you did not continue to make payments during your leave, you may reinstate your Dental Plan coverage within 30 days of your return based on the rules that apply to a **life status change**.

The maximum period of a leave of absence for any reason is 30 months. If, at the end of 30 months of leave of absence, you have not returned to active employment, your **Cigna** employment will be terminated. See "If Your Cigna Employment Ends" for the effect of a termination of employment on your Dental Plan coverage.

If You Take a Disability Leave

Generally, you will be on a disability leave of absence during any period when you are eligible to receive benefits under either the Cigna Short-Term Disability Plan (STD) or Cigna Long-Term Disability Plan (LTD). During a disability leave, the Leave of Absence rules described above apply. Any period that you receive STD benefits is treated as a paid leave of absence, and any period that you receive LTD benefits is treated as an unpaid leave. On December 31 following the date you first receive benefits under the Cigna Long-Term Disability Plan, your eligibility for coverage under this Plan will end. For details, see that plan's SPD.

If You Take a Military Leave of Absence

Generally, a paid or unpaid military leave (see *Military Leave* in the *Returns & Rewards* section on the *Your Cigna Life* website) is a leave of absence. If you are on a paid military leave of absence, your coverage may continue if you continue to make Dental Plan **payroll cost** contributions through payroll deduction or direct billing. If you are on an unpaid military leave of absence, the Leave of Absence rules for unpaid leave (described above) will apply.

If Your Cigna Employment Ends

Dental Plan coverage ends on the last day of the month of your termination of employment. If you are enrolled in the Dental Plan on your **termination of employment date**, you may elect to continue Dental Plan coverage under COBRA. You will find more information about COBRA under the "COBRA" section of this document.

If you elect to continue Dental Plan coverage under COBRA you will be billed for the full cost of COBRA coverage at unsubsidized rates, plus a 2% administration fee.

If you do elect COBRA coverage:

- You will have the opportunity to change coverage options during the COBRA annual enrollment period.
- You will receive a new Dental Plan ID card for COBRA coverage (unless you were enrolled in PPO coverage). DESTROY THE OLD CARD.

If You Retire from Cigna

If your most recent hire or re-hire date with **Cigna** was before January 1, 2011, and you are at least age 55 and have at least five years of service on your **termination of employment date**, you are eligible for the Cigna Retiree Dental Plan coverage beginning as early as the first day of the month following your **termination of employment date**. If you are rehired by Cigna after December 31, 2010, you will be eligible for the Cigna Retiree Dental Plan if you were at least age 55 with five years of service as of your previous **termination of employment date**. **Cigna** currently shares the cost of Retiree Dental Plan coverage for some retirees.

If You Die While Employed

Dental Plan coverage ends on the last day of the month in which you die. Your **covered dependents** may elect COBRA coverage for up to 36 months at company-subsidized rates. There are no Dental Plan conversion rights available. In certain limited cases, if you die while employed, your **covered dependents** may also be eligible for dental coverage under the Cigna Retiree Dental Plan. For details, see that plan's SPD.

If You Change Cigna Dental Plan Options

If you change Dental Plan options during an annual enrollment period or because of a **life status change** the following rules apply:

- If you transfer from the **Preferred Provider Organization (PPO)** or Dental Select option to Cigna Dental Care ("Cigna DHMO"), Cigna DHMO will generally only cover treatment you or your **covered dependent** receives after the effective date of the option change.
- The PPO or Dental Select options may continue to pay for some procedures, like bridges, dentures or root canal therapy, if the treatment begins before the date your coverage ends and is completed within 90 days after your coverage changes.
- If you transfer to Cigna DHMO from the PPO or Dental Select option while receiving orthodontic care, the fees listed on the Schedule in Appendix II will not apply. However, you may be eligible for a contribution from Cigna Dental for continued treatment with your current orthodontist. Contact the Customer Service Center at 1.888.99Cigna (1.888.992.4462) to discuss your case.
- If you transfer from Cigna DHMO to either the PPO or Dental Select option, Cigna DHMO will cover the completion of covered dental procedures that have been started by the participating **dentist**. For a more detailed explanation, see the "Continued Dental Benefits When Your Coverage Ends" section. You will have no coverage for these procedures under the PPO or Dental Select options. For example, if you are in the process of having a root canal and transfer from Cigna DHMO to the PPO or Dental Select coverage, your Cigna DHMO **dentist** will have to complete all work on the root canal in order for you to be covered.
- For purposes of your **deductible**, expenses that you have incurred before the change will be credited to the new option.

WHEN YOUR DENTAL COVERAGE ENDS

Your Dental Plan coverage ends automatically on December 31 of a **plan year** if your coverage option is no longer available in the following **plan year** or if you decline coverage during the annual enrollment period.

Your Dental Plan coverage ends on the last day of the month during which one of these events occurs:

- You have a qualified **life status change** and choose to cancel coverage within 30 days after the qualifying event, if cancellation is consistent with the **life status change** event;
- You fail to make required **payroll cost** payments;
- You transfer from **regular employee** status to an ineligible status;
- Your **covered dependent** is no longer an **eligible dependent** (coverage ends only for the no-longer-**eligible-dependent**);
- Your **Cigna** employment terminates (including on account of retirement);
- **Cigna** terminates the Dental Plan.

Cigna DHMO coverage for you or your **covered dependents** may also end for any of the following reasons:

- There is a permanent breakdown of the provider-patient relationship as determined by Cigna Dental after you are offered at least two opportunities to transfer to another Cigna DHMO network **dentist** and after at least 30 days of notice by Cigna Dental.
- After 30 days' notice from Cigna Dental due to fraud or misuse of dental services and/or dental offices.
- After 60 days' notice from Cigna Dental, due to continued lack of a dental office in your **service area**.
- Cigna Dental cancels its agreement with **Cigna**.

Events That May Cause Cigna to Cancel Your Dental Plan Coverage

Cigna may cancel or terminate your Dental Plan coverage for any of these reasons:

- You provide false material information-
    - During enrollment or after a **life status change** -- such as false information about a person to try to have the person covered under the Plan as your **eligible dependent**; or
    - In communications with **Cigna** or the **plan administrator** (including a failure to contact the Your Cigna Life Service Center at 1.800.551.3539 or update your dependent information on the *Life Events* section of the *Your Cigna Life* website.
- You permit anyone who is not your **covered dependent** to use your or your **covered dependent's** Plan identification card or to obtain **covered services** and benefits.
- You obtain or attempt to obtain **covered services** or benefits by means of false, misleading or fraudulent information, acts, or omissions.
- You fail to pay any **coinsurance**, supplemental charge or other amount due in connection with **covered services** and benefits.
- You cannot establish a satisfactory **dentist**/patient relationship after efforts are made by Cigna Dental after you are offered at least one opportunity to transfer to another Cigna DHMO network **dentist** and after at least 30 days' of notice by Cigna Dental to establish such a relationship.
- Your behavior, in the opinion of Cigna Dental, is unruly, abusive or uncooperative to the extent that the ability to provide services to you or any other person is seriously impaired.
- You threaten the life or well-being of Dental Plan personnel, individuals who provide services and benefits, or any Plan participant.

Termination of coverage under this provision due to an act, practice or omission by you that is fraudulent or due to your intentional misrepresentation of material fact may, in the **plan administrator's** sole discretion, cause coverage for you and your **covered dependents** to be cancelled retroactively to as early as when the coverage began. You will receive written notice describing the reasons for the termination of your coverage. Termination of coverage for reasons that constitute misconduct under **Cigna's** employment policies may also result in the termination of your employment.

Continued Dental Benefits When Your Coverage Ends

When your coverage ends, some benefits under Cigna DHMO, the PPO and Dental Select options continue to be payable for up to 90 days. The following are included:

- Fixed bridgework and full or partial dentures if first impressions are taken and/or abutment teeth are fully prepared while you are covered. The device must be installed or delivered to you within 90 days after the date your coverage ends.
- Crowns or inlays if the tooth is prepared while you or your dependent is covered. Installation must be completed within 90 days after the date your coverage ends.
- Root canal therapy on one tooth if the pulp chamber of the tooth is opened while you are covered and treatment is completed within 90 days after the date your coverage ends.
- Any scheduled Plan payments for orthodontia that are due within 60 days after the date your coverage ends. Your Cigna DHMO continued coverage is only valid at Cigna Dental participating network offices.

Rescissions

Coverage under the Dental Plan may not be rescinded (retroactively terminated) by **Cigna** unless you (or someone seeking coverage on your behalf) (1) performs an act, practice or omission that constitutes fraud or (2) makes an intentional misrepresentation of material fact.

Conversion Rights

You cannot convert your Dental Select or PPO coverage to an individual contract when your **Cigna** group coverage ends. You can, however, convert your Cigna DHMO coverage to an individual contract when your Cigna DHMO group coverage ends. If Cigna DHMO is not available in your area, there is no other dental conversion coverage available to you.

If Cigna DHMO is available in your area, you may convert to individual coverage provided you apply and pay Cigna DHMO's required prepayment fee within 90 days of the date coverage would otherwise end for you or a **covered dependent**. Cigna DHMO's conversion schedule of benefits may differ from the schedules described here.

You should review it carefully before making a decision to convert your coverage. Call the Customer Service Center for additional information at 1.888.99Cigna (1.888.992.4462).

You and your dependents may apply for conversion to individual Cigna DHMO coverage if:

- Eligibility for COBRA continuation coverage has expired; or
- You or your dependent is not eligible for COBRA continuation coverage, or chooses not to elect coverage under COBRA, unless you live in a state where expiration of the COBRA continuation period is required.

To exercise your conversion rights, you must contact the Customer Service Center at 1.888.99Cigna (1.888.992.4462) for the necessary application(s) and premium information within 31 days of termination. It is your responsibility to request information on converting your dental coverage. Your application to convert your coverage must include the appropriate premium and should be sent to the Insurer at the address listed on the application.

DENTAL PLAN OPTIONS OVERVIEW

- At most **Cigna** locations you can choose managed care coverage through the Cigna DHMO option (referred to as "DHMO"). This option has a Patient Charge Schedule that lists covered dental procedures and the amount you are required to pay for each service. With the Cigna DHMO, you choose your **network general dentist** from a list of participating **dentists** and offices in your area who have agreed to be part of the network. You must use your selected network **dentist** in order for your services to be covered. There is no out-of-network feature.
- In addition, a **Preferred Provider Organization** through Cigna Dental (referred to as a "**PPO**") may be offered in most locations, including Puerto Rico. The PPO has deductibles, coinsurance, and annual maximums. However, when you need care, the PPO lets you decide whether to go to a network **dentist** or to a **dentist** outside the network. Benefit levels are higher if you use a network **dentist**.
- The Dental Select option is offered where Cigna DHMO or a PPO is not available, or in locations where networks are limited. You choose any **dentist** and are reimbursed for covered dental expenses after you meet a deductible up to an annual maximum. If you use a network **dentist**, your costs may be lower as a result of network discounts.

Where to Find Information About the Dental Plan Options in Your Area

You will receive information about the dental options available in your area when you first become eligible for the Dental

Plan, or during the annual enrollment period.

You can find a Cigna DHMO or Cigna Dental PPO network **dentist** near you online at *www.myCigna.com*. You can also call the Customer Service Center at 1.888.99Cigna (1.888.992.4462).

Your Identification Card

If you and your **covered dependents** enroll in Cigna Dental PPO coverage, you will not receive Plan identification (ID) cards but you may print an ID card by logging into *myCigna.com*. If you enroll in Cigna DHMO coverage, you and your **covered dependents** each will receive a Plan ID card approximately 10 business days after you enroll in the Cigna Dental Plan. You may receive new cards at the beginning of new **plan years**. Your ID card contains important information, including your ID number and instructions on what to do in an emergency. Remember to carry your card with you at all times and present it each time you need dental care.

Covered Services

This section provides an overview of services covered through Cigna DHMO, Dental Select and Cigna Dental PPO. All Cigna dental options cover the four general classes of treatment described below.

The Cigna DHMO Patient Charge Schedule, and the Dental Select and PPO Services Schedule in the Appendices list the covered dental services within each of four classes.

Class I: Diagnostic and Preventive Care

Class I services are diagnostic and routine care for maintaining good dental health, including:

- Oral examinations;
- Routine cleaning;
- Fluoride treatment for children;
- Fixed band space maintainers (non-orthodontic);
- Emergency treatment to relieve pain when no other services are performed;
- Bitewing X-ray;
- Full-mouth Panoramic Bitewing X-ray; and
- Application of sealants.

See Appendices II and III for coverage limitations on the frequency of the above services.

Class II: Basic Services

Basic services include:

- Fillings (amalgam, silicate, acrylic or composite);
- General anesthesia is covered when medically necessary; (under Cigna DHMO, when performed by a periodontist or oral surgeon for covered procedures);
- Local anesthesia;
- Periodontics (treatment of structures surrounding teeth);
- Endodontics (root canal treatment), including any biopsies, pulp vitality tests, pathology reports or follow-up care;

- Maintenance of dentures that have been installed for more than six months; and
- Simple extractions.

Class III: Major Services

Major services involve restorative work (rebuilding teeth) and prosthodontic work (replacing teeth). Major services include:

- Crowns;
- Pontics;
- Gold inlay fillings;
- Gold onlays; and
- Dentures.

There is an additional cost for gold/high noble metal when used for some procedures. You should consult Appendices II and III before undergoing these procedures or complete a pre-treatment review.

Class IV: Orthodontia

Orthodontia involves straightening teeth. Orthodontic services include:

- Orthodontic evaluation — including diagnosis;
- Treatment plan and records — including x-rays and diagnostic casts;
- Fitting with an appliance — removable and/or fixed appliance insertion for interceptive treatment and/or fixed appliance insertion (banding) for comprehensive treatment;
- 24 months of interceptive and/or comprehensive treatment; and
- Retention (the period of time following orthodontic treatment when the patient needs an appliance to keep teeth in position).

Participants in the Cigna DHMO Plan are responsible for the fees listed in Appendix III.

With the Cigna Dental PPO and Dental Select options, there is a separate maximum benefit limit for orthodontia. PPO and Dental Select payments for orthodontia are made in installments. The first payment is made when the appliance is installed. It is based on 25 percent of **covered expenses** for the full course of the orthodontia treatment. Payments for the balance of **covered expenses** are then made every three months in equal amounts until treatment ends.

If you terminate employment or retire during the course of orthodontic treatment for you or your **covered dependent**, some benefits will continue to be payable for up to 60 days. See the “Continued Dental Benefits When Your Coverage Ends” section. This does not apply if you transfer your dental coverage from either the PPO or the Dental Select option to Cigna DHMO.

Maximum Reimbursable Charges

When you receive care in-network, your cost will generally be lower because charges are subject to discounts negotiated by Connecticut General Life Insurance Company (**CHLIC)** and the Plan generally pays a greater share of the cost than if you receive care out-of-network. Charges for out-of-network services are covered only up to the **maximum**

reimbursable charge. This is the maximum amount the Plan pays for out-of-network care. You are responsible for any amount above this maximum limit.

The **maximum reimbursable charge** for **covered services** is determined based on the lesser of:

- the provider's normal charge for a similar service or supply; or
- the policyholder-selected percentile of all charges made by providers of all charges made by providers of such services or supplies in the geographic area where received. The nature and severity of an injury, illness or treatment may be considered when determining whether a charge exceeds the Maximum Reimbursable Charge.

The **maximum reimbursable charge** is subject to all other benefit limitations and Plan provisions applicable coding and payment methodologies determined by **CHLIC**. Additional information about how **CHLIC** determines the **maximum reimbursable charge** is available upon request. To obtain the **maximum reimbursable charge** for a particular procedure or treatment, contact the Customer Service Center at 1.888.992.4462.

Calculation of Covered Expenses

CHLIC will calculate **covered expenses** after evaluating and validating the bills submitted for payment in accordance with the most recent edition of the Current Dental Terminology (CDT) codes published by the American Dental Association and generally recognized methodologies for claims administration.

ACCESSING CARE

The following sections provide detailed information about how your Plan coverage works.

Cigna DHMO

Cigna DHMO is a managed dental care plan. The contribution you pay through payroll deduction, along with the fees **Cigna** pays on your behalf, cover most necessary preventive and basic restorative treatments, such as routine cleanings or basic fillings. These services are provided at no additional cost to you if they are performed by your **network general dentist**.

Major services, such as crowns or bridgework, are also provided if your **network general dentist** determines they are necessary for good oral health. When you need services for which there is a charge the schedule in Appendix III lists the exact patient charge. There are no claim forms to complete or **deductibles** to pay. If you receive services from a non-participating dental office, you are responsible for the full cost of the services, with the exception of emergency care, as described in the "Emergency Care" section.

There is no maximum annual benefit under the Cigna DHMO option.

Selecting a Network General Dentist for You and Your Family

When you initially enroll in Cigna DHMO, you select a dental office from Cigna DHMO's network of participating offices. A list of dental care professionals is available online at *www.myCigna.com* under the tab, *Find a Doctor or Service* or by calling the Customer Service Center at 1.888.99Cigna (1.888.992.4462). If your first choice is not available and you make an alternate selection when you enroll, you will be assigned to that office, if it is available. Otherwise, the office nearest your home will be selected for you. You and your **covered dependents** can select different participating network offices. Children up to their 7th birthday may see a participating pediatric **dentist**. A completed specialty referral form from your participating **dentist** should be submitted to Cigna Dental.

When you visit your participating dental office, you pay the amount shown on Schedule in Appendix III for the **covered services**. Care received from a network **specialist** is covered when Cigna Dental authorizes a referral for payment. A

Cigna Dental payment authorization is valid for 90 days. If you receive unauthorized specialty care, or if you visit a non-participating dental office, you will be responsible for paying the full **dentist's** charges for your visit.

Cigna DHMO does not have an out-of-network feature. You must receive all dental care services covered by the Plan from your **network general dentist** or a **specialist** that has been referred by your **network general dentist** and authorized for payment by Cigna Dental. If you do not receive services from either of these sources, there is no coverage. You will be required to pay for the services. You may obtain a referral to a specialist by contacting the Customer Service Center by telephone at 1.888.9Cigna (1.888.992.4462) or by writing to:

Cigna Dental
P.O. Box 188045
Chattanooga, TN 37422-8045

If You Need Specialized Care

If you need specialized dental care, your **network general dentist** may refer you to a network **specialist** as authorized by Cigna Dental. You will need to obtain a specialty referral form, completed by your **network general dentist** and approved for payment by Cigna Dental. The treatment must be received no later than 90 days from the approval by Cigna Dental.

How to Change Dentists

You and your **covered dependents** can change to another participating dental office for any reason. We suggest that you complete any dental procedures in progress before transferring to another dental office. Transfers will be effective the first day of the month after the processing of your request. There is no charge to you for the transfer; however, all patient charges, which you owe to your current dental office, should be paid before requesting the transfer. If you wish to change **dentists**, call the Customer Service Center at 1.888.99Cigna (1.888.992.4462).

Canceled Appointments

You may cancel an appointment without penalty if you do so at least 24 hours before your scheduled visit. If you or a **covered dependent** fails to provide at least 24 hours of notice, your **dentist** may charge you for each 15-minute block of time he or she had reserved for you, up to the maximum shown in the schedule. The broken appointment fee will not be charged if Cigna Dental determines that you were unable to provide at least 24 hours of notice through no fault of your own.

For patient charges, see the fee schedule in Appendix III.

Emergency Care

An emergency is a dental condition of recent onset and severity that 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**.

Away from Home

If you have an emergency while you are out of your **service area** or unable to contact your **network general dentist**, you may receive emergency **covered services** 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 fees for emergency **covered services** and your patient charge, up to a total of $50 per incident.

- Arizona residents: 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.
- Pennsylvania residents: If any emergency arises and you are out of your **service area** or are unable to contact your **network general dentist**, Cigna Dental covers the cost of emergency dental services so that you are not responsible for greater out-of-pocket expenses than if you were attended by your **network general dentist**.
- Texas residents: Emergency dental services are limited to procedures administered in a dental office, dental clinic, or other comparable facility to evaluate and stabilize emergency dental conditions of recent onset and severity accompanied by excessive bleeding, severe pain, or acute infection that would allow a prudent layperson with average knowledge of dentistry to believe that immediate care is needed.

After Hours

There is a patient charge listed in the Patient Charge Schedule, in Appendix III, for emergency care rendered after regularly scheduled office hours. This charge will be in addition to other applicable patient charges. After you receive emergency care, you must return to your **network general dentist** for on-going treatment.

Cigna Dental PPO and Dental Select Options

In addition to Cigna DHMO, **Cigna** offers you coverage through the **PPO** and in some areas, the Dental Select option. With the **PPO**, each time you need care, you decide whether to use a provider who is participating in the network or a provider outside the network. Benefit levels are higher when you use a network provider.

With the Dental Select option, you may use any licensed **dentist** to provide dental care, but there may be times that you can use a **PPO** network **dentist**. When you use a **PPO** network **dentist**, your out-of-pocket costs will be determined on the basis of the lower, contracted rates.

Your Deductibles, Coinsurance, and Maximum Benefits

The PPO and Dental Select options have a per person calendar-year **deductible**. This means you and each of your **covered dependents** must pay a certain amount out-of-pocket before you are reimbursed for covered dental services. After you satisfy the **deductible**, you will be reimbursed for a portion of the covered dental expense. The PPO and Dental Select options also limit the total amount of benefits payable per person in a calendar year. There are separate lifetime **deductibles** and benefit limits for orthodontia services. The Chart At-A-Glance in Appendix I provides information about **deductibles**, **coinsurance** levels, and maximum benefits available.

Network and Out-of-Network Services Overview

The Cigna PPO option has a tiered network with two levels of in-network coverage, in addition to out-of-network coverage. You may receive care outside of the network, but the benefit levels are higher if you receive care from network dental professionals. You can maximize your benefits and lower your costs further by selecting "Advantage" tier dental professionals. For more information, see the chart in Appendix I.

- Your **deductibles** and **coinsurance** are highest when you use out-of-of network services. See the charts in Appendices for further details.

The Plan uses the Cigna Dental network. The directory of participating dental professionals is available online at *www.myCigna.com* under the tab, *Find a Doctor or Service* or by calling the Customer Service Center at 1.888.99Cigna (1.888.992.4462).

Deductibles and Coinsurance

Deductibles

A **deductible** is the annual dollar amount you are required to pay before the Dental Plan begins to pay its share of your **covered expenses**. After the **deductible** is met, you share in the cost of **covered expenses** at a percent called **coinsurance** as explained later in this section. The chart in Appendix I shows the **deductibles** for each Plan option. There is no **deductible** for the Cigna DHMO Plan.

For the Cigna PPO and Dental Select plans, your **deductible** amount depends on your "coverage tier"- that is, whether you cover only yourself or also cover other family members. If you cover only yourself, you must meet the individual **deductible**. If you also cover family members, you have a higher collective **deductible**. With a collective **deductible** your out-of-pocket expenses for all **covered dependents** must reach the entire collective **deductible** amount before the Plan pays for **covered expenses** for you or your **covered dependents** at the **coinsurance** level.

Your **deductible** amount also depends on how you receive **covered services**. The **deductible** amount for network services is lower than the **deductible** amount for out-of-network services. **Covered expenses** will count toward both your network and out-of-network **deductibles** until you meet your network **deductible**. These expenses are combined to calculate the amount applied towards your annual network and out-of-network **deductibles**. However, once you reach your network **deductible** and pay a **coinsurance** percent for covered network services, those expenses are not subject to your network **deductible** and will not count towards your out-of-network **deductible**.

The following expenses do NOT count toward meeting your annual **deductible**:

- Expenses that are not subject to an annual **deductible**; and
- Expenses that are not covered by the Dental Plan, including charges in excess of **maximum reimbursable charges**.

Coinsurance

Once you have met your annual **deductible**, you pay part of the cost for **covered services** by paying **coinsurance**. **Coinsurance** is a percent of the **covered expense** that you must pay. The Plan pays the rest of the cost.

The charts in the Appendices show the **coinsurance** percentages for the Plan's **covered services** for each Dental Plan option. For most **covered services**, the **coinsurance** percentages that you pay are higher for out-of-network services. See the charts in the Appendices.

Pretreatment Review

The Dental Select option and the PPO (both network and out-of-network) offer a special feature that can help you decide what course of treatment to follow when you need extensive dental work. Pretreatment review lets your **dentist** know how much the Plan will pay for the proposed treatment before any work begins. The review may also identify other, more cost-effective methods of treatment.

CHLIC, **Cigna's** Claims Administrator, reserves the right to pay for a less expensive procedure if it would be as effective. You should use the pretreatment review process to determine what **CHLIC** will cover, particularly when you expect to have extensive dental work (*i.e.*, $150 or more).

How Pretreatment Review Works

If your **dentist** recommends extensive dental care (*i.e.*, $150 or more) ask your **dentist** to complete the "Attending Dentist" section of a claim form. This section asks your **dentist** to describe the problem, indicate the work to be done and estimate the cost. Your **dentist** should send the completed form to **CHLIC** at the address printed on the form.

CHLIC will notify your **dentist** how much the option will pay for the proposed treatment.

If **CHLIC's** consulting **dentist** believes another, more cost-effective treatment would be just as effective, **CHLIC** may exercise its right to pay for the less expensive procedure. This applies to all services. You and your **dentist** can decide how to proceed based on the pretreatment review.

Annual Maximum Benefit

The Dental Plan has no annual maximum benefit for participants enrolled in the Cigna DHMO; however, there is a $2,000 annual maximum benefit for participants enrolled in the Dental PPO and Dental Select options.

Preventive Care

The Plan covers the full cost of preventive care services, which includes cleanings, X-rays, and oral examinations.

Network Specialists

If you or your dentist decides that you need specialized care, you may see any **specialist** in or out of the Cigna Dental network. Plan benefits are higher and your out-of-pocket costs are lower if you choose a network **specialist**.

WHAT'S NOT COVERED- ADDITIONAL EXCLUSIONS AND GENERAL LIMITATIONS

Certain dental expenses may NOT be considered **covered expenses** under the Dental Plan and coverage for some services may depend on your state of residence. The following lists some, but not all, exclusions and limitations under the Dental Plan. You should review the certificates and riders documents, available on the Y*our Cigna Life* website, for more information about exclusions and limitations.

Cigna DHMO Option

The Cigna DHMO Plan will not reimburse you for expenses related to the following:

- Services or expenses incurred by you or your covered family members before coverage started or after coverage has ended under the Plan.
- Services, supplies, charges or expenses not listed on the schedules in Appendix III.
- Services related to an injury or illness covered under Workers' compensation, occupational disease, or similar laws.
    - − Florida Residents - this exclusion relates to such services 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.
- Cosmetic dentistry or cosmetic dental surgery (dentistry or dental surgery performed solely to improve appearance.)

- Prescription drugs.

  The completion of crown and bridge, dentures, root canal treatment, or other multiple-visit procedures already in progress on the date the covered person becomes covered by the Dental Plan.

  − Texas Residents - **Pre-existing conditions**, including the completion of crown and bridge, dentures or root canal treatment already in progress on the effective date of your coverage, are not excluded, if otherwise covered under the schedule in Appendix III.

- Procedures or services associated with placement or prosthodontic restoration of a dental implant.
- Services to the extent that the covered person is compensated for them under any group medical plan, no-fault auto insurance policy, or insured motorist policy.

  − Arizona and Pennsylvania Residents – this exclusion does not apply.

  − Kentucky and North Carolina Residents – services compensated under no-fault or insured motorist policies not excluded.

  − Maryland Residents – services compensated under group medical plans not excluded.

- Services relating to injuries that are intentionally self-inflicted.

  − Texas and Ohio Residents – services related to self-inflicted injuries are not excluded.

- Services considered being unnecessary or experimental in nature.

  − Pennsylvania Residents – services considered to be experimental in nature.

  − California and Maryland Residents – services considered to be unnecessary.

- 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.

  − Texas Residents — 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 your medical carrier for benefit determination.

- Replacement of fixed and/or removable prosthodontic or orthodontic appliances that have been lost, stolen or damaged due to patient abuse, misuse or neglect.
- 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.
- Procedures, appliances, or restorations if the main purpose is to:

  − Change vertical dimension (degree of separation of the jaw when teeth are in contact.)

  − Diagnose or treat abnormal conditions of the temporomandibular joint, or (TMJ), unless TMJ therapy is specifically listed on the schedule in Appendix III.

  − Restore teeth that have been damaged by attrition, abrasion, erosion and/or abfraction.

  − California Residents — except for medically necessary treatment where functionality of teeth has been impaired.

- Services provided by a non-network **dentist** without Cigna Dental Heath's prior approval except emergencies.
- 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 conduction with **covered services** performed by an oral surgeon or periodontist.

− Maryland Residents — Covered when medically necessary and authorized by the covered person's physician.

- Crowns and bridges used solely for splinting.
- Resin bonded retainers and associated pontics.
- Except as set forth above, **pre-existing conditions** are not excluded.

Some Limitations Apply to Your Cigna DHMO Benefits

The following limitations apply to your benefits:

- The frequency of certain covered procedures is limited as shown on the schedule in Appendix III.
- Payment authorization is required for coverage of services by a network **specialist**.
- Coverage for referral to a pediatric **dentist** ends on an enrolled child's 7th birthday; however, exceptions for medical reasons may be considered on an individual basis. The **network general dentist** shall provide care after the child's 7th birthday.
- The surgical removal of an impacted wisdom tooth is not covered if the tooth is not diseased or if the removal is only for orthodontic reasons.

Cigna Dental PPO and Dental Select Options

The Dental PPO and Dental Select Options will not reimburse you for expenses related to the following:

- Services or expenses incurred by you or your covered family members before coverage started or after coverage has ended under the Plan.
- Services or supplies not medically necessary for diagnosis or treatment of an active dental disease or injury, unless specifically covered by the Plan.
- Services, supplies, or expenses that are not covered by the Plan.
- Services related to an injury or illness covered under Workers' Compensation, occupational disease, or similar laws.
- Charges for services made by a hospital owner 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.
- Cosmetic dentistry or cosmetic dental surgery (dentistry or dental surgery performed solely to improve appearance).
- Any condition, disability or expense resulting from or sustained as a result of:

  − Being engaged in an illegal occupation.

  − Duty as a member of the armed forces of any state, country at war or act of war, declared or undeclared.

  − Participation in a civil insurrection or riot.
- Any services for which a charge would not have been made in the absence of coverage.
- Prescription drugs.
- Procedures or services associated with placement or prosthodontic restoration of a dental implant.
- Charges for gold foil restorations.
- Charges for bleaching teeth.

- Services to the extent that the covered person is compensated for them under any group medical plan, no-fault auto insurance policy, or insured motorist policy.
- Services relating to injuries that are intentionally self-inflicted.
- Services considered being unnecessary or experimental in nature.
- Services rendered by a **dentist** beyond the scope of his or her license, or any services provided by an unlicensed dentist.
- Procedures or appliances for minor tooth guidance or to control harmful habits.
- Instruction for plaque control, oral hygiene and diet.
- Hospitalization, including any associated incremental charges for dental services performed in a hospital.
- Services that are deemed to be medical services.
- Replacement of fixed and/or removable prosthodontic appliances that have been lost, stolen or damaged due to patient abuse, misuse or neglect.
- Procedures, appliances, or restorations that have as their main purpose to:
  - Change vertical dimension (degree of separation of the jaw when teeth are in contact.)
  - Diagnose or treat abnormal conditions of the temporomandibular joint.
  - Stabilize periodontally involved teeth.
  - Restore occlusion.
- Porcelain or acrylic veneers on crowns and pontics on or replacing the upper and lower first, second and third molars.
- Bite registrations; precision or semiprecision attachments; or splinting.
- Charges over and above maximum reimbursable limits.
- Dental services that do not meet common dental standards. Charges for unnecessary care; treatment or surgery.
- Charges for non-dental services such as filling out insurance forms.
- Charges for failure to keep an appointment.
- Charges for any other services not specifically listed as covered.
- Except as set forth above, **pre-existing conditions** are not excluded.

Some Limitations Apply to Your Dental PPO and Dental Select Benefits

The following limitations apply to your benefits:

- The frequency of certain covered procedures is limited as shown on the services schedule.
- Replacement of crowns, fixed bridgework and full or partial denture are only covered if:
  - Such crowns, bridgework or dentures are a replacement for a previously placed crown, bridge or denture, and
  - The replacement occurs more than one year after the patient first becomes covered under the PPO or Select options and more than five years after the installation of the existing crown, bridge or denture being replaced, and the old crown, bridge or denture cannot be made serviceable.

These benefits 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 by **Cigna**.

- The benefit levels provided by that option.

COORDINATION OF BENEFITS

This section applies if you or a **covered dependent** is enrolled in more than one group dental plan (for example, if your **spouse** has dental plan coverage through **Cigna** as your **covered dependent** and is also covered by his or her current employer's plan). This section describes coordination of benefits (COB), the process for determining which plan is the "primary plan" that pays first and which plan is the "secondary" plan that pays only the remaining balance up to the total covered charges.

COB allows group dental plans to avoid duplication of benefits so that the total paid does not exceed the total covered amount for the services received.

Definitions for Coordination of Benefit Rules

The following terms apply to the COB section:

Group Dental Plan

A group dental plan either pays benefits or provides services for dental care or treatment and is one of the following:

- Group insurance and/or group-type coverage, whether insured or self-insured, which: (a) cannot be purchased by the general public, and (b) is not individually underwritten.
- Closed panel coverage that provides services through a panel of employed or contracted dental care professionals and that limits or excludes services provided by dental care professionals outside of the panel (except in the case of emergency or if referred by a dental care professional within the panel).
- Coverage under Medicare and other governmental program as permitted by law, except Medicaid and Medicare supplement policies.
- Dental coverage under group, group-type contracts.
- Coverage under group health plans that offer coverage for dental services.

Each group dental plan or part of a plan that has the right to coordinate benefits is considered a separate plan.

Allowable Expense

An allowable expense is a necessary, reasonable and customary service or expense for a service that is covered in full or in part by any group dental plan in which you are enrolled. When a group dental plan provides services, the reasonable cash value of each service is the allowable expense and considered the amount paid by the plan for the purposes of coordination of benefits.

Expenses or services that are not allowable expenses include, but are not limited to:

- An expense or service or a portion of an expense or service that is not covered by any of the group dental plans coordinating benefits.
- Any amount in excess of the highest reasonable and customary fee if you are covered by two or more group dental plans that provide services or supplies on the basis of reasonable and customary fees.

- If you are covered by one group dental plan that provides services or supplies on the basis of reasonable and customary fees and another group dental plan that provides services and supplies on the basis of negotiated fees, the allowable expense will be determined by the fee arrangement used by the plan that pays first.
- If the plan that pays first reduces your benefits because you did not comply with the plan provisions (including second surgical opinions) or because you did not use a preferred dental care professional, the amount of the reduction is not an allowable expense.

Claim Determination Period

A calendar year, excluding any part of a year during which you are not covered under the Dental Plan.

Reasonable Cash Value

An amount which a licensed dental care professional usually charges patients for a service if it is within the range of fees usually charged for the same service by other dental care professionals who (1) are located in the immediate geographic area where the dental care service is provided and (2) provide dental care services under similar or comparable circumstances.

Order of Benefit Determination Rules

A group dental plan that does not have a COB rule consistent with this section is always the plan that pays first. If a group dental plan has a COB rule consistent with this section, the first of the following rules that applies determines which plan pays first and which plan pays second:

(1) The group dental plan that covers you as an employee or enrollee is the plan that pays before the group dental plan that covers you as a dependent.

(2) For a dependent child whose parents are not divorced or legally separated if both cover their dependent child under a group dental plan, the “birthday rule” applies. The plan covering the parent whose birthday falls earlier in the year pays first. Birthday refers to only the month and day in a calendar year, not the year in which someone was born. If both parents have the same birthday (month and day), the plan that has provided coverage longer pays first.

(3) If your child is covered by more than one group dental plan and you are divorced or separated from the other parent, the plans would pay in the following order:

   (a) first, if a court decree states that one parent is responsible for the child’s health care expenses or health coverage, the group dental plan for that parent -- if the plan is notified of the terms of the order, but only from the time of notification;

   (b) next, the group dental plan of the parent with custody of the child;

   (c) next, the group dental plan of the **spouse**/**partner** of the parent with custody of the child;

   (d) then, the group dental plan of the parent not having custody of the child, and

   (e) finally, the group dental plan of the **spouse**/**partner** of the parent not having custody of the child.

(4) The group dental plan that covers you as an active employee (or as the dependent of an active employee) is the plan that pays first and the group dental plan that covers you as a former employee (or as the dependent of a former employee) is the plan that pays second. If the other group dental plan does not have a similar provision and, as a result, the plans cannot agree on the order of benefit determination, this paragraph does not apply.

(5) The group dental plan that covers you as an active employee or as a retiree (or as the dependent of an active employee or retiree) is the plan that pays first and the group medical plan that covers you under federal COBRA continuation or a state law requiring health care coverage continuation is the plan that pays second. If the other group dental plan does not have a similar provision and, as a result, the plans cannot agree on the order of benefit determination, this paragraph does not apply.

(6) If you and your **covered dependents** are covered under Cigna DHMO, but obtain services from a **dentist** that is not in the Cigna Dental network, there is no coverage under Cigna DHMO and you would have to submit all expenses for consideration to the other plan.

If none of these rules determines the order of benefits, the group dental plan that has covered you for the longer period of time is the plan that pays first.

Here are some examples of how these rules apply:

- If you (the **Cigna** employee) are the patient, but you also have coverage as a dependent under your **spouse**/**partner's** group dental plan, the Cigna Dental Plan (coverage option and accompanying account) will pay first and your **spouse** or **partner's** plan will pay next.
- If your **spouse**/**partner** is the patient and has coverage through his or her employer and under the Cigna Dental Plan as your **covered dependent**, your **spouse**/**partner's** plan will pay first and the Cigna Dental Plan will pay next.
- If your child is the patient, both you and your **spouse**/**partner** cover your child, you were born in January and your **spouse** was born in August, the Cigna Dental Plan will pay first (the plan of the parent whose birthday falls earlier in the year, regardless of the ages of the parents, is the plan that pays first). However, special coordination of benefits rules described above apply if you are divorced or legally separated from the child's other parent.

When the Cigna Dental Plan Pays Second

If the Cigna Dental Plan pays second, the amount you receive may be reduced, so that the total benefits paid by all group dental plans during a claim determination period are not more than 100% of the total of all allowable expenses.

The difference between the benefits that the Cigna Dental Plan would have paid if the Cigna Dental Plan had paid first, and the amount that the Cigna Dental Plan actually pays, will be recorded as a benefit reserve for you.

The Plan will use this benefit reserve to pay any allowable expense not otherwise paid in full during the calendar year. As each claim is submitted, **CHLIC** will automatically determine whether there are any unpaid allowable expenses and use the benefits reserve recorded for you to pay up to 100% of this amount. At the end of the claim determination period, which is also the end of the calendar year in the case of the Cigna Dental Plan, any dollars remaining in the benefit reserve will be forfeited and not carried over to the subsequent calendar year.

Recovery of Excess Benefits

Payments are made in accordance with the provisions of the Plan. If it is determined that payment was made for services or expenses that are not covered by the Plan, or for a participant who is not covered by the Plan, the Plan has the right to recover the overpayment. The Plan will have the right to recover an actual payment made or the reasonable cash value of any services provided if the Plan pays benefits that should have been paid first by another group dental plan or the Plan pays more than the covered amount under the Plan when the Plan pays first.

CHLIC will have sole discretion to seek this recovery from any person to, or for whom, or with respect to whom, these services were provided or payments made by any insurance company, health care plan or other organization. **CHLIC** will attempt to collect the overpayment from the party to whom the payment was made. However, **CHLIC** reserves the right to seek overpayment from you and/or your **covered dependents**. Failure to comply with a request to repay an overpayment will entitle the Plan to withhold benefits due you and/or your **covered dependents**.

CHLIC has the right to refer a claim for overpayment to an outside collection agency. It may also bring a lawsuit to enforce its rights to recover overpayments.

If requested, you must provide any requested information as determined necessary by **CHLIC** to secure the right of recovery.

Right to Receive and Release Information

CHLIC, without consent or notice to you, may obtain information from and release information to any other group dental plan relating to you in order to coordinate your benefits under this section.

You must provide any requested information in order to coordinate your benefits. When a request for information relates to a submitted claim, you will be advised that the "other coverage" information, (including an Explanation of Benefits paid by the other medical plan) is required before **CHLIC** will process the claim. If you do not respond within 90 days of this request, the claim will be denied. **CHLIC** will automatically reopen and process your claim provided the requested information is received by the end of the 90-day period.

WHEN A THIRD PARTY MAY BE RESPONSIBLE FOR BENEFITS

This section describes the Plan's rights to be repaid if you receive Plan benefits after an injury, illness or other condition and then recover from someone else (a third party) money in payment for your related medical expenses. That money must be repaid to the Plan. As is true in most other parts of the SPD, "you" as used here includes your **covered dependents**.

The Plan does NOT cover:

(1) Expenses you incur if another party may be responsible for those expenses because that party caused or contributed to your injury, illness, or other condition.

(2) Expenses you incur to the extent you receive any payments 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 of the following or a similar type of coverage: compromises or awards, medical payment coverage (auto, homeowners or otherwise), any no-fault insurance, uninsured or underinsured motorist insurance, workers' compensation settlement, government insurance (other than Medicaid), and other group insurance (including student plans).

If another party is, or may be considered, liable for your injury, illness or other condition, the Plan will not cover either the reasonable value of the services to treat such an injury, illness or other condition or the treatment of such an injury, illness or other condition. These benefits are specifically excluded.

Subrogation/Right of Reimbursement

If you incur a **covered expense** and the Plan or its **claims administrator** determines that another party may be responsible for the expenses or you may receive payment as described above:

(1) Subrogation: The Plan shall, to the fullest extent permitted by law in the appropriate jurisdiction, be subrogated to all rights, claims, demands or interests that you may have against the responsible party. Such party may include (i) any other person (including, but not limited to, his or her insurance companies and carriers), whose action or inaction caused or contributed to the injury, illness or other condition for which Plan benefits are paid; and (ii) any other third party, including, but not limited to, your automobile or other insurance company or carrier. The amount of subrogation will equal the total amount paid under the Plan arising out of the injury, illness or other condition together with any attorneys' fees and costs that the Plan incurs in enforcing its subrogation rights under these subrogation and right to reimbursement provisions. The Plan is not required to participate in or pay attorneys' fees, costs, or expenses to any attorney hired by you (or your guardian, estate, heir, or other representative) in pursuit of claims against a person who caused or contributed to the injury, illness or other condition; however, the Plan may bring an action on its own behalf or your behalf against any responsible party or third party involved in the injury, illness or other condition.

The Plan may advance monies or provide benefits for an injury, illness or other condition for which another party is responsible, and, if so, the Plan is subrogated to all of your rights against any party liable for your injury, illness or other condition, or who is or may be liable for the payment for the medical treatment of such injury, illness or other condition in the amount of monies or value of other benefits advanced or provided by the Plan to you. The Plan may assert this right independently of you. The Plan is not obligated in any way to pursue this right

independently or on your behalf, but may choose to pursue its rights to reimbursement under the Plan, in its sole discretion.

You are obligated to cooperate with the Plan and its agents to protect the Plan's subrogation rights. Your obligations include, but are not limited to, providing the Plan or its agents with any relevant information requested by them, signing and delivering such documents as the Plan or its agents reasonably request to enforce the Plan's subrogation rights, and obtaining the consent of the Plan or its agents before releasing any party from liability for payment of medical expenses.

If you enter into litigation or settlement negotiations relating to your injury, illness or other condition, you must not prejudice, in any way, the subrogation rights of the Plan. If you fail to cooperate as provided, including executing any required documents, the Plan may, in addition to remedies provided elsewhere in the SPD and/or under the law, set off from any future benefits otherwise payable under the Plan the money and value of other benefits advanced to the extent not recovered by the Plan.

The Plan will automatically have a lien on the proceeds of any recovery by you from that third party to the extent of any benefits paid under the Plan.

(2) Right of Reimbursement: The Plan is also granted a right to be reimbursed from the proceeds of any recovery you (or your attorney, guardian, heir, estate, or other representative) receive from any sources related to such injury, illness or condition (including, but not limited to: (i) any policy or contract from any insurance company or carrier (including your automobile or other insurer); and/or (ii) any third party, plan, or fund as a result of a judgment, arbitration award, verdict, insurance payment, settlement or other recovery, regardless of whether or not (i) you have been fully compensated, or made whole for your loss, (ii) liability is admitted by you or any other party, or (iii) the recovery by you is itemized or specified as a recovery for medical expenses incurred).

If a recovery is made, the Plan shall have first priority in payment over you or any other party to receive reimbursement of the monies and value of the other benefits advanced on your behalf. This reimbursement shall be from any recovery made by you, and includes, but is not limited to, uninsured and underinsured motorist coverage, any no-fault insurance, medical payment coverage (auto, homeowners or otherwise), workers' compensation settlement, compromises or awards, other group insurance (including student plans), and direct recoveries from liable parties. The Plan has a right to be reimbursed from such payment for all amounts the Plan has paid or will pay as a result of that illness, injury or other condition. This right of reimbursement is cumulative with, and not exclusive of, the Plan's subrogation right granted in paragraph 1, but only to the extent of the benefits provided by the Plan.

Lien of the Plan

By accepting any benefits advanced under this Plan, you:

- Acknowledge that if the Plan advances monies or provides benefits for an injury, illness or other condition, and you recover monies or benefits from a third party due to that particular injury, illness or condition (of any sum up to the amount of the monies or benefits advanced), the Plan has an equitable lien in connection with such payments. This lien is binding on any attorney or other party who represents you, whether or not that attorney is your agent or the agent of any insurance company or other financially responsible party against whom you may have a claim if the attorney, insurance carrier or other party has been notified by the Plan or its agents;
- Acknowledge that any proceeds of settlement or judgment, including your claim to such proceeds held by another person, held by you, or by another, are being held for the benefit of the Plan;
- Agree that this lien shall constitute a charge against the proceeds of any recovery and the Plan shall be entitled to assert a security interest thereon; and
- Agree to hold the proceeds of any recovery in trust for the benefit of the Plan to the extent of any payment made by the Plan. Failure to hold such received funds in trust, and in a separate, identifiable account, will be deemed a breach of your obligation to the Plan.

Additional Terms

- The above subrogation and reimbursement rights arise immediately upon payment of any benefits under the Plan.
- You (and your guardian, heir, estate or other representative) shall cooperate fully with the Plan and **Cigna** in asserting and protecting the Plan's subrogation and reimbursement rights.
- When requested by the Plan, **CHLIC**, or their designees, you (or your guardian, estate, heir or other representative) specifically agree to notify **Cigna** in writing if benefits are paid under the Plan for care arising out of any injury or illness that provides or may provide the Plan subrogation or reimbursement rights pursuant to the above subrogation and right to reimbursement provisions.
- When requested by the Plan, **CHLIC**, or their designees, you (or your guardian, estate, heir or other representative) specifically agree to notify the Plan in writing of your intent to pursue or investigate a claim to recover damages or obtain compensation due to sustained injuries or illness.
- You and your adult **covered dependents** may not assign any rights to recover medical expenses from any third party or other person or entity to any minor dependent without the prior express written consent of the Plan. The Plan's right to recover shall apply to the settlements or recoveries of decedents, minors, and incompetent or disabled persons.
- You (and your guardian, estate, heir or other representative) shall not to do anything to prejudice the Plan's right to reimbursement or subrogation, including making any settlement which specifically reduces or excludes, or attempts to reduce or exclude, the benefits provided by the Plan.
- The Plan's right of recovery shall be a prior lien against any proceeds you recover and this right shall not be defeated or reduced by the application of any so-called "Made-Whole Doctrine," "Rimes Doctrine," or any other such doctrine purporting to defeat the Plan's recovery rights by allocating the proceeds exclusively to non-medical expense damages.
- You must assign to the Plan any benefits you may have under any automobile policy or other coverage, to the extent of the Plan's claim for reimbursement. You shall sign and deliver, at the request of the Plan or its agents, any documents needed to effect such assignment of benefits.
- You shall not incur any expenses on behalf of the Plan in pursuit of the Plan's rights. Specifically; no court costs, attorneys' fees or other representatives' fees may be deducted from the Plan's recovery without the prior express written consent of the Plan. This right shall not be defeated by any so-called "Fund Doctrine," "Common Fund Doctrine," "Attorney's Fund Doctrine," or other equitable defenses.
- The Plan shall recover the full amount of benefits provided hereunder without regard to any claim of fault on your part, whether under comparative negligence or otherwise.
- If you fail or refuse to honor your obligations, then the Plan will be entitled to recover any costs incurred in enforcing these terms. These costs may include, but are not limited to, attorney's fees, litigation, court costs, and other expenses. The Plan is also entitled to offset the reimbursement obligation against any entitlement to future medical benefits hereunder until you have fully complied with your reimbursement obligations hereunder, regardless of how those future medical benefits are incurred.

Any reference to state law in this SPD shall not be applicable to this provision. By accepting benefits under the Plan, you agree that a breach would cause irreparable and substantial harm and that no adequate remedy at law would exist. Further, the Plan shall be entitled to invoke such equitable remedies as may be necessary to enforce the terms of the Plan, including, but not limited to, specific performance, restitution, the imposition of an equitable lien and/or constructive trust, as well as injunctive relief.

Cigna, in its sole and absolute discretion, may waive or modify any or all of the above provisions.

CLAIMS AND BENEFIT PAYMENTS

How to File Your Claims

With Cigna DHMO there are no claim forms to fill out. If you are enrolled in the Dental PPO or Dental Select options and you use a network provider, your provider will submit claims on your behalf. You will file claims for dental care services under the Dental PPO or Dental Select options whenever you use out-of-network providers. You can get claim forms on *www.myCigna.com*. Instructions for completing and submitting claims are provided on the website.

Payment of Benefits

The Plan generally makes payments directly to network providers or facilities that provide your **covered services**. By using network services, you are automatically authorizing Cigna DHMO, CHLIC Life and any network provider or facilities to release your relevant medical records to **CHLIC,** the **claims administrator**, to determine applicable benefits or reimbursements for the services you receive.

Any dental benefits for emergency dental treatment received from a non-participating **dentist** will be paid, less applicable patient charges, at the option of Cigna Dental, either to you or to the person or institution providing the dental care. Reimbursement will be made after you submit appropriate reports and x-rays to Cigna Dental. Contact the Customer Service Center at 1.888.99Cigna (1.800.992.4462) for more information.

All out-of-network dental benefits under the PPO and the Dental Select option are payable to you. You may have payments made directly to the **dentist** by completing the "Authorization To Pay Benefits To Dentist" section of the claim form. However, the Claims Administrator reserves the right to reimburse providers directly for those charges. You will receive notification if a payment is made directly to a provider.

Plan benefits are not assignable unless agreed to by **CHLIC**. **CHLIC** may, at its option, make payment to you for the cost of any **covered services** received by you or your **covered dependent** out-of-network, even if benefits have been assigned. When benefits are paid to you, you are responsible for reimbursing the health care professional or facility. If the person to receive the payment is a minor or, in **CHLIC**'s opinion, cannot give a valid receipt for the payment, the Plan will pay that person's legal guardian. If no legal guardian requests payment, the Plan may, at its option pay the person or institution that appears to have responsibility for the person's custody and support.

If you die while any Plan benefits remain unpaid, the Plan may pay any of your following living relatives: **spouse** or **partner**, mother, father, child or children, brothers or sisters; or to the executors or administrators of your estate.

The Plan will not be liable for any additional payments to the extent it makes a payment to a living relative or other person listed above.

Recovery of Overpayments

If the Plan makes an overpayment, the Plan or its designee has the right at any time to: (a) recover that overpayment from the person to whom or on whose behalf it was made; or (b) offset the amount of that overpayment from a future claim payment.

CLAIM DETERMINATION PROCEDURES

If Your Claim is Denied

Most issues can be resolved by working with your **network general dentist** and his or her office staff. If you have questions about your dental office, you may contact the Customer Service Center by telephone at 1.888.9Cigna (1.888.992.4462), or by writing to:

Cigna DHMO (for participants in the managed care/DHMO option)
P.O. Box 188046
Chattanooga, TN 37422-8046

OR

Cigna Dental PPO (for participants in the PPO or Dental Select option)
P.O. Box 188037
Chattanooga, TN 37422-8037

Most matters can be resolved with the initial phone call. If more time is needed to review or investigate your concern, you will receive a response 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.

Notice of Adverse Determination

Every notice of an adverse benefit determination will be provided in writing or electronically, and will include all of the following that relate to the determination:

- The specific reason or reasons for the denial;
- Reference to the specific Plan provisions on which the determination is based;
- A description of any additional material or information necessary to perfect the claim and an explanation of why such material or information is necessary;
- A description of the Plan's review procedures including the applicable time limits and a statement of your right to bring a civil action under section 502(a) of **ERISA** following an adverse benefit determination on appeal;

APPEALS PROCESS

The Cigna Dental Plan has two different appeal procedures. One is for eligibility/election issues; the other is for coverage/benefit issues.

An "eligibility/election" issue is one that deals with:

- Your eligibility to enroll in a Cigna Dental Plan option;
- The eligibility of your dependents;
- Your enrollment;
- Your coverage elections;
- Your dependent elections;
- Your cost for coverage (your **payroll cost**); or
- Changes in your elections – including **life status changes**.

A "coverage/benefit" issue is one that deals with:

- Whether the option you elected covers a particular illness, injury, treatment or procedure; or
- If there is coverage, the level of benefit the option provides and the level of benefit to which you might be entitled.

The appeals process for eligibility/election issues is described below, followed by the appeals process for coverage/benefit issues.

You may treat any issue that does not clearly fall into one of the above categories as an eligibility/election issue.

Eligibility/Election Issues

Level One Appeals

If you have a problem with or disagree with a decision about an eligibility/election issue, you may file an appeal by using the process described in this section. As part of the process, you are entitled to review pertinent documents and have a qualified person represent you in the review.

You may start the appeal process by writing about your problem to the Your Cigna Life Service Center at:

Post Office Box 62825
Phoenix, AZ 85082

You must make your written appeal within 180 days after the event that gives rise to your problem. Your appeal letter should include (1) your name, (2) the plan name, (3) an explanation of why you believe your claim is valid and (4) copies of any supporting documents. Someone other than you may write an appeal letter on your behalf if you have clearly authorized that person in writing to represent you and a copy of that written authorization, signed by you, is included with the appeal letter.

The Your Cigna Life Service Center will normally make a decision on your appeal within 30 days after receipt of your appeal letter. However, if special circumstances require more time to make a decision, the Your Cigna Life Service Center may need an extension of up to 15 more days to consider your appeal. The Your Cigna Life Service Center will notify you in writing prior to the end of the 30-day period of any extension and the reason for it and if additional information is required.

If you must provide additional information to support your appeal:

- The notice of the extension will detail the information you need to provide;
- You will have at least 45 days to provide the information; and
- The running of the 15-day extension period will be suspended until the Your Cigna Life Service Center receives the additional information.

The Your Cigna Life Service Center will notify you in writing of the decision on your appeal. If your appeal is denied in whole or in part, the notice will include:

- The specific reason for the denial;
- References to Plan provisions on which the denial is based;
- A statement that you may request access to or copies, free of charge, of all documents, records and other information relevant to your claim; and
- A description of the Plan's procedures for appealing the decision and a statement of your rights to bring a civil action under **ERISA**.

If you have not received a decision by the end of the 30-day period (or the end of the extended period, if you received notice about the extension), you may treat your appeal as denied.

Filing a Final Appeal

If your appeal to the Your Cigna Life Service Center is denied in whole or in part, and you disagree with the decision, you may make a final appeal to the **plan administrator**. Your final appeal must also be in writing and must be sent within 180 days from the date that you receive written notice of the denial of your level one appeal from the Your Cigna Life Service Center. You should address your final appeal letter to:

Office of the Plan Administrator
Cigna Corporation
Two Liberty Place, TL05T
1601 Chestnut Street
Philadelphia, PA 19192

Your final appeal letter should contain an explanation of why you think your request should be approved and copies of any supporting documents. Someone other than you may write an appeal letter on your behalf if you have clearly authorized that person in writing to represent you and a copy of that written authorization, signed by you, is included with the appeal letter.

In considering your appeal, the **plan administrator** will review your written appeal letter, any relevant documents you provide, the relevant Plan provisions and other relevant information. The **plan administrator** will normally make a decision on your appeal within 60 days after receiving your appeal letter.

The **plan administrator** will notify you in writing of the decision on your final appeal, and that decision is final. If your appeal is denied, this written notice will include:

- The specific reason for the denial;
- References to Plan provisions on which the denial is based;
- A statement that you may request access to or copies, free of charge, of all documents, records and other information relevant to your claim; and
- A statement of your right to bring a civil action for Plan benefits under **ERISA** section 502(a).

If you have not received a decision by the end of the 30-day period, you may treat your appeal as denied.

The **plan administrator** has the sole discretion to determine any eligibility/election issues; to interpret any of the Plan's provisions relevant to eligibility/election issues (and issues, if any, that are neither eligibility/election issues; nor coverage/benefit issues), including any ambiguous or disputed terms; and to make any related factual determinations. The **plan administrator's** determinations and interpretations are final and binding on all parties.

Coverage/Benefit Issues

If you have a problem with or disagree with a decision about a coverage/benefit issue, you may file an appeal by using the process described in this section. In this section, the terms "you" and "your," depending on the context, may also refer to your authorized representative or health care professional.

"Dental Reviewers" are licensed **dentists** who specialize in areas appropriate for the care, service or treatment under review.

Start With the Customer Service Center

If you have a concern about a person, a service, the quality of care, Plan benefits, or a rescission of coverage, you may call the Customer Service Center -- at 1.888.99Cigna (1.888.992.4462) -- to explain your concern to a Customer Service representative. The Customer Service representative will try to resolve the matter on your initial contact. If the Customer Service Center needs more time to review or investigate your concern, a representative will get back to you as soon as possible, but in any case within 30 days. If you are not satisfied with the results of a coverage or benefits decision, you may start the appeals procedure.

You may also express your concern in writing.

The Dental Plan has a two-step appeals procedure for coverage decisions. To initiate an appeal, you must submit a request in writing to the address below within one year from the date of the initial Plan decision. You should state the reason why you believe your request should be approved and include any information supporting your request.

For Cigna DHMO	OR	For Cigna Dental PPO & Dental Select
Cigna Dental Care P.O. Box 188047 Chattanooga, TN 37422-8047		Cigna Dental PPO P.O. Box 188044 Chattanooga, TN 37422-8044

Notice of Adverse Coverage/Benefit Determination

The notice of an adverse coverage/benefit determination will be provided in writing or electronically, and will include all of the following that relate to the determination:

- The specific reason or reasons for the denial;
- Reference to the specific Plan provisions on which the determination is based;
- A description of any additional material or information necessary to perfect the claim and an explanation of why such material or information is necessary;
- A description of the Plan's review procedures including the applicable time limits and a statement of your right to bring a civil action under section 502(a) of **ERISA** following an adverse benefit determination on appeal;
- Upon your request and free of charge, a copy of any internal rule, guideline, protocol or other similar criterion that was relied upon in denying your claim;
- An explanation of the scientific or clinical judgment for a determination that is based on a **dental necessity**, experimental treatment or other similar exclusion or limit; and
- In the case of a claim involving **urgent care**, a description of the expedited review process applicable to such claim.

Internal Appeals Procedure

CHLIC has a two-step appeals procedure for coverage decisions. To start an appeal, you must submit a written request for an appeal to **CHLIC** within 180 days after you receive a denial notice. Address the appeal to:

For Cigna DHMO	For Cigna Dental PPO & Select
Cigna Dental Care P.O. Box 188047 Chattanooga, TN 37422-8047	Cigna Dental PPO P.O. Box 188044 Chattanooga, TN 37422-8044

Your appeal letter should explain why you think your appeal should be approved and include any information that supports your appeal. If you cannot or choose not to write, you may start your appeal by telephone. Call **CHLIC** at 1.888.992.4462 for assistance.

Level One Appeals

Your appeal will be reviewed and decided by someone not involved in the initial decision. A dental professional will consider appeals involving **dental necessity** or clinical appropriateness.

CHLIC will respond in writing with a decision on your appeal:

- within 15 calendar days after receiving an appeal for a required preauthorization or concurrent care coverage determination or a post-service **dental necessity** determination, and
- within 30 calendar days after receiving an appeal for any other post-service coverage determination.

If you are enrolled in the Cigna DHMO option:

- For New Jersey residents, Cigna Dental will respond in writing within 15 working days.
- For Colorado residents, Cigna Dental will respond within 20 working days.
- For Nebraska residents, Cigna Dental will respond within 15 working days if your complaint involves an adverse determination.

If **CHLIC** needs more time or information to make the determination, **CHLIC** will notify you in writing to request an extension of up to 15 more calendar days and will specify any additional information it needs to complete the review.

In the event any new or additional information (evidence) is considered relied on or generated by **CHLIC** in connection with the appeal, **CHLIC** will provide this information to you as soon as possible and sufficiently in advance of the decision so that you will have an opportunity to respond. Also, if any new or additional rationale is considered by **CHLIC**, **CHLIC** will provide the rationale to you as soon as possible and sufficiently in advance of the decision so that you will have an opportunity to respond.

You may ask **CHLIC** for a quicker decision (an expedited appeal) if the above timing would seriously jeopardize your life, health or ability to regain the maximum dental functionality that existed prior to the onset of your current condition, or in your **dentist's** opinion would cause you severe pain which cannot be managed without the requested services.

When an appeal is expedited, **CHLIC** will respond orally with a decision within 72 hours, with a written follow up.

If you are enrolled in the Cigna DHMO option:

- For Maryland residents, Cigna Dental will respond within 24 hours.
- For Texas residents, Cigna Dental will respond within one business day.

Level Two Appeals

To initiate a level two appeal, follow the same process required for a level one appeal. Level two appeals will be conducted by an Appeals Committee, which consists of a minimum of three people. Anyone involved in the prior decision may not vote on the Appeals Committee. For appeals involving **dental necessity** or clinical appropriateness, the committee will include at least one **dentist**. If specialty care is in dispute, the committee will consult with a **dentist** in the same or similar specialty as the care under consideration, as determined by the **plan administrator**.

Your appeal will acknowledged in writing within five business days and schedule a committee review. The acknowledgment letter will include the name, address, and telephone number of the appeals coordinator. Additional information may be requested at that time. If your appeal concerns a denied pre-authorization or a post-service **dental necessity** determination, the Appeals Committee review will be completed within 15 calendar days. For appeals concerning all other coverage issues, the Appeals Committee review will be completed within 30 calendar days. If more time or information is needed to complete the review, you will be notified in writing to request an extension of up to 15 calendar days and to specify any additional information needed by the Appeals Committee to complete the review.

You may present your situation to the committee in person or by conference call. Please advise the **plan administrator** five days in advance if you or your representative plans to be present. You will be notified in writing of the committee's decision within five business days after the committee meeting. The resolution will include the specific contractual or clinical reasons for the resolution, as applicable.

Notice of Benefit Determination on Appeal

Every notice of a determination on appeal will be provided in writing or electronically. If the decision involves a denial of your claim, the notice will include:

- The specific reason or reasons for the denial;
- Reference to the specific Plan provisions on which the determination is based;

- A statement that you are entitled to receive, upon request and free of charge, reasonable access to and copies of all documents, records, and other relevant information as defined below;
- A description of available external review processes, including information about how to initiate an appeal;
- A statement describing any voluntary appeal procedures offered by the Plan and your right to bring an action under **ERISA** section 502(a);
- Upon your request and free of charge, a copy of any internal rule, guideline, protocol or other similar criterion that was relied upon in denying your claim; and
- An explanation of the scientific or clinical judgment for any determination that is based on a **dental necessity**, experimental treatment or other similar exclusion or limit.

Relevant Information

"Relevant information" is any document, record or other information that:

- Was relied on in making the benefit determination;
- Was submitted, considered or generated in the course of making the decision, even if the document, record, or other information was not actually relied on in making the benefit determination;
- Demonstrates compliance with the administrative processes and safeguards required by federal law in making the benefit determination; or
- Constitutes a statement of policy or guidance under the Plan about the denied treatment option or benefit for the applicable diagnosis, even if the advice or statement was not actually relied on in making the benefit determination.

Cigna DHMO Appeals to the State

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

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

Participating Provider

If you have questions about the participating provider office or the treatment process, you should speak with a Customer Service Representative at 1.888.99Cigna (1.888.992.4462), or write to:

For Cigna DHMO	OR For Cigna Dental PPO & Dental Select
Cigna Dental Care P.O. Box 188046 Chattanooga, TN 37422-8046	Cigna Dental PPO P.O. Box 188036 Chattanooga, TN 37422-8036

Your concern will be reviewed by the Network Management Department and you can expect a response within 30 days of receipt.

If you are not satisfied with the resolution of your complaint about network or dental office issues, you may appeal through the Grievance Committee at the address above. Such appeal should be made in writing within 60 days of your notification of the resolution to your complaint. The written request should state the reasons you feel the resolution is not

just, including any additional documentation to support the position. You can also request additional information from **CHLIC** representatives or request to review pertinent documents.

You will be notified of a final decision within 60 days, but special circumstances requiring additional time for investigation and resolution may require up to 120 days.

Non-Participating Provider

If you have questions about coverage or claims payments, go to *www.myCigna.com* to review a summary of your coverage and claim history or call the Customer Service Center at 1.888.99Cigna (1.888.992.4462). In most cases you will receive an immediate response to your inquiry. In some cases it may take from 24 hours to a maximum of 15 business days, depending on the issue.

If your Dental PPO out-of-network claim is denied, the claims office will provide you a written explanation of the denial. You may request, in writing, a review of the denial within 60 days of your receipt of the denial notice. Your written request should state the reasons why you feel the claim should not have been denied, including any additional documentation (medical or dental records) to support your claim. You can also request additional information from **CHLIC** or request to review pertinent documents.

You will be notified of a decision within 60 days of the date your request is reviewed by **CHLIC**. However, special circumstances, such as lengthy investigation, may require up to 120 days.

External Review Process

If you are not satisfied with **CHLIC's** decision on your internal appeal review and the appeal involves medical judgment or a rescission of coverage, you may request that your appeal be referred to an Independent Review Organization (IRO). The IRO is composed of persons who are not employed by **CHLIC,** Cigna Dental, or any of their affiliates. A decision to use the voluntary level of appeal will not affect your rights to any other Plan benefits.

There is no charge for you to initiate the independent review process. **CHLIC** will accept the decision of the IRO.

To request an independent review, you or an authorized designated representative, must notify the Appeals Coordinator within 4 months after you receive notice that **CHLIC** has denied your appeal. **CHLIC** will then forward the claim file to a randomly selected IRO. The IRO will render an opinion within 30 days.

You can ask for an expedited review process if a delay would be detrimental to your medical condition, as determined by **CHLIC's** Dental Reviewer. If your request is granted, the review will be completed within 72 hours.

Legal Action

You have the right to bring a civil action under section 502(a) of **ERISA** if you are not satisfied with the outcome of the Appeals Procedure. In most instances, you may not begin a legal action until you have completed the appeal processes. You must file any lawsuit for benefits within one year after the final decision on appeal. You may not file suit after the one-year period expires. You or your **covered dependent(s)** are not required to request voluntary internal review or an external review before filing a lawsuit. If you or your **covered dependent(s)** do request voluntary internal review or an external review of the decision, the time taken to appeal under the voluntary review process will not be counted against the one year in which you have to file a lawsuit.

Voluntary Review of Your Coverage Appeal Decision

If you have exhausted the appeals process described above and you believe there has been an error or that your appeal has not been handled properly, you may make a voluntary request that the **plan administrator** review your claim.

You do not have to ask for this voluntary review, and whether you ask or not will have no effect on your right to: any other Plan benefits, to pursue any legal remedies you have, to information about applicable Plan rules or to be represented

by someone during your appeal. If you do not ask for a **plan administrator** review, the Plan will not assert any claim that you failed to exhaust the appeal process, for failing to request such review. If you do ask for a **plan administrator** review, the Plan agrees that any statute of limitation or lack of timeliness defenses it may have are suspended while the review is pending.

If you want the **plan administrator** to review your claim, send a written request addressed to:

Office of the Plan Administrator
Cigna Corporation
Two Liberty Place, TL05T
1601 Chestnut Street
Philadelphia, PA 19192

You must mail your request within 60 days after you receive notice of the denial of your second appeal, or, if you request independent review, 60 days after that denial. You must explain in your request letter why you think the decision of your appeal is wrong.

The **plan administrator** will investigate the decision on your appeal and determine whether all the appeal procedures were followed in reaching a decision and whether the decision was consistent with the terms of the Plan. The **plan administrator** will notify you of the results of the review within 30 days after receiving your request for review. If the Plan Administrator needs more time (but not more than 60 days), the **plan administrator** will notify you about the extension and the reason for it.

COBRA

This section of the SPD contains important information about your right to COBRA continuation coverage (or COBRA coverage), which is a temporary extension of Plan coverage on a self-pay basis. The right to COBRA coverage was created by a federal law, the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA). COBRA coverage can become available to you and to other members of your family who are covered under the Plan when you would otherwise lose your group health coverage. This section explains COBRA coverage, when it may become available to you and your family, and what you need to do to protect the right to receive it.

Your rights to COBRA coverage may change as further amendments to COBRA are made by Congress or as interpretations of COBRA are made by the courts and by federal regulatory agencies.

COBRA Continuation Coverage

COBRA coverage is a continuation of Plan coverage when coverage would otherwise end because of a qualifying event. Specific qualifying events are listed later in this section. COBRA coverage must be offered to each person who is a qualified beneficiary. A qualified beneficiary is someone who will lose coverage under the Plan because of a qualifying event. Depending on the type of qualifying event, employees, **spouses** of employees, and dependent children of employees may be qualified beneficiaries. You are a qualified beneficiary under COBRA if you were a covered employee or a **covered dependent** of a covered employee on the day before the occurrence of a qualifying event. A child is a qualified beneficiary if he or she is born to the covered employee, while the covered employee is covered under COBRA. Qualified beneficiaries have the same rights as active employees.

Under the Plan, qualified beneficiaries who elect COBRA coverage must pay the full cost of the coverage (employer and employee share) plus an administrative fee. In most instances the cost is the full group rate plus a 2% administration fee.

If the cost of active coverage changes after your COBRA coverage starts, the cost of your COBRA coverage also changes. You must send your first COBRA payment to the address listed on your COBRA election notice postmarked no more than 45 days after the date that you elect COBRA coverage. **You must make the rest of your monthly payments in full postmarked no more than 30 days after the date they are due or your COBRA coverage could terminate retroactive to the last date for which premiums were paid.**

For more information about COBRA rates, contact the Plan's COBRA Administrator at 1.888.678.4881.

Adding Dependents

Only children born to you or adopted by you during your COBRA coverage may be added as **covered dependents**. If you do not choose COBRA coverage and did not pay for COBRA coverage within the time limits set by COBRA, you may not be eligible for COBRA coverage in the future for the same qualifying event.

Removing Dependents

You do not have to elect full family coverage; you can elect coverage for yourself and/or any **eligible dependents**.

Partners

Your **partner** and his or her dependent children do not have rights to COBRA coverage under existing federal law, but **Cigna** offers them the same right to continued coverage that an employee's **spouse** and the **spouse's eligible dependent** children have.

Qualifying Events

You are eligible for COBRA coverage only if a qualifying event occurs that results in the loss of active coverage for you or for your **covered dependents**. If you are an employee, you become a qualified beneficiary if you lose your Plan coverage because of either one of these qualifying events:

- Your hours of employment are reduced, or
- Your employment ends for any reason other than your gross misconduct.

Your covered **spouse** becomes a qualified beneficiary if you lose your Plan coverage because of any of these qualifying events:

- You die;
- Your hours of employment are reduced;
- Your employment ends for any reason other than your gross misconduct;
- You become enrolled in Medicare (Part A, Part B or both);
- You become divorced or legally separated from your **spouse**; or
- Your marriage is annulled.

Your **covered dependent** child becomes a qualified beneficiary if he or she loses Plan coverage because of any of these qualifying events:

- You die;
- Your hours of employment are reduced;
- Your employment ends for any reason other than your gross misconduct;
- You become enrolled in Medicare (Part A, Part B, or both);
- You become divorced or legally separated; or
- The child stops being an **eligible dependent**.

Notices About Qualifying Events

The Plan offers COBRA coverage to qualified beneficiaries only after the Your Cigna Life Service Center has been notified that a qualifying event has occurred.

Your employer notifies the Plan Administrator or Your Cigna Life Service Center if the qualifying event is the termination of your employment; reduction of your hours of employment; or your death. The employer must provide notice of the qualifying event within 30 days of the event.

You must notify the Your Cigna Life Service Center about any other qualifying events (your divorce or legal separation or when a child stops being an **eligible dependent**). To qualify for COBRA continuation, you must provide the notice within 60 days after the later of the qualifying event or when you would lose coverage as a result of the qualifying event.

If you do not record these qualifying events within the appropriate 60-day period, COBRA coverage will not be available.

You may provide this notice by going to the Life Events section of the *Your Cigna Life* website if the notice is within 30 days after the qualifying event. You may also send your notice of a qualifying event to the Your Cigna Life Service Center by fax to 855.674.5282, by email to YCLServiceCenter@Cigna.com or by mailing a hard copy to the following address:

Post Office Box 62825
Phoenix, AZ 85082

Electing COBRA

Once the Your Cigna Life Service Center receives notice that a qualifying event has occurred, COBRA coverage is offered to each qualified beneficiary, who has a right to elect COBRA coverage independently of other qualified beneficiaries. The Plan's COBRA Administrator will issue a COBRA election notice, which will list the individuals who are eligible for COBRA coverage and inform you of the applicable premium. As an employee, you may elect COBRA coverage on behalf of your **spouse**, and you or your **spouse** may elect COBRA coverage on behalf of your children. You must notify the Plan's COBRA Administrator of your election no later than the due date stated on the COBRA election notice by following the procedures specified on the election form.

COBRA Premiums

If you elect continuation coverage, you do not have to send any payment with the election form. However, you must make your first payment for continuation coverage not later than 45 days after the date of your election. If you do not make your first payment in full by that date, you will lose your right to COBRA coverage under the Plan.

After you make your first payment for COBRA coverage, you must then make subsequent payments each month of the required premium for each additional month of coverage. More details on the required premium amount and payment deadlines will be provided in your COBRA election notice.

The COBRA Period

COBRA coverage is a temporary continuation of coverage. If it is elected, COBRA coverage begins on the date that Plan coverage would otherwise have been lost.

The maximum COBRA Period is 36 months if the qualifying event is the death of the employee, enrollment of the employee in Medicare (Part A, Part B, or both), your divorce or legal separation, the dissolution of your **partnership**, or when a **covered dependent** child stops being an **eligible dependent**.

The maximum COBRA period is <u>18 months</u> if the qualifying event is the termination of your employment with **Cigna** for reasons other than gross misconduct, as defined by **Cigna** or the reduction of your work hours. However, if you become entitled to (enroll in) Medicare less than 18 months before your termination or reduction in hours, the maximum COBRA period for your qualified beneficiaries ends 36 months after the date you became entitled to Medicare. For example, if you become entitled to Medicare 8 months before your employment terminates, COBRA coverage for your **spouse** and children can last up to 36 months after the date of Medicare entitlement, or 28 months after your termination date.

Extension of the 18-Month COBRA Period

There are several ways in which the 18-month COBRA period described above can be extended. In all of these cases, you must notify the Plan's COBRA Administrator about the second qualifying event within 60 days after it happens. Send the notice to:

CONEXIS, a division of WageWorks
P.O. Box 223684
Dallas, TX 75222-3684

Include with the notice copies of documents that prove the second qualifying event actually happened.

Disability Extension

If the Social Security Administration determines that you or one of your qualified beneficiaries is disabled before the qualifying event or at any time during the first 60 days of COBRA coverage and you notify the Plan's COBRA Administrator in a timely fashion as described in the preceding paragraph, you and each of your qualified beneficiaries who has elected continuation coverage can receive up to an additional 11 months of COBRA coverage, for a total maximum of 29 months.

The disability must start before the 60th day of your initial COBRA period and last at least until the end of the initial 18-month COBRA period. If you or the qualified beneficiary is determined by the Social Security Administration to no longer be disabled, you must notify the Plan's COBRA Administrator of that fact within 30 days after the determination.

The Plan provides the longer period of COBRA coverage only if the Social Security Administration sends you a notice confirming your disability before the end of the 18th month of your COBRA coverage and confirms the disability onset was no later than the 61st day of COBRA coverage. The notification from the Social Security Administration must be sent to the Plan's COBRA Administrator no more than 60 days after the latest of any one of the following events:

- The date of the notice from the Social Security Administration;
- The date of the qualifying event;
- The date that benefits are terminated; or
- The date on which the qualified beneficiary is informed, through the Plan's SPD or the general COBRA notice, of his or her obligation to provide notice, and the procedures for providing such notice.

Second Qualifying Event Extension

If your family experiences another qualifying event during the initial 18-month period of COBRA coverage, your **spouse** and **covered dependent** children can receive up to 18 additional months of COBRA coverage (for a maximum of 36 months after the initial qualifying event). This extension is available to:

- Your **spouse** and **covered dependent** children if you die, enroll in Medicare (Part A, Part B, or both), get divorced or legally separated, have a dissolution of your **partnership**, or your employment with **Cigna** ends for any reason; and
- Your child if he or she stops qualifying as an **eligible dependent**.

The extended COBRA period is available only if the new qualifying event would have caused your **spouse** or child to lose coverage under the Plan if the first event had not occurred.

Terminating COBRA Coverage Before the End of the Maximum COBRA Period

COBRA coverage will be terminated before the end of the maximum period if:

- Any required premium is not paid in full on time or within the grace period required by COBRA;

- A qualified beneficiary begins coverage under another group health plan after electing COBRA coverage (as long as that plan doesn't impose an exclusion or limitation with respect to a preexisting condition of the qualified beneficiary-if there is such an exclusion or limitation, COBRA coverage does not end for this reason until the exclusion or limitation no longer applies);
- A qualified beneficiary enrolls in Medicare (Part A, Part B, or both) after electing continuation coverage;
- **Cigna** ceases to offer the plan in which you are enrolled. However, COBRA coverage may be available under other **Cigna** plans. If all **Cigna** plans are terminated, all COBRA coverage is also terminated; or
- A qualified beneficiary engages in conduct that would justify the Plan in terminating coverage of a similarly situated participant or beneficiary not receiving continuation coverage (such as fraud).

When COBRA Coverage Ends Generally

COBRA coverage ends on the date any one of the following events occur, whichever comes first:

- The date the maximum COBRA coverage period ends.
- A special rule applies to the extra 11 months of COBRA coverage in the event that you are disabled. This coverage ends on the last date for which a premium was paid in the month that starts more than 30 days after the Social Security Administration finds that you are no longer disabled. You must inform the COBRA Administrator no more than 30 days after the latter of either the finding that you are no longer disabled or the date on which the qualified beneficiary is informed of his or her obligation to provide notice through the Plan's SPD or the general COBRA notice, and the procedures for providing such notice. All other rules still apply.
- If you added dependents to your COBRA coverage who are not also qualified enrollees, coverage for those dependents ends on the date your coverage ends.

Effect of COBRA Election on Your Rights Under Other Federal Laws

[You should take into account that you have special enrollment rights under federal law. You have the right to request special enrollment in another group health plan for which you are otherwise eligible (such as a plan sponsored by your **spouse's** employer) within 30 days after your group health coverage ends because of a qualifying event. You will also have the same special enrollment right at the end of COBRA coverage if you get COBRA coverage for the maximum time available to you.] You may also have other health coverage options available to you through the Health Insurance Marketplace. Visit www.healthcare.gov for further information.

If You Have Questions About COBRA

If you have questions about your COBRA coverage, contact the Plan's COBRA Administrator (see "Who to Contact") or the nearest Regional or District Office of the U.S. Department of Labor's Employee Benefits Security Administration (EBSA). Addresses and phone numbers of Regional and District EBSA Offices are available through EBSA's website at www.dol.gov/ebsa.

Keep Your Plan Informed of Address Changes

In order to protect your family's COBRA rights, you should notify the Your Cigna Life Service Center about any changes in address for you or any of your **covered dependents**. You should also keep a copy, for your records, of any notices you send to the Your Cigna Life Service Center.

COBRA Appeals

For Eligibility/Election Issues:

If you have a problem with or disagree with a decision about any COBRA eligibility or election issue, you may start the appeal process by filing a formal appeal with the Plan's COBRA Administrator at:

CONEXIS, a division of WageWorks
P.O. Box 223684
Dallas, TX 75222-3684

The eligibility/election appeal process applies except that the COBRA Administrator, rather than the Your Cigna Life Service Center, will handle your appeal.

If you believe that your right to enroll in COBRA coverage should not have been terminated, you may request that the decision be reconsidered by filing an eligibility/election issue appeal. In your appeal request, please explain why you believe that your right to COBRA coverage during the initial enrollment period was improperly terminated, including all information that you wish to be reviewed. Be sure to include your name, current address, and the names of other covered individuals that you wish to include in your appeal.

For Coverage/Benefits Issues:

The coverage/benefits appeals process described applies.

HIPAA PRIVACY

In administering the Dental Plan, the Plan and **CHLIC** may come into contact with what is considered "protected health information" ("PHI") under the Health Insurance Portability and Accountability Act (**HIPAA**). The Plan and **CHLIC** are permitted to disclose PHI to **Cigna** to enable **Cigna** to carry out plan administration functions or as otherwise permitted by the Standard for Privacy of Individually Identifiable Health Information, and in accordance with the following **HIPAA** privacy protection provisions.

Permitted Uses and Disclosures of PHI by Cigna Corporation

The Plan may only disclose PHI to Cigna Corporation, as sponsor of the Plan, to enable it to carry out plan administration functions or as otherwise permitted by the Standards for Privacy of Individually Identifiable Health Information ("HIPAA Privacy Rule") and HIPAA Security Standards ("HIPAA Security Rule"), found at 45 CFR Parts 160-164 (collectively "HIPAA Privacy and Security Rule"). Only persons involved with plan administration functions of the Plan may have access to any information disclosed under these HIPAA privacy protection provisions. If the persons to whom information is disclosed violate these privacy protection provisions or applicable law, violations may be treated as misconduct under Cigna Corporation's policies and procedures related to employees or a breach of contract in situations involving contracts with third parties. Cigna Corporation shall take appropriate action, up to and including terminating the employment of the employee who commits the violation or terminating the contract with the third party that commits the breach, as applicable.

Cigna Corporation may perform its obligations under these **HIPAA** privacy protection provisions by members of its workforce or those of its subsidiaries and affiliates, or through contractual arrangements with third parties. All such arrangements shall comply with the applicable requirements of these **HIPAA** privacy protection provisions and the HIPAA Privacy and Security Rule.

Unless otherwise indicated, any definitions under these HIPAA privacy protection provisions shall have the meaning given them under the HIPAA Privacy and Security Rule.

Privacy Requirements

- Further Disclosure. Cigna Corporation agrees not to use or further disclose the information obtained under these HIPAA privacy protection provisions other than as permitted or required by the Plan document, or as required by law.

- Agents. Cigna Corporation will require that any agents, including any subcontractors, to whom it provides PHI received under these **HIPAA** privacy protection provisions agree to the same restrictions and conditions that apply to Cigna Corporation with respect to such information.

- Employment Actions. Cigna Corporation agrees not to use or disclose any information received under these **HIPAA** privacy protection provisions for employment-related actions and decisions, or in connection with any other benefit or employee benefit plan sponsored by Cigna Corporation.

- Duty to Report. Cigna Corporation will report to the Plan any use or disclosure of information that is inconsistent with the uses or disclosures provided for under these **HIPAA** privacy protection provisions of which it becomes aware.

- Access. Cigna Corporation will make available any information it holds under these **HIPAA** privacy protection provisions in order for the Plan to comply with the access requirements under the HIPAA Privacy Rule.

- Amendment. Cigna Corporation will make available any information it holds under these **HIPAA** privacy protection provisions in order for the Plan to comply with the amendment requirements under the HIPAA Privacy Rule, and will incorporate any amendments to PHI it holds, as required under the HIPAA Privacy Rule.

- Accounting. Cigna Corporation agrees to document and provide a description of any disclosures of protected health information, and information related to such disclosures, as would be required for the Plan to respond to a request by an individual for an accounting of disclosures of PHI in accordance with the HIPAA Privacy Rule.

- Internal Books. Cigna Corporation agrees to make its internal practices, books, and records relating to the use and disclosure of PHI received from the Plan available to the Secretary of Health and Human Services, for purposes of the Secretary determining the Plan's compliance with the HIPAA Privacy Rule.

- Return of Information. Cigna Corporation will, if feasible, return or destroy all PHI received from the Plan that it maintains in any form, and retain no copies of such information, when it is no longer needed for the purpose for which the disclosure was made, except that, if such return or destruction is not feasible, Cigna Corporation will limit further uses or disclosures of the information to those purposes that make the return or destruction of the information not feasible.

- Adequate Separation. Cigna Corporation will establish adequate separation between it and the Plan, as required under the HIPAA Privacy Rule. Cigna Corporation will limit access to PHI to those employees or classes of employees entitled to use or disclose such information and will require that these employees only may use or disclose such information for plan administration functions.

- Noncompliance. Cigna Corporation will resolve issues of noncompliance with the terms of these **HIPAA** privacy protection provisions by persons entitled to use or disclose PHI in a timely manner.

HIPAA Security Standards

- Safeguards. Cigna Corporation will implement administrative, physical, and technical safeguards that reasonably and appropriately protect the confidentiality, integrity, and availability of the electronic PHI, as defined in the HIPAA Security Rule, that it creates, receives, maintains, or transmits on behalf of the Plan, as required in the HIPAA Security Rule.

- Agents. Cigna Corporation will ensure that any agent, including a subcontractor, to whom it provides electronic PHI agrees to implement reasonable and appropriate safeguards to protect such information.

- Security Incidents. Cigna Corporation will report to the Plan any security incident under the HIPAA Security Rule of which it becomes aware.

- Adequate Separation. Cigna Corporation will establish reasonable and appropriate security measures to ensure adequate separation between it and the Plan, in support of the requirements described in these **HIPAA** privacy protection provisions.

Cigna and the **plan administrator** have also taken specific steps to protect and limit access to PHI. For example, **Cigna** has:

- Designated a Privacy Officer;
- Developed privacy policies and procedures, including a sanctions policy that applies to employees and business partners who violate privacy policies;
- Implemented safeguards to protect against improper disclosure of PHI;
- Provided a complaint resolution process; and
- Entered into agreements requiring its business associates to safeguard PHI.

As part of the compliance efforts, a **HIPAA** Notice of Privacy Practices is provided to employees. If you would like to receive another copy of the privacy notice, please consult the Appendix to this SPD, go to the *Your Cigna Life* website, or contact the **Cigna** Customer Service Center at 1.888.992.4462.

ADMINISTRATIVE INFORMATION

If You Have Questions

See “WHO TO CONTACT”

Plan Administration Information

Name of Plan:	Cigna Dental Plan
Plan Number	520
Plan Type	Group Health Plan
Type of Administration	Self-funded; third-party administration
Plan Administrator	Office of the Plan Administrator Cigna Corporation Two Liberty Place, TL05T 1601 Chestnut Street Philadelphia, PA 19192 215.761.2563

Claims Administrator	Connecticut General Life Insurance Company (**CHLIC**) 900 Cottage Grove Road Bloomfield, CT 06002 Send all claims correspondence to: Cigna HealthCare P.O. Box 5200 Scranton, PA 18505-5200
Agent for Service of Legal Process	Office of Corporate Secretary Cigna Companies Two Liberty Place – TL07 1601 Chestnut Street Philadelphia, PA 19192 Process may also be served on the **plan administrator**.
Plan Year	January 1 to December 31
Plan Sponsor	Cigna Corporation, Tax ID Number 06-1059331

The Dental PPO, Dental Select and Puerto Rico Dental PPO are self-insured. All valid claims and fees are paid through the plan's Claims Administrator and are funded by employee **pre-tax contributions** (except in Puerto Rico) and **Cigna** contributions paid from its general assets. All network dental services or other benefits are provided directly by your local Cigna Dental. The managed care plan provides services in accordance with its contract with **Cigna.**

Discretion of Plan Administrator and Claims Administrator

The **plan administrator** (or its delegate(s)) shall have complete discretion to interpret and construe the provisions of the plans, programs and policies described in this SPD, to determine benefit eligibility for participation and for benefits, make findings of fact, correct errors and supply omissions. All decisions and interpretations of the **plan administrator** (or its delegate(s)) made pursuant to the plans, programs and policies described in this SPD shall be final, conclusive and binding on all persons and may not be overturned unless found by a court to be arbitrary and capricious. The **plan administrator** may delegate this discretionary authority to selected service providers.

CHLIC, the **claims administrator**, has the sole discretion to determine whether the Plan provides coverage for any covered person's particular dental care situation and the level or amount of any benefit to which he or she might be entitled, as well as to interpret any of the Plan's provisions, including ambiguous and disputed terms and to make any related factual determinations. **CHLIC**'s determinations and interpretations on these issues are final and binding on all parties.

No manager or Human Resources representative is authorized to waive requirements of the Plan, to interpret any Plan terms, to grant any exceptions to any Plan provisions or to contract with employees to provide benefits beyond those described in this SPD.

Continuation of the Plans

Cigna Corporation currently expects to continue the Cigna Dental Plan indefinitely but reserves the right to modify, suspend, or terminate the Plan, and Plan options, or any networks at any time. As a result of any such change, your coverage, **payroll costs** and benefits may be changed or your Plan coverage may be terminated.

Any change in or termination of the Cigna Dental Plan will not affect any covered person's rights as to **covered expenses** he or she incurs while the Plan is still in effect.

Neither the Plan nor the benefits described in this book can be orally amended. All oral statements and representations shall be without force or effect even if such statements and representations are made by the **plan administrator**, by any delegate of the **plan administrator**, or by **Cigna** management.

ERISA Statements

As a participant in the Cigna Dental Plan, you are entitled to certain rights and protection under **ERISA**. **ERISA** provides that all plan participants shall be entitled to:

Receive Information about Your Plan and Benefits

- Examine, without charge at the **plan administrator's** office in Philadelphia during normal working hours, all documents governing the Plan and a copy of the latest annual report (Form 5500) filed by the Plan with the U.S. Department of Labor and available at the Public Disclosure Room of the Employee Benefit Security Administration.
- Obtain, upon written or electronic mail request to the **plan administrator**, copies of documents governing the operation of the Plan and copies of the latest annual report (Form 5500) and updated summary plan description. The **plan administrator** may make a reasonable charge for copies.
- Receive a summary of the Plan's annual financial report. The **plan administrator** is required by law to furnish each participant with a copy of this summary annual report.

Continue Group Health Plan Coverage

Continue health care coverage for yourself, **spouse** or dependents if there is a loss of coverage under the Plan as a result of a qualifying event. You or your dependents may have to pay for such coverage. Review this summary plan description and the documents governing the Plan on the rules governing your COBRA continuation coverage rights.

Prudent Action by Plan Fiduciaries

In addition to creating rights for plan participants, **ERISA** imposes duties on the people responsible for the operation of the employee benefit plan. The people who operate your Plan, called "fiduciaries" of the Plan, have a duty to do so prudently and in the interest of you and other Plan participants and beneficiaries. No one, including your employer or any other person, may fire you or otherwise discriminate against you in any way to prevent you from obtaining a benefit or exercising your rights under **ERISA**.

Enforce Your Rights

If your claim for a Plan benefit is denied or ignored, you have a right to know why this was done, to obtain copies of documents relating to the decision, without charge, and to appeal any denial, all within certain time schedules.

Under **ERISA**, there are steps you can take to enforce the above rights. For instance, if you request a copy of Plan documents or the latest annual report from the **plan administrator** and do not receive them within 30 days, you may file suit in a Federal court. In such a case, the court may require the **plan administrator** to provide the materials and pay you up to $110 a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the **plan administrator**.

If you have a claim for benefits that has been denied or ignored, in whole or part, you may file suit in a state or federal court.

In addition, if you disagree with the Plan's decision or lack of a decision concerning a medical child support order, you may file suit in Federal court.

If it should happen that Plan fiduciaries misuse the Plan's money, or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor, or you may file suit in a Federal court.

The court will decide who should pay court costs and legal fees. If you are successful, the court may order the person you have sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees, for example, if it finds your claim is frivolous.

Assistance with Your Questions

If you have any questions about the Plan, you should contact the **plan administrator**. If you have any questions about this statement or about your rights under **ERISA**, or if you need assistance in obtaining documents from the **plan administrator**, you should contact the nearest office of the Employee Benefits Security Administration, U.S. Department of Labor, listed in your telephone directory or the:

Division of Technical Assistance and Inquiries
Employee Benefits Security Administration
U.S. Department of Labor
200 Constitution Avenue, N.W.
Washington, D.C. 20210

You may also obtain certain publications about your rights and responsibilities under **ERISA** by calling the publications hotline of the Employee Benefits Security Administration.

Other Important Notices

The Appendices to this document and the accompanying certificates and riders contain other important notices about the Plan and your legal rights under the Plan. These documents are part of this SPD and you should review them carefully. You may access these documents on the *Your Cigna Life* website.

GLOSSARY

Here are definitions of some important terms. The definitions are an integral part of the Cigna Dental Plan provisions. These terms appear in bold type in the rest of the SPD.

Affidavit of Domestic Partnership — The formal written statement used to notify **Cigna** that you have a **domestic partner**. The affidavit must be sworn and signed in the presence of a notary. It is available on the *Your Cigna Life* website.

CHLIC — Connecticut General Life Insurance Company, which serves as the **claims administrator**.

Cigna — Any corporation or other business entity that is owned by Cigna Corporation and that participates in the **Cigna** Dental Plan. As of January 1, 2016, the companies listed on the following chart are eligible to participate in the **Cigna** Dental Plan.

Bravo Health Mid-Atlantic, Inc.	Cigna Life Insurance Company of New York
Bravo Health Pennsylvania, Inc.	GulfQuest, LP
Cigna Behavioral Health, Inc.	HealthSpring Inc.
Cigna Behavioral Health of California, Inc.	HealthSpring Management of America, LLC
Cigna Corporation	HealthSpring USA, LLC
Cigna Dental Health, Inc.	Life Insurance Company of North America
Cigna Dental Health of California, Inc.	NewQuest, LLC
Cigna Dental Health of Florida, Inc.	NewQuest, Management Northeast, LLC (known as Bravo Health, LLC through February 3, 2015)
Cigna Health and Life Insurance Company	NewQuest Management of Alabama, LLC
Cigna Health Management, Inc.	NewQuest Management of Florida, LLC
Cigna HealthCare of Arizona, Inc.	NewQuest Management of Illinois, LLC
Cigna HealthCare of California, Inc.	Tel-Drug, Inc.
Cigna HealthCare of North Carolina, Inc.	Tel-Drug of Pennsylvania, LLC
Cigna Holdings, Inc.	
Cigna International Services, Inc.	

Cigna company or companies — Refers collectively to Cigna Corporation and any subsidiary or affiliate in which Cigna Corporation owns directly or indirectly at least an 80-percent interest.

civil union — A formal relationship legally-recognized in some states, but not under federal law, that gives same-gender couples rights and responsibilities similar to those of a marriage. State law imposes requirements and conditions that you must meet to have a valid **civil union**.

claims administrator — means the entity described in the "Administrative Information" section of this SPD, who is appointed to administer benefits described in this SPD, including initial and/or appeals claims determinations.

coinsurance — The part of the cost of medical services that you must pay, usually stated as a percent of the amount charged by a health care professional or health care facility. See the charts in the Appendices.

covered dependent — An **eligible dependent** you elect to cover under the Plan.

covered expenses — Expenses you incur for services and supplies that, as described in this SPD, are covered by the Plan.

covered services — Services that, as described in this SPD, are considered eligible under the Plan.

deductible — The dollar amount you must pay out-of-pocket (that is, with your money) before the Plan begins to reimburse you for **covered expenses**. When you cover family members, the **deductible** amount is collective. That is, you will pay out-of-pocket for yourself and all covered family members until you reach the designated amount.

dentist— A person practicing dentistry or oral surgery within the scope of his or her license. This also includes a physician operating within the scope of his or her license when performing any of the services covered by one of **Cigna'**s dental options.

domestic partner — A person in a relationship with a **Cigna** employee that meets the following conditions:

- For at least twelve months, you have shared the same principal residence in an intimate, committed relationship of mutual caring and intend to do so indefinitely;

- Each of you agree to be responsible for the other's basic living expenses during the domestic **partnership**, and agree that anyone who is owed these expenses can collect from either of you;
- You are both at least 18 years old and mentally competent to enter binding legal contracts;
- Neither of you is married to anyone, and you are not so closely related by blood that a legal marriage between you would be prohibited for that reason in your state of residence;
- Neither of you has a different **domestic partner** at the time; and
- Neither of you had a different **domestic partner** during the last twelve months.

The employee and his/her **domestic partner** must also have on file with **Cigna** a valid **Affidavit of Domestic Partnership**.

eligible dependent — As a regular employee, the following persons qualify as your **eligible dependent**:

- Your legal **spouse**
- Your **domestic partner**.
- Your child — natural or legally adopted, a child placed with you for adoption, your stepchild (that is, the natural or legally-adopted child of your current **spouse**), the natural or legally-adopted child of your **partner**, or a child for whom you are the legal guardian (by court or testamentary appointment), but only if the child is under age 26.
- A person who meets all the above requirements to be an **eligible dependent** child except that the person has passed his/her 26th birthday, but only if the person:
    - Is physically or mentally handicapped and incapable of attending school or engaging in self-sustaining employment prior to the date he/she became eligible for coverage under the Plan; and
    - Before reaching age 26, was continuously covered in a **Cigna company** sponsored Dental Plan or in another employer-sponsored group health plan prior to enrollment in the Cigna Dental Plan.
- A child under age 26 for whom you are legally required to provide health care under a divorce decree or **QMCSO**.

You must provide the **plan administrator** with documented proof (such as copies of official court documents) as evidence of a legal adoption or guardianship or the placement with you of a child for adoption. A child who is placed with you for adoption will become your **eligible dependent** when you become legally obligated to support the child — even if that is before you formally adopt the child.

The **plan administrator** has the right to require proof from you at any time of the eligibility of anyone you claim as an **eligible dependent**. If you do not submit the required proof, Plan coverage for the person you claim as a dependent will be terminated.

If there is evidence that you intentionally claim as your **eligible dependent** a person who does not qualify, you may be subject to disciplinary action, up to and including the termination of your **Cigna** employment, as well as possible legal action.

ERISA — The Employee Retirement Income Security Act of 1974, as amended.

FMLA leave — A leave of absence under the Family and Medical Leave Act. See *Family & Medical Leave* on the *Your Cigna Life* website (go to *Returns & Rewards>Time Away from Work>Family & Medical Leave (FMLA)*).

HIPAA — the Health Insurance Portability and Accountability Act of 1996.

life status change — A term defined in accordance with IRS rules as described in the "Events Affecting Your Plan Coverage, Eligibility or Costs" section of this SPD that describes when you may be permitted to change your elections under the Dental Plan other than during an annual enrollment period. You may make election changes if you have a **life status change** event and the benefit election change you want to make is consistent with your **life status change** event.

maximum reimbursable charges — The maximum amount the Plan pays for out-of-network **covered services**. See the "Maximum Reimbursable Charges" section of the SPD for a discussion of how the maximum reimbursable charge for **covered services** is determined.

medically necessary/medical or dental necessity — Services or supplies that are determined by **Cigna DHMO** to be:

- Required to diagnose or treat an illness, injury, disease or its symptoms;
- In accordance with generally accepted standards of medical/dental practice;
- Clinically appropriate in terms of type, frequency, extent, site and duration;
- Not primarily for the convenience of the patient, **dentist** or other provider; and
- Rendered in the least intensive setting that is appropriate for the delivery of the services and supplies. Where applicable, **Cigna DHMO** may compare the cost-effectiveness of alternative services, settings or supplies when determining least intensive setting.

network general dentist — The **dentist** you select from Cigna Dental's network of dental care providers, authorized by the provider organization to provide or arrange for dental care for you or your covered dependents.

partner — A person with whom a **regular employee** has a **domestic partner** arrangement or **civil union** that is legally recognized in the state in which the employee resides.

partnership — A domestic **partnership** arrangement or **civil union** that is legally recognized in the state in which the employee resides.

payroll cost — Your share of the annual cost for Plan coverage that you pay through payroll deduction contributions or a direct billing arrangement.

Plan — the **Cigna Dental Plan** and, where indicated, the Dental Plan coverage options.

plan administrator —the person or entity described in the "Administrative Information" section of this SPD.

plan sponsor —the entity described in the "Administrative Information" section of this SPD.

plan year — The calendar year. That is, the 12-month period beginning January 1 and ending December 31.

pre-existing condition — An injury or illness for which a person receives treatment, incurs expenses or receives a diagnosis from a physician or dentist during a specific time period prior to the day that the person becomes covered under a **Cigna** group plan. The term **pre-existing condition** also includes any condition which is related to any such injury or illness.

pre-tax contributions — Contributions deducted from your wages before federal, Social Security, and in most cases, state and local income taxes have been withheld.

QMCSO — A Qualified Medical Child Support Order – that is, a judgment, decree or court order that provides for dental coverage for a child of an employee who participates in the Dental Plan. To be a **QMCSO**, the order must:

- Specify the employee's name and last known address, and the child's name and last known address;
- Provide a description of the coverage to be provided, or the manner in which the type of coverage is to be determined;
- State the time period to which it applies; and
- Specify each plan to which it applies.

The **QMCSO** may not require the Cigna Dental Plan to provide coverage for any type or form of benefit that the Plan does not otherwise provide.

regular employee — A person who meets these three conditions and is not in any of the excluded categories described below:

- Employed by **Cigna**;
- Works in the United States, the District of Columbia, Puerto Rico, Guam or the Virgin Islands or is designated by the **plan administrator** as an eligible U.S. expatriate; and
- Is classified in **Cigna** personnel records as a regular full-time employee or a regular part-time employee (for employees hired before January 1, 2014, a regular part-time employee is generally someone who is regularly scheduled to work at least 24 hours a week; for employees hired or rehired on or after January 1, 2014, a regular part-time employee is generally someone who is regularly scheduled to work at least 28 hours a week).

The excluded categories are:

- Hourly, temporary, casual, and leased employees (whether or not within the meaning of section 414(n) of the Internal Revenue Code of 1986, as amended (Code)), staffing or payroll agency employees, even if such persons are later determined by a court, regulatory body or administrative agency to be or have been common law employees of **Cigna** or any participating subsidiary;
- Interns;
- Employees who belong to a collective bargaining unit, unless the applicable collective bargaining agreement provides that unit members are eligible for specified benefit plans;
- Persons who are employed and paid by a company or organization not affiliated with **Cigna** but in some way perform work for **Cigna** under a contract or other business arrangement between **Cigna** and their employer;
- Persons who perform work for **Cigna** as independent contractors or consultants;
- Persons not classified as full-time employees or regular part-time employees in **Cigna** personnel records; and
- An individual on a temporary assignment to the US (as determined by the **plan administrator** in its sole discretion).

The **plan administrator** has sole discretion to determine whether an employee is a **regular employee**. **Cigna** has not entered into an employment contract with any employee by adopting and maintaining these benefits. Nothing in the Plan documents or in this SPD gives any employee the right to be employed by **Cigna** or to interfere with **Cigna's** right to discharge any employee at any time.

service area — the geographic area defined by a managed care network and approved by the applicable regulatory agency as the area in which the managed care network offers health care services.

specialist — Any person or organization (licensed as necessary) with specialized dental training and experience that provides dental care in any generally accepted medical specialty or subspecialty.

spouse — A person who is married to a **Cigna** employee, under the laws of any state, possession, or territory of the United States, but excluding a person who is legally separated.

termination of employment date — The date your employment with a **Cigna company** officially ends (usually, your last day of work at **Cigna**).

urgent care — Any dental care services and testing which are not emergency services, but which are determined by **CHLIC**, in accordance with generally accepted medical standards, to have been necessary to treat a condition requiring prompt medical attention. This does not include care that could have been foreseen before leaving the immediate area where you ordinarily receive and/or were scheduled to receive services.