Cigna Health and Life Insurance Company ("Cigna")

Home Office: 900 Cottage Grove Road Bloomfield, CT 06002

Cigna Dental 1000 Plan

POLICY FORM NUMBER: INDDENPOL2024PA.SAD1000v1

OUTLINE OF COVERAGE

READ YOUR POLICY CAREFULLY. This outline of coverage provides a very brief description of the important features of your Policy. This is not the insurance contract and only the actual Policy provisions will control. The Policy itself sets forth, in detail, the rights and obligations of both You and Cigna Health and Life Insurance Company. It is, therefore, important that you **READ YOUR POLICY CAREFULLY!**

A. Coverage is provided by Cigna Health and Life Insurance Company (referred to herein as "Cigna"), an insurance company that provides participating provider benefits.

B. To **obtain additional information**, including Provider information write to the following address or call the toll-free number:

Cigna
Individual Services
P. O. Box 30365
Tampa, FL 33630
1-877-484-5967

C. A **Participating Provider Plan** enables the Insured to incur lower dental costs by using Providers in the Cigna network.

A **Participating Provider** is a Dentist or a professional corporation, professional association, partnership, or any other entity which is entered into a contract with Cigna to provide dental services at predetermined fees to a Covered Person through the Cigna Network associated with this plan, which can be found on Your ID card. Participating Dental Provider status may change from time to time. In order to be reimbursed at the in-network level, Your provider must be a Participating Dental Provider in the network utilized by Your plan when the services are rendered. It is Your responsibility to verify Your provider's network participation status.

A **Non-Participating Provider** is a Dentist, or a professional corporation, professional association, partnership, or other entity that has not entered into a contract with Us to provide dental services for the network listed in this Policy. Services received from Non-Participating Dental Providers are considered Out-of-Network.

D. Covered Services and Benefits

Benefits covered by Your Dental Plan include Preventive & Diagnostic Care such as oral exams, cleanings and x-rays. Your Plan also includes Basic Restorative Care such as fillings and simple extractions. Major Restorative Care is covered under your plan and includes Crowns, Dentures and Bridges. For a complete listing of Covered Services, please read your plan documents.

The frequency of certain Covered Services, like cleanings, are limited. Refer to your Policy for specific limitations on frequency under Your plan.

BENEFIT SCHEDULE

Following is the Benefit Schedule of the Policy. The Policy sets forth, in more detail, the rights and obligations of both You, Your Dependent(s) and Cigna. It is, therefore, important to **READ THE ENTIRE POLICY CAREFULLY!**

The benefits outlined in the table below show the payment percentages for Covered Expenses **AFTER** any applicable Deductibles have been satisfied unless otherwise stated.

CIGNA DENTAL INSURANCE ***Benefit Schedule***
For You and Your Dependent(s)
Benefit Schedule If You select a Participating Dental Provider, Your cost will be less than if You select a Non-Participating Dental Provider.
Dental Emergency Services The Coinsurance payable for Dental Emergency charges made by a Non-Participating Dental Provider is the same Coinsurance payable as for Participating Dental Provider. Dental Emergency services are required immediately to either alleviate pain or to treat the sudden onset of an acute dental condition. These are usually minor procedures performed in response to serious symptoms, which temporarily relieve significant pain, but do not effect a definitive cure, and which, if not rendered, will likely result in a more serious dental or medical complication.
Deductibles Deductibles are expenses to be paid by You or Your Dependent(s). Deductibles are in addition to any Coinsurance. Once the Deductible maximum in the Benefit Schedule has been reached, You and Your Dependent(s) need not satisfy any further Deductible for the rest of that year.
Participating Dental Provider Payment Payment for a Covered Service delivered by a Participating Dental Provider is the Contracted Fee, times the benefit percentage (Coinsurance) that applies to the class of service, as specified in the Benefit Schedule. To be considered a Participating Dental Provider the Provider must be in the Cigna network associated with Your plan. The Covered Person is responsible for the balance of the Contracted Fee.

Non-Participating Dental Provider Payment
Payment for a Covered Service delivered by a Non-Participating Dental Provider is the Contracted Fee for that procedure as aligned for the geographical area where the service is performed, times the benefit percentage (Coinsurance) that applies to the class of service, as specified in the Benefit Schedule. The Primary Schedule is the fee schedule with the lowest Contracted Fees currently being accepted by a Participating Dental Provider.

If a Covered Service is performed by a Non-Participating Dentist, We will base the benefit on the Covered Percentage listed in this policy for that procedure at the lowest Contracted Fee being accepted by a Participating Provider in Your area.

Non-Participating Providers may charge You more than this Contracted Fee, which means you will be balanced billed for the difference. If a Non-Participating Provider performs a Covered Service, You will be responsible for paying:

• the Deductible (as applicable)
• the remaining coinsurance for the service; and
• any amount in excess of the Contracted Fee the Non-Participating Provider bills.

Simultaneous Accumulation of Amounts
Expenses incurred will be used to satisfy both the Participating and Non-Participating Dental Provider Deductibles shown in the Benefit Schedule.

Benefits paid will be applied toward both the Participating and Non-Participating Dental Provider maximum shown in the Benefit Schedule.

BENEFIT HIGHLIGHTS	PARTICIPATING PROVIDER	NON-PARTICIPATING PROVIDER
Classes I, II, III **Calendar Year Maximum**	$1000	

BENEFIT HIGHLIGHTS	PARTICIPATING PROVIDER	NON-PARTICIPATING PROVIDER
Calendar Year Deductible Individual	$50 per person Not Applicable to Class I	
Family Maximum	$150 per family Not Applicable to Class I	
Class I	**The Percentage of Covered Expenses the Plan Pays**	**The Percentage of Covered Expenses the Plan Pays**
Preventive Care Oral Exams Routine Cleanings Routine X-rays Fluoride Application Sealants Space Maintainers (non-orthodontic)	100%	100%
Class II	**The Percentage of Covered Expenses the Plan Pays**	**The Percentage of Covered Expenses the Plan Pays**
Basic Restorative Fillings Non-Routine X-rays Emergency Care to Relieve Pain Oral Surgery, Simple Extractions	80% after plan deductible	80% after plan deductible

BENEFIT HIGHLIGHTS	PARTICIPATING PROVIDER	NON-PARTICIPATING PROVIDER
Class III	**The Percentage of Covered Expenses the Plan Pays**	**The Percentage of Covered Expenses the Plan Pays**
Major Restorative Crowns / Inlays / Onlays Root Canal Therapy / Endodontics Minor Periodontics Major Periodontics Oral Surgery, All Except Simple Extractions Surgical Extraction of Impacted Teeth Relines, Rebases, and Adjustments Repairs - Bridges, Crowns, and Inlays Repairs – Dentures Anesthetics Dentures Bridges	50% after plan deductible	50% after plan deductible

Waiting Periods

A Covered Person may access their dental Covered Services once the following waiting periods are satisfied.

- there is no waiting period for Class I and Class II services;
- after 12 consecutive months of coverage, Covered Services will increase to include the list of Class III dental procedures

E. Insured's Financial Responsibility

The Insured is responsible for paying the monthly or quarterly premium on a timely basis. The Insured is also responsible to pay Providers for charges that are applied to the Deductibles, Coinsurance, and any amounts charged by Non-Participating Providers in excess of the Contracted Fee. In addition, any charges for Dentally Necessary items that are excluded under the Policy are the responsibility of the Insured.

F. Exclusions and Limitations: What Is Not Covered By This Policy

Expenses Not Covered

Covered Expenses do not include expenses incurred for:

- procedures which are not included in the list of Covered Expenses.
- procedures which are not Necessary and which do not have uniform professional endorsement.
- procedures for which a charge would not have been made in the absence of coverage or for which the Covered Person is not legally required to pay.
- services performed solely for cosmetic reasons.
- replacement of a lost or stolen appliance.

- replacement of a bridge, crown or denture within 7 years after the date it was originally installed unless: (a) the replacement is made Necessary by the placement of an original opposing full denture or the Necessary extraction of natural teeth; or (b) the bridge, crown or denture, while in the mouth, has been damaged beyond repair as a result of an injury received while a Covered Person is insured for these benefits.
- any replacement of a bridge, crown or denture which is or can be made useable according to common dental standards.
- precious or semi-precious metals for crowns, bridges and abutments.
- procedures, appliances or restorations whose main purpose is to diagnose or treat jaw joint problems, including dysfunction of the temporomandibular joint and craniomandibular disorders, or other conditions of the joints linking the jawbone and skull, including the complex muscles, nerves and other tissues related to that joint.
- implants or implant related services.
- Orthodontic Treatment.
- bite registrations; precision or semi-precision attachments; or splinting.
- charges for travel time or transportation costs.
- temporary, transitional or interim dental services.
- any charge for any treatment performed outside of the United States other than for Dental Emergency treatment (any benefits for Dental Emergency treatment which is performed outside of the United States will be limited to a maximum of $100 per consecutive 12-month period).
- oral hygiene and diet instruction; broken appointments; completion of claim forms; personal supplies (e.g., water pick, toothbrush, floss holder, etc.); duplication of x-rays and exams required by a third party.
- any charges, including ancillary charges, made by a hospital, ambulatory surgical center or similar facility.
- dental services that are deemed to be medical services.
- services for which benefits are not payable according to the "General Limitations" section.

General Limitations

No payment will be made for expenses incurred for You or Your Dependent(s):

- for services not specifically listed as Covered Services in this Policy.
- for services or supplies that are not Medically Necessary and/or Dentally Necessary.
- for services received before the Effective Date of coverage.
- for services received after coverage under this Policy ends.
- for services for which You have no legal obligation to pay or for which no charge would be made if You did not have insurance coverage.
- for or in connection with a sickness which is covered under any workers' compensation or similar law.
- for charges made by a Hospital owned or operated by or which provides care or performs services for, the United States Government, if such charges are directly related to a military-service-connected condition; Cigna will refund premiums as applicable on a pro-rata basis to a Covered Person for any charges related to a military-service condition if Cigna receives written notice of military service.

- services or supplies received as a result of dental disease, defect or injury due to an act of war, declared or undeclared while serving in the military or an associated auxiliary unit, Cigna will refund premiums as applicable on a pro-rata basis to a Covered Person if Cigna receives written notice of military service.
- to the extent that You or Your Dependent(s) is in any way paid or entitled to payment for those expenses by or through a public program, other than Medicaid.
- for or in connection with experimental dental procedures or dental treatment methods not approved by the American Dental Association or the appropriate dental specialty society.
- to the extent that benefits are paid or payable for those expenses under the mandatory part of any auto insurance policy written to comply with a "no-fault" insurance law or an uninsured motorist insurance law. Cigna will take into account any adjustment option chosen under such part by You or Your Dependent(s).

G. Predetermination of Dental Benefits

Predetermination of Benefits is a voluntary review of a Dentist's proposed treatment plan and expected charges. It is not preauthorization of service and is not required.

The treatment plan should include supporting pre-operative x-rays and other diagnostic materials as requested by Cigna's dental consultant. If there is a change in the treatment plan, a revised plan should be submitted.

Cigna will determine covered dental expenses for the proposed treatment plan. If there is no Predetermination of Benefits, Cigna will determine covered dental expenses when it receives a claim.

Review of proposed treatment is advised whenever extensive dental work is recommended when charges exceed $500.

Predetermination of Dental Benefits is not a guarantee of a set payment. Payment is based on the services that are actually delivered and the coverage in force at the time services are completed.

H. General Provisions

When You Have a Complaint or an Appeal

For the purposes of this section, any reference to "You," "Your" or "Yourself" also refers to a representative or Provider designated by You to act on Your behalf, unless otherwise noted.

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

Start with Member Services

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

Cigna
Individual Services
P. O. Box 30365
Tampa, FL 33630
1-877-484-5967

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

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

Appeals Procedure

Cigna has a two-step appeals procedure for coverage decisions. To initiate an appeal, submit a request for an appeal in writing within 365 days of receipt of the denial notice. You should state the reason(s) why You feel Your appeal should be approved and include any information supporting Your appeal . If, for any reason, You are unable to submit your appeal in writing, You may ask to initiate Your appeal by telephone.

Level-One Appeal

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

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

Level-Two Appeal

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

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

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

Notice of Benefit Determination on Appeal

Every notice of an appeal decision will be provided in writing or electronically and, if an adverse determination, will include:

- the specific reason or reasons for the denial decision;
- reference to the specific Policy provisions on which the decision is based;
- a statement that the claimant is entitled to receive, upon request and free of charge, reasonable access to and copies of all documents, records, and other Relevant Information as defined;
- upon request and free of charge, a copy of any internal rule, guideline, protocol or other similar criterion that was relied upon in making the adverse determination regarding Your appeal, and an explanation of the scientific or clinical judgment for a determination that is based on a Medical or Dental Necessity, experimental treatment or other similar exclusion or limit.

Relevant Information

Relevant Information is any document, record, or other information which:

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

Dispute Resolution

All complaints or disputes relating to coverage under this Policy must be resolved in accordance with Our complaint and adverse determination appeal procedures. Complaints and adverse determination appeals may be reported by telephone or in writing. All complaints and adverse determination appeals received by Us that cannot be resolved by telephone conversation (when appropriate) to the mutual satisfaction of both the Covered Person and Us will be acknowledged in writing, along with a description of how We propose to resolve the grievance.

Binding Arbitration

To the extent permitted by law, any controversy between Cigna and an Insured (including any legal representative acting on Your behalf), arising out of or in connection with this Policy may be submitted to binding arbitration upon written notice by one party to another. Such arbitration shall be governed by the provisions of the Commercial Arbitration Rules of the American Health Lawyers Association, to the extent that such provisions are not inconsistent with the provisions of this section.

If the parties cannot agree upon a single arbitrator within 30 days of the effective date of written notice of arbitration, each party shall choose one arbitrator within 15 working days after the expiration of such 30-day period and the two arbitrators so chosen shall choose a third arbitrator, who shall be an attorney duly licensed to practice law in the applicable state. If either party refuses or otherwise fails to choose an arbitrator within such 15-working-day-period, the arbitrator chosen shall choose a third arbitrator in

accordance with these requirements.

The arbitration hearing shall be held within 30 days following appointment of the third arbitrator, unless otherwise agreed to by the parties. If either party refuses to or otherwise fails to participate in such arbitration hearing, such hearing shall proceed and shall be fully effective in accordance with this section, notwithstanding the absence of such party. The arbitrator(s) shall render their decision within 30 days after the termination of the arbitration hearing.

To the extent permitted by law, the decision of the arbitrator, or the decision of any two arbitrators if there are three arbitrators, shall be binding upon both parties conclusive of the controversy in question, and enforceable in any court of competent jurisdiction.

No party to this Policy shall have a right to cease performance of services or otherwise refuse to carry out its obligations under this Policy pending the outcome of arbitration in accordance with this section, except as otherwise specifically provided under this Policy.

I. Participating Providers

Cigna will provide a current list of Dentists currently participating with Cigna and their locations to each Insured upon request.

To verify if a Dentist is currently participating with Cigna and is accepting new Cigna Insureds, the Insured should visit Our website at Cigna.com.

J. Renewability, Eligibility, and Continuation

1. The Policy will renew except for the specific events stated in the Policy. Cigna may change the premiums of the Policy with 30 days written notice to the Insured. However, Cigna will not refuse to renew or change the premium schedule for the Policy on an individual basis, but only for all insured's in the same class and covered under the same Policy as You.

2. The Individual Plan is designed for residents of Pennsylvania who are not enrolled under or covered by any other group or individual health coverage. You must notify Cigna of all changes that may affect any Insured Person's eligibility under the Policy.

3. A Covered Person will become ineligible for coverage:
   - When premiums are not paid according to the due dates and grace periods described in the Premium section.
   - With respect to Your Spouse, Domestic Partner, or partner to a Civil Union; when the Spouse is no longer married to the Insured, the Domestic Partner no longer lives with You, or when the Civil Union is dissolved.
   - With respect to You and Your Dependent(s): when You no longer meet the requirements listed in the Conditions of Eligibility section.
   - The date the Policy terminates.
   - When the Insured no longer lives in the Service Area. Moving out of the Service Area will require a new application.

4. If a Covered Person's eligibility under this plan would terminate due to the Insured's death, divorce or if other Dependent(s) would become ineligible due to age or no longer qualify as Dependent(s) for coverage under this plan; except for the Insured's failure to pay premium, the Covered Person's insurance will be continued if the Covered Person exercising the continuation right notifies Cigna and

pays the appropriate monthly premium within 60 days following the date this Policy would otherwise terminate. Any waiting periods in the new plan will be considered as being met to the extent coverage was in force under this plan.

K. Premiums

There is a grace period of 31 days for the receipt at Our office or P.O. Box of any premium due after the first premium. Coverage will continue during the grace period. If the premium due is not paid during the grace period, the Policy will terminate. You will be responsible for any claims incurred after the termination date.

You will be responsible for an additional $45 charge for any check or electronic funds transfer that is returned to Us unpaid.

Your premium listed on the Policy specification page may change from time to time due to (but not limited to):

- Deletion or addition of a new eligible Covered Person(s);
- A change in age of any member which results in a higher premium;
- A change in residence within the Service Area of this Policy.

These changes will be effective on the first of the month following the change, unless as otherwise stated on Your premium notice.

Cigna also reserves the right to change the premium on 30 days' prior written notice to You. However, We will not modify the premium schedule on an individual basis, but only for all Covered Persons covered under the same Policy as You. The change will become effective on the date shown on the notice. After the Policy is issued, any change that reduces or eliminates benefits will be provided in an endorsement and is subject to Your signed acceptance. For any other changes, d payment of the new premiums will indicate acceptance of the change.