Cigna Health and Life Insurance Company ("Cigna")
Home office: 900 Cottage Grove Road Bloomfield, CT 06002
State of Domicile - Connecticut

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

Cigna Dental Vision Hearing 3500 Plan

BENEFITS ARE SUPPLEMENTAL AND ARE NOT INTENDED TO COVER ALL DENTAL, VISION OR HEARING EXPENSES

POLICY FORM NUMBER: INDDVHPOLUT1021.3500

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!**

This Policy is NOT A MEDICARE SUPPLEMENT policy. If You are eligible for Medicare review the Medicare Supplement Buyer's Guide available from the company.

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

A **Participating Dental Provider - Cigna Dental Preferred Provider** is a Dentist or a professional corporation, professional association, partnership, or any other entity that has a direct or indirect contractual arrangement with Cigna to provide Covered Services at predetermined fees with regard to a particular Policy under which a Covered Person is covered. The Providers qualifying as Participating Dental Providers may change from time to time.
A **Non-Participating Dental Provider** (Out of Network Provider) is a Provider who does not have a Participating Dental Provider agreement in effect with Cigna for this Policy at the time services are rendered. Covered Expenses for Non-Participating Dental Providers are based on the Contracted Fee which may be less than actual billed charges. Non-Participating Dental Providers can bill You for amounts exceeding Covered Expenses.

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. Implants, including surgical placement of the implant body or framework, are also covered by Your plan. 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

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, VISION, AND HEARING INSURANCE ***The Schedule***
For You and Your Dependents
The Schedule – Dental Benefits
If You select a Participating Dental Provider, Your cost will be less than if You select a Non-Participating Dental Provider.
Dental Deductibles Dental Deductibles are expenses to be paid by You or Your Dependent. Dental Deductibles are in addition to any Coinsurance. Once the individual Dental Deductible maximum in The Schedule has been reached ,that individual need not satisfy any further dental deductible for the rest of that year.
Participating Dental Provider Payment Participating Dental Provider services are paid based on the Contracted Fee agreed upon by the Provider and Cigna.
Non-Participating Dental Provider Payment Non-Participating Dental Provider services are paid based on the Contracted Fee.

DENTAL BENEFIT HIGHLIGHTS	
Classes I, II, III, IX Calendar Year Maximum	$2,500 per person
Class IX Lifetime Maximum	$2,000 per person
Calendar Year Dental Deductible Individual	$100 per person Not Applicable to Class I
Class I	**The Percentage of Covered Expenses the Plan Pays**
Preventive Care Oral Exams Routine Cleanings Routine X-rays Non-Routine X-rays Fluoride Application Sealants Space Maintainers (non-orthodontic) Emergency Care to Relieve Pain	100%
Class II	**The Percentage of Covered Expenses the Plan Pays**
Basic Restorative Fillings Surgical Extraction of Impacted Teeth Oral Surgery, Simple Extractions Relines, Rebases, and Adjustments Repairs - Bridges, Crowns, and Inlays Repairs – Dentures	80% after dental deductible
Class III	**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 Prosthesis Over Implant Anesthetics Dentures Bridges	50% after dental deductible
Class IX	**The Percentage of Covered Expenses the Plan Pays**
Implants	50% after plan deductible

The Schedule - Vision Benefits	
VISION BENEFIT HIGHLIGHTS	
Eye Examinations, including refraction	The plan pays 90% of expenses, not to exceed a $100 calendar year maximum per person
Materials (corrective eyeglasses or contact lenses, including fittings and follow-up visits)	$300 calendar year maximum per person

The Schedule - Hearing Benefits	
HEARING BENEFIT HIGHLIGHTS	
Hearing Examinations	$50 calendar year maximum per person
Materials (Hearing Aids, including fittings and repairs)	$700 calendar year maximum per person

Waiting Periods

A Covered Person may access their dental, vision, and hearing benefit insurance once he or she has satisfied the following waiting periods.

- there is no waiting period for Class I or II dental benefits or for vision and hearing benefits.
- after 6 consecutive months of coverage dental benefits will increase to include the list of Class III procedures.
- after 12 consecutive months of coverage dental benefits will increase to include the list of Class IX procedures.

Missing Teeth Limitation

There is no payment for replacement of teeth that are missing when a person first becomes insured.

This payment limitation no longer applies after 24 months of continuous coverage.

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 Dental Providers in excess of the Contracted Fee. In addition, any charges for Medically Necessary and/or 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 will not include, and no payment will be made for:

- procedures which are not included in the list of Covered Dental Services, Covered Vision Services, or Covered Hearing Services;
- cone beam imaging;
- instruction for plaque control, oral hygiene and diet;
- core build-ups;
- veneers;
- precious or semi-precious metals for crowns, bridges and abutments;
- restoration of teeth which have been damaged by erosion, attrition or abrasion;
- bite registrations; precision or semi-precision attachments; or splinting;
- orthodontic treatment, except for the treatment of cleft lip and cleft palate;
- general anesthesia or intravenous sedation, when used for the purposes of anxiety control or patient management is not covered; may be considered only when medically or dentally necessary and when in conjunction with covered complex oral surgery;
- athletic mouth guards;
- services performed solely for cosmetic reasons;
- personalization or decoration of any dental device or dental work;
- replacement of an appliance per benefit guidelines;
- services that are medical in nature;
- services and supplies received from a hospital;
- prescription drugs;
- plano lenses;
- VDT (video display terminal)/computer eyeglass benefit;
- medical or surgical treatment of the eyes;
- any type of corrective vision surgery, including LASIK surgery, radial ketatonomy (RK), automated lamellar keratoplasty (ALK), or conductive keratoplasty (CK);
- Orthoptic or vision training and any associated supplemental testing;
- any eye examination, or any corrective eyewear, required by an employer as a condition of employment;
- safety eyewear;
- sub-normal vision aids or non-prescription lenses;
- Magnification or low vision aids not shown as covered in the Schedule of Vision Coverage;
- Assistive Listening Devices (ALDs);
- medical and/or surgical treatment of the internal or external structures of the ear, including but not limited to Cochlear implants;
- Hearing Aids not prescribed by a Licensed Hearing Care Professional;
- ear protective devices or plugs;
- Hearing Aids maintenance/service contracts, ear molds and other miscellaneous repairs;
- Hearing Aids purchased online or over the counter (OTC); or
- Disposable Hearing Aids.

General Limitations

No payment will be made for expenses incurred for You or any one of Your Dependents:

- For services not specifically listed as Covered Services in this Policy;
- For services or supplies that are not Medically 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 Professional services or supplies received or purchased directly or on Your behalf by anyone, including a Provider, from any of the following:
  - Yourself or Your employer;
  - a person who lives in the Covered Person's home, or that person’s employer;
  - a person who is related to the Covered Person by blood, marriage or adoption, or that person’s employer.
- for or in connection with an Injury arising out of, or in the course of, any employment for wage or profit;
- 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 condition which occurred while serving in the military or an associated auxiliary unit;
- services or supplies received due to an act of war, declared or undeclared while serving in the military or an associated auxiliary unit;
- to the extent that payment is unlawful where the person resides when the expenses are incurred;
- for charges which the person is not legally required to pay;
- for charges which would not have been made if the person had no insurance;
- to the extent that billed charges exceed the rate of reimbursement as described in the Schedule;
- for charges for unnecessary care, treatment or surgery;
- to the extent that You or any of Your Dependents 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 procedures or 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 any one of Your Dependents.

G. Predetermination of Dental Benefits Program

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

Customer Services Toll-Free Number or address that appears on mycigna.com,
explanation of benefits or claim form.

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

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

Appeals Procedure

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

Level-One Appeal

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

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

Level Two Appeal

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

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

For level two appeals we will acknowledge in writing that we have received Your request and schedule a Committee review. For postservice claims, the Committee review will be completed within 30 calendar days. If more time or information is needed to make the determination, we will notify You in writing to request an extension of up to 15 calendar days and to specify any additional information needed by the Committee to

complete the review. You will be notified in writing of the Committee's decision within five working days after the Committee meeting, and within the Committee review time frames above if the Committee does not approve the requested coverage.

Independent Review Procedure

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

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

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

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

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

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

Appeal to the State of Utah

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

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

Notice of Benefit Determination on Appeal

Every notice of an appeal decision will be provided in writing or electronically and, if an adverse determination, will include: (1) the specific reason or reasons for the denial decision; (2) reference to the specific Policy provisions on which the decision is based; (3) 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; (4) upon request and free of charge, a copy of any internal rule, guideline, protocol or other similar criterion that was relied upon in making the adverse determination regarding your appeal, and an explanation of the scientific or clinical judgment for a determination that is based on a medical necessity, experimental treatment or other similar exclusion or limit.

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 Insured Person and Us will be acknowledged in writing, along with a description of how We propose to resolve the grievance.

Compulsory 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 his (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 Dental Providers

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

To verify if a Dentist is currently participating with Cigna and is accepting new Cigna Insureds, the Covered Person should visit Our website at mycigna.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 60 days written notice to the Insured prior to the renewal date. However, Cigna will not refuse to renew or change the premium schedule for the Policy on an individual basis, but only for all Insureds in the same class and covered under the same Policy as You.

2. The individual plan is designed for residents of Utah 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 Covered Person's eligibility under the Policy.

3. You or Your Dependent(s) 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 or when the union is dissolved.
- With respect to You and Your Family Member(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.

4. If a Covered Person's eligibility under this Plan would terminate due to the Insured's death, divorce or if other Dependents would become ineligible due to age or no longer qualify as dependents 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. Premium

The monthly premium amount is listed on the Policy specification page which was sent with this Policy. This monthly premium amount applies to individuals who pay monthly. If You pay quarterly, the quarterly premium amount due is 3 times the monthly premium.

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

There is a grace period of 30 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, however, if We do not receive Your premium before the end of the grace period, Your coverage will be terminated as of the last date for which You have paid premiums.

Your premium may change from time to time due to (but not limited to):

a. Deletion or addition of a new eligible Covered Person(s);

b. A change in age of any member which results in a higher premium;

c. A change in residence.

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 the renewal date with 60 days' prior written notice to You. However, We will not modify the premium schedule on an individual basis, but only for all Covered Persons in the same class and covered under the same Policy as You. The change will become effective on the date shown on the notice, and payment of the new premiums will indicate acceptance of the change.