Learning Care Group

CIGNA DENTAL PREFERRED
PROVIDER INSURANCE
Basic - MS

EFFECTIVE DATE: January 1, 2021

CN003
3343732

This document printed in February, 2021 takes the place of any documents previously issued to You which described Your benefits.

Printed in U.S.A.

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Home Office: Bloomfield, Connecticut
Mailing Address: Hartford, Connecticut 06152

CIGNA HEALTH AND LIFE INSURANCE COMPANY

a Cigna company (hereinafter called Cigna) certifies that it insures certain Employees for the benefits provided by the following policy(s):

POLICYHOLDER: Learning Care Group

GROUP POLICY(S) — COVERAGE
3343732 - DENM1 CIGNA DENTAL PREFERRED PROVIDER INSURANCE

EFFECTIVE DATE: January 1, 2021

This certificate describes the main features of the insurance. It does not waive or alter any of the terms of the policy(s). If questions arise, the policy(s) will govern.
This certificate takes the place of any other issued to You on a prior date which described the insurance.

Anna Krishtul

Anna Krishtul, Corporate Secretary

Explanation of Terms

You will find terms starting with capital letters throughout Your Certificate. To help You understand Your benefits, most of these terms are defined in the Definitions section of Your Certificate.

The Schedule

The Schedule is a brief outline of Your maximum benefits which may be payable under Your insurance. For a full description of each benefit, refer to the appropriate section listed in the Table of Contents.

Important Notices

Discrimination is Against the Law

Cigna complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability or sex. Cigna does not exclude people or treat them differently because of race, color, national origin, age, disability or sex.

Cigna:

- Provides free aids and services to people with disabilities to communicate effectively with us, such as:
  - Qualified sign language interpreters
  - Written information in other formats (large print, audio, accessible electronic formats, other formats)
- Provides free language services to people whose primary language is not English, such as
  - Qualified interpreters
  - Information written in other languages

If you need these services, contact customer service at the toll-free phone number shown on your ID card, and ask a Customer Service Associate for assistance.

If you believe that Cigna has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability or sex, you can file a grievance by sending an email to ACAGrievance@cigna.com or by writing to the following address:

Cigna
Nondiscrimination Complaint Coordinator
P.O. Box 188016
Chattanooga, TN 37422

If you need assistance filing a written grievance, please call the number on the back of your ID card or send an email to ACAGrievance@cigna.com. You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights electronically through the Office for Civil Rights Complaint Portal, available at: https://ocrportal.hhs.gov/ocr/portal/lobby.jsf, or by mail or phone at:

U.S. Department of Health and Human Services
200 Independence Avenue, SW
Room 509F, HHH Building
Washington, D.C. 20201
1-800-368-1019, 800-537-7697 (TDD)

Complaint forms are available at http://www.hhs.gov/ocr/office/file/index.html.

HC-NOT96 07-17

Proficiency of Language Assistance Services

English – ATTENTION: Language assistance services, free of charge, are available to you. For current Cigna customers, call the number on the back of your ID card. Otherwise, call 1.800.244.6224 (TTY: Dial 711).

Spanish – ATENCIÓN: Hay servicios de asistencia de idiomas, sin cargo, a su disposición. Si es un cliente actual de Cigna, llame al número que figura en el reverso de su tarjeta de identificación. Si no lo es, llame al 1.800.244.6224 (los usuarios de TTY deben llamar al 711).

Chinese – 注意：我們可為您免費提供語言協助服務。對於 Cigna 的現有客戶，請致電您的 ID 卡背面的號碼。其他客戶請致電 1.800.244.6224（聽障專線：請撥 711）。

Vietnamese – XIN LƯU Ý: Quý vị được cấp dịch vụ trợ giúp về ngôn ngữ miễn phí. Dành cho khách hàng hiện tại của Cigna, vui lòng gọi số ở mặt sau thẻ Hội viên. Các trường hợp khác xin gọi số 1.800.244.6224 (TTY: Quay số 711).

Korean – 주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 현재 Cigna 가입자님들께서는 ID 카드 뒷면에 있는 전화번호로 연락해주십시오. 기타 다른 경우에는 1.800.244.6224 (TTY: 다이얼 711)번으로 전화해주십시오.

Tagalog – PAUNAWA: Makakakuha ka ng mga serbisyo sa tulong sa wika nang libre. Para sa mga kasalukuyang customer ng Cigna, tawagan ang numero sa likuran ng iyong ID card. O kaya, tumawag sa 1.800.244.6224 (TTY: I-dial ang 711).

Russian – ВНИМАНИЕ: вам могут предоставить бесплатные услуги перевода. Если вы уже участвуете в плане Cigna, позвоните по номеру, указанному на обратной стороне вашей идентификационной карточки участника плана. Если вы не являетесь участником одного из наших планов, позвоните по номеру 1.800.244.6224 (TTY: 711).

Arabic – برجاء الانتباه خدمات الترجمة المجانية متاحة لكم. لعملاء Cigna الحاليين برجاء الاتصال بالرقم المدون علي ظهر بطاقتكم الشخصية. او اتصل ب 1.800.244.6224 (TTY : اتصل ب 711).

French Creole – ATANSYON: Gen sèvis èd nan lang ki disponib gratis pou ou. Pou kliyan Cigna yo, rele nimewo ki

dèyè kat ID ou. Sinon, rele nimewo 1.800.244.6224 (TTY: Rele 711).

French – ATTENTION: Des services d'aide linguistique vous sont proposés gratuitement. Si vous êtes un client actuel de Cigna, veuillez appeler le numéro indiqué au verso de votre carte d'identité. Sinon, veuillez appeler le numéro 1.800.244.6224 (ATS : composez le numéro 711).

Portuguese – ATENÇÃO: Tem ao seu dispor serviços de assistência linguística, totalmente gratuitos. Para clientes Cigna atuais, ligue para o número que se encontra no verso do seu cartão de identificação. Caso contrário, ligue para 1.800.244.6224 (Dispositivos TTY: marque 711).

Polish – UWAGA: w celu skorzystania z dostępnej, bezpłatnej pomocy językowej, obecni klienci firmy Cigna mogą dzwonić pod numer podany na odwrocie karty identyfikacyjnej. Wszystkie inne osoby prosimy o skorzystanie z numeru 1 800 244 6224 (TTY: wybierz 711).

Japanese –
注意事項：日本語を話される場合、無料の言語支援サービスをご利用いただけます。現在のCignaのお客様は、IDカード裏面の電話番号まで、お電話にてご連絡ください。その他の方は、1.800.244.6224（TTY: 711）まで、お電話にてご連絡ください。

Italian – ATTENZIONE: Sono disponibili servizi di assistenza linguistica gratuiti. Per i clienti Cigna attuali, chiamare il numero sul retro della tessera di identificazione. In caso contrario, chiamare il numero 1.800.244.6224 (utenti TTY: chiamare il numero 711).

German – ACHTUNG: Die Leistungen der Sprachunterstützung stehen Ihnen kostenlos zur Verfügung. Wenn Sie gegenwärtiger Cigna-Kunde sind, rufen Sie bitte die Nummer auf der Rückseite Ihrer Krankenversicherungskarte an. Andernfalls rufen Sie 1.800.244.6224 an (TTY: Wählen Sie 711).

Persian (Farsi) – توجه: خدمات کمک زبانی، به صورت رایگان به شما ارائه می‌شود. برای مشتریان فعلی Cigna، لطفاً با شماره‌ای که در پشت کارت شناسایی شماست تماس بگیرید. در غیر اینصورت با شماره 1.800.244.6224 تماس بگیرید (شماره تلفن ویژه ناشنوایان: شماره 711را شمارگیری کنید).

HC-NOT97 07-17

How To File A Claim

There's no paperwork to submit for Covered Services received from a Participating Provider. Pay Your share of the cost, if any; Your provider will submit a claim to Us for reimbursement. Claims for services received from a Non-Participating Provider can be submitted by the provider if the provider is able and willing to file on Your behalf. If Your plan provides coverage when care is received only from a Participating Provider, You may still have claims for services received from a Non-Participating Provider. For example, when Emergency Services are received from a Non-Participating Provider, You should follow the claim submission instructions for those claims. Claims can be submitted by the provider if the provider is able and willing to file on Your behalf. If the provider is not submitting on Your behalf, You must send Your completed claim form and itemized bills to the claims address listed on the claim form.

You may get the required claim forms from the website listed on Your identification card, if You received one, or by calling Customer Services using the toll-free number listed below.

Cigna's Toll-Free Number(s):

1-(800) Cigna24 (1-800-244-6224)

CLAIM REMINDERS

- BE SURE TO USE YOUR MEMBER ID AND ACCOUNT/GROUP NUMBER WHEN YOU FILE CLAIM FORMS, OR WHEN YOU CALL OUR CLAIM OFFICE.

  YOUR MEMBER ID IS THE ID SHOWN ON YOUR BENEFIT IDENTIFICATION CARD. YOUR ACCOUNT/GROUP NUMBER IS SHOWN ON YOUR BENEFIT IDENTIFICATION CARD.
- BE SURE TO FOLLOW THE INSTRUCTIONS LISTED ON THE BACK OF THE CLAIM FORM CAREFULLY WHEN SUBMITTING A CLAIM TO US.

Timely Filing Of Claims

We will consider claims for coverage under Your plan when proof of loss (a claim) is submitted to Us within:

- 12 months for both In-Network and Out-of-Network claims

after services are rendered. If services are rendered on consecutive days, the limit will be counted from the last date of service. If claims are not submitted to Us within the timeframe shown above, the claim will not be considered valid and will be denied.

NOTE: We consider one month to equal 30 days regardless of the number of days within a calendar month.

WARNING: Any person who knowingly and with intent to defraud any insurance company or other person: files an application for insurance or statement of claim containing any materially false information; or conceals for the purpose of misleading, information concerning any material fact thereto, commits a fraudulent insurance act.

HCDFB-CLM23 01-19

Eligibility - Effective Date

Eligible Classes

Each Employee as reported to Us by the Policyholder.

Your Insurance

This plan is offered to You as an Employee of the Policyholder.

Eligibility for Dental Insurance

You will become eligible for insurance on the day You complete the Eligibility Waiting Period, if any, and:

- You are an eligible Full-Time Employee;
- You normally work at least 30 hours a week; and
- You pay any required contribution.

Eligibility Waiting Period – New Hire

Initial Group:

You are in the Initial Group of Employees if You are:

- employed in a class of Employees on the date that class of Employees becomes a Class of Eligible Employees as determined by Your Employer.
- in the employ of an Employer on the Participation Date of the Employer.

Your Waiting Period is:

- None, coverage effective on date of hire.

New Group:

You are in a New Group of Employees if You are:

- not in the Initial Group, or
- Your employment with an Employer starts after the Effective Date of that Employer's Policy.
- You were previously insured and Your insurance ceased, and You seek to become insured again.

Your Waiting Period is:

- 90 days after date of hire.

Effective Date of Your Insurance

Subject to any Eligibility Waiting Period, You will become insured on:

- the date that:

  You are in Active Service and You elect the insurance by:

  - authorizing premium payment,
  - approving a payroll deduction,
  - signing a written agreement with the Policyholder to make the required contribution, or
  - signing an enrollment form, as applicable,

  but no earlier than the date You become eligible.

You will become insured on Your first day of eligibility, following Your election, if You are in Active Service on that date, or if You are not in Active Service on that date due to Your health status.

Late Entrant

You are a Late Entrant if:

- You elect the insurance more than 30 days after You initially become eligible; or
- You again elect it after You cancel Your payroll deduction (if required).

If You are a Late Entrant:

- You will not be able to enroll in the plan, until the next enrollment period, except due to a life status change event.

Dependent Insurance

For Your Dependents to be insured under the policy, You must elect the Dependent Insurance for Yourself no later than 30 days after You become eligible. For Your Dependents to be insured, You will have to pay the required contribution, if any, toward the cost of Dependent Insurance.

Eligibility for Dependent Insurance

Your Dependent will become eligible for Dependent Insurance on the later of:

- the day You meet the eligibility requirements noted above; or
- the day You acquire Your first Dependent.

Effective Date of Dependent Insurance

Insurance for Your Dependents will become effective on the date You elect it, by signing a written agreement with the Policyholder to make the required contribution, but no earlier than the day You become eligible for Dependent Insurance. All of Your Dependents as defined will be included.

Your Dependents will be insured only if You are insured.

Eligibility for Coverage for Adopted Children

Any child who is adopted by You, including a child who is placed with You for adoption, will be eligible for Dependent coverage, if otherwise eligible as a Dependent, upon the date of placement with You. A child will be considered placed for adoption when You become legally obligated to support that child, totally or partially prior to that child's adoption. If a child placed for adoption is not adopted, all dental coverage ceases when the placement ends, and will not be continued. The provisions in the Exception for Newborns provision that describe requirements for enrollment and Effective Date of insurance will also apply to an adopted child or a child placed with You for adoption.

Late Entrant - Dependent

You are a Late Entrant for Dependent Insurance if:

- You elect that insurance more than 30 days after You initially become eligible for it; or
- You again elect it after You cancel Your payroll deduction (if required).

If You are a Late Entrant:

- You will not be able to enroll in the plan, until the next enrollment period, except due to a life status change event.

Exception for Newborns

Any Dependent child born while You are insured will become insured on the date of the child's birth if You elect Dependent Insurance no later than 31 days after birth. If You do not elect to insure Your newborn child within such 31 days, coverage for that child will end on the 31st day. No benefits for expenses incurred beyond the 31st day will be payable.

Student Medical Leave of Absence

Coverage will continue for a Dependent child who is enrolled as a full-time student and takes a leave of absence from school due to an illness or injury that is certified as Medically Necessary by the student's attending physician. Certification of the leave of absence will satisfy Cigna's annual requirement of verification of full-time student status. Coverage will continue until the earlier of 12 months from the last day of attendance at school or the date the Dependent child reaches the limiting age under the definition of Dependent.

Dual Eligibility

If both You and Your Spouse or Your Domestic Partner are in an Eligible Class of the Employer, You may each enroll individually or as a Dependent of the other, but not as both. Any eligible Dependent child may also be enrolled by either You or Your Spouse or Your Domestic Partner. If the Spouse or Your Domestic Partner who enrolls for Dependent coverage ceases to be eligible, notify Your Plan Administrator immediately for coverage to continue under the plan of the other Spouse or Domestic Partner.

Covered Dental Expenses

Dental services described in this section are Covered Dental Expenses when such services are:

- Medically Necessary and/or Dentally Necessary (refer to the Section entitled Definitions);
- Provided by or under the direction of a Dentist or other appropriate provider as specifically described;
- The least costly, clinically accepted treatment; Covered after Your Deductible, if any, has been met;
- Eligible for reimbursement because the maximum benefit in The Schedule has not been exceeded;
- The charge does not exceed the amount allowed under the Alternate Benefit Provision;
- Not excluded as described in the Section entitled General Limitations and Expenses Not Covered.

Alternate Benefit Provision

If more than one Covered Service will treat a dental condition, payment is limited to the least costly service provided it is a professionally accepted, Medically Necessary and/or Dentally Necessary, and appropriate treatment.

If the Covered Person requests or accepts a more costly Covered Service, he or she is responsible for expenses that exceed the amount covered for the least costly service. Therefore, We recommend Predetermination of Benefits before major treatment begins.

Predetermination of 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 Our dental consultant. If there is a change in the treatment plan, a revised plan should be submitted. We will determine Covered Dental Expenses for the proposed treatment plan. If there is no Predetermination of Benefits, We will determine Covered Dental Expenses when We receive a claim.

Review of proposed treatment is advised whenever extensive dental work is recommended when charges exceed $200. 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.

The Schedule lists Covered Services, if a service is not listed there is no coverage.

HCDFB-COV8 01-19

Payment Options

If You or any one of Your Dependents, while insured for these benefits, incurs Covered Dental Expenses, We will pay an amount determined as follows:

Plan payment for a Covered Service delivered by a Participating Provider is the Contracted Fee for that procedure, times the benefit percentage that applies to the class of service, as specified in The Schedule. The Covered Person is responsible for the balance of the Contracted Fee.

Plan payment for a Covered Service delivered by a Non-Participating Provider is the Maximum Allowable Charge for that procedure times the benefit percentage that applies to the class of service, as specified in The Schedule. The Covered Person is responsible for the balance of the Non-Participating Provider's actual charge.

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Missing Teeth Limitation

The amount payable for the replacement of teeth that are missing when a person first becomes insured is 50% of the amount payable for the replacement of teeth that are extracted after a person has dental coverage.

This payment limitation no longer applies after 12 months of continuous coverage.

This limit will not apply to any person who is a member of the Initial Employee group.

HCDFB-MTL1

Cigna Dental Preferred Provider Insurance

The Schedule

Benefits For You and Your Dependents

The Dental Benefits Plan offered by Your Employer includes Participating and Non-Participating Providers. If You select a Participating Provider, Your cost will be less than if You select a Non-Participating Provider.

The Benefit Percentage payable for Emergency Services charges made by a Non-Participating Provider is the same Benefit Percentage as for Participating Provider Charges. 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.

Participating Provider Payment

Participating Provider services are paid based on the Contracted Fee that is agreed to by the provider and Us. Based on the provider's Contracted Fee, a higher level of plan payment may be made to a Participating Provider resulting in a lower payment responsibility for You. To determine how Your Participating Provider compares, refer to Your provider directory.

Provider information may change annually; refer to Your provider directory prior to receiving a service. You have access to a list of all providers who participate in the network by visiting www.mycigna.com.

Non-Participating Provider Payment

The Primary Schedule is usually the fee schedule with the lowest Contracted-Fees available for acceptance by a Participating Provider in the relevant 3-digit zip code.

BENEFIT MAXIMUMS AND DEDUCTIBLES	TOTAL CIGNA DPPO PARTICIPATING PROVIDER	NON-PARTICIPATING PROVIDER
Calendar Year Maximum Classes I, II		
Individual Maximum	$1,000	$1,000
Calendar Year Plan Deductible		
Individual	$50 per Member per Calendar Year Not Applicable to Class I	$50 per Member per Calendar Year Not Applicable to Class I
Family	$150 per family per Calendar Year Not Applicable to Class I	$150 per family per Calendar Year Not Applicable to Class I
Expenses incurred for either Participating or Non-Participating Provider charges will be used to satisfy both the Participating and Non-Participating Provider Deductibles shown in the Schedule.		
Benefits paid for Participating and Non-Participating Provider services will be applied toward both the Participating and Non-Participating Provider maximum shown in the Schedule.		

COVERED SERVICES BENEFIT DESCRIPTION & LIMITATION	TOTAL CIGNA DPPO PARTICIPATING PROVIDER	NON-PARTICIPATING PROVIDER
Class I		
CATEGORY: DIAGNOSTIC SERVICES		
Sub-Category: Oral Evaluations		
Periodic Oral Evaluation Limited to 2 services per Calendar Year. All Oral Evaluation services cross accumulate for Frequency Limit. D0120 CG080	100% no Deductible	100% no Deductible Subject to MAC
Comprehensive Oral Evaluation Limited to 2 services per Calendar Year. Not Covered if done in conjunction with other evaluations. All Oral Evaluation services cross accumulate for Frequency Limit. D0150 CG018	100% no Deductible	100% no Deductible Subject to MAC
Limited or Detailed Oral Evaluation Limited to 2 services per Calendar Year. All Oral Evaluation services cross accumulate for Frequency Limit. Only 1 evaluation is Covered per date of service. D0140 D0160 D0170 CG063	100% no Deductible	100% no Deductible Subject to MAC

COVERED SERVICES BENEFIT DESCRIPTION & LIMITATION	TOTAL CIGNA DPPO PARTICIPATING PROVIDER	NON-PARTICIPATING PROVIDER
Comprehensive Periodontal Evaluation - new or established patient Limited to 2 services per Calendar Year. All Oral Evaluation services cross accumulate for Frequency Limit. D0180 CG020	100% no Deductible	100% no Deductible Subject to MAC
Oral Evaluation for a Patient under three Years of Age and Counseling Primary Caregiver Limited to 2 services per Calendar Year. All Oral Evaluation services cross accumulate for Frequency Limit. D0145 CG071	100% no Deductible	100% no Deductible Subject to MAC
Sub-Category: Radiographs		
Intraoral Periapical Radiographic Images Unlimited D0220 D0230 CG059	100% no Deductible	100% no Deductible Subject to MAC
Intraoral Occlusal Radiographic Images Unlimited D0240 CG058	100% no Deductible	100% no Deductible Subject to MAC

COVERED SERVICES BENEFIT DESCRIPTION & LIMITATION	TOTAL CIGNA DPPO PARTICIPATING PROVIDER	NON-PARTICIPATING PROVIDER
Vertical Bitewings, 7-8 Radiographic Images Limited to 1 image per Calendar Year. Vertical bitewings cannot be billed in conjunction with a complete series. D0277 CG135	100% no Deductible	100% no Deductible Subject to MAC
Intraoral Bitewing Radiographic Images Limited to 1 service per Calendar Year. Vertical bitewings cannot be billed in conjunction with a complete series. D0270 D0272 D0273 D0274 CG056	100% no Deductible	100% no Deductible Subject to MAC
Extra-Oral Radiographic Images Limited to 1 image per Calendar Year. D0251 CG038	100% no Deductible	100% no Deductible Subject to MAC
Sub-Category: Radiographs – Other		
Intraoral Complete Series of Radiographic Images Limited to 1 service per consecutive 36 months. Vertical bitewings cannot be billed in conjunction with a complete series. Intraoral Complete Series and Panoramic Radiograph cross accumulate for Frequency Limit. D0210 CG057	100% no Deductible	100% no Deductible Subject to MAC

COVERED SERVICES BENEFIT DESCRIPTION & LIMITATION	TOTAL CIGNA DPPO PARTICIPATING PROVIDER	NON-PARTICIPATING PROVIDER
Panoramic Radiographic Image Limited to 1 service per consecutive 36 months. Intraoral Complete Series and Panoramic Radiograph cross accumulate for Frequency Limit. D0330 CG079	100% no Deductible	100% no Deductible Subject to MAC
CATEGORY: PREVENTIVE SERVICES		
Sub-Category: Oral Cleanings		
Dental Prophylaxis Limited to 2 services per Calendar Year. Oral Cleaning Services include Prophylaxis, Periodontal Maintenance, and Scaling in the Presence of Gingival Inflammation; all Oral Cleaning services cross accumulate for Frequency Limit. D1110 D1120 CG032	100% no Deductible	100% no Deductible Subject to MAC
Scaling in presence of generalized moderate or severe gingival inflammation – full mouth, after oral evaluation Limited to 2 services per Calendar Year. Oral Cleaning Services include Prophylaxis, Periodontal Maintenance, and Scaling in the Presence of Gingival Inflammation; all Oral Cleaning services cross accumulate for Frequency Limit. D4346 CG115	100% no Deductible	100% no Deductible Subject to MAC

COVERED SERVICES BENEFIT DESCRIPTION & LIMITATION	TOTAL CIGNA DPPO PARTICIPATING PROVIDER	NON-PARTICIPATING PROVIDER
Sub-Category: Periodontal Maintenance		
Periodontal maintenance procedures (following active therapy) Limited to 2 services per Calendar Year. Oral Cleaning Services include Prophylaxis, Periodontal Maintenance, and Scaling in the Presence of Gingival Inflammation; all Oral Cleaning services cross accumulate for Frequency Limit. D4910 CG081	100% no Deductible	100% no Deductible Subject to MAC
Sub-Category: Fluoride		
Topical Application of Fluoride – excluding Varnish Limited to 1 service per Calendar Year for ages 0 - 15. D1208 CG133	100% no Deductible	100% no Deductible Subject to MAC
Topical Application of Fluoride Varnish Limited to 1 service per Calendar Year for ages 0 - 15. D1206 CG134	100% no Deductible	100% no Deductible Subject to MAC
Sub-Category: Sealants		
Sealants Limited to 1 service per consecutive 36 months for ages 0 - 15. D1351 CG116	100% no Deductible	100% no Deductible Subject to MAC

COVERED SERVICES BENEFIT DESCRIPTION & LIMITATION	TOTAL CIGNA DPPO PARTICIPATING PROVIDER	NON-PARTICIPATING PROVIDER
Preventive Resin Restoration in a Moderate to High Caries Risk Patient - Permanent Tooth Limited to 1 service per consecutive 36 months for ages 0-15. D1352 CG090	100% no Deductible	100% no Deductible Subject to MAC
Sub-Category: Space Maintainers		
Removal of Fixed Space Maintainer Unlimited D1556 D1557 D1558 CG105	100% no Deductible	100% no Deductible Subject to MAC
Space Maintainer – Fixed Limited to one per tooth per lifetime for ages 0 - 25. D1510 D1516 D1517 CG118	100% no Deductible	100% no Deductible Subject to MAC
Space Maintainer - Removable Limited to one per tooth per lifetime for ages 0 - 25. D1520 D1526 D1527 CG119	100% no Deductible	100% no Deductible Subject to MAC
Distal Shoe Space Maintainer Limited to one per tooth per lifetime for ages 0 - 25. D1575 CG145	100% no Deductible	100% no Deductible Subject to MAC

COVERED SERVICES BENEFIT DESCRIPTION & LIMITATION	TOTAL CIGNA DPPO PARTICIPATING PROVIDER	NON-PARTICIPATING PROVIDER
CATEGORY: ORAL SURGERY		
Sub-Category: Biopsy		
Biopsy (Including Brush Biopsy) Coverage limited to only tooth/gingival related. Unlimited D7285 D7286 D7288 CG012	100% no Deductible	100% no Deductible Subject to MAC
Class II		
CATEGORY: BASIC RESTORATIVE SERVICES		
Sub-Category: Minor Restoration Services		
Amalgam Restorations Limited to 1 service per tooth per consecutive 24 months. Multiple restorations on one surface will be treated as a single restoration. D2140 D2150 D2160 D2161 CG006	70% after plan Deductible	70% after plan Deductible Subject to MAC
Resin-Based Composite Restorations - Anterior Limited to 1 service per tooth per consecutive 24 months. Multiple restorations on one surface will be treated as a single restoration. D2330 D2331 D2332 D2335 CG110	70% after plan Deductible	70% after plan Deductible Subject to MAC

COVERED SERVICES BENEFIT DESCRIPTION & LIMITATION	TOTAL CIGNA DPPO PARTICIPATING PROVIDER	NON-PARTICIPATING PROVIDER
Gold Foil Restorations Limited to 1 service per tooth per consecutive 24 months. Multiple restorations on one surface will be treated as a single restoration. D2410 D2420 D2430 CG043	70% after plan Deductible	70% after plan Deductible Subject to MAC
CATEGORY: ENDODONTICS		
Sub-Category: Anterior/Premolar Root Canal		
Anterior Root Canal Therapy – excluding final restoration Primary and Permanent Anterior Teeth Covered. Limited to 1 service per tooth per lifetime. D3310 CG007	70% after plan Deductible	70% after plan Deductible Subject to MAC
Premolar Root Canal Therapy – excluding final restoration Primary and Permanent Premolar Teeth Covered. Limited to 1 service per tooth per lifetime. D3320 CG089	70% after plan Deductible	70% after plan Deductible Subject to MAC
Sub-Category: Minor Endodontics		
Retrograde Filling D3430 CG113	70% after plan Deductible	70% after plan Deductible Subject to MAC

COVERED SERVICES BENEFIT DESCRIPTION & LIMITATION	TOTAL CIGNA DPPO PARTICIPATING PROVIDER	NON-PARTICIPATING PROVIDER
Hemisection Limited to permanent teeth only. D3920 CG045	70% after plan Deductible	70% after plan Deductible Subject to MAC
Retreatment of Previous Root Canal Therapy D3346 D3347 D3348 CG112	70% after plan Deductible	70% after plan Deductible Subject to MAC
Therapeutic Pulpotomy Limited to 1 service per primary or permanent tooth per lifetime. D3220 D3222 CG128	70% after plan Deductible	70% after plan Deductible Subject to MAC
Pulpal Therapy (resorbable filling) - Anterior or Posterior, Primary Tooth (excluding final restoration) D3230 D3240 CG098	70% after plan Deductible	70% after plan Deductible Subject to MAC
Pulp Caps - Direct/Indirect – excluding final restoration Limited to one tooth per lifetime. D3110 D3120 CG095	70% after plan Deductible	70% after plan Deductible Subject to MAC

COVERED SERVICES BENEFIT DESCRIPTION & LIMITATION	TOTAL CIGNA DPPO PARTICIPATING PROVIDER	NON-PARTICIPATING PROVIDER
CATEGORY: PERIODONTICS		
Sub-Category: Periodontal Scaling and Root Planing		
Periodontal Scaling and Root Planing Limited to 1 service per quadrant per consecutive 24 months. D4341 D4342 CG082	70% after plan Deductible	70% after plan Deductible Subject to MAC
Sub-Category: Minor/Non-Surgical Periodontics		
Full Mouth Debridement Limited to one per lifetime. D4355 CG040	70% after plan Deductible	70% after plan Deductible Subject to MAC
Localized Delivery of Antimicrobial Agents via a controlled release vehicle into diseased crevicular tissue, per tooth D4381 CG064	70% after plan Deductible	70% after plan Deductible Subject to MAC
CATEGORY: ORAL SURGERY		
Sub-Category: Simple Extractions Erupted Tooth		
Extraction, coronal remnants D7111 CG146	70% after plan Deductible	70% after plan Deductible Subject to MAC
Simple Extraction of Erupted Teeth or Exposed Roots D7140 CG169	70% after plan Deductible	70% after plan Deductible Subject to MAC

COVERED SERVICES BENEFIT DESCRIPTION & LIMITATION	TOTAL CIGNA DPPO PARTICIPATING PROVIDER	NON-PARTICIPATING PROVIDER
CATEGORY: DIAGNOSTIC SERVICES		
Sub-Category: Other Diagnostic Services		
Consultation (diagnostic service provided by dentist or physician other than requesting dentist or physician) Unlimited Covered if performed by the non-treating dentist. Covered when Necessary in conjunction with Covered Dental Services. D9310 CG142	70% after plan Deductible	70% after plan Deductible Subject to MAC
CATEGORY: ADJUNCTIVE SERVICES		
Sub-Category: Emergency Services		
Palliative Treatment Unlimited Covered as a separate benefit only if no other services, other than exam and radiographs, were performed during the visit. D9110 CG078	70% after plan Deductible	70% after plan Deductible Subject to MAC
Sub-Category: Other Adjunctive Services		
Desensitizing Medicament per tooth and per visit Per tooth: Limited to 1 service per consecutive 12 months for ages 0 - 17. D9910 CG034	70% after plan Deductible	70% after plan Deductible Subject to MAC
Occlusal Adjustment Unlimited D9951 D9952 CG067	70% after plan Deductible	70% after plan Deductible Subject to MAC

COVERED SERVICES BENEFIT DESCRIPTION & LIMITATION	TOTAL CIGNA DPPO PARTICIPATING PROVIDER	NON-PARTICIPATING PROVIDER
Occlusal Guard Reline and Repair Limited to more than 6 months after the initial insertion. Unlimited D9942 CG068	70% after plan Deductible	70% after plan Deductible Subject to MAC
Occlusion Analysis - Mounted Case Unlimited D9950 CG070	70% after plan Deductible	70% after plan Deductible Subject to MAC

General Limitations and Expenses Not Covered

General Limitations

For limitations on specific covered services, please see The Schedule.

- any treatment received outside of the United States is not covered except for treatment received as an Emergency Service;
- replacement of any amalgam or resin-based composite restoration involving the same surface(s) on the same tooth by the same Dentist or a different Dentist in the same office within the frequency limitation stated on the Schedule is not covered;
- a combination of radiographic images (such as ten or more periapical radiographic images; or a panoramic radiographic image with bite-wing radiographic images) completed on the same date of service will not be covered when the allowance meets or exceeds the allowance for an intraoral complete series of radiographic images. Plan reimbursement will be based on an intraoral complete series;
- localized delivery of antimicrobial agents via a controlled release vehicle into diseased crevicular tissue, per tooth. Allowable only on teeth with both periodontal pocket depths of 5 mm or greater and a prior history of Periodontal Therapy. Not allowable when more than eight (8) of these procedures are reported on the same date of service;
- tissue preparation such as gingivectomy/gingivoplasty or crown lengthening as a separate allowance on the same date as a restoration on the same tooth;
- when covered by Your plan, any prosthesis over an implant is subject to the same exclusions, limitations, alternate benefit provisions, time limitations, and missing tooth limitations as standard traditional restorative, fixed and removable prosthetics;
- covered Services to the extent that billed charges exceed the rate of reimbursement as described in The Schedule;

The benefits provided under this plan will be reduced so that the total payment will not be more than 100% of the charge made for the dental service if benefits are provided for that service under this plan and any medical expense plan or prepaid treatment program sponsored or made available by Your Employer.

Expenses Not Covered

Covered Expenses will not include, and no payment will be made for:

- any services not stated under Covered Dental Services and The Schedule;
- procedures that are a covered expense under any other medical plan which provides group hospital, surgical, or medical benefits whether or not on an insured basis;
- charges incurred due to injuries which are intentionally self-inflicted;
- charges for or in connection with an injury or illness arising out of, or in the course of any employment for wage or profit;
- charges for or in connection with an injury or illness which is covered under any workers' compensation or similar law;
- charges made by a hospital owned or operated by or which provides care or performs services for, the United States Government, if such charges are directly related to a military-service-connected condition;
- services or supplies received as a result of dental disease, defect or injury due to an act of war, declared or undeclared;
- consultations and/or evaluations associated with services that are not covered;
- cosmetic dentistry or cosmetic dental surgery (dentistry or dental surgery performed solely to improve appearance) which may include but is not limited to the following: bleaching (tooth whitening), facings, repairs to facings or replacement of facings on crowns or bridge units on molar teeth will always be considered cosmetic;
- replacement of fixed and/or removable appliances (including fixed and removable orthodontic appliances, if orthodontics is covered) that have been lost, stolen, or damaged due to patient abuse, misuse, or neglect;
- procedures, services, supplies, restorations, or appliances (except complete dentures), whose sole or primary purpose is to change or maintain vertical dimension;
- procedures, services, supplies, restorations or appliances whose main purpose is to diagnose or treat jaw joint problems, including dysfunction of the temporomandibular joint and craniomandibular disorders, or other conditions of the joints linking the jawbone and skull, including the complex muscles, nerves and other tissues related to that joint;
- occlusal adjustment or the alteration or restoration of occlusion;
- the restoration of teeth which have been damaged by erosion, attrition, abfraction or abrasion;

- bite registration or bite analysis;
- porcelain, ceramic, resin, or acrylic materials on crowns or pontics on, or replacing the upper or lower first, second and/or third molars;
- services to correct congenital malformations, including the replacement of congenitally missing teeth;
- procedures, restorations, appliances or services to stabilize periodontally involved teeth;
- services associated with the diagnosis, placement, treatment, repair, removal or replacement of a dental implant, or any other services related to implants, unless covered by Your specific plan, including but not limited to: the surgical placement of a dental implant body; the surgical implant index or template guide used for implant surgery; implant abutment(s) and/or connecting bar(s); periodontal/peri-implant and/or maintenance services specifically related to a dental implant; and/or removal of an existing implant(s);
- fixed or removable space maintainers for patients on or after their 25th birthday;
- myofunctional therapy;
- the re-cementation and/or repair of any inlay, onlay, crown, post and core, or fixed bridge within 6 months of initial placement by the same Dentist or a different Dentist in the same office. We consider re-cementation and/or repair within this timeframe to be incidental to and part of the charges for the initial restoration;
- replacement of a partial denture or complete denture which can be made serviceable;
- prescription drugs;
- treatment of jaw fractures and/or orthognathic surgery;
- Orthodontic Treatment;
- the treatment of cleft lip and cleft palate;
- charges for sterilization of equipment, infection control processes and procedures, disposal of medical waste or other requirements mandated or recommended by the Centers for Disease Control and Prevention (CDC), OSHA or other regulatory agencies; We consider these to be incidental to and part of the charges for services provided and not separately chargeable;
- charges for travel time; transportation costs; or professional advice given on the phone;
- temporary, transitional or interim dental services;
- diagnostic casts, diagnostic models or study models;
- personal supplies, including but not limited to toothbrushes, rotary toothbrushes, floss holders, and water irrigation devices;
- charges for broken appointments; completion of claim forms; duplication of x-rays and/or exams required by a third party;
- services that are deemed to be medical services;
- any charges, including ancillary charges, for services and supplies received from a hospital, outpatient facility, ambulatory surgical center or similar facility;
- charges for treatment or surgery that does not meet plan guidelines;
- general anesthesia or intravenous sedation when used for the purposes of anxiety control or patient management;
- indirect pulp capping on the same date of service as a permanent restoration, We consider this to be incidental to and part of the charges for services provided and not separately chargeable;
- endodontic treatment and/or periodontal (gum tissue and supporting bone) surgery of teeth exhibiting a poor or hopeless periodontal prognosis;
- harmful habits treatment;
- intentional root canal treatment in the absence of injury or disease solely to facilitate a restorative procedure;
- services to the extent You or Your enrolled Dependent(s) are compensated under any group medical plan;
- house/extended care facility calls; hospital calls; office visits for observation (during regularly scheduled hours) when no other services are performed; office visits after regularly scheduled hours; and case presentations;
- procedures performed by a Dentist who is a member of the Covered Person's family except in the case of a dental emergency when no other Dentist is available. (Covered Person's family is limited to a Spouse, siblings, parents, children, grandparents, and the Spouse's siblings and parents);
- dental services that do not meet commonly accepted dental standards;
- replacement of teeth beyond the normal adult dentition of thirty-two (32) teeth;
- services not included in the list of Covered Services, unless We agree to accept such expense as a Covered Dental Expense, in which case payment will be made consistent with similar services which would provide the least expensive professionally satisfactory result;
- to the extent that You or any of Your Dependents are in any way paid or entitled to payment for those expenses by or through a public program, other than Medicaid;
- charges in excess of the Maximum Reimbursable Charge allowances;

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

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

Coordination of Benefits

This section applies if You or any one of Your Dependents are covered under more than one Plan and determines how benefits payable from all such Plans will be coordinated. You should file all claims with each Plan. Any other health coverage plans for You or any of Your covered Dependents are taken into account when benefits are paid.

Coverage under this Plan plus another Plan will not guarantee 100% reimbursement.

Definitions

For the purposes of this section, the following terms have the meanings set forth below:

A. **Coordination of Benefits or COB**. Means a provision establishing an order in which plans pay their claims, and permitting secondary plans to reduce their benefits so that the combined benefits of all plans do not exceed total allowable expenses.

B. **Plan.** A Plan is any of the following that provides benefits or services for medical or dental care or treatment. Plan includes group and non-group insurance and subscriber contracts, health maintenance organization (HMO) contracts, Closed Panel Plans or other forms of group or non-group type coverage (whether insured or uninsured); medical care components of long term care contracts, such as skilled nursing care and medical benefits under group or individual automobile contracts and no fault policies; Medicare, Medicaid or any other federal governmental plan, as permitted by law; group and non-group insurance and subscriber contracts that pay or reimburse for the cost of dental care.

   Each Plan or part of a Plan which has the right to coordinate benefits will be considered a separate Plan.

C. **Closed Panel Plan.** A Plan that provides medical or dental benefits primarily in the form of services through a panel of employed or contracted providers, and that limits or excludes benefits provided by providers outside of the panel, except in the case of emergency or if referred by a provider within the panel.

D. **Primary Plan.** The Plan that determines and provides or pays benefits without taking into consideration the existence of any other Plan. A Plan that does not contain a coordination of benefits provision that is consistent with this section is always primary. A Plan is primary if all plans use the order of benefit determination rules, and under those rules the Plan determines its benefits first.

E. **Secondary Plan.** A Plan that determines, and may reduce its benefits after taking into consideration, the benefits provided or paid by the Primary Plan. A Secondary Plan

may also recover from the Primary Plan the Reasonable Cash Value of any services it provided to You.

F. **Group-type Contract.** A contract for coverage which is not available to the general public and can be obtained and maintained only because of membership in or a connection with a particular organization or group, including blanket coverage. A Group-type Contract does not include an individually underwritten and issued guaranteed renewable policy even if the policy is purchased through payroll deduction at a premium savings to the insured since the insured would have the right to maintain or renew the policy independently of continued employment with the Employer.

G. **Allowable Expenses.** The amount of charges considered for payment under the Plan for a Covered Service prior to any reductions due to Coinsurance, Copayment or Deductible amounts. If We contract with an entity to arrange for the provision of Covered Services through that entity's contracted network of health care providers, the amount that We have agreed to pay that entity is the allowable amount used to determine Your Coinsurance or Deductible payments. If the Plan provides benefits in the form of services, the Reasonable Cash Value of each service is the Allowable Expense and is a paid benefit.

Examples of expenses or services that are not Allowable Expenses include, but are not limited to the following:

- An expense or service or a portion of an expense or service that is not covered by any of the Plans is not an Allowable Expense.
- An expense that a provider, by law or by contract, is prohibited from charging a Covered Person. If You are covered by two or more Plans that provide services or supplies on the basis of Reasonable and Customary fees, any amount in excess of the highest Reasonable and Customary fee is not an Allowable Expense.
- For two or more plans that provide benefits for negotiated fees, any amount in excess of the highest negotiated fee.
- If You are covered by one Plan that provides services or supplies on the basis of Reasonable and Customary fees and one Plan that provides services and supplies on the basis of negotiated fees, the Primary Plan's fee arrangement shall be the Allowable Expense.
- Coverage or benefits that are not Covered Services under the terms of this Plan, such as medical care, vision care, prescription drugs or hearing aids. A plan may limit the definition of allowable expense to expenses that are similar to the expenses that it provides.
- The amount of any reduction when a Covered Person's benefits are reduced under the primary plan because the person did not comply with plan provisions concerning second surgical opinions or pre-certification, or because the person has a lower benefit because they did not use a preferred provider.
- If Your benefits are reduced under the Primary Plan (through the imposition of a higher Copayment amount, higher Coinsurance percentage, a Deductible, and/or a penalty) because You did not comply with Plan provisions or because You did not use a Participating Provider, the amount of the reduction is not an Allowable Expense. Such Plan provisions include second surgical opinions and pre-certification of services.

H. **Custodial Parent**. The parent awarded custody by a court decree or, in the absence of a court decree, is the parent with whom the child resides more than one-half of the Calendar Year, excluding any temporary visitation.

I. **Claim Determination Period**. A Calendar Year, but does not include any part of a year during which You are not covered under this Policy or any date before this section or any similar provision takes effect.

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

K. **Birthday.** Refers only to the month and day in a Calendar Year and does not include the year in which the individual was born.

L. **COBRA.** Means coverage provided under a right of continuation pursuant to federal law.

Order of Benefit Determination Rules

A Plan that does not have a coordination of benefits rule consistent with this section shall always be the Primary Plan. If the Plan does have a coordination of benefits rule consistent with this section, the first of the following rules that applies to the situation is the one to use:

- Employee: The Plan that covers a person as an Employee shall be the Primary Plan and the Plan that covers a person as a Dependent shall be the Secondary Plan.
- Dependent: For a Dependent child whose parents are not divorced or legally separated, whether or not they have ever been married, the Primary Plan shall be the Plan which covers the parent whose birthday falls first in the Calendar Year. If both parents have the same birthday, the plan that has covered the parent longest is the primary plan.

- For the Dependent of divorced or separated parents, whether or not they have ever been married, benefits for the Dependent shall be determined in the following order:
  - first, if a court decree states that one parent is responsible for the child's healthcare expenses or health coverage and the Plan for that parent has actual knowledge of the terms of the order, but only from the time of actual knowledge; that plan is primary. If the responsible parent has no health coverage for the child's expenses, but that parent's spouse does, the spouse's plan is primary;
  - then, if a court decree states that both parents are responsible for the child's health care expenses or coverage, the birthday rule will determine the order of benefits. If both parents have the same birthday, the plan that has covered the parent longest is the primary plan;
  - then, if a court decree states that the parents have joint custody without specifying that which parent is responsible for providing health care coverage to the child, follow the birthday rule. If both parents have the same birthday, the plan that has covered the parent longest is the primary plan.

    If there is no court decree allocating responsibility for the child's health care coverage, the order of benefits for the child are as follows:
    - then, the Plan of the parent with custody of the child;
    - then, the Plan of the spouse of the parent with custody of the child;
    - then, the Plan of the non-custodial parent of the child; and
    - finally, the Plan of the spouse of the parent not having custody of the child.

For a child covered under more than one plan of individuals who are not the child's parents, the order of benefits should be determined using the rules above as if those individuals were the child's parents.

- For a child covered under either or both parents' plans and also his or her own coverage as a dependent under a spouse's plan, Longer or Shorter Length of Coverage applies:
- In the event the child's coverage under the spouse's plan began on the same date as the coverage under the parents' plan(s), the order of benefits will be determined by applying the birthday rule to the child's parent(s) and the spouse. If both parents have the same birthday, the plan that has covered the parent longest is the primary plan.
- **Employee in Active Service or laid-off Employee or Retiree:** The Plan that covers You as an Employee in Active Service and Your Dependent shall be the Primary Plan and the Plan that covers You as a laid-off Employee or Retiree and Your Dependent shall be the Secondary Plan. If the other Plan does not have a similar provision and, as a result, the Plans cannot agree on the order of benefit determination, this paragraph shall not apply.
- **COBRA or State Continuation of Coverage**: The Plan that covers You under a right of continuation which is provided by federal or state law shall be the Secondary Plan and the Plan that covers You as an Employee in Active Service or Retiree or Your Dependent shall be the Primary Plan. If the other Plan does not have a similar provision and, as a result, the Plans cannot agree on the order of benefit determination, this paragraph shall not apply.
- If one of the Plans that covers You is issued out of the state whose laws govern this Policy, and determines the order of benefits based upon the gender of a parent, and as a result, the Plans do not agree on the order of benefit determination, the Plan with the gender rules shall determine the order of benefits.
- **Longer or Shorter Length of Coverage**: The Plan that covers a person for a longer period of time is the Primary Plan and the Plan that covered the person for the shorter period of time is the Secondary Plan.

If the preceding rules do not determine the order of benefits, the Allowable Expenses shall be shared equally between each of the Plans meeting the definition of a Plan. In addition, this Plan will not pay more than it would have paid had it been the Primary Plan.

Effect on the Benefits of This Plan

If this Plan is the Secondary Plan, this Plan may reduce benefits so that the total benefits paid by all Plans during a Claim Determination Period are not more than 100% of the total of all Allowable Expenses.

The difference between the amount that this Plan would have paid if this Plan had been the Primary Plan, and the benefit payments that this Plan had actually paid as the Secondary Plan, will be recorded as a benefit reserve for You. We will use this benefit reserve to pay any Allowable Expense not otherwise paid during the Claim Determination Period.

As each claim is submitted, We will determine the following:

- Our obligation to provide services and supplies under this Policy;
- whether a benefit reserve has been recorded for You; and
- whether there are any unpaid Allowable Expenses during the Claims Determination Period.

If there is a benefit reserve, We will use the benefit reserve recorded for You to pay up to 100% of the total of all Allowable Expenses. At the end of the Claim Determination Period, Your benefit reserve will return to zero and a new

benefit reserve will be calculated for each new Claim Determination Period.

Recovery of Excess Benefits

If We pay charges for benefits that should have been paid by the Primary Plan, or if We pay charges in excess of those for which We are obligated to provide under the Policy, We will have the right to recover the actual payment made or the Reasonable Cash Value of any services.

We will have sole discretion to seek such recovery from any person to, or for whom, or with respect to whom, such services were provided or such payments made by any insurance company, healthcare plan or other organization. If We request, You must execute and deliver to Us such instruments and documents as We determine are necessary to secure the right of recovery.

Right to Receive and Release Information

We, without consent or notice to You, may obtain information from and release information to any other Plan with respect to You in order to coordinate Your benefits pursuant to this section. You must provide Us with any information We request in order to coordinate Your benefits pursuant to this section. This request may occur in connection with a submitted claim; if so, You will be advised that the "other coverage" information, (including an Explanation of Benefits paid under the Primary Plan) is required before the claim will be processed for payment. If no response is received within 90 days of the request, the claim will be denied. If the requested information is subsequently received, the claim will be processed.

Expenses For Which A Third Party May Be Responsible

This plan does not cover:

- Expenses incurred by You or Your Dependent(s) for which another party may be responsible as a result of having caused or contributed to an injury or sickness.
- Expenses incurred by You or Your Dependent(s) to the extent any payment is received either directly or indirectly from a third party tortfeasor or as a result of a settlement, judgment or arbitration award in connection with any automobile medical, automobile no-fault, uninsured or underinsured motorist, homeowners, workers' compensation, government insurance (other than Medicaid), or similar type of insurance or coverage. The coverage under this plan is secondary to any automobile no-fault or similar coverage.

Right of Reimbursement

If a Covered Person incurs expenses for Covered Services for which another party may be responsible or for which the Covered Person may receive payment as described above, We will be granted a right of reimbursement, to the extent of the benefits provided by Us, from the proceeds of any recovery whether by settlement, judgment, or otherwise.

Lien of the Plan

By accepting benefits under this plan, a Covered Person:

- grants a lien and assigns to Us an amount equal to the benefits paid under this plan against any recovery made by or on behalf of the Covered Person which is binding on any attorney or other party who represents the Covered Person whether or not an agent of the Covered Person or of any insurance company or other financially responsible party against whom a Covered Person may have a claim provided said attorney, insurance carrier or other party has been notified by Us or Our agents;
- agrees that this lien shall constitute a charge against the proceeds of any recovery and We shall be entitled to assert a security interest thereon;
- agrees to hold the proceeds of any recovery in trust for Our benefit to the extent of any payment made by Us.

Additional Terms

- No adult Covered Person may assign any rights that he may have to recover dental expenses from any third party or other person or entity to any Dependent child without Our prior express written consent. Our right to recover shall apply to decedents', minors', and incompetent or disabled persons' settlements or recoveries.
- No Covered Person shall make any settlement, which specifically reduces or excludes, or attempts to reduce or exclude, the benefits provided by the plan.
- Our right of recovery shall be a prior lien against any proceeds recovered by the Covered Person. This right of recovery shall not be defeated nor reduced by the application of any so-called "Made-Whole Doctrine", "Rimes Doctrine", or any other such doctrine purporting to defeat Our recovery rights by allocating the proceeds exclusively to non-dental expense damages.
- No Covered Person shall 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 Our prior express written consent. This right shall not be defeated by any so-called "Fund Doctrine", "Common Fund Doctrine", or "Attorney's Fund Doctrine".
- We shall recover the full amount of benefits provided under the plan without regard to any claim of fault on the part of

any Covered Person, whether under comparative negligence or otherwise.

- We hereby disavow all equitable defenses in the pursuit of Our right of recovery. Our recovery rights are neither affected nor diminished by equitable defenses.
- In the event that a Covered Person fails or refuses to honor his obligations under the plan. We shall be entitled to recover any costs incurred in enforcing the terms of the Policy including, but not limited to, attorney's fees, litigation, court costs, and other expenses. We shall also be entitled to offset the reimbursement obligation against any entitlement to future dental benefits under the Covered Person has fully complied with his reimbursement obligations, regardless of how those future dental benefits are incurred.
- Any reference to state law in any other provision of this plan shall not be applicable to this provision, if the plan is governed by ERISA. By acceptance of benefits under the plan, the Covered Person agrees that a breach hereof would cause irreparable and substantial harm and that no adequate remedy at law would exist. Further, We 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.
- Covered Persons must assist Us in pursuing any recovery rights by providing requested information.

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Payment of Benefits

Assignment and Payment of Benefits

You may not assign to any party, including, but not limited to, a provider of healthcare services/items, Your right to benefits under this plan, nor may You assign any administrative, statutory, or legal rights or causes of action You may have under ERISA, including, but not limited to, any right to make a claim for plan benefits, to request plan or other documents, to file appeals of denied claims or grievances, or to file lawsuits under ERISA. Any attempt to assign such rights shall be void and unenforceable under all circumstances.

You may, however, authorize Us to pay any healthcare benefits under this Policy to a Participating or Non-Participating Provider. When You authorize the payment of Your healthcare benefits to a Participating or Non-Participating Provider, You authorize the payment of the entire amount of the benefits due on that claim. If a provider is overpaid because of accepting duplicate payments from You and Us, it is the provider's responsibility to reimburse the overpayment to You. We may pay all healthcare benefits for Covered Services directly to a Participating Provider without Your authorization. You may not interpret or rely upon this discrete authorization or permission to pay any healthcare benefits to a Participating or Non-Participating Provider as the authority to assign any other rights under this Policy to any party, including, but not limited to, a provider of healthcare services/items.

Even if the payment of healthcare benefits to a Non-Participating Provider has been authorized by You, We may, at Our option, make payment of benefits to You. When benefits are paid to You, You or Your Dependents are responsible for reimbursing the Non-Participating Provider.

Initial Determination

A claim for dental benefits will be reviewed upon receipt. We will notify You of Our decision to approve or deny the claim within 30 days from the date You submitted the claim, unless an extension is required due to matters beyond Our control. Any extension will not be more than 15 days.

If We require an extension, You will be notified in writing before the end of the initial 30 day period. The notice of extension will explain the reasons for the extension and will state when a determination will be made. If an extension is required because We require additional information from You, the time from the date of Our notice requesting further information and the time We receive the necessary information does not count toward the time period We are allowed to notify You of the claim determination. You will have 45 days from the date You receive the request for additional information to provide the requested information.

Claim Denial

If Your claim is denied, in whole or in part, the notification of the claim decision will state the reason why Your claim was denied and reference the specific plan provisions upon which the denial is based. If the claim is denied because more information is needed from You, the claims decision will describe the additional information needed and why such information is needed. If We relied on an internal rule or other criterion when denying the claim, the claim decision will include the rule or other criteria or will indicate that such rule or criteria was relied upon and You may request a copy free of charge.

To Whom Payable

Dental benefits are assignable to the provider. When You assign benefits to a provider, You have assigned the entire amount of the benefits due on that claim. If the provider is overpaid because of accepting a patient's payment on the charge, it is the provider's responsibility to reimburse the

patient. Because of Our contracts with providers, all claims from contracted providers should be assigned.

We may, at Our option, make payment to You for the cost of any Covered Services from a Non-Participating Provider even if benefits have been assigned. When benefits are paid to You or Your Dependent(s). You or Your Dependent(s) are responsible for reimbursing the provider.

If any person to whom benefits are payable is a minor or is not able to give a valid receipt for any payment due him, such payment will be made to his legal guardian. If no request for payment has been made by his legal guardian, We will make payment to the person or institution appearing to have assumed his custody and support.

In the event of the death of a Covered Person, We may receive notice that an executor of the estate has been established. The executor has the same rights as the Covered Person and benefit payments for unassigned claims should be made payable to the executor.

Payment as described above will release Us from all liability to the extent of any payment made.

Recovery of Overpayment

When We have made an overpayment, We will have the right at any time to: recover that overpayment from the person to whom or on whose behalf it was made; or offset the amount of that overpayment from a future claim payment. In addition, Your acceptance of benefits under this Policy and/or assignment of Medical Benefits separately creates an equitable lien by agreement pursuant to which We may seek recovery of any overpayment. You agree that in seeking recovery of any overpayment as a contractual right or as an equitable line by agreement, We may pursue the general assets of the person or entity to whom or on whose behalf the overpayment was made.

HCDFB-POB28 01-19

Termination of Insurance

Termination of Your Insurance

Your insurance will cease on the earliest date below:

- the date You cease to be in a Class of Eligible Employees or cease to qualify for the insurance.
- the last day for which You have made any required contribution for the insurance.
- the date the Policy is canceled or lapses due to a nonpayment of premium.
- the date Your Active Service ends except as described below.
- Your death.

Any continuation of insurance must be based on a plan which precludes individual selection.

Temporary Layoff or Leave of Absence

If Your Active Service ends due to temporary layoff or leave of absence, Your insurance will be continued until the date Your Employer stops paying premium for You; or otherwise cancels Your insurance. However, Your insurance will not be continued for more than 60 days past the date Your Active Service ends.

Injury or Sickness

If Your Active Service ends due to an injury or sickness, Your insurance will be continued while You remain totally and continuously disabled as a result of the injury or sickness. However, Your insurance will not continue past the date Your Employer stops paying premium for You or otherwise cancels Your insurance.

Termination of Insurance - Dependents

Your insurance for all of Your Dependents will cease on the earliest date below:

- the date Your insurance ceases; or
- the date You cease to be eligible for Dependent insurance; or
- the last day for which You have made any required contribution for the insurance; or
- the date Dependent insurance is canceled; or
- the date that Dependent no longer qualifies as a Dependent; or
- Your death.

Coverage for any Dependent child will terminate the end of the month the Dependent child turns age 26.

Such termination will be without prejudice to any claim originating prior to the termination date. Our acceptance of any premium after such date will be considered as premium for only the remaining Covered Person(s) under the Policy.

However, coverage will continue for any Dependent child regardless of age, who is incapable of self-sustaining employment by reason of intellectual disabilities or a physical handicap. Proof of the child's condition and dependence may be required to be submitted to Us within 31 days after the date the child reaches the Dependent age limit.

HCDFB-TRM43 01-19

Dental Benefits Extension

An expense incurred in connection with a Covered Service that is completed after a person's benefits cease will be deemed to be incurred while You are insured if:

- for root canal therapy, the pulp chamber of the tooth is opened while You are insured and the treatment is completed within 1-4 calendar month(s) after Your insurance ceases.

There is no extension for any Covered Service not shown above.

HCDFB-BEX6 01-19

Special Plan Provisions

Notice of an Appeal or a Grievance

The appeal or grievance provision in this Certificate may be superseded by the law of Your state. Please see Your explanation of benefits for the applicable appeal or grievance procedure.

HCDFB-SPP2 01-19

Appointment of Authorized Representative

You may appoint an authorized representative to assist You in submitting a claim or appealing a claim denial. However, We may require You to designate Your authorized representative in writing using a form approved by Us. At all times, the appointment of an authorized representative is revocable by You. To ensure that a prior appointment remains valid, We may require You to re-appoint Your authorized representative, from time to time.

We reserve the right to refuse to honor the appointment of a representative if We reasonably determine that:

- the signature on an authorized representative form may not be Yours, or
- the authorized representative may not have disclosed to You all of the relevant facts and circumstances relating to the overpayment or underpayment of any claim, including, for example, that the billing practices of the provider of dental services may have jeopardized Your coverage through the waiver of the cost-sharing amounts that You are required to pay under Your plan.

If Your designation of an authorized representative is revoked, or We do not honor Your designation, You may appoint a new authorized representative at any time, in writing, using a form approved by Us.

HCDFB-AAR3 01-19
V1

When You Have a Complaint or an Appeal

For the purposes of this section, any reference to "You" or "Your" also refers to a representative or provider designated by You to act on Your behalf; 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 Customer Service

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 may call the toll-free number on Your ID card, explanation of benefits, or claim form and explain Your concern to one of Our Customer Service representatives. You may also express that concern in writing.

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. We may request an extension of up to an additional 10 business days with Your approval.

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

Internal Appeals Procedure

We have a one-step appeals procedure for coverage decisions. To initiate an appeal, You must submit a request for an appeal in writing to Us within one year from the date We issue Our last adverse benefit determination, to the following address:

Cigna
National Appeals Organization (NAO)
PO Box 188011
Chattanooga, TN 37422

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 Us to register Your appeal by telephone. Call or write Us at the toll-free number or address on Your ID card, explanation of benefits, or claim form.

Most requests for an appeal 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 Our Dentist reviewer. You may present Your situation to the Committee in person or by conference call.

We will acknowledge in writing that We have received Your request and schedule a Committee review, if requested. 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 10 calendar days and to specify any additional information needed for Us to complete the review. You will be notified in writing of the decision within review time frames above if the Committee does not approve the requested coverage.

You may request that the appeal process be expedited if, the time frames under this process would seriously jeopardize Your life, health or ability to regain maximum function or in the opinion of Your Dentist would cause You severe pain which cannot be managed without the requested services; or Your appeal involves non-authorization of an admission or continuing inpatient hospital stay. Our Dental reviewer, in consultation with the treating Dentist will decide if an expedited appeal is necessary. When an appeal is expedited, We will respond orally with a decision within 72 hours, followed up in writing.

External Review Procedure

If You are not fully satisfied with the decision of Our internal appeal review regarding Your Medically Necessary or clinical appropriateness issue, 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 Us, or any of its affiliates. A decision to request an external review to an IRO will not affect the claimant's rights to any other benefits under the plan.

There is no charge for You to initiate an external review. We and Your benefit plan will abide by the decision of the IRO.

In order to request a referral to an IRO, the reason for the denial must be based on a Medically Necessary or clinical appropriateness determination by Us. Administrative, eligibility or benefit coverage limits or exclusions are not eligible for appeal under this process.

To request a review, You must file a request for an independent review with Michigan's Director of Insurance not later than 127 days after Your receipt of Our review denial. The Director will review Your request for external review. If Your request is accepted for external Review, the Director will assign an Independent Review Organization or may keep the request for review by the Director if appropriate. We will then forward Your file to the Independent Review Organization or Director as appropriate.

The contact information to begin the Independent Review Organization process is as follows:

Department of Insurance and Financial Services
Office of General Counsel/Appeals Section
By mail:
PO Box 30220
Lansing, MI 48909-7720

By courier/overnight delivery:
530 W. Allegan Street, 7th Floor
Lansing, MI 48933

www.michigan.gov/difs
phone: 877-999-6442
fax: 517-284-8838
email: DIFS-HealthAppeal@michigan.gov
Patients Right to Independent Review (External Appeals)
On-Line:
https://difs.state.mi.us/Complaints/ExternalReview.aspx

The Independent Review Organization will provide its recommendation to the Director within 14 days. The Director will review the recommendations and notify You within 7 business days of the decision. When appropriate, the Director may decide to keep Your request for review. When this happens, the Director will notify You within 14 days of the Director's decision to keep request.

You may request an expedited independent review within 10 days after You receive Your review denial if. You had filed a request for an expedited appeal and when a delay would be detrimental to Your medical condition. The Independent Review Organization will make its recommendations to the Director within 36 hours. The Director will review the recommendations and notify You of the decision within 24 hours.

Appeal to the State of Michigan

You have the right to contact the Office of Financial and Insurance Services for assistance at any time. The Director of Insurance may be contacted at the following address and telephone number:

Department of Insurance and Financial Services
Office of General Counsel/Appeals Section
By mail:
PO Box 30220
Lansing, MI 48909-7720

By courier/overnight delivery:
530 W. Allegan Street, 7th Floor
Lansing, MI 48933

www.michigan.gov/difs
Toll Free Number: 1-877-999-6442
Fax: 517-284-8838
Email: DIFS-HealthAppeal@michigan.gov

Notice of Benefit Determination on Appeal

Every notice of a determination on appeal will be provided in writing or electronically and, if an adverse determination, will include: the specific reason or reasons for the adverse determination; reference to the specific plan provisions on which the determination 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 below; a statement describing any voluntary appeal procedures offered by the plan and the claimant's right to bring an action under ERISA section 502(a), if applicable; 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 Medically Necessary, 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.

Legal Action

If Your plan is governed by ERISA, 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 initiate a legal action against Us until You have completed the one-step appeal process. However, no action will be brought at all unless brought within 3 years after a claim is submitted for In-Network Services or within three years after proof of claim is required under the Plan for Out-of-Network services.

HCDFB-APL87 01-19

Miscellaneous

Notice Regarding Provider Directory

You may obtain a listing of Participating Providers who participate in Our dental network without charge by visiting www.cigna.com; mycigna.com; or by calling the toll-free telephone number 1-(800) CIGNA24 (1-800-244-6224).

Additional Programs

We may, from time to time, offer or arrange for various entities to offer discounts, benefits or other consideration to Employees for the purpose of promoting the general health and well-being of Employees. We may also arrange for the reimbursement of all or a portion of the cost of services provided by other parties to the Group. Contact Us for details regarding any such arrangements.

Oral Health Integration Program

If You are a Cigna Dental Customer You may be eligible for additional dental benefits during certain episodes of care. For example, You may be eligible for additional dental benefits when You have any of the following: pregnancy; diabetes; head and neck cancer radiation; chronic kidney disease; organ transplant; cerebrovascular disease; or cardiac disease. Please review Your plan enrollment materials for details.

Administrative Policies Relating to this Contract

We may adopt reasonable policies, procedures, rules and interpretations that promote orderly administration of this Contract.

Assignability

The benefits under this Contract are not assignable unless agreed to by Us. We may, at Our option, make payment to the Employee for any cost of any Covered Expense received by the Employee or Employee’s covered Dependents from a Non-Participating Provider. The Employee is responsible for reimbursing the Non-Participating Provider.

Clerical Error

No clerical error on the part of Us shall operate to defeat any of the rights, privileges or benefits of any Employee.

Entire Contract

The entire Contract will be made up of the Policy; the Certificate; the application of the Policyholder, a copy of which is attached to the Policy; any riders and amendments to the Policy or Certificate; and any enrollment forms.

Conformity with State and Federal Statutes

Any provision of this Certificate that is in conflict with the applicable statutes of the state whose law governs the Policy or this Certificate or with any applicable federal statute is amended to conform to the minimum requirements of such statutes.

Statements not Warranties

All statements made by the Policyholder or any person covered under the Certificate will, in the absence of fraud, be deemed representations and not warranties. No statement made by You or the Policyholder to obtain insurance will be

used to avoid or reduce the insurance unless it is made in writing and signed by You or the Policyholder and a copy is sent to the Policyholder, You and/or Your beneficiary.

Time Limit on Certain Defenses

After two years from the Effective Date, no misstatements, except fraudulent misstatements, made by You in the application or any application amendment will be used to void this Certificate or to deny a claim for loss incurred after the expiration of such two-year period. No claim for loss commencing after 12 months from the Effective Date will be reduced or denied on the grounds that a disease or physical condition, not excluded from coverage by name or specific description, had existed prior to such Effective Date.

Your Dental Records

In order to provide benefits under this Certificate, process claims, make payments or review appeals and/or grievances, We may need to obtain information and records from Dentists who provided Your services or treatment. Your acceptance of coverage under the Policy gives Us permission to obtain, copy and use Your dental records and information for such purposes and authorizes Your Dentist to disclose information that pertains to Your physical condition or the services or treatment You receive. We agree to maintain Your dental records and information in accordance with state and federal confidentiality requirements.

HCDFB-MISC18 01-19
V3

Definitions

Active Service

You will be considered in Active Service:

- on any of Your Employer's scheduled work days if You are performing the regular duties of Your work on a Full-Time basis on that day either at Your Employer's place of business or at some location to which You are required to travel for Your Employer's business.
- on a day which is not one of Your Employer's scheduled work days if You were in Active Service on the preceding scheduled work day.

HCDFB-DFS194 01-19

Amount Eligible for Coverage by Your Plan

The term means, part of the “Amount Your Health Care Professional Charged” or “Your Health Care Professional’s Contracted Amount” (if present) eligible for coverage under Your plan. This amount is used to help calculate how much will be paid by Your plan.

HCDFB-DFS206 01-19

Balance Billing

When a Dentist bills an enrollee for amounts above the Amount Eligible for Coverage by You, the Dentist may bill You for the difference. Non-contracted dentists are under no obligation to limit the amount of their fees.

HCDFB-DFS196 01-19

Calendar Year

The term Calendar Year means the period that begins on January 1st and ends on December 31st of that year.

HCDFB-DFS4

Calendar Year Maximum

This is the most We will pay for dental care within a Calendar Year. Once You reach the maximum amount, You will be responsible for paying any costs for the remainder of the benefit period.

HCDFB-DFS195 01-19

Certificate

The term Certificate means this document, including any riders and attachments hereto, which sets forth Your benefits under the plan.

HCDFB-DFS207 01-19

Chewing Injury

The term Chewing Injury means an injury which occurs during the act of chewing or biting. The injury may be caused by biting on a foreign object not expected to be a normal constituent of food; by parafunctional (i.e., abnormal) habits such as chewing on eyeglass frames or pencils; or biting down on a suddenly dislodged or loose dental prosthesis.

HCDFB-DFS6

Civil Union

The term Civil Union means a state sanctioned or legally recognized union of two eligible individuals of the same or opposite sex.

HCDFB-DFS7

Coinsurance

The term Coinsurance means the percentage of charges for Covered Expenses that a Covered Person is required to pay under the Plan.

HCDFB-DFS8

Contract

The Contract will be made up of the Policy; the Certificate; the application of the Policyholder, a copy of which is attached to the Policy; any riders and amendments to the Policy or Certificate; and any enrollment forms.

HCDFB-DFS9 01-18

Contracted Fee

The term Contracted Fee means the total compensation level that a Participating Provider has agreed to accept as payment for dental procedures and services performed on You or Your Dependent, according to Your dental benefit plan.

HCDFB-DFS14

Covered Dental Expenses

The term Covered Dental Expenses means that portion of a Dentist's charge that is payable for a service delivered to a Covered Person provided:

- It is Medically Necessary and/or Dentally Necessary (refer to the Section entitled Definitions);
- Provided by or under the direction of a Dentist or other appropriate Participating Provider as specifically described;
- It is the least costly, clinically accepted treatment;
- Your Deductible, if any, has been met;
- The maximum benefit in The Schedule has not been exceeded;
- The charge does not exceed the amount allowed under the Alternate Benefit Provision;
- It is not excluded as described in the Section entitled General Limitations and Expenses Not Covered.

HCDFB-DFS15

Covered Person

The term Covered Person means a person who is insured for dental coverage under the terms of the Policy and this Certificate.

HCDFB-DFS16

Covered Service

The term Covered Service means a dental service used to treat a Covered Person's dental condition and which is:

- prescribed or performed by a Dentist while the insurance provided under this Certificate is in effect;
- Medically Necessary and/or Dentally Necessary to treat the Covered Person's condition; and
- described in The Schedule.

HCDFB-DFS17

Deductible

The term Deductible means expenses to be paid by You or Your Dependents before benefits are paid under the Policy.

HCDFB-DFS19

Dentist

The term Dentist means a person practicing dentistry or oral surgery within the scope of his license. It will also include a provider operating within the scope of his license when he performs any of the Dental Services described in the Policy.

HCDFB-DFS21

Dependent

The term Dependent means:

- Your lawful Spouse; or
- Your Domestic Partner; and
- any child of Yours who is;
  - less than 26 years old.

- 26 or more years old, unmarried, and primarily supported by You and incapable of self-sustaining employment by reason of intellectual disabilities or a physical handicap. Proof of the child's condition and dependence may be required to be submitted to Us within 31 days after the date the child ceases to qualify above.

The term child means a child born to You or a child legally adopted by You. It also includes a stepchild, a child for whom You are the legal guardian or a child supported pursuant to a court order imposed on You (including a Qualified Medical Child Support Order). If Your Domestic Partner has a child, that child will also be included as a Dependent.

Benefits for a Dependent child will continue until the last day of the calendar month in which the limiting age is reached.

Anyone who is eligible as an Employee will not be considered as a Dependent.

No one may be considered as a Dependent of more than one Employee.

HCDFB-DFS184 01-18

Domestic Partner

The term Domestic Partner means a person of the same or opposite sex who:

- shares Your permanent residence;
- has resided with You for no less than one year;
- is no less than 18 years of age;
- is financially interdependent with You and has proven such interdependence by providing documentation of at least two of the following arrangements: common ownership of real property or a common leasehold interest in such property; community ownership of a motor vehicle; a joint bank account or a joint credit account; designation as a beneficiary for life insurance or retirement benefits or under Your partner's will; assignment of a durable power of attorney or health care power of attorney; or such other proof as is considered by Us to be sufficient to establish financial interdependency under the circumstances of Your particular case;
- is not a blood relative any closer than would prohibit legal marriage; and
- has signed jointly with You, a notarized affidavit attesting to the above which can be made available to Us upon request.

In addition, You and Your Domestic Partner will be considered to have met the terms of this definition as long as neither You nor Your Domestic Partner:

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

You and Your Domestic Partner must have registered as Domestic Partners, if You reside in a state that provides for such registration.

The section of this Certificate entitled "COBRA Continuation Rights Under Federal Law" will not apply to Your Domestic Partner and his or her Dependents.

HCDFB-DFS23

Effective Date

The term Effective Date means the date that coverage for insurance begins under the Policy. See the Certificate cover page for the Effective Date.

HCDFB-DFS24

Eligibility Waiting Period

The term Eligibility Waiting Period means the period of time that an Employee must be in an Eligible Class in order to be eligible for coverage under the Policy.

HCDFB-DFS29

Eligible Class

The term Eligible Class means a group of people who are eligible to enroll for insurance coverage under the Policy as determined by the Employer. See The Schedule for a list of Eligible Classes.

HCDFB-DFS26

Eligible Employee

The term Eligible Employee means a person who is in Active Service with the Employer and who meets all the conditions to enroll for insurance under this plan as determined by the Employer.

HCDFB-DFS25

Eligible Person

The term Eligible Person means a person who meets the Employer's conditions for enrollment for insurance coverage under the Policy.

HCDFB-DFS28

Emergency Services

The term Emergency Services means a service 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.

HCDFB-DFS30

Employee

The term Employee means, an individual meeting the eligibility criteria as an Employee who is enrolled for Dental coverage and for whom all required Premiums have been received by Us. Also referred to as "You" or "Your".

HCDFB-DFS197 01-19

Employer

The term Employer means the Policyholder and all Affiliated Employers.

HCDFB-DFS69 01-18

Full-Time

The term Full-Time means the number of hours set by the Employer as a regular work-week for persons in an Employee's Eligible Class.

HCDFB-DFS33

Functioning Natural Tooth

The term Functioning Natural Tooth means a Natural Tooth which is performing its normal role in the mastication (i.e., chewing) process in the Covered Person's upper or lower arch and which is opposed in the Covered Person's other arch by another natural tooth or prosthetic (i.e., artificial) replacement.

The term Natural Tooth means any tooth or part of a tooth that is organic and formed by the natural development for the body (i.e., not manufactured). Organic portions of a tooth include the crown enamel and dentin, the root cementum and dentin, and the enclosed pulp (nerve).

HCDFB-DFS34

Handicapping Malocclusion

The term Handicapping Malocclusion means a malocclusion which severely interferes with the ability of a person to chew food, as determined by Us.

HCDFB-DFS35

Late Entrant

The term Late Entrant means a person who elects the insurance under this Policy more than 30 days after he becomes a member of an Eligible Class or a person who again elects the insurance under the Policy after cancelling or terminating premium payments, if required.

HCDFB-DFS36

Maximum Allowable Charge (MAC)

The term Maximum Allowable Charge (MAC) means the fee for that procedure as listed in The Primary Schedule aligned to the zip code for the geographical area where the service is performed, times the benefit percentage that applies to the class of service, as specified in The Schedule.

The Primary Schedule is usually the fee schedule with the lowest Contracted Fees available for acceptance by a Participating Provider in the relevant 3-digit zip code.

HCDFB-DFS199 01-19
V1

Maximum Benefit Amount

The term Maximum Benefit Amount means the maximum dollar amount payable under the plan for Covered Services for each Covered Person in a Calendar Year. No further benefits are payable after the Maximum Benefit Amount is reached.

HCDFB-DFS201 01-19

Medicaid

The term Medicaid means a state program of medical aid for needy persons established under Title XIX of the Social Security Act of 1965 as amended.

HCDFB-DFS40

Medically Necessary and/or Dentally Necessary

Services provided by a Dentist or Physician as determined by Us are Medically/Dentally Necessary if they are:

- required for the diagnosis and/or treatment of the particular dental condition or disease; and
- consistent with the symptom or diagnosis and treatment of the dental condition or disease; and
- commonly and usually noted throughout the medical/dental field as proper to treat the diagnosed dental condition or disease; and
- the most fitting level or service which can safely be given to You or Your Dependent.

A diagnosis, treatment and service with respect to a dental condition or disease, is not Medically/Dentally Necessary if made, prescribed or delivered solely for convenience of the patient or provider.

HCDFB-DFS202 01-19

Medicare

The term Medicare means the program of medical care benefits provided under Title XVIII of the Social Security Act of 1965 as amended.

HCDFB-DFS42

Network General Dentist

The term Network General Dentist means a Dentist who is not a Specialist, who has entered into a Contract with Us to provide dental services at predetermined fees and who directly provides or coordinates Your dental services.

HCDFB-DFS44

Non-Participating Provider

The term Non-Participating Provider means 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. Services received from Non-Participating Providers are considered Out-of-Network.

HCDFB-DFS45

Orthodontic Treatment

The term Orthodontic Treatment means the corrective movement of the teeth through the alveolar bone by means of an active appliance to correct a handicapping malocclusion of the mouth.

HCDFB-DFS46

Participating Provider

The term Participating Provider means: a Dentist, or a professional corporation, professional association, partnership, or other entity which is entered into a Contract with Us to provide dental services at predetermined fees.

The providers qualifying as Participating Providers may change from time to time. A list of the current Participating Providers will be provided by Your Employer. Services received from Participating Providers are considered In-Network.

HCDFB-DFS50 07-19
V1

Policyholder

The term Policyholder means the owner of the group Policy as identified on the Certification page.

HCDFB-DFS53

Qualified Medical Child Support Order

A Qualified Medical Child Support Order is a judgment, decree or order (including approval of a settlement agreement) or administrative notice, which is issued pursuant to a state domestic relations law (including a community property law), or to an administrative process, which provides for child support or provides for health benefit coverage to such child and relates to benefits under the group health plan, and satisfies all of the following:

- the order recognizes or creates a child's right to receive group health benefits for which a participant or beneficiary is eligible;
- the order specifies Your name and last known address, and the child's name and last known address, except that the name and address of an official of a state or political subdivision may be substituted for the child's mailing address;
- the order provides a description of the coverage to be provided, or the manner in which the type of coverage is to be determined;
- the order states the period to which it applies; and
- if the order is a National Medical Support Notice completed in accordance with the Child Support Performance and Incentive Act of 1998, such notice meets the requirement above.

HCDFB-DFS204 01-19

Specialist

The term Specialist means a Dentist who focuses on a specific area of dentistry, including oral surgery, endodontia, periodontia, orthodontia, pediatric dentistry or a group of patients to diagnose, manage, prevent or treat certain types of symptoms and conditions.

HCDFB-DFS57

Spouse

The term Spouse means Your legally recognized Spouse, lawful Domestic Partner or Civil Union Partner in the state where You reside.

HCDFB-DFS58

Usual Fee

The fee that an individual Dentist most frequently charges for a given dental service.

HCDFB-DFS66 01-18

We, Us and Our

The terms We, Us and Our, mean Cigna Health and Life Insurance Company.

HCDFB-DFS59

You, Your, Yourself

The Employee and/or any of his/her Dependents.

HCDFB-DFS60

Federal Requirements

The following pages explain your rights and responsibilities under federal laws and regulations. Some states may have similar requirements. If a similar provision appears elsewhere in this booklet, the provision which provides the better benefit will apply.

HC-FED1 10-10

Notice of Provider Directory/Networks

Notice Regarding Provider Directories and Provider Networks

A list of network providers is available to you without charge by visiting the website or by calling the phone number on your ID card. The network consists of dental practitioners, of varied specialties as well as general practice, affiliated or contracted with Cigna or an organization contracting on its behalf.

HC-FED78 10-10

Qualified Medical Child Support Order (QMCSO)

Eligibility for Coverage Under a QMCSO

If a Qualified Medical Child Support Order (QMCSO) is issued for your child, that child will be eligible for coverage as required by the order and you will not be considered a Late Entrant for Dependent Insurance.

You must notify your Employer and elect coverage for that child, and yourself if you are not already enrolled, within 31 days of the QMCSO being issued.

Qualified Medical Child Support Order Defined

A Qualified Medical Child Support Order is a judgment, decree or order (including approval of a settlement agreement) or administrative notice, which is issued pursuant to a state domestic relations law (including a community property law), or to an administrative process, which provides for child support or provides for health benefit coverage to such child and relates to benefits under the group health plan, and satisfies all of the following:

- the order recognizes or creates a child's right to receive group health benefits for which a participant or beneficiary is eligible;
- the order specifies your name and last known address, and the child's name and last known address, except that the name and address of an official of a state or political subdivision may be substituted for the child's mailing address;
- the order provides a description of the coverage to be provided, or the manner in which the type of coverage is to be determined;
- the order states the period to which it applies; and
- if the order is a National Medical Support Notice completed in accordance with the Child Support Performance and Incentive Act of 1998, such Notice meets the requirements above.

The QMCSO may not require the health insurance policy to provide coverage for any type or form of benefit or option not otherwise provided under the policy, except that an order may require a plan to comply with State laws regarding health care coverage.

Payment of Benefits

Any payment of benefits in reimbursement for Covered Expenses paid by the child, or the child's custodial parent or legal guardian, shall be made to the child, the child's custodial parent or legal guardian, or a state official whose name and address have been substituted for the name and address of the child.

HC-FED4 10-10

Effect of Section 125 Tax Regulations on This Plan

Your Employer has chosen to administer this Plan in accordance with Section 125 regulations of the Internal Revenue Code. Per this regulation, you may agree to a pretax salary reduction put toward the cost of your benefits. Otherwise, you will receive your taxable earnings as cash (salary).

A. Coverage elections

Per Section 125 regulations, you are generally allowed to enroll for or change coverage only before each annual benefit period. However, exceptions are allowed:

- if your Employer agrees, and you meet the criteria shown in the following Sections B through F and enroll for or change coverage within the time period established by your Employer.

B. Change of status

A change in status is defined as:

- change in legal marital status due to marriage, death of a spouse, divorce, annulment or legal separation;
- change in number of Dependents due to birth, adoption, placement for adoption, or death of a Dependent;
- change in employment status of Employee, spouse or Dependent due to termination or start of employment, strike, lockout, beginning or end of unpaid leave of absence, including under the Family and Medical Leave Act (FMLA), or change in worksite;
- changes in employment status of Employee, spouse or Dependent resulting in eligibility or ineligibility for coverage;
- change in residence of Employee, spouse or Dependent to a location outside of the Employer's network service area; and
- changes which cause a Dependent to become eligible or ineligible for coverage.

C. Court order

A change in coverage due to and consistent with a court order of the Employee or other person to cover a Dependent.

D. Medicare or Medicaid eligibility/entitlement

The Employee, spouse or Dependent cancels or reduces coverage due to entitlement to Medicare or Medicaid, or enrolls or increases coverage due to loss of Medicare or Medicaid eligibility.

E. Change in cost of coverage

If the cost of benefits increases or decreases during a benefit period, your Employer may, in accordance with plan terms, automatically change your elective contribution.

When the change in cost is significant, you may either increase your contribution or elect less-costly coverage. When a significant overall reduction is made to the benefit option you have elected, you may elect another available benefit option. When a new benefit option is added, you may change your election to the new benefit option.

F. Changes in coverage of spouse or Dependent under another employer's plan

You may make a coverage election change if the plan of your spouse or Dependent: incurs a change such as adding or deleting a benefit option; allows election changes due to Change in Status, Court Order or Medicare or Medicaid Eligibility/Entitlement; or this Plan and the other plan have different periods of coverage or open enrollment periods.

HC-FED95 04-17

Eligibility for Coverage for Adopted Children

Any child who is adopted by you, including a child who is placed with you for adoption, will be eligible for Dependent Insurance, if otherwise eligible as a Dependent, upon the date of placement with you. A child will be considered placed for adoption when you become legally obligated to support that child, totally or partially, prior to that child's adoption.

If a child placed for adoption is not adopted, all health coverage ceases when the placement ends, and will not be continued.

HC-FED67V1 09-14

Group Plan Coverage Instead of Medicaid

If your income and liquid resources do not exceed certain limits established by law, the state may decide to pay premiums for this coverage instead of for Medicaid, if it is cost effective. This includes premiums for continuation coverage required by federal law.

HC-FED13 10-10

Requirements of Family and Medical Leave Act of 1993 (as amended) (FMLA)

Any provisions of the policy that provide for: continuation of insurance during a leave of absence; and reinstatement of insurance following a return to Active Service; are modified by the following provisions of the federal Family and Medical Leave Act of 1993, as amended, where applicable:

Continuation of Health Insurance During Leave

Your health insurance will be continued during a leave of absence if:

- that leave qualifies as a leave of absence under the Family and Medical Leave Act of 1993, as amended; and
- you are an eligible Employee under the terms of that Act.

The cost of your health insurance during such leave must be paid, whether entirely by your Employer or in part by you and your Employer.

Reinstatement of Canceled Insurance Following Leave

Upon your return to Active Service following a leave of absence that qualifies under the Family and Medical Leave Act of 1993, as amended, any canceled insurance (health, life or disability) will be reinstated as of the date of your return.

You will not be required to satisfy any eligibility or benefit waiting period to the extent that they had been satisfied prior to the start of such leave of absence.

Your Employer will give you detailed information about the Family and Medical Leave Act of 1993, as amended.

HC-FED93 10-17

Uniformed Services Employment and Re-Employment Rights Act of 1994 (USERRA)

The Uniformed Services Employment and Re-employment Rights Act of 1994 (USERRA) sets requirements for continuation of health coverage and re-employment in regard to an Employee's military leave of absence. These requirements apply to medical and dental coverage for you and your Dependents. They do not apply to any Life, Short-term or Long-term Disability or Accidental Death & Dismemberment coverage you may have.

Continuation of Coverage

For leaves of less than 31 days, coverage will continue as described in the Termination section regarding Leave of Absence.

For leaves of 31 days or more, you may continue coverage for yourself and your Dependents as follows:

You may continue benefits by paying the required premium to your Employer, until the earliest of the following:

- 24 months from the last day of employment with the Employer;
- the day after you fail to return to work; and
- the date the policy cancels.

Your Employer may charge you and your Dependents up to 102% of the total premium.

Following continuation of health coverage per USERRA requirements, you may convert to a plan of individual coverage according to any "Conversion Privilege" shown in your certificate.

Reinstatement of Benefits (applicable to all coverages)

If your coverage ends during the leave of absence because you do not elect USERRA or an available conversion plan at the expiration of USERRA and you are reemployed by your current Employer, coverage for you and your Dependents may be reinstated if you gave your Employer advance written or verbal notice of your military service leave, and the duration of all military leaves while you are employed with your current Employer does not exceed 5 years.

You and your Dependents will be subject to only the balance of a waiting period that was not yet satisfied before the leave began. However, if an Injury or Sickness occurs or is aggravated during the military leave, full Plan limitations will apply.

If your coverage under this plan terminates as a result of your eligibility for military medical and dental coverage and your order to active duty is canceled before your active duty service commences, these reinstatement rights will continue to apply.

Claim Determination Procedures under ERISA

Procedures Regarding Medical Necessity Determinations

In general, health services and benefits must be Medically Necessary to be covered under the plan. The procedures for determining Medical Necessity vary, according to the type of service or benefit requested, and the type of health plan.

You or your authorized representative (typically, your health care professional) must request Medical Necessity determinations according to the procedures described below, in the Certificate, and in your provider's network participation documents as applicable.

When services or benefits are determined to be not covered, you or your representative will receive a written description of the adverse determination, and may appeal the determination. Appeal procedures are described in the Certificate, in your provider's network participation documents as applicable, and in the determination notices.

Postservice Determinations

When you or your representative requests a coverage determination or a claim payment determination after services have been rendered, Cigna will notify you or your representative of the determination within 30 days after receiving the request. However, if more time is needed to make a determination due to matters beyond Cigna's control Cigna will notify you or your representative within 30 days after receiving the request. This notice will include the date a determination can be expected, which will be no more than 45 days after receipt of the request.

If more time is needed because necessary information is missing from the request, the notice will also specify what information is needed and you or your representative must provide the specified information to Cigna within 45 days after receiving the notice. The determination period will be suspended on the date Cigna sends such a notice of missing information, and the determination period will resume on the date you or your representative responds to the notice.

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 pertain to the determination: the specific reason or reasons for the adverse determination; 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 and the time limits applicable, including a statement of a claimant's rights to bring a civil action under section 502(a) of ERISA following an adverse benefit determination on appeal, if applicable; 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 claim, 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; and in the case of a claim involving urgent care, a description of the expedited review process applicable to such claim.

COBRA Continuation Rights Under Federal Law

For You and Your Dependents

What is COBRA Continuation Coverage?

Under federal law, you and/or your Dependents must be given the opportunity to continue health insurance when there is a "qualifying event" that would result in loss of coverage under the Plan. You and/or your Dependents will be permitted to continue the same coverage under which you or your Dependents were covered on the day before the qualifying event occurred, unless you move out of that plan's coverage area or the plan is no longer available. You and/or your Dependents cannot change coverage options until the next open enrollment period.

When is COBRA Continuation Available?

For you and your Dependents, COBRA continuation is available for up to 18 months from the date of the following qualifying events if the event would result in a loss of coverage under the Plan:

- your termination of employment for any reason, other than gross misconduct; or
- your reduction in work hours.

For your Dependents, COBRA continuation coverage is available for up to 36 months from the date of the following qualifying events if the event would result in a loss of coverage under the Plan:

- your death;
- your divorce or legal separation; or
- for a Dependent child, failure to continue to qualify as a Dependent under the Plan.

Who is Entitled to COBRA Continuation?

Only a "qualified beneficiary" (as defined by federal law) may elect to continue health insurance coverage. A qualified beneficiary may include the following individuals who were covered by the Plan on the day the qualifying event occurred: you, your spouse, and your Dependent children. Each qualified beneficiary has their own right to elect or decline COBRA continuation coverage even if you decline or are not eligible for COBRA continuation.

The following individuals are not qualified beneficiaries for purposes of COBRA continuation: domestic partners, grandchildren (unless adopted by you), stepchildren (unless adopted by you). Although these individuals do not have an independent right to elect COBRA continuation coverage, if you elect COBRA continuation coverage for yourself, you may also cover your Dependents even if they are not considered qualified beneficiaries under COBRA. However, such individuals' coverage will terminate when your COBRA continuation coverage terminates. The sections titled "Secondary Qualifying Events" and "Medicare Extension For Your Dependents" are not applicable to these individuals.

Secondary Qualifying Events

If, as a result of your termination of employment or reduction in work hours, your Dependent(s) have elected COBRA continuation coverage and one or more Dependents experience another COBRA qualifying event, the affected Dependent(s) may elect to extend their COBRA continuation coverage for an additional 18 months (7 months if the secondary event occurs within the disability extension period) for a maximum of 36 months from the initial qualifying event. The second qualifying event must occur before the end of the initial 18 months of COBRA continuation coverage or within the disability extension period discussed below. Under no circumstances will COBRA continuation coverage be available for more than 36 months from the initial qualifying event. Secondary qualifying events are: your death; your divorce or legal separation; or, for a Dependent child, failure to continue to qualify as a Dependent under the Plan.

Disability Extension

If, after electing COBRA continuation coverage due to your termination of employment or reduction in work hours, you or one of your Dependents is determined by the Social Security Administration (SSA) to be totally disabled under Title II or XVI of the SSA, you and all of your Dependents who have elected COBRA continuation coverage may extend such continuation for an additional 11 months, for a maximum of 29 months from the initial qualifying event.

To qualify for the disability extension, all of the following requirements must be satisfied:

- SSA must determine that the disability occurred prior to or within 60 days after the disabled individual elected COBRA continuation coverage; and
- A copy of the written SSA determination must be provided to the Plan Administrator within 60 calendar days after the date the SSA determination is made AND before the end of the initial 18-month continuation period.

If the SSA later determines that the individual is no longer disabled, you must notify the Plan Administrator within 30 days after the date the final determination is made by SSA. The 11-month disability extension will terminate for all covered persons on the first day of the month that is more than 30 days after the date the SSA makes a final determination that the disabled individual is no longer disabled.

All causes for "Termination of COBRA Continuation" listed below will also apply to the period of disability extension.

Medicare Extension for Your Dependents

When the qualifying event is your termination of employment or reduction in work hours and you became enrolled in Medicare (Part A, Part B or both) within the 18 months before the qualifying event, COBRA continuation coverage for your Dependents will last for up to 36 months after the date you became enrolled in Medicare. Your COBRA continuation coverage will last for up to 18 months from the date of your termination of employment or reduction in work hours.

Termination of COBRA Continuation

COBRA continuation coverage will be terminated upon the occurrence of any of the following:

- the end of the COBRA continuation period of 18, 29 or 36 months, as applicable;
- failure to pay the required premium within 30 calendar days after the due date;
- cancellation of the Employer's policy with Cigna;
- after electing COBRA continuation coverage, a qualified beneficiary enrolls in Medicare (Part A, Part B, or both);
- after electing COBRA continuation coverage, a qualified beneficiary becomes covered under another group health plan, unless the qualified beneficiary has a condition for which the new plan limits or excludes coverage under a pre-existing condition provision. In such case coverage will continue until the earliest of: the end of the applicable maximum period; the date the pre-existing condition provision is no longer applicable; or the occurrence of an event described in one of the first three bullets above;
- any reason the Plan would terminate coverage of a participant or beneficiary who is not receiving continuation coverage (e.g., fraud).

Employer's Notification Requirements

Your Employer is required to provide you and/or your Dependents with the following notices:

- An initial notification of COBRA continuation rights must be provided within 90 days after your (or your spouse's) coverage under the Plan begins (or the Plan first becomes subject to COBRA continuation requirements, if later). If you and/or your Dependents experience a qualifying event before the end of that 90-day period, the initial notice must be provided within the time frame required for the COBRA continuation coverage election notice as explained below.
- A COBRA continuation coverage election notice must be provided to you and/or your Dependents within the following timeframes:
  - if the Plan provides that COBRA continuation coverage and the period within which an Employer must notify the Plan Administrator of a qualifying event starts upon the loss of coverage, 44 days after loss of coverage under the Plan;
  - if the Plan provides that COBRA continuation coverage and the period within which an Employer must notify the Plan Administrator of a qualifying event starts upon the occurrence of a qualifying event, 44 days after the qualifying event occurs; or
  - in the case of a multi-employer plan, no later than 14 days after the end of the period in which Employers must provide notice of a qualifying event to the Plan Administrator.

How to Elect COBRA Continuation Coverage

The COBRA coverage election notice will list the individuals who are eligible for COBRA continuation coverage and inform you of the applicable premium. The notice will also include instructions for electing COBRA continuation coverage. You must notify the Plan Administrator of your election no later than the due date stated on the COBRA election notice. If a written election notice is required, it must be post-marked no later than the due date stated on the COBRA election notice. If you do not make proper notification by the due date shown on the notice, you and your Dependents will lose the right to elect COBRA continuation coverage. If you reject COBRA continuation coverage before the due date, you may change your mind as long as you furnish a completed election form before the due date.

Each qualified beneficiary has an independent right to elect COBRA continuation coverage. Continuation coverage may be elected for only one, several, or for all Dependents who are qualified beneficiaries. Parents may elect to continue coverage on behalf of their Dependent children. You or your spouse may elect continuation coverage on behalf of all the qualified beneficiaries. You are not required to elect COBRA continuation coverage in order for your Dependents to elect COBRA continuation.

How Much Does COBRA Continuation Coverage Cost?

Each qualified beneficiary may be required to pay the entire cost of continuation coverage. The amount may not exceed 102% of the cost to the group health plan (including both Employer and Employee contributions) for coverage of a similarly situated active Employee or family member. The premium during the 11-month disability extension may not exceed 150% of the cost to the group health plan (including both employer and employee contributions) for coverage of a similarly situated active Employee or family member.

For example: If the Employee alone elects COBRA continuation coverage, the Employee will be charged 102% (or 150%) of the active Employee premium. If the spouse or one Dependent child alone elects COBRA continuation coverage, they will be charged 102% (or 150%) of the active Employee premium. If more than one qualified beneficiary

elects COBRA continuation coverage, they will be charged 102% (or 150%) of the applicable family premium.

When and How to Pay COBRA Premiums

First payment for COBRA continuation

If you elect COBRA continuation coverage, you do not have to send any payment with the election form. However, you must make your first payment no later than 45 calendar days after the date of your election. (This is the date the Election Notice is postmarked, if mailed.) If you do not make your first payment within that 45 days, you will lose all COBRA continuation rights under the Plan.

Subsequent payments

After you make your first payment for COBRA continuation coverage, you will be required to make subsequent payments of the required premium for each additional month of coverage. Payment is due on the first day of each month. If you make a payment on or before its due date, your coverage under the Plan will continue for that coverage period without any break.

Grace periods for subsequent payments

Although subsequent payments are due by the first day of the month, you will be given a grace period of 30 days after the first day of the coverage period to make each monthly payment. Your COBRA continuation coverage will be provided for each coverage period as long as payment for that coverage period is made before the end of the grace period for that payment. However, if your payment is received after the due date, your coverage under the Plan may be suspended during this time. Any providers who contact the Plan to confirm coverage during this time may be informed that coverage has been suspended. If payment is received before the end of the grace period, your coverage will be reinstated back to the beginning of the coverage period. This means that any claim you submit for benefits while your coverage is suspended may be denied and may have to be resubmitted once your coverage is reinstated. If you fail to make a payment before the end of the grace period for that coverage period, you will lose all rights to COBRA continuation coverage under the Plan.

You Must Give Notice of Certain Qualifying Events

If you or your Dependent(s) experience one of the following qualifying events, you must notify the Plan Administrator within 60 calendar days after the later of the date the qualifying event occurs or the date coverage would cease as a result of the qualifying event:

- Your divorce or legal separation; or
- Your child ceases to qualify as a Dependent under the Plan.
- The occurrence of a secondary qualifying event as discussed under "Secondary Qualifying Events" above (this notice must be received prior to the end of the initial 18- or 29-month COBRA period).

(Also refer to the section titled "Disability Extension" for additional notice requirements.)

Notice must be made in writing and must include: the name of the Plan, name and address of the Employee covered under the Plan, name and address(es) of the qualified beneficiaries affected by the qualifying event; the qualifying event; the date the qualifying event occurred; and supporting documentation (e.g., divorce decree, birth certificate, disability determination, etc.).

Newly Acquired Dependents

If you acquire a new Dependent through marriage, birth, adoption or placement for adoption while your coverage is being continued, you may cover such Dependent under your COBRA continuation coverage. However, only your newborn or adopted Dependent child is a qualified beneficiary and may continue COBRA continuation coverage for the remainder of the coverage period following your early termination of COBRA coverage or due to a secondary qualifying event. COBRA coverage for your Dependent spouse and any Dependent children who are not your children (e.g., stepchildren or grandchildren) will cease on the date your COBRA coverage ceases and they are not eligible for a secondary qualifying event.

COBRA Continuation for Retirees Following Employer's Bankruptcy

If you are covered as a retiree, and a proceeding in bankruptcy is filed with respect to the Employer under Title 11 of the United States Code, you may be entitled to COBRA continuation coverage. If the bankruptcy results in a loss of coverage for you, your Dependents or your surviving spouse within one year before or after such proceeding, you and your covered Dependents will become COBRA qualified beneficiaries with respect to the bankruptcy. You will be entitled to COBRA continuation coverage until your death. Your surviving spouse and covered Dependent children will be entitled to COBRA continuation coverage for up to 36 months following your death. However, COBRA continuation coverage will cease upon the occurrence of any of the events listed under "Termination of COBRA Continuation" above.

Interaction With Other Continuation Benefits

You may be eligible for other continuation benefits under state law. Refer to the Termination section for any other continuation benefits.

ERISA Required Information

The name of the Plan is:

Learning Care Group

The name, address, ZIP code and business telephone number of the sponsor of the Plan is:

Learning Care Group
21333 Haggerty Road, #100
Nova, MI 48375
248-697-9072

Employer Identification Number (EIN):	Plan Number:
431243221	502

The name, address, ZIP code and business telephone number of the Plan Administrator is:

Employer named above

The name, address and ZIP code of the person designated as agent for service of legal process is:

Employer named above

The office designated to consider the appeal of denied claims is:

The Cigna Claim Office responsible for this Plan

The cost of the Plan is shared by Employee and Employer.

The Plan's fiscal year ends on 12/31.

The preceding pages set forth the eligibility requirements and benefits provided for you under this Plan.

Plan Trustees

A list of any Trustees of the Plan, which includes name, title and address, is available upon request to the Plan Administrator.

Plan Type

The plan is a healthcare benefit plan.

Collective Bargaining Agreements

You may contact the Plan Administrator to determine whether the Plan is maintained pursuant to one or more collective bargaining agreements and if a particular Employer is a sponsor. A copy is available for examination from the Plan Administrator upon written request.

Discretionary Authority

The Plan Administrator delegates to Cigna the discretionary authority to interpret and apply plan terms and to make factual determinations in connection with its review of claims under the plan. Such discretionary authority is intended to include, but not limited to, the determination of the eligibility of persons desiring to enroll in or claim benefits under the plan, the determination of whether a person is entitled to benefits under the plan, and the computation of any and all benefit payments. The Plan Administrator also delegates to Cigna the discretionary authority to perform a full and fair review, as required by ERISA, of each claim denial which has been appealed by the claimant or his duly authorized representative.

Plan Modification, Amendment and Termination

The Employer as Plan Sponsor reserves the right to, at any time, change or terminate benefits under the Plan, to change or terminate the eligibility of classes of employees to be covered by the Plan, to amend or eliminate any other plan term or condition, and to terminate the whole plan or any part of it. Contact the Employer for the procedure by which benefits may be changed or terminated, by which the eligibility of classes of employees may be changed or terminated, or by which part or all of the Plan may be terminated. No consent of any participant is required to terminate, modify, amend or change the Plan.

Termination of the Plan together with termination of the insurance policy(s) which funds the Plan benefits will have no adverse effect on any benefits to be paid under the policy(s) for any covered medical expenses incurred prior to the date that policy(s) terminates. Likewise, any extension of benefits under the policy(s) due to you or your Dependent's total disability which began prior to and has continued beyond the date the policy(s) terminates will not be affected by the Plan termination. Rights to purchase limited amounts of life and medical insurance to replace part of the benefits lost because the policy(s) terminated may arise under the terms of the policy(s). A subsequent Plan termination will not affect the extension of benefits and rights under the policy(s).

Your coverage under the Plan's insurance policy(s) will end on the earliest of the following dates:

- the date you leave Active Service (or later as explained in the Termination Section;)
- the date you are no longer in an eligible class;
- if the Plan is contributory, the date you cease to contribute;
- the date the policy(s) terminates.

See your Plan Administrator to determine if any extension of benefits or rights are available to you or your Dependents under this policy(s). No extension of benefits or rights will be available solely because the Plan terminates.

Statement of Rights

As a participant in the plan you are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974 (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 and at other specified locations, such as worksites and union halls, all documents governing the plan, including insurance

contracts and collective bargaining agreements and a copy of the latest annual report (Form 5500 Series) filed by the plan with the U.S. Department of Labor and available at the Public Disclosure room of the Employee Benefits Security Administration.

- obtain, upon written request to the Plan Administrator, copies of documents governing the Plan, including insurance contracts and collective bargaining agreements, and a copy of the latest annual report (Form 5500 Series) and updated summary plan description. The administrator may make a reasonable charge for the copies.
- receive a summary of the Plan's annual financial report. The Plan Administrator is required by law to furnish each person under the Plan with a copy of this summary financial report.

Continue Group Health Plan Coverage

- continue health care coverage for yourself, your 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 the documents governing the Plan on the rules governing your federal continuation coverage rights.

Prudent Actions by Plan Fiduciaries

In addition to creating rights for plan participants, ERISA imposes duties upon 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, your union, or any other person may fire you or otherwise discriminate against you in any way to prevent you from obtaining a welfare benefit or exercising your rights under ERISA. If your claim for a welfare 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.

Enforce Your Rights

Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request a copy of documents governing the plan or the latest annual report from the plan 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 administrator. If you have a claim for benefits which is denied or ignored, in whole or in part, you may file suit in a state or federal court.

In addition, if you disagree with the plan's decision or lack thereof concerning the qualified status of a domestic relations order or 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 your 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.

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